State-Level Population Policies and Family Planning Service Provision in India: Case Studies of Madhya Pradesh and West Bengal

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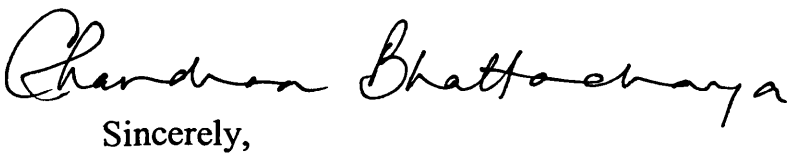


Sincerely,

Contents

Glossary of Terms

ANM	Auxiliary Nurse Midwives
BEE	Block Extension Educator
BIMARU	Literal meaning sickly – acronym for Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh
BMO	Block Medical Officer
BPHC	Block Primary Health Centre
CC	Conventional Contraception – Condoms
CHC	Community Health Centre
CMO	Chief Medical Officer
Crore	Unit of Indian Numbering System (1 crore =10,000,000)
CTT	Conventional tubectomy technique
C.N.A	Community-Needs Assessment Approach
CYP	Couple-Year Protection
DANIDA	Danish International Development Agency
DFID	Department of International Development, United Kingdom
EAG	Empowered Action Group States
ELA	Expected Level of Achievement
GOI	Government of India
ICPD	International Conference on Population and Development
IEC	Information Education Counselling
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
IUD	Intra-Uterine Device
JNU	Jawaharlal Nehru University
Lakh	Unit of Indian numbering system (1 lakh = 100,000)
LTT	Laparoscopic tubectomy
MMR	Maternal Mortality Rate
MTP	Medically terminated pregnancy
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NPP	National Population Policy 2000
NSVT	Non-scalpel vasectomy technique
OP	Oral Pills
PHC	Primary Health Centre
POA	Programme of Action
PRI	Panchayati Raj Institutions (also used as Panchayat in the text)
RCH	Reproductive and Child Health Project
RTI/STD	Reproductive Tract Infections/Sexually Transmitted Diseases
SC	Sub-centre
SIDA	Swedish International Development Agency
TFR	Total Fertility Rate
TT	Tubectomy
UNICEF	United National Children's Education Fund
UNDP	United Nations Development Programme
UNFPA	United Fund for Population Activities
USAID	United States Agency for International Development
VT	Vasectomy
WHO	World Health Organization

Abstract

This thesis investigates the historical origins and the factors leading to the adoption of State-level Population Policies in India, focussing on two case study States, Madhya Pradesh and West Bengal. It analyses the effects of the adoption of such policies on the provision of family planning services in these two States. In examining the socio-economic considerations behind adoption of these policies, the role of state level political leaders and administrators, the function of the central government, the effect of assistance from donor agencies, and the global atmosphere of a 'paradigm shift' created by the 1994 Cairo conference are analysed. The effects of a State-level Population Policy on the services provided by the Family Welfare Programme are examined by focussing on three family planning strategies: contraceptive method mix; involvement of the Panchayati Raj Institutions (community-based institutions); and, discontinuation of demographic targets, incentives and disincentives. The objects of the research, namely, population policies and family planning services were studied in India in New Delhi (the country capital), Bhopal (in Madhya Pradesh) and Calcutta (in West Bengal) and eight districts in two states and two blocks and two health centres in each district over a period of nine months. In-depth semi-structured interviews and documentary research were selected as methods of data collection. The thesis is based on qualitative and quantitative data derived from one hundred and thirty-two in-depth semi-structured interviews, a literature review, family planning performance data and NFHS data. The thesis concludes that Madhya Pradesh policy and the draft policy of West Bengal had their historical origins in national reports, state-specific policy development plans and committees. Demographic trends were considered pressing problems by the Madhya Pradesh policymakers at the time of policy adoption. Commitment and political leadership, effective officials in the Department of Family Welfare at the time and the presence of assistance from the USAID-funded Policy Project led to the adoption of the policy. In contrast, for West Bengal, formulation of the draft was simply a result of following national recommendations without any involvement of external population policy experts. Madhya Pradesh was found to be providing a greater range of contraceptive methods in comparison to West Bengal. In both States, Panchayat representatives were not much involved in the functioning of the Family Welfare Programme. Madhya Pradesh was found to be actively setting demographic targets and was putting pressure on health workers to achieve such targets. Evidence of the disqualification of Panchayat leaders based on a two-child norm was found in Madhya Pradesh. No such evidence was found in West Bengal.

It needs to be mentioned that a substantial part of the text of Chapter 6 is to be published as a chapter titled "Examining Quality of Care in family planning service provision at the state-level in India: Case studies of Madhya Pradesh and West Bengal" in a forthcoming book 'Population, Reproductive Health and Development: Issues of Choice, Gender and Rights', published by Population Foundation of India.

Finally I take this opportunity to acknowledge the help and support of the following people without whom this thesis would not have been completed: Mr. S.N. Menon, Dr. Dipendra Das and Dr. Bhaswati Das in New Delhi, Mr. Bijan Saha and Dr. Ashok Sharma in Bhopal, Mr. Gautama and Mrs. Leena Chakraborti in Calcutta, Prof. Tim Dyson, Dr. Ernestina Coast, Dr. Peter Levin, Prakash Fernandes, and finally Suhrita Bhattacharya, Nandan Bhattacharya, Churni Bhattacharya and Milton D'Costa.

Chapter 1: Introduction

1.1. Research context

Population policies are statements of demographic objectives of governments to affect changes in fertility, mortality and migration. Family planning programmes constitute a set of measures to achieve anti-natalist policy objectives. India was the first country in the world to adopt a family planning programme in 1952 (Merrick 1996; Swaminathan et al 1996) although the country did not have an official national population policy until 2000. This research explores the factors leading to adoption of population policies at the state-level in India focussing on two case study States, Madhya Pradesh (MP) and West Bengal (WB). Madhya Pradesh adopted a State-level Population Policy in 2000 and West Bengal currently has a draft policy. It analyses the effects of adoption of State-level Population Policies on the provision of family planning services in these two States.

A population policy addresses three elements of a human population, namely, fertility, mortality, and migration. Depending on context, the policy outlines various demographic goals along with the strategies of action that are designed to fulfil them. The literature contains many definitions as to what might constitute a population policy. Berelson (pp 173, 1971) defines population policy as any "*actions by government,* whether statements of position, laws, decrees, or administrative programmes" when they are directed towards the human population. Driver (1972) on the other hand as quoted in Mahadevan (1989) has described all "direct and indirect measures" of a government which influence the "size, distribution, or composition of human population" as a population policy. The United Nations Population Commission (1974) as quoted in Raina (pp 4, 1988) defined such a policy as "measures and programmes designed to contribute to the achievement of economic, social, demographic, political and other collective goals through affecting critical demographic variables, namely, the size, and growth of population, its geographical distribution (national and international) and its demographic characteristics". Demeny (2003) summarised these views in his definition of these policies as the ones that "are deliberately constructed or modified institutional arrangements and/or specific programs through which governments influence, directly or indirectly, demographic change" (pp. 2, 2003). Though the above definitions regard any government measures designed to affect

the size, growth and distribution of the human population as population policies, only Berelson (1971) specified what types of such government measures can be considered 'population policy', including: any legislative acts, bills, decrees, administrative measures like government schemes, changes to the existing family planning programme, and statements of position by the government that are directed towards changing the size, growth and distribution of a human population. However, it needs to be stated here that according to the Constitution of India a governmental action becomes an official population policy when it is cleared both by the cabinet (the executive) and the parliament (the legislature) (Basu, 1960, Chaubey 2001).

Since the middle of the last century developing countries, especially in Asia, witnessed rapid population growth leading to concerns about it and its relationship with economic underdevelopment (Sinding, Ross and Rosenfield 1994, Caldwell 1996). Surveys of knowledge of, attitude towards and practice of (KAP) family planning in these countries showed there was a high proportion of couples wishing to space or limit childbearing who were not practicing any form of family planning (Casterline and Sinding 2000). In order to ensure the effective implementation of family planning programmes, donor agencies such as the World Bank and research institutes such as the Population Council proposed different family planning strategies or action plans. These strategies include: information, education and communication (IEC); provision of contraceptive methods; manipulation of desired family size through incentives and disincentives; changing social institutions (for example, age at first marriage); improving child mortality levels in order to affect fertility preference; involvement of community in service delivery and programme management; and, employing coercion to achieve desired demographic objectives (Berelson 1974, Korten 1975). At the beginning of the Twenty First century, there is broad agreement about the positive impact of these programmes in reducing global fertility and restricting the world population to below 10 billion (Caldwell et al 2002).

The population of India crossed the one billion mark in 2000 and is expected to reach 1.26 billion by 2016 (Wadhva et al 2003). Population scientists like Srinivasan (1996) suggest that India is in the fourth or the final stage of its demographic transition. The national total fertility rate (TFR) is 2.6 children per woman though there is significant inter-State variation of TFR from 1.5 in Kerala to 3.8 to Meghalaya (NFHS 3, Government of India

2005-06). However, thirteen percent of Indian women aged 15-49 still have an unmet need for family planning (NFHS 3, Government of India 2005-06). Faced with the problem of rising rate of population growth and socio-economic underdevelopment, India adopted the Family Planning Programme in 1952 (renamed Family Welfare Programme in 1982) to operationalise its anti-natalist objectives. The programme has evolved over the past five decades, and seven broad phases to controlling population growth can be identified (Visaria 1994, Simon 1996):

(1) clinic-oriented approach (1952-64);

(2) extension approach (1964-71);

(3) target-based approach simultaneously along with other approaches (1969-1995);

(4) intensive approach during national Emergency (the President of India proclaimed failure of the constitutional machinery leading to political instability of the country from 1975-77) (1971-77);

(5) development based welfare approach (1977-1995);

(6) target-free approach (1996-97);

(7) a community-needs assessment approach (1997 to present).

India is one of the 180 signatories to the Programme of Action (PoA) of International Conference on Population and Development (ICPD) held in Cairo in 1994. As part of its commitment to ICPD and the implementation of reproductive health services, it adopted a target-free approach when demographic target-setting was abolished nationally in 1996. In 1997, World Bank funding facilitated implementation of the "Reproductive and Child Health Project" at district (an administrative sub-division in a State) level. Reproductive health is also reflected in the objectives and strategies of the National Population Policy (2000), although the official name of the Indian family planning programme remains the Family Welfare Programme since 1982.

> "The National Population Policy, 2000 affirms the commitment of (the) government towards voluntary and informed choice and consent of citizens while availing reproductive health care services, and continuation of the target-free approach in administering family planning services" (pp 2, National Population Policy 2000).

At the State-level, since 1997 a majority of Indian States adopted and are in the process of making their own population policies, breaking with the tradition of more than four decades

under which population policy making occurred at the national level only. So far, twelve out of twenty eight States have formulated their own population policies. First was Andhra Pradesh in 1997, followed by a gap of two years with Rajasthan on July 31, 1999. Then came Madhya Pradesh on January 2000, behind it was Gujarat on May 11, 2000, Uttar Pradesh on July 11, 2000, Uttaranchal and Maharashtra in March 2002, Haryana in 2003, Jharkhand in 2004, Bihar and Tamil Nadu in 2005 and Chhatisgarh in 2006. By focusing on three family planning strategies, namely provision of different contraceptive methods; involvement of the Panchayati Raj Institutions – community-based institutions in the Family Planning Programme; and use of demographic targets, incentives and disincentives, this thesis examined the provision of contraceptive services at the state-level. It hypothesized to find a positive relationship between the State-level Population Policy and the provision of family planning services by comparing the findings in Madhya Pradesh and West Bengal. This introductory chapter discusses the conceptual framework and the research context focusing on the research questions. Secondly the research design is highlighted and finally the chapter ends with a discussion with the structure of the thesis.

1.2. Emergence of the Research Questions

Indian population policies in general, and the Family Welfare Programme in particular, have been closely examined and analysed over the last four decades. Much of this work has focused on the historical development of the population policy (Banerji 1989; Conly and Camp 1992; Narayana and Kantner 1992; Visaria and Chari 1998), during the Emergency (1975-77) when the President of India declared failure of the country's constitutional machinery leading to political unrest in the country (Panandiker *et al* 1978; Gwatkin 1979; Pethe 1981; Panandiker and Umashanker 1994), and during the recent period of the transition toward reproductive health approach (Farrell *et al* 1998; Visaria and Chari 1998; Visaria and Visaria 1998; Hardee *et al* 1999; Visaria *et al* 1999; Reddy *et al* 2000; Donaldson 2001; Khan and Townsend 2001). Much has been written on the relationship between the central government (interchangeably referred as Centre in the text) and the States (Conly and Camp 1992; Narayana and Kantner 1992; Panandiker and Umashanker 1994) and on quality of care after reproductive health programme implementation (World Bank 1995; Koenig *et al* 2000) and on the implementation of the target-free approach when the central government abolished demographic-setting for the entire nation (Srinivasan

1996; Rao 2000; Reddy *et al* 2000; Donaldson 2001; Khan and Townsend 2001). The studies that looked at the target-free approach have focused their attention at the national level (Merrick 1996; Farrell *et al* 1998; Visaria *et al* 1999; Sen and Ramachandran 2001) and some have examined the impact of the adoption of the National Population Policy in 2000 (Donaldson 2001; Sen and Ramachandran 2001; Visaria 2001). However, very few studies have examined family planning service and policy implementation at the state-level, and those that did pre-date 2000 when the National Population Policy was adopted (Pethe 1981, Banerji 1989, Srinivasan *et al* 1991, Visaria and Visaria 1998).

Despite this extensive body of work, research into the process of adoption of population policies by individual States remains limited, in part because evidence pertaining to State-level Population Policies has become available only recently. Studies that have examined States with population policies (Sen and Ramachandran 2001; Visaria 2001; Wadhva et al 2003; Badri *et al* 2004; Dass 2004; Rao 2005; Reddy 2005) have analysed their content, in particular the use of incentives and disincentives as family planning strategies and their divergence with the objectives of the National Population Policy 2000. In reviewing the Indian population policy scene in the context of adoption of this policy, Visaria (2001) touched upon three State-level Population Policies that were adopted by 2001. Unlike others who have criticized these policies (Sen and Ramachandran 2001), Visaria provides recommendations that include political commitment, people's participation, substantial improvement in the rural infrastructures and proper training of the health workers. However, none of these studies have analyzed these policies in-depth, nor have they explicitly examined the impact of policies on the Family Welfare Programme. A knowledge gap therefore exists in relation to the cause of the emergence of these State policies and their impact on the Family Welfare Programme. This hiatus produces a series of related research questions:

- **Why have State-level Population Policies been introduced in some States, but not others?**
  - **What are the historical origins of State-level Population Policies (both at the national and State-levels)?**
  - **What are the socio-economic considerations that have given rise to such policies?**

- **What effects have the adoption of State-level Population Policies had on the services provided by the Family Welfare Programme?**

In order to examine the processes associated with State-level Population Policy adoption and their potential impact on the Family Welfare Programme, this study draws on evidence from two contrasting States, Madhya Pradesh and West Bengal. Madhya Pradesh is the seventh most populated State of the country being the second largest State geographically (Census 2001). Ever since 1980s, it has been termed as one of the *BIMARU* states - (literal meaning sickly but acronym stands for Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, the four poor performing northern States) by the Centre because of its poor demographic performance. On the other hand, until 1980s West Bengal was included in the group of BIMARU States by the Centre because of its high population density (West Bengal Human Development Report 2004). Since then, however, West Bengal has done relatively better demographically mainly due to the success in implementation of the family planning programme (Srinivasan 1995). Politically, Madhya Pradesh has shared an amicable relation with the Centre because of the rule of the Congress Party both at the Centre and at the State. In contrast, the thirty years old Communist government of West Bengal has always had a lukewarm relation as it has been in the opposition in the Centre. In recent years, both nationally and internationally, Madhya Pradesh has been hailed because of its model of political decentralisation "Gram Swaraj" (district government) (Manor 2001; Behar 2003) and industrial and agrarian reforms have begun to show signs of improvement (Kela 2003). On the other hand, West Bengal's nationally acclaimed agricultural performance and decentralisation through Panchayati Raj institutions of the past two decades have plateaued with industry, higher education and public finances deteriorating considerably in recent years (Banerjee et al 2002).

As part of the World Bank's review of the Indian Family Welfare Programme, Merrick (1996) recommended three key issues for India to consider moving from a target-oriented family planning programme to a Reproductive Child Health programme: contraceptive method mix; community involvement; and, discontinuation of demographic targets, incentives, and disincentives. He discussed their importance for the country as a whole in

order to make the programme more client-oriented (pp 13:23, 1996). This study uses and builds on Merrick's framework by focusing on these three areas.

Contraceptive method mix

Koenig, Foo and Joshi (2000) reviewed literature on India's Family Welfare Programme based on the 'quality of care' framework (Donabedian 1988; Bruce 1990), examining the provision of a range of contraceptive methods. The study found that it is service providers who decide the type of contraceptive method, with an emphasis on female sterilisation since the 1980s (pp 4:5, 2000). Preference by a provider in India for both reversible and irreversible methods is a good indicator to understand the client-focus of the providers. This highlights a transition from an era of (irreversible) method –specific family planning targets to an client-friendly need-based choice-oriented service. It is also a "good example of the compatibility of demographic and individual reproductive health goals and illustrates the importance of making sure that demographic objectives at the policy level do not govern the *implementation* of efforts to improve mix of methods" (pp. 20, Measham and Heaver 1996). Hence, the thesis, by examining how this strategy is used by Madhya Pradesh and West Bengal, wanted to find out:

- **What is the range of contraceptive methods available and how has this range changed between 1996 and 2004 in both Madhya Pradesh and West Bengal?**
- **To what extent can trends in the range of contraceptive methods available in Madhya Pradesh and West Bengal be interpreted as a result of the (non-) adoption of State-level Population Policies?**

Community involvement

It is important to examine if there is a differential, and why is it so, between policy and non-policy States in involving the Panchayati Raj Institutions (interchangeably used as panchayat) - the locally elected rural self-government bodies with a three-tier administrative machinery - for implementing and monitoring family planning service provision under the reproductive health integration process. By analysing how their

involvement is also helping to address needs of the community in Madhya Pradesh and West Bengal, the research tried to answer the following questions:

- **To what extent, and how, are the Panchayati Raj Institutions involved in the Family Welfare Programme provision in each State?**
- **What roles do the Panchayati Raj Institutions play in providing family planning services at the village level?**

Discontinuation of demographic targets, incentives, and disincentives

Removal of demographic targets, incentives and disincentives is a policy initiative that bases a programme on the needs and desires of individuals and on the quality of care. Achievement of this policy goal for improving the quality of care requires provision of a range of contraceptive methods, reflecting a client-oriented approach. Implementation of this policy objective needs involvement of the community in implementation and monitoring and the evaluation of such programme action. Hence the research wanted to investigate:

- **To what extent are demographic targets, incentives and disincentives being used in Madhya Pradesh and West Bengal?**

1.3. Research Design

Due to the exploratory and explanatory nature of the study, the objects of the research, namely population policies and family planning services, were studied in India in their natural settings for a period of nine months. The fieldwork was conducted in three study sites, Delhi the country capital, Bhopal in Madhya Pradesh, and Calcutta in West Bengal. Case study was chosen as a strategy to find in-depth knowledge about the research topics. In-depth semi-structured interviews and documentary research were selected as methods of data collection. The research design had elements of both flexibility and pre-structuring. Most of the planning was done based in London before the fieldwork. The planning involved initial identification of the interview respondents, designing the topic guide, developing the time-table to conduct the fieldwork and operationalising the research

questions. But only after going to the field were the practical details finalised. These included establishing contacts with the interview respondents, conducting three pilot testing and pre-testing of topic guides, decisions on sampling patterns, and honing and finalising the topic guide.

1.4. Thesis Structure

This thesis is written in seven chapters, including this one. Chapter two elaborates the research design and use of a cross-State comparative case-study research strategy to answer the research questions. It outlines the use of documentary sources and semi-structured interviews for data collection, the operationalisation of the research questions, linking them with the topic guide and the data collected. Finally, it highlights in detail the planning and preparatory processes in developing the research design and issues of language, access and relationship with the interview respondents.

Chapters three and four review the literature that informs the study's conceptual framework. Chapter three reviews literature on the historical origins of State population policies and explores the factors that led to State-level Population Policy adoption in Madhya Pradesh, but not in West Bengal, including state-level political commitment, function of the bureaucracy, involvement of donor agencies, attitudes of the central government, and the impact of ICPD. Chapter four contextualises the international and national literature exploring the evolution and use of different family planning programme strategies, including the range of contraceptives, involvement of community-based institutions in the family planning service delivery, and the (non-) use of demographic targets, incentives and disincentives.

Chapters five and six present the data and their analysis. Chapter five presents evidence (both primary and secondary) relating to State-level Population Policy development in Madhya Pradesh and West Bengal. Chapter six compares the family planning performance of Madhya Pradesh and West Bengal, using the Evaluation Project framework (1994). It also examines the relationship between the adoption of a State-level Population Policy and Family Welfare Programme performance. Finally, the thesis is concluded in chapter seven

where key arguments from the findings are analysed against the conceptual framework. It also examines the future implications of the research.

Chapter 2: Methodology

2.1. Conceptualising data collection

This chapter is an account of the entire process of research inquiry from planning, to collecting and analysing the data collected during the fieldwork. The study uses a case study research strategy in two contrasting States, Madhya Pradesh and West Bengal. Due to the exploratory and explanatory nature of the study, the objects of the research, namely State-level Population Policies and the Family Welfare Programme were studied in their natural settings for a period of nine months. The case study approach was chosen as a strategy to find in-depth knowledge about the research topics.

The objective behind such a decision was to conduct a cross-State comparative analysis of findings in order to examine a possible causal relationship between the two research objectives. The fieldwork was carried out over nine months in three Indian cities, New Delhi, Bhopal (in Madhya Pradesh) and Calcutta (in West Bengal) and eight districts in two States and two blocks and two health centres in each district. The exploratory nature of the study demanded a combination of pre-structuring and flexibility. Pre-structuring involved planning and preparation prior to data collection. It comprised of three pilot studies prior to the start of fieldwork, sampling decisions on selection of study sites and interview respondents, topic guide design and plans for data analysis. During the fieldwork the in-depth semi-structured interviews and documentary research provided room for flexibility in exploring the research topics.

The chapter begins with a discussion of the research strategy. This section describes the methods of data collection and the operationalisation of the research questions in linking the methods with the data collected. Secondly, planning and preparing of the fieldwork is examined. The section enumerates pilot studies, sampling decisions in terms of choice of study sites and interview respondents, access to interviews and language and transcription and plans for analysis of data. The final section highlights how issues of confirmability, dependability, credibility and transferability were dealt with in the research.

2.2. Research Strategy

Case studies are one of the common research strategies employed in social science research. In qualitative research, the rationale behind studying cases of interest is to "gather comprehensive, systematic, and in-depth information" (pp. 447, Patton 2002). It is all about studying the specifics, the unique aspects of what we are interested in. Because of their value in qualitative research, case studies can be differentiated by the objective and purpose of the studies undertaken (Stake 1995, 2002), number of cases to be studied, and the number of researchers involved in that inquiry (Miles and Huberman 1994, Yin 1994, Patton 2002, Robson 2002,). However, debate exists as to the purpose and interest of cases between particularity versus generalisability and as to how much generalisation one can make from studying a case. Robson (2002), for example, is of the opinion that cases lack the basis needed to make scientific generalisations. Yin (1994) and Maxwell (1996) argue that theoretical generalisations (covering different perspectives and insights on one topic) can be made when multiple cases are studied. However, these generalisations are not to be made for larger populations or for the bigger contexts. One of the common concerns raised against case studies is the absence of rigour on the part of the investigator. By that the critics mean that in an attempt to find out everything about a case, the investigators sometimes use doubtful evidence and biased views that influence their data collection process and drawing of conclusions (Yin 1994; Robson 2002). On the other hand, if hard and thorough work is put in when studying a case, investigators get the chance to employ different sources of evidence, or triangulation (Yin 1994; Robson 2002; Stake 1995, 2000). As a result, they get the advantage of developing "converging lines of inquiry" leading to a more convincing and accurate conclusion (pp. 98 Yin 1994). Moreover, employing case study over other research inquiries (like experiments and surveys), gives the advantage of studying a contemporary phenomenon in its context (Yin 1994, Robson 2002).

To serve the purpose of the research, case study was chosen as the research strategy after carefully examining strategies like ethnography that studies a culture following participant observation and grounded theory focussing on generating theory from the data collected. The rationale behind this choice was to understand in-depth the reasons behind the adoption of a State-level Population Policy and the process of its formulation, and to analyse its impact on the Family Welfare Programme. However, the ulterior motive or the 'external

interest' as Stake (2002) calls it, was to understand the history behind the origin of State-level Population Policy in India and any relationships between their adoption and changes in Family Welfare Programme. In India so far, twelve out of twenty-four States have adopted population policies. Purposive sampling was used to select a policy and a non-policy State, the rationale of employing this kind of sampling was to select an "information-rich case" that "yields insights and in-depth understanding" (pp. 230 Patton 2002).

The selection of Madhya Pradesh was based on three key concerns. First of all, considering the focus of the research meant that a policy State should be chosen with a relatively high total fertility rate and a relatively high population growth rate, leading to an emphasis on family planning services. Secondly, Madhya Pradesh was one of the earlier States to announce a policy. As a result, it was a good case to investigate the effect of the policy on the provision of family planning services. The population policy was announced in 2000 so there was four years' of data that could be collected before the fieldwork commenced. Thirdly, during the planning stage it was realised that gaining access to government officials and administrators who were the potential interview respondents would be easier due to some contacts already established in the State. Stake (1995, 2000) differentiates cases between an intrinsic case, (the one that is studied due to an intrinsic interest in its particularity), and an instrumental case (the one that is studied to provide insight on an issue and to redraw generalisations). Going by this distinction, Madhya Pradesh was an instrumental case as it was examined to provide insights about the phenomenon of State-level Population Policy and their influence on the changes in the provision of family planning services.

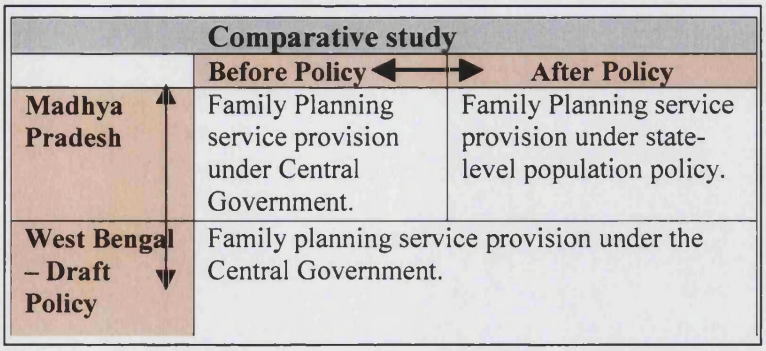
In order to analyse whether State population policies in any way influenced the changes in the family planning services, comparative analysis of the findings for a policy State with a non-policy State (a State which has not officially adopted a policy but could have drafted one) was necessary. Cross-State analysis would help in going deeper in understanding this relationship and in developing more sophisticated descriptions and more powerful explanations. Moreover, analysing more than one State would help to construct a stronger hypothesis built through examination of similarities and differences across the States (Miles and Huberman 1994). So the logical question that comes to mind is what would be the

optimum number of cases to be studied for such analyses. While discussing two approaches, namely, 'case-oriented' and 'variable-oriented', Miles and Huberman (1994) have discussed this issue. Under the case-oriented approach, specifics of cases are studied in-depth and then a comparative analysis is done of usually a limited number of cases. On the other hand, following the variable-oriented approach, concepts and theory are developed after studying a large number of cases. So instead of giving priority to the details of a specific case, it is the variables across the cases that determine the analysis. Therefore, taking the research topics into consideration, the decision was taken to study in-depth the specifics and complexities of one State with a policy and compare it with another State that has not adopted a policy.

Consequently, non-policy States from the north of India were considered, taking into consideration the similar socio-economic context. Following purposeful sampling, I chose West Bengal. First of all, despite the difference in political leadership between the State and the Centre, since 1952 West Bengal has been following the central government's guidelines in implementation of national population policy and family planning programme. Therefore, it provided a good opportunity to compare the family planning services of a State, following the national prescriptions with a State with a State-level Population Policy (Madhya Pradesh). Furthermore, due to political stability as a result of the presence of a Marxist regime for the past thirty years, there has been an uninterrupted policy and programme implementation in the State. Technical considerations including good data access and interviewee identification, and my proficiency in the State's official language (Bengali) also influenced the selection decision.

The cross-State comparative analysis of the data was done at two levels. The first consisted of a comparison of the family planning service provision focusing on the family planning strategies before and after the formulation and adoption of the policy in Madhya Pradesh. At the second level, the family planning service of Madhya Pradesh and West Bengal were compared (as illustrated in the diagram 2.1 below). This analysis is done in Chapter 6.

Diagram 2.1



2.2.1. Methods of data collection

Interviews play a significant role in the case studies presented here. In order to understand the complexities of a case, they help in getting different perspectives, descriptions and interpretations of it (Yin 1994). In-depth semi-structured interviews were appropriate to examine the State-level Population Policy and Family Welfare Programme in order to study the actions and decisions behind their adoption in their social, cultural and political context. To conform to the purpose of case studies of collecting data from multiple sources, it was important to corroborate the interview data with other sources (Yin 1994), and so documentary evidence was used wherever possible.

2.2.1.1. Interviews

In-depth semi-structured interviews were considered to be ideal sources of data for the research. The interview respondents reported the data through their descriptions and interpretations of the interview topics (Yin 1994, Stake 1995, Patton 2002). A combination of certain degree of structure along with openness was employed to capture respondents' opinions and insights about the interview topics. As a result the research topics were defined ahead of the interviews and the topic guides were formulated within the conceptual and contextual framework (Lincoln and Guba 1985). However the degree of structure varied from one topic to another. When I was looking for the accounts of how and why the State level Population Policies were formulated, and issues relating to the whole process of policy formulation, the interviews were more in the form of conversations. The questions

were less structured and more flexible in terms of the topics discussed in order to explore and understand the history of policy adoption. Also, no definite structure was followed in the order in which they were discussed. On the other hand, more structure was employed when the conversation was on specific topics relating to the family planning service provision. Due to the variety of issues related to the Indian Family Welfare Programme that could have been raised during the interviews it was important to structure the interviews keeping in mind the focus of my research.

In total, one hundred and thirty two interviews were conducted. Unlike the small sample sizes used in some in-depth interviews leading to problems of representativeness (Campbell et al 1999), there was no problem of poor representation in the present work. I employed purposeful sampling to identify the respondents. Maxwell (1996) quotes Weiss (1994) who describes respondents of such sampling as those who are "uniquely able to be informative because they are expert in an area" (pp. 70 Maxwell 1996). Also the relatively large sample size took care of the problem of "key informant bias" meaning reliance on a small group of informants whose views are typical and therefore lacking diversity of insight and perspective (Maxwell 1996). Going by the types of triangulation espoused by Patton (1987) and Denzin (1988), by using a large sample size the study employed "theory triangulation" covering different perspectives on the same topics and data, countering any threats to the authenticity of the data that were collected.

2.2.1.2. Documentary Analysis

During the fieldwork, I collected relevant documentary evidence including: annual Family Welfare Programme performance data at the district and block levels; government letters; memoranda; communiqués of both the Government of India and the State governments; written reports of workshops and meetings; and, publications and reports on population policy and family planning programme from various government offices. I also collected newspaper clippings on population policies and reporting on the family planning programme from 1999, when the process of policy formulation started, to early 2005. A wide range of sources were consulted, including government department, libraries, research institutes, INGOs and NGOs.

One of the advantages of using documentary research, is its non reactive and unobtrusive nature (Robson 2002, Ulin 2002). Unlike other research methods, where the influence of the investigator plays an important role, collection of documents is one method where there is little room for investigator bias. Documentary research also gives the history of an event which is available through writings and reporting from the past (Ulin 2002). For this study, documents played an important role in examining the historical origins of State-level Population Policies. However, like all research methods, it has its limitations. Yin (1994) warns against use of documents as they should not be "accepted as literal recordings of events that have taken place" (pp. 81, 1994). Furthermore documents should be used cautiously as the objective like specific purpose and specific audience for whom it was intended is not always known (Yin 1994, Stake 1995). Yin (1994) goes on to say that the importance of use of documents in case studies lies in their usefulness to confirm and augment evidence from other sources as part of triangulation. As a result, the research employed a second type of triangulation called methodological triangulation (Patton 1987, Denzin 1988) whereby same the data are collected using interviews and documents to corroborate their authenticity (Yin 1994, Robson 2002)

Operationalisation of the research questions

Pre-structuring was employed during the planning stage, as the research involved multiple-site data collection when time constraints and data overload were two possible issues to be faced (Miles and Huberman 1994). Before beginning data collection, it was essential to ensure that each component of the research was compatible with one another. It was also important to find out how methods of data collection would help to me collect the right kind of data needed to answer the research questions. I developed a table operationalising the research questions. This table linked the research questions with the topic guide and types of data needed and the data sources to be explored. During the fieldwork it served the purpose of a "data-collection map" or a guidebook since it helped to remain open to constant checking of the data collected and extending findings of data when needed (Appendix 1).

Plans for analysis – the selection of indicators

During the planning stage of the research, decisions were taken on the selection of indicators that would be used to analyse the research findings against the research questions. The indicators (Appendix 1) were compiled from a variety of sources and customised for the purpose of the research. The key sources used were the handbooks of indicators for evaluating family planning and reproductive health programmes by the Evaluation Project, 1994, of the United States Agency for International Development (USAID). The indicators discussed in these handbooks have been widely used in the family planning literature. The objectives behind developing these handbooks were to compile all family planning indicators into a single source and to provide a consistent definition of the indicators (Bertrand et al 1994). These indicators were used both for analysing the population policy environment as well as to evaluate the changes in the family planning services. Taking the lead from these handbooks, with the same set of indicators, the Population Technical Assistance Project of USAID, in 1997 came out with a series of toolkits for evaluating population policy environment and family planning and reproductive health programmes. This study has used some of the indicators from these toolkits for analysing the policy environment, the socio-economic factors attributing to policy adoption and family service provision in Madhya Pradesh and West Bengal. However, they were modified and reworded for the need of the study but keeping the purpose of the indicators. Also, some of the quantitative indicators were customised to provide qualitative measures.

Thus, this section has discussed the selection of a case study approach as the strategy for this research. It argued how purposeful sampling was employed to choose Madhya Pradesh as an instrumental case to conduct a comparative analysis with West Bengal. The section also deliberated on the use of case-oriented approach in the research to examine the specifics and complexities of the two States. Further, it discussed employing in-depth semi-structured interviews and documentary research as the two main methods of data collection. The study used one hundred and thirty two in-depth semi-structured interviews conducted during the fieldwork. It also used Family Welfare Programme performance data, government letters, memoranda, government and academic reports and newspaper clippings. The section also discussed benefits of use an "Operationalisation Table" which linked the topic guide with data and served as a guidebook during the fieldwork. Finally, it talked about the selection of indicators from the handbooks produced by the Evaluation Project that were linked to the corresponding interview and research topics for data

analysis. The next section elaborates the process of planning and preparation before the start of the fieldwork.

2.3. Planning and Preparing

Getting acquainted with the research context, and understanding the complexities of the fieldwork, was essential before commencing it. First of all, it was essential to decide on the sample size regarding number of study sites (number of districts, number of blocks in each district and number of health centres each block) and number of interview respondents at different levels. Secondly, access to the interview respondents was a crucial element for data collection. Therefore establishing contact in New Delhi and for the State-level interview respondents in both States and developing the topic guide for different categories of interview respondents had to be done prior to the fieldwork. Despite my knowledge of the country as an Indian national, it was important to understand the social, political and cultural difference in realities of the two States. Furthermore as a researcher it was during the fieldwork that I first visited rural India. Therefore conducting pilot studies was essential to test my research tools.

2.3.1. Pilot studies

Much has been written on the importance of pilot studies, especially for case studies (Maxwell 1996; Robson 2002; Ulin 2002). Yin (1994) distinguishes between pilot testing and pre-testing based on the time when the testing is done. A pilot test is conducted to refine data collection plans in the formative stage of the research whereas pre-testing is the "formal dress rehearsal" (pp 74, Yin 1994). In order to get accustomed to the context of the research, I had visited India twice before the actual fieldwork commenced. It was during these visits that the first two pilot studies were carried out. The first pilot study was conducted in December 2002 in Delhi. The main purpose of the study was not only to examine the feasibility of the research but also to establish access to potential respondents. After identifying a couple of key respondents (official in the Department of Family Welfare, Government of India and programme manager of UNFPA), three background interviews were carried out. These background interviews served three purposes. First, they

helped to form an understanding of the realities and examine the policy and programme environment. Second they led to sources for collection of information in the form of documents (official reports and publications) on population policy and family planning programme. Third, they helped to establish access to people who were going to be the potential key respondents for the fieldwork. Based on the trip to New Delhi, I was able to determine the ways of establishing access to key respondents in the case study States; this was based on snowballing from initial contacts.

The second pilot study was conducted at the end of 2003. There was a gap of one year between the two pilot studies because the first one was an exploration of the field and the second study was conducted after the major review. The purpose of this study was to get a feel of how family planning services are provided in the field. I established contact with an NGO, called CINI (Child in Need) ASHA, in West Bengal. Through them, a health centre was visited, and the environment on a busy clinic day, and the relations between the clients and the health workers were observed. During this trip, a list of names of potential respondents in West Bengal for the fieldwork was collected. This study helped in the sampling decision for choosing districts. Initially, I had planned to select districts based on presence or absence of a NGO implementing the Reproductive Child Health (RCH) programme of the Government of India. The rationale behind this was to find inter-district difference in family planning performance based on presence or absence of a NGO implementing RCH programme. But it was only through this study I found out that by then majority of the districts had RCH NGO presence. Furthermore this study also made me aware of the dynamics of the relationship between a health worker and a NGO person and to ensure zero presence of anybody other than the interview respondent during my interviews. In my interview with the health worker it was the NGO person who dominated the entire interview and the health worker hardly spoke.

Before starting the final data collection the third pilot study was carried out April 2004 as a combination of pilot test and pre-test. It tested the interview questions and finalised the sampling. The study was conducted just before the main data collection began. This was a study to test the interview questions and also the effectiveness of the tape recorder. I did the study in the Birbhum district in West Bengal, and interviewed four key informants, one from each of: female health worker; male health worker supervisor; village panchayat

representative; and a representative of a local NGO. This was a good lesson to think about ways of establishing access to the respondents and modifying the topic guide.

2.3.2. Sampling decisions

> "Whenever you have a choice about when and where to observe, who to talk to, or what information sources to focus on, you are faced with a sampling decision" (pp 69, Maxwell 1996).

Purposeful sampling was chosen as the preferred technique to select samples, as in the majority of qualitative studies. Sampling decisions were needed to achieve representativeness of the States studied. So in order to collect data representative of a State, I decided to cover all the administrative levels of the Departments of Family Planning starting from State to district, to block levels and finally down to the sub centre levels. These administrative levels were chosen keeping in mind the presence of the corresponding panchayat representatives in each level. It needs to be mentioned here that a State is divided into districts, a district is then divided into blocks and within a block, the health service is divided into primary health centres. Similarly, each primary health centre area is then divided into sub centres. Since parity with the panchayat representation was maintained, the primary health centre level was skipped as there are no corresponding Panchayati Raj levels. The sampling decision was employed at all levels in the selection of districts, blocks and sub centre levels. Moreover, sampling was used to identify the interview respondents. With regard to the choice of districts in a State, the districts were selected based on heterogeneous sampling. The selection was based on family planning performance data included in the annual reports from the Departments of Health and Family Planning in each State. In West Bengal, Burdwan is the best performing district, South Dinajpur is the worst performing, and Hoogly and Birbhum are close to the median. Similarly in Madhya Pradesh, Khargone is the best performing district among the rural districts, Rajgarh is the worst performing, and Vidisha and Betul are close to the median. The selection of blocks in each district was based on proximity to urban life (geographic location and number of towns) and the level of socio-economic development (literacy rate, employment rates, and number of industrial establishments, factories). The choice of the sub-centres was based on random sampling. As a check on whether the sample size was sufficient for a good

representation of a State, data collection continued in the first State until information saturation was reached (Robson 2002, Ulin 2002).

To sum up, in West Bengal, four districts were selected namely, Burdwan, Hoogly, Birbhum and South Dinajpur (as shown in diagram 2.2). In each district, two blocks were chosen and in each block one sub centre (as shown in the diagram 2.3 below the map)

Diagram 2.2: Fieldwork districts, West Bengal

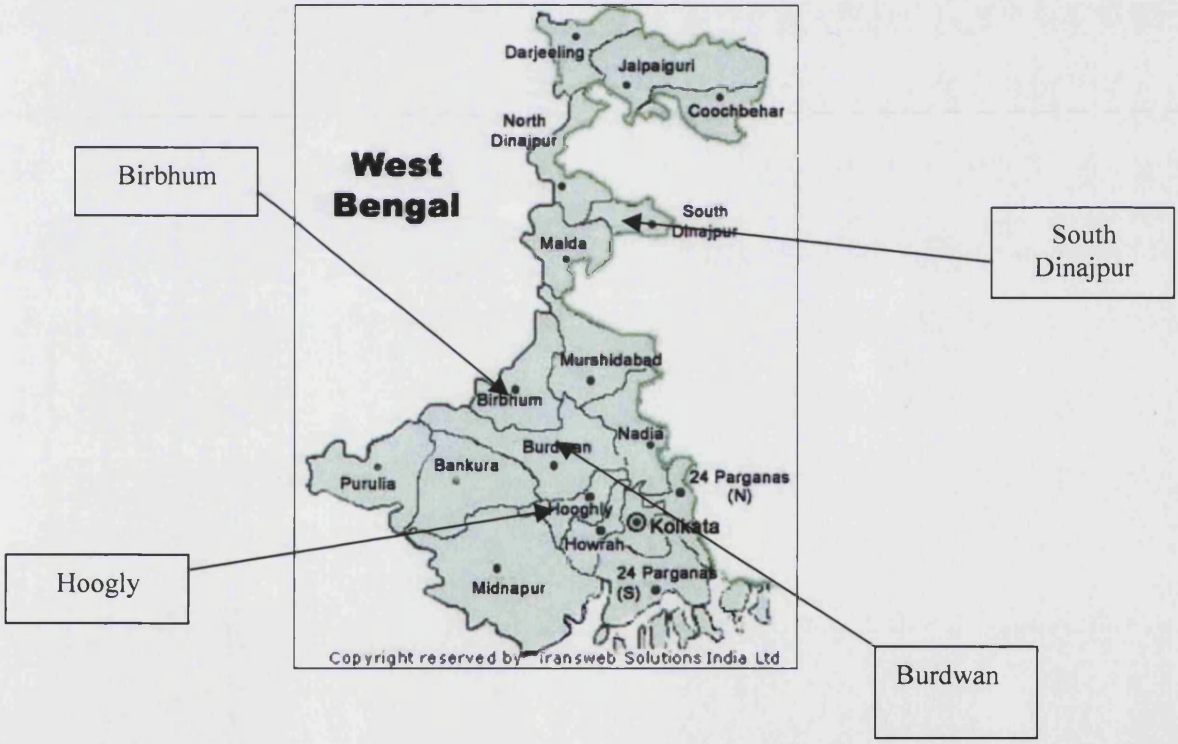
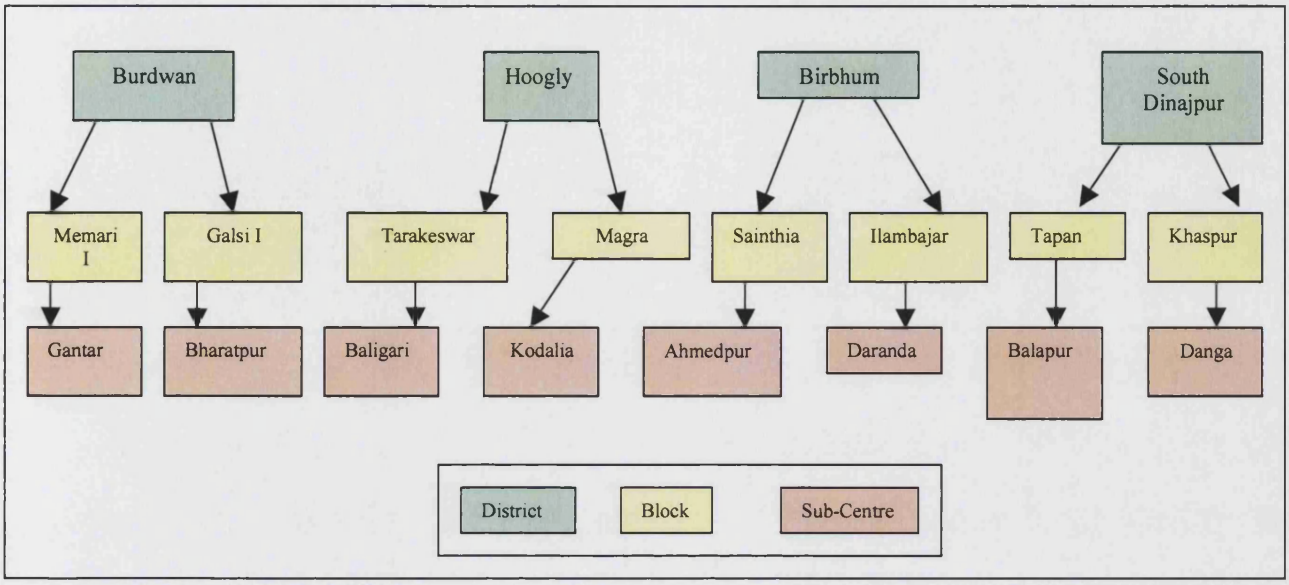


Diagram 2.3: Study sites in West Bengal



Similarly, in Madhya Pradesh the four districts selected were Betul, Rajgarh, Vidisha and Khargone (as shown in diagram 2.4). In each district, following the same sampling pattern, two blocks were chosen and one sub centre in each block (shown in the diagram 2.5 below the map). Due to transportation problems only one sub centre could be visited in Betul district.

Diagram 2.4: Fieldwork districts, Madhya Pradesh

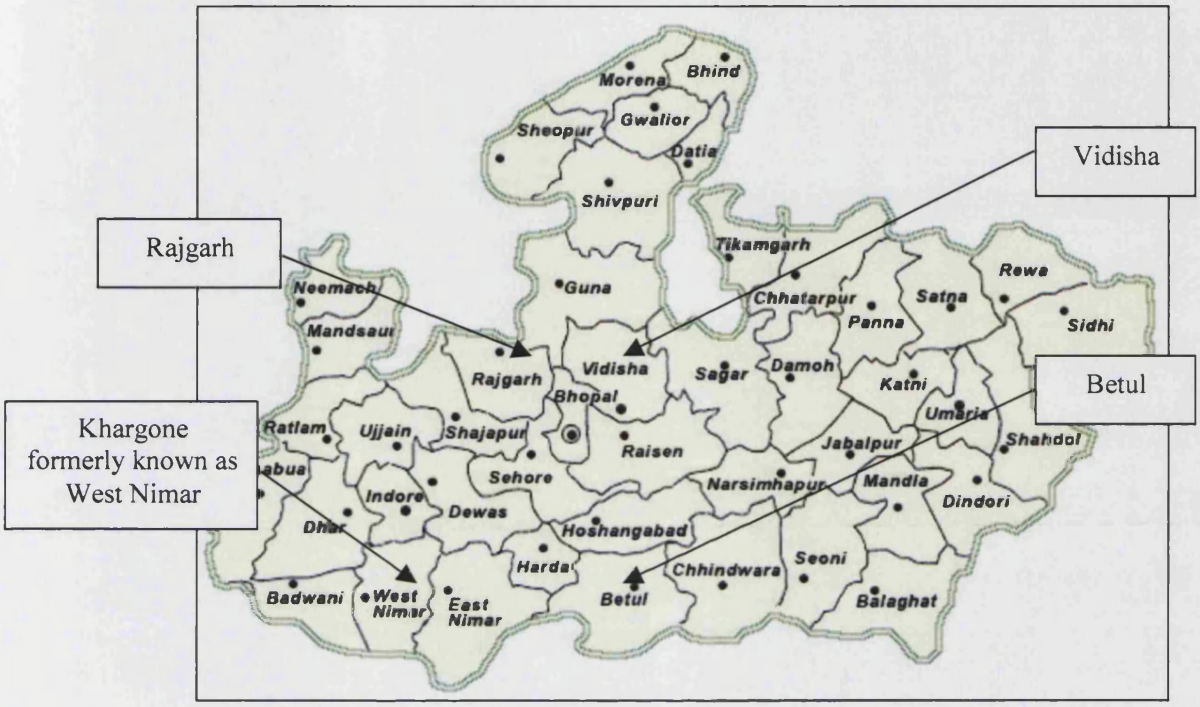
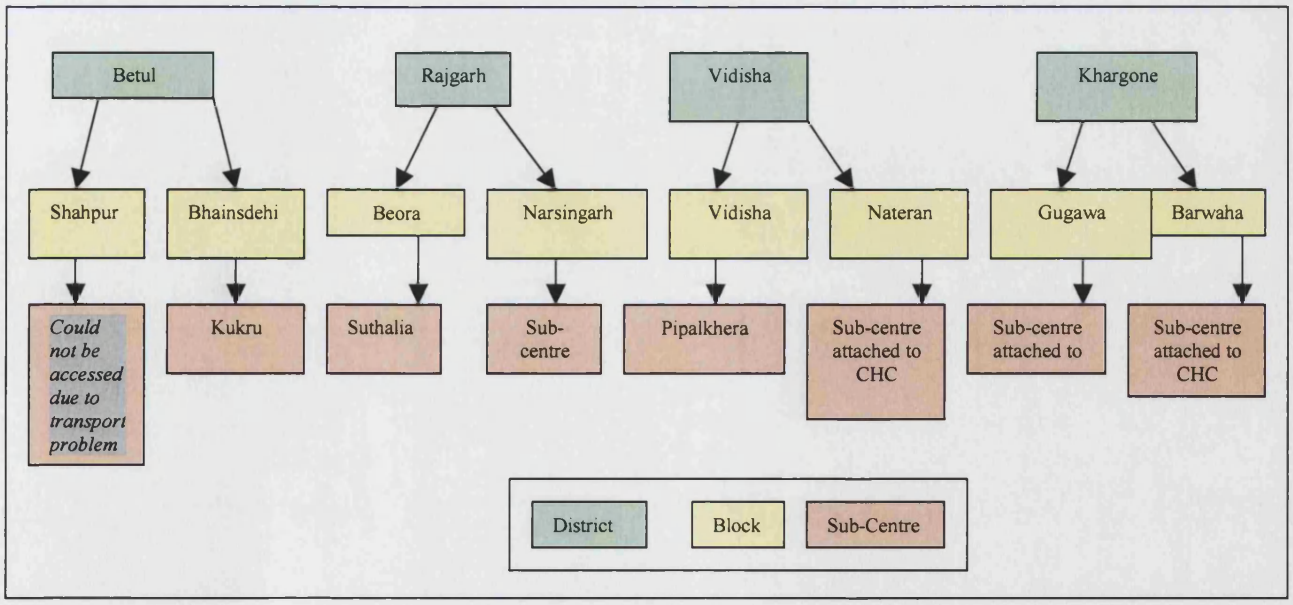


Diagram 2.5: Study sites in Madhya Pradesh



After the third pilot study, a list of different categories of interview respondents and corresponding topic guides were finalised. The topic guide for each group of respondents was developed based on the type of data needed and expected from each group. For example, from the respondents based in Delhi, the topics related to the national perspective on State population policies and family planning service. With regard to the family planning service provision for all the levels from the State down to the sub centre, corresponding sets of interview questions relevant to each level were used both in Madhya Pradesh and West Bengal. Table 2.1 lists the topic guide followed during interviews with different categories of interview respondents.

Table 2.1: Topic Guide used for Corresponding Interview respondents

Category of interview respondents	Topic guide
Delhi – Central Government, International Donors.	o Reasons for the States to adopt population policies, o Different factors responsible for the adoption of the policies, o Historical origins of State level population policies, o Changes in the range of Family Planning services since 1996 o Consideration given by stated to RH preference and needs of the people, o Involvement of Panchayati Raj Institution in the family planning programme o Use of demographic targets, incentives and disincentives o Current scenario with State level population policies with regard to Centre's views and actions.
State - State level population policies – Madhya Pradesh	o Reasons for the State to adopt a policy, o Historical origins of the policy, o Process from decision to have a policy to the announcement of the policy, o Factors responsible for the policy adoption,
State – Family Planning – Madhya Pradesh and West Bengal	o Change in the range of contraceptives provided since 1996 o Relation between changes in family planning service provision and adoption of the State level population policies o Change in the supply and availability of contraceptive methods (after the policy in case of Madhya Pradesh o Reproductive Child Health programme implementation, o Current involvement of Panchayat leaders, o Participation of the Panchayati Raj Institutions leaders in the family planning programme, o Any new initiatives to bring together Panchayati Raj Institutions and health together o Use of incentives, disincentives and demographic targets and their need.
State – Panchayati Raj Institutions – Madhya Pradesh and West Bengal	o Current involvement of Panchayati Raj Institutions in health and family planning, o Training of Panchayati Raj Institutions leaders on Family Welfare Programme details, o Roles played by the Panchayati Raj Institutions leaders, o New initiatives by the government to bring together Panchayati Raj Institutions and health together. o Disincentives for Panchayati Raj Institutions leaders based on 2 child norm.
Districts, Blocks and Sub-centre levels for family planning – Madhya Pradesh and West Bengal	o Types and kinds of family planning methods provided, o Introduction of any new family planning methods or types of each family planning method in last 5-10 years o Presence of different service delivery points, local sales outlets for family planning, o Offering of methods to all sections of the population within the reproductive age, o IEC and counselling and their types used for generation of awareness, o Placement of restrictions on family planning method choice, o Training of health workers and medical officers, o Current involvement of Panchayati Raj Institutions, o Participation of the Panchayati Raj Institutions leaders in the family planning programme, o Help provided by them, o Any new initiatives to bring together Panchayati Raj Institutions and health together and progress made in implementation of those initiatives o Use of incentives, disincentives and demographic targets and their need.
Districts, Blocks and Sub-centre levels for Panchayati Raj Institutions – Madhya Pradesh and West Bengal	o Involvement in family planning service provision, o Current and future plans regarding health and family planning in specific, o Views/opinions on the work done by the health staff, o Relation with the health administration, o Training on family planning issues, o Awareness about different service delivery points in the area, o Organisation of IEC camps on family planning, o New initiatives to bring together Panchayati Raj Institutions and health together – progress made so far.

Table 2.2 lists the different categories of interview respondents at the national level in Delhi, at the State levels in Bhopal and Calcutta, and health professionals and Panchayat leaders at the district, block and sub-centre levels respectively whom I interviewed. The

interview respondents at the national and State levels included government officials, donor agency representatives, academics and officials from NGOs.

Table 2.2: Categories of Interview Respondents

Study Sites	Category	
Delhi	Government	o Secretary, Dept. of Family Welfare o Joint Secretary of Department of Family Welfare, policy and planning o Director of policy and planning, Dept. of Family Welfare
	Non-Government	o Future Groups International o UNFPA o DFID o Academics and experts o NGO and research institutes working on family planning, panchayat involvement.
Madhya Pradesh		
State	**Government**	
	Policy	o Former Director for Family Planning o Former Commissioner of Health and Family planning o Current Deputy Director of Family Planning o Former Chief Secretary of State o Former Principal Secretary of Health o Former Commissioner of Policy Implementation, Department of Family Welfare
	Family planning	o Director for Family Planning o Commissioner of health and Family Planning o Deputy Director of Family Planning
	Panchayati Raj Institutions	o Secretary for Panchayati Raj Institutions o Commissioner for Panchayati Raj Institutions
	Non-government	o Academics and experts o UNFPA o DFID o DANIDA o NGOs working on family planning.
District	Family planning	o Chief Medical Officer (CMO) o District Family Planning officer
	Panchayati Raj Institutions	o Panchayati Raj Institutions rep at district level o District Panchayati Raj Institutions and Rural development officer
Block, levels below	Family planning	o Block Medical Officer (BMO) o Block Education Extension officer (BEE) o Health supervisors, and Health workers
	Panchayati Raj Institutions	o Panchayati Raj Institutions rep at block level o Panchayati Raj Institutions rep at village level
West Bengal		
State	**Government**	
	Family planning	o Joint Secretary, Department of Health o Commissioner of Family Planning o Deputy Director o Director of Health Info Bureau
	Panchayati Raj Institutions	o Joint Secretary, Panchayati Raj Institutions o Deputy Director o Officer on Panchayati Raj Institutions and health
	Non-government	o Academics and experts o DFID, consultant o NGOs working on Family Planning
District	Family planning	o Deputy CMO, Family Planning and Reproductive Health o District Public Health Nursing officer
	Panchayati Raj Institutions	o Panchayati Raj Institutions rep at block level o Panchayati Raj Institutions rep at village level
Block, levels below	Family Planning	o BMO, Block primary health nurse (BPHN and PHN) o Medical Officers o Health supervisors and Health workers
	Panchayati Raj Institutions	o Block development officer o Panchayati Raj Institutions at the block level o Panchayati Raj Institutions at the village level

2.3.3. Access to interviews

> "Gaining access is an essential phase in the research process. For access is a prerequisite; a precondition for research to be conducted" (pp. 45, Burgess 1984).

Establishing contact with different sets of respondents (as illustrated in Table 2.2 above) was a key factor during the data collection process. During the pilot studies, I realised that in order to gain access, especially with government officials at the national and State levels, contacts had to be used. Gaining access to interview respondents through initial points of contacts has been discussed at length in literature (Hunt, Crane and Wahlke 1964, Dexter 1970, Burgess 1982, 1984, Goldstein 2002). However Goldstein (2002) in gaining access to elite interview of Senators and Congressmen of Washington DC justifies use of different kind of contact (pp 671: 2002). I approached the State health departments with an introduction letter from my academic supervisors. Then I obtained a permission letter from the State health departments to visit the districts. To interview the panchayat representatives in the districts, there were two available options. One was to approach via the district administration, the other was to know somebody within the ruling party in the State. It needs to be mentioned here that the panchayat representatives are the elected representatives of the people belonging to a political party. So I chose to follow the former option of approaching the district magistrates of each study district, in each case via a contact. In Delhi, accessing the administrators at the national level, the interview process began with a contact who set up an appointment with the Joint Secretary of Policy and Planning in the Department of Family Welfare. From him the snowballing started with the Director of Policy and Planning and to the officer in Department of Family Welfare who was in charge of government documents and correspondence. As for reaching academics in Delhi, my contacts were research scholars of population studies from the Jawaharlal Nehru University (JNU). So through them, approaching the JNU professors was easy. As for rest of the academics and research institutes, the introduction letter from my academic supervisors helped me to get access. In Madhya Pradesh, the contact with regard to the government interview respondents helped to get access to the interviewees by introducing me to the Director of Family Welfare. I got the names and contact details of the district and block officials from his office. But for the rest of the interviews in the capital city of

Bhopal, I approached the respondents with the introduction letter and the data collection went quite smoothly.

2.3.4. Language

India is a country of linguistic diversity. Although Hindi is the national language, English is the associate official language (Hohenthal 2003). The interviews were conducted in three different languages – Bengali, English and Hindi. Bengali is widely spoken and used in West Bengal although administratively both Bengali and English are used. Hindi on the other hand is the national language of the country and officially used in Madhya Pradesh. Bengali is my mother tongue and I am fluent in speaking and reading it. I had learned Hindi during grade school but did not get the chance to use it frequently in the last few years. So before starting the fieldwork in Madhya Pradesh, I sought linguistic advice from native Hindi speakers to develop and translate the topic guide. For the respondents based in Delhi and State capitals, I conducted interviews in English but not all the time. All my interviews in West Bengal were in Bengali, except one. It was the interview with the British consultant of DFID which was conducted in Calcutta.

2.3.5. Relation with the Interview Respondents

The fieldwork was conducted from May 2004 until January 2005. I started the fieldwork with West Bengal in May 2004, went to Delhi in August 2004, followed by Madhya Pradesh in beginning of September 2004, back to Delhi in November 2004, and then returned to West Bengal at the end of December 2004. Establishing rapport with the interview respondents and creating the "right" atmosphere for the interviews were important. Before the interviews I always got permission to conduct them. Some people gave crafted responses while others were more open and free with me. Before every interview, I made it very clear that the interviews would be treated as confidential. For some respondents that made a difference, but for others it did not. Some health workers thought that I was a government official from the capital (either State or national) initially and as a result their responses were affected by such perceptions. But once the misconception was cleared, responses quickly changed to frank and informal ones. It was also interesting to find how the respondents perceived me as I had introduced myself as a

student from London. Some respondents were curious and interested about me and my life in London. Since dress is an important aspect of any culture, I had made sure to wear the right kind of dress so that I fitted well with the respondents and their perceptions of me did not affect their responses.

2.3.6. Challenges faced during data collection

During the fieldwork I encountered both major and minor challenges. First of all, despite having authorization letters, there were bureaucratic delays in accessing documents and family planning data in Delhi, the State level in West Bengal, and the district levels in Madhya Pradesh. In all such cases the officials responsible either refused access initially or took time to locate them. Secondly, it was difficult to find the current family planning performance data on Madhya Pradesh and West Bengal especially below the district levels as they are available from the district capitals only. Since the study compared the family planning service provision in the last ten years in each State, collection of data from the previous years was also problematic. However, both in Madhya Pradesh and West Bengal, data from blocks and levels below blocks were not kept at the State capitals. They were sent to the districts and it was the districts that compiled all the data and gave aggregated figures to the States. Also, there was no data available for both male and female sterilization for 1996-97 for West Bengal and no disaggregated data for different techniques of such sterilization (unlike in Madhya Pradesh). Thirdly, in the initial phase of fieldwork in West Bengal, I faced serious problems in gaining access to the State level government officials in the Department of Family Welfare. There was one high ranking official whom I visited six times and had many phone conversations before the actual interview. He not only refused the use of a tape recorder but also did not let me complete the interview leaving many questions unanswered and did not agree for a future date. He also prevented his junior officials from giving me any interviews as they said he was the only authority to give interviews. However, this official got transferred by the time I finished the data collection in Delhi and Madhya Pradesh and went back to West Bengal. Fourthly, despite taking the monsoon season in West Bengal into consideration while planning the fieldwork, on and off the weather was a deterrent during the visits to the sub-centres in Burdwan and Hoogly in West Bengal. On one occasion I took ill due to the rain and at other times transport was affected due to poor road conditions. Finally, a minor challenge was low or

dead batteries of the tape recorder. It was only after two interviews when I would listen to them that I would realise such incidents but since they were fresh in my mind I could write the points discussed by the interview respondents.

2.3.7. Transcription

I was responsible for all tape transcription. It took one and half months to transcribe all the interviews. The interviews in Hindi and Bengali were translated in English and transcribed at the same time. As Ulin (2002) says "translation of vernacular expression is always challenging". It was difficult sometimes to find the exact translated words in English that were used in Hindi or Bengali. However, the main advantage of transcribing the interviews myself was that I could capture not only what was said but also how interviewers described things. So every effort was made to ensure that the transcripts were "faithful representations" (Ulin 2002) of what the interviewers told me. Along with the interviews, I made sure to write my observations as notes. At the beginning of 2005, I returned to London with twenty eight audio tapes, transcripts of one hundred and thirty two interviews, documents and notes, and memos made during the fieldwork.

2.3.8. Plans for Analysis

The plans for analysing the data started during the fieldwork. After completing a set of interviews, I listened to the interviews and started to draw up codes. However, during transcribing, coding of the interviews was done simultaneously based on the topic guide so that it would help in my analytical thinking later on. This helped in the data reduction process. As part of the data analysis plan, memoing, contextualizing and coding as strategies of data analysis were identified. Memo writing began from the very beginning of the research that helped to capture the analytical thinking. Contextualizing commenced when I collected data based on the indicators that I have listed in Appendix 1. These indicators helped to categorize the data to be collected based on the conceptual framework. After the fieldwork when I returned to London, coding of data began by using NVivo, computer-assisted qualitative data analysis software (CAQDAS). NVivo was selected over the other available software after careful examination, and for three main reasons. Firstly, unlike the other softwares, it helped to create different databases within the system. It also

helped to write notes and memos alongside the codes and nodes. Secondly, it gave a complete picture of the coding after it was completed, that is the linkages between different codes. This helped in thinking about the data and understanding relationships between various codes. Finally, I chose Nvivo because of its compatibility with Microsoft Word. It was easy to code my interview transcripts which were written in Microsoft Word. Nvivo was used in the analysis of the data for chapters 4 and 6. Appendix 2 lists the Nvivo codes used for both chapters.

Thus, this section enumerated the planning and preparing process before the fieldwork that involved three pilot studies, sampling decisions regarding study sites and interview respondents, and access to the national and State level respondents. The section also discussed use of three languages in conducting interviews, relation with the respondents during the fieldwork. It also examined translation and transcription of interviews and use of NVivo for coding the data. The next section talks about how confirmability, dependability, credibility ad transferability were thought about during designing the research in order to maintain quality.

2.4. Evaluating the research

The final and crucial point when planning the research design is to think about the quality of the research and the quality of the conclusions it produces. The common standards discussed in the literature to assess the calibre of a qualitative study are confirmability, dependability, credibility and transferability (Robson 1983, 2002; Miles and Huberman 1994; Denzin and Lincoln 2000; Ulin 2002; Ritchie and Lewis 2003). By confirmability is meant whether the conclusions of the research are drawn from the subjects and conditions of inquiry and whether the researchers were conscious of their own subjectivity and bias. When the standard of dependability is raised, the issues are whether there is a degree of clarity in the research design and whether the claims made are based on trustworthy evidence. Subsequently, credibility standards look for authentic portrayal and evidence of the objects of the study. Finally evaluation of the quality of research wants to find out to what extent the findings can be generalised or transferred to other settings. This is the issue of transferability (Miles and Huberman 1994; Ulin 2002).

In order to make sure that the research was able to meet these standards of quality, careful attention was paid all along to the planning stage and the data collection stage of the research. The "Operationalisation Table" helped to make sure the research followed standards of dependability. During the fieldwork, audio recording was employed for all interviews. This was done in order to avoid inaccurate and incomplete data collection. After the interviews, verbatim transcription was done and for two interviews when batteries went dead, notes were jotted down immediately after the interviews. This ensured confirmability and credibility. During the interviews, I made sure that different perspectives of the interview respondents were taken into consideration. One way of doing that was ensuring that the topic guide did not carry any leading questions. In order to ensure that my own biases and assumptions were not clouding my conclusions to maintain confirmability, all throughout my study period, I sought feedback from a variety of people, both those who are familiar with the research topic and its context as well as those who are strangers to them (Maxwell 1996). Finally, the conceptual framework developed for this study can be used for any other Indian State that adopted a population policy, therefore maintaining the standard of transferability.

Research Ethics

Before I started my fieldwork, I explained the aim and implication of the study to all interview respondents. I ensured that I had consent from all the interview respondents before starting the interviews. I used the tape recorder only with their consent. I switched it off if and when requested. To maintain confidentiality I explained to the interviewees that the information they provide will be kept confidential. So in the main body of the text I have depersonalised all interview quotes and listed the names and designation of each interview respondents in Appendix 4.

2.5. Conclusions

This chapter located the present research within the field of qualitative research. It presented the research design as an iterative, flexible and inductive process. The choice of the data collection methods of in-depth semi-structured interviews, and documentary analysis and case study as the research strategy was guided by the research questions. Case

study was the most suitable research strategy for cross-State comparative analysis of findings from Madhya Pradesh and West Bengal to explore for linkages between the adoption of State population policies and family planning service provision in the States. One hundred and thirty two in-depth semi-structured interviews were conducted in three main study sites in Bengali, English and Hindi. Documentary data were gathered from a wide range of sources. During the entire data collection process operationalisation of the research questions in linking the data with the research questions and topic guide helped to safeguard quality of academic standards. Thus the chapter gave an account of how the data were collected and analysed and how the research can be evaluated. It has also shown how the research was influenced by the context in which it was undertaken. The next chapter is a review of literature to locate the historical origins of State-level Population Policies in India and the factors that led to such policy initiatives.

Chapter 3: Historical Origins of Indian State Population Policies

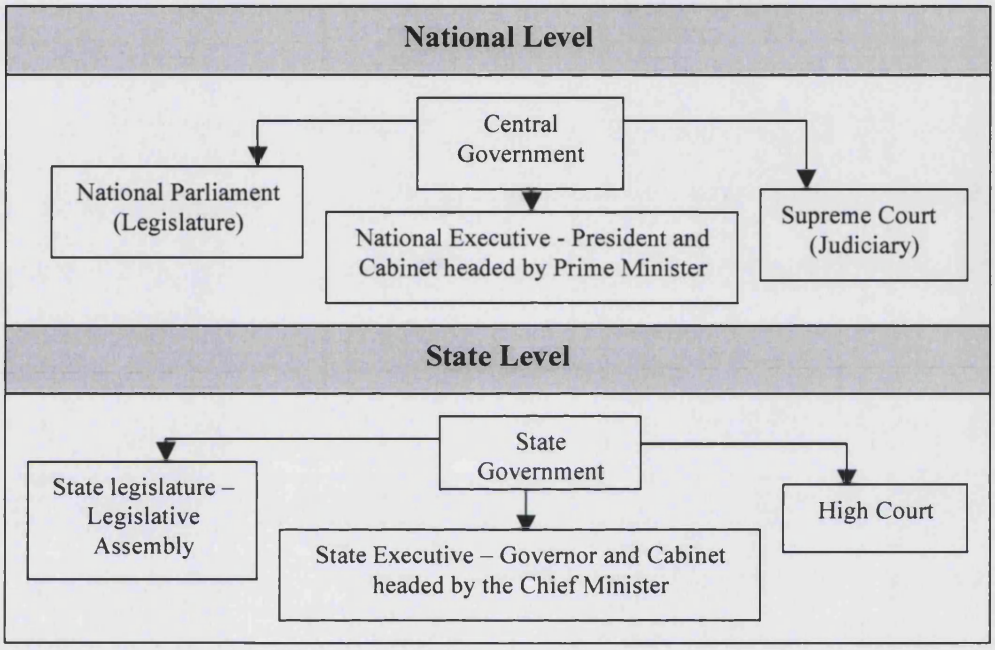
3.1. Background

Since 1952 Indian States have undertaken various governmental measures that were "population policy initiatives" rather than "official" policies. This was because they were not cleared by both the legislature and executive branches of the State governments. Since the mid-1990s, however, some States have started announcing official population policies, and currently some other States have State-level Population Policies under development. Considering that State-level Population Policies are a new development in the long history of Indian policy making, the current chapter examines the context within which these policies have emerged. The chapter touches upon time periods that are considered to be important milestones in the history of population policy in India. It starts with the year 1952 when the Indian family planning programme was launched. Although the chapter tries to locate State actions for each decade since the 1950s, it will focus upon two turning points. The first watershed period is 1975-77 when the country was declared to be under Emergency and the first national population policy statement was announced. The second turning point period is 1996-97 when the central government decided to stop determining demographic targets for the States and instead adopted a bottom-up community needs assessment approach. In order to trace the origins of the State-level Population Policy initiatives, various government documents relating to the country's five-year plans, government bills, acts, laws, administrative measures, and references to them in the literature were analysed. The chapter begins with an investigation of a range of State government population measures between 1952 and 1996. Secondly, it examines the State policy initiatives from 1997 until the present. Thirdly, the factors contributing to these population actions are investigated. These include the roles played by the political leadership and the bureaucracy at the State level and the function of the donor agencies. The changing attitude of the central government towards the States in matters of family planning and population, the influence of the report of the Expert Committee of 1994, and the atmosphere that arose from ICPD in the same year, are also discussed as key factors behind the adoption of these policies.

3.2. State-level population actions from 1952 to the present

The administration of India is undertaken by the central government at the national level, and twenty- eight State governments at the State level. The structure of the Indian polity both at the national and at the State levels is quite similar with three branches: the legislature, the executive and the judiciary (Diagram 3.1).

Diagram 3.1: The political structure of India



The eminent analyst of the Constitution of India, D.D. Basu, in "Introduction to the Constitution of India" states that "the Government has the sole initiative in formulating its policies and in presenting its demands for carrying out those policies" (pp 172, 1960) to the Parliament. "The function of the Parliament is to bring about a discussion and criticism of that policy on the floor of the Houses, so that not only the Cabinet can get the advice of the deliberative body and learn about its errors and deficiencies but the nation as a whole can be apprised of an alternative point of view, on the evaluation of which representative democracy rests in theory" (pp 150, Basu 1960). Ever since 1952, as measures for birth control and for reducing birth rates (Chaubey 2001) the States have initiated different government measures, the majority of which constituted the formulation of bills, laws and (dis)incentive schemes to promote the acceptance of family planning. However, these

measures were generally not cleared by both the State cabinet and State legislative assembly (as illustrated in diagram 3.1 above) and hence they cannot strictly be considered as official population policies. It was only in 1997 that Andhra Pradesh adopted the first State-level Population Policy in India.

3.2.1. From 1952 to 1996

During the 1950s, when the Indian family planning programme had started to take shape, there were rare instances of population policy initiatives by the States. These initiatives were primarily in the form of incentive and disincentive schemes. Tamil Nadu was the first State during the second five-year plan (1956-61), to introduce an incentive scheme of Rs. 10 made to the acceptors of male sterilisation. Other States like Maharashtra subsequently followed Tamil Nadu's lead (Srinivasan 1995; Chaubey 2001; Visaria 2002). The central government decided to adopt a target-oriented approach to family planning in 1969. This was mainly in the form of holding mass sterilisation camps and the adoption of incentive schemes. The first vasectomy camp was organised in Maharashtra in 1961 "where 1400 men were sterilised in three days only" (Chaubey 2001 pp 55; Visaria 2002). This was followed by the holding of a camp in Ernakulum district of Kerala in 1971 "in which over 65,000 vasectomies were done in two weeks" (Srinivasan 1995 pp 37; Visaria and Chari 2001). Following Kerala, government officials in Gujarat exercised their influence to motivate a large number of vasectomy acceptors (Gwatkin 1979). However, along with incentive payments, State governments such as that of Maharashtra employed disincentives like non-eligibility to loans, grants, subsidies and other benefits based on three child norm (Gwatkin 1979). Similarly, Uttar Pradesh provided educational benefits to children whose parents restricted their family size (Gwatkin 1979). Also, in 1969 the government of Haryana tabled a bill in the State assembly which "contemplated fines and even imprisonment for parents producing beyond three children" (pp 111 Rao 1989).

Following the central government's population policy statement of 1976 at the time of the Emergency (1975-77), most States actively took different kinds of policy initiatives, some of which were forced on the target audience (Panandiker *et al* 1978; Gwatkin 1979). Most States resorted to compulsion at this time not only because of pressure from the central government, but also because of promises of financial assistance from it (a topic discussed

further below). Instances of drastic State action in relation to fertility control were seen in March 1976 when Maharashtra introduced a bill for compulsory sterilisation in the State assembly (Gwatkin 1979, Pethe 1981, Chaubey 2001). The Uttar Pradesh government, on the other hand, issued a government order in 1976 which assigned a sterilisation target of 55,000 to the employees of various State departments including the police and prison personnel (Panandiker and Umashanker 1994, pp 91). Madhya Pradesh passed a scheme of denial of facilities including government allowances and loans for government staff, for not undergoing compulsory sterilisation based on three-child norm (Panandiker, Bishnoi and Sharma 1978). Andhra Pradesh gave raises in salary to government employees who underwent male sterilisation (Gwatkin 1979). Regarding disincentives, in 1976 the Himachal Pradesh government withdrew maternity leave for female employees if they had more than two births (Gwatkin 1979). In the same year, West Bengal refused to cover travel leave costs of government staff with more than two children (Gwatkin 1979). In 1976 the government of Uttar Pradesh withheld the pay of employees in the health and family planning department if they could not meet their specified number of acceptors (Gwatkin 1979). Some States, for example Uttar Pradesh, included the general public alongside State government employees in their targets. It introduced incentives (including rebates in land revenue) for male farmers who underwent sterilisation and it introduced disincentives (disqualification from applying for loans, land allotment or free medical treatment) based on a three-child norm for the general public (Panandiker *et al* 1978).

The target-oriented approach of the Central government continued until 1995, as did the use of incentives and disincentives by the States. However, the intensity of such measures was reduced because of the backlash to the 1976 population policy statement. Many States passed laws to promote small family norms, most of which included disqualification from the membership of civic bodies. Examples of such government measures include the Rajasthan Municipalities Act of 1992, the Rajasthan Panchayat Raj Act of 1995, the Orissa Zilla Parishad Act of 1993, the Haryana Panchayat Act of 1994, the Andhra Pradesh Municipalies Act 1994, the Madhya Pradesh Nagarpalika Vidhi of 2000, and the local government act of 1996 in Delhi (Tandon 2003). Although the central government decided to remove demographic targets for the States in 1996, some States had already started to initiate different schemes without reference to these targets (Khan and Townsend 2001). Tamil Nadu was the first State (in 1991-92) to withdraw the use of family planning targets

for non-health department staff in two of its districts (Khan and Townsend 2001). Therefore in 1995, when the central government decided to experiment with the new target-free approach prior to its formal announcement, some States had already demonstrated their readiness for change by adopting different innovative work plans. Thus, Andhra Pradesh had introduced a comprehensive monitoring system for programme implementation, while Rajasthan had developed an information and delivery system for the family planning programme (Narayana and Sangwan 2001). Similarly, Uttar Pradesh and Tamil Nadu designed innovative information systems to implement the family planning programme without reference to any guidelines from the centre (Narayana and Sangwan 2001). In 1993, Tamil Nadu announced a population policy statement (Visaria and Chari 1998, Visaria 2002, Government of Tamil Nadu 2005). There is no evidence as to whether this policy was restricted to one document and whether it was official. However, in 2002 the State announced that it was planning to launch an official population policy (Government of Tamil Nadu, 2004, National Commission on Population 2002) although until 2005 it had not formally done so.

3.2.2. From 1997 to the present

From 1997 onwards, half of the States have adopted official State-level Population Policies that were passed by the State legislative assembly and ratified by the State cabinet, as shown in Table 3.1. Andhra Pradesh set the precedent by officially adopting a policy in 1997. Along with twelve states, five Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadar and Nagar Haveli, Daman and Diu and Lakshadweep) have also adopted population policies. Arunachal Pradesh, Assam, Kerala, Punjab and West Bengal are in the process of developing their policies. Also, in 2004 Jharkhand adopted a combined Population and Reproductive Child Health Policy, and Karnataka adopted an Integrated Health Policy.

Table 3.1. List of official State-level Population Policies

State	Year of Formulation	Status
Andhra Pradesh	1997	Officially adopted
Rajasthan	1999	Officially adopted
Madhya Pradesh	2000	Officially adopted
Gujarat	2000	Officially adopted
Uttar Pradesh	2000	Officially adopted
Maharashtra	2002	Officially adopted
Uttaranchal	2002	Officially adopted
Haryana	2003	Officially Adopted
Jharkhand	2004	Officially adopted
Bihar	2005	Officially adopted
Tamil Nadu	2005	Officially adopted
Chhatisgarh	2006	Officially adopted
Arunachal Pradesh	—	Under Development
Assam	—	Under Development
Kerala	—	Under Development
Punjab	—	Under Development
West Bengal	—	Under Development

A review of these policies shows that the overarching objective running through them is to provide integrated reproductive health care services within each State. A stress on demographic targets to reduce the total fertility rate to the approximate replacement level of 2.1 births per woman by a specific deadline is present in all of them too (Governments of Andhra Pradesh, 1997, Rajasthan 1999, Madhya Pradesh 2000, Uttar Pradesh 2000, Gujarat 2000 and Maharashtra 2002). Also stated as being among the demographic objectives of these policies are the reduction of infant, child and maternal mortality, the reduction of the incidence of RTI/STDs and HIV/AIDS, and increases in the levels of contraceptive prevalence (Governments of Andhra Pradesh, 1997, Rajasthan 1999, Madhya Pradesh

2000, Uttar Pradesh 2000, Gujarat 2000 and Maharashtra 2002). With respect to the strategies of these policies, they all mention a 'paradigm shift' from 'population control' to a 'reproductive health care' approach (Governments of Rajasthan 1999, Madhya Pradesh 2000, Uttar Pradesh 2000, Gujarat 2000 and Maharashtra 2002). They also talk about improving the quality of services and making them more client-focused. In terms of mechanisms for the implementation of the policy directives, all the policies refer to the setting up of State-level Population Commissions and at lower levels, district family welfare committees (Governments of Andhra Pradesh, 1997, Rajasthan 1999, Gujarat 2000, Madhya Pradesh 2000, Uttar Pradesh 2000, and Maharashtra 2002). Instead of relying exclusively upon the staff of the health departments, the policies of Madhya Pradesh (Government of Madhya Pradesh 2000) and Uttar Pradesh (Government of Uttar Pradesh 2000) mention the involvement of members of the Panchayat Raj Institutions and other government departments. Finally, the use of incentives and disincentives as strategies to promote acceptance of family planning is present in the policies of Andhra Pradesh, Madhya Pradesh and Rajasthan (Governments of Andhra Pradesh, 1997, Rajasthan 1999, and Madhya Pradesh 2000).

Thus, evidence of population policy measures by the States can be found since 1952 in incentive and disincentive schemes to promote small family norms. The literature gives evidence of such measures by Tamil Nadu, Maharashtra, Kerala, Gujarat, Haryana and Uttar Pradesh. However, compulsive drastic measures were undertaken by States following the prescriptions of the national population policy statement of 1976. The States resorted to such measures to meet sterilisation targets of the central government and to get financial assistance from it. In the 1990s target-setting was stopped with Tamil Nadu setting the precedent in 1991-92 and the rest of the country followed suit in 1996. Since 1997 twelve States and five Union Territories have adopted population policies on their own and some others are in the pipe-line. Review of the State-level Population Policies show that incentive and disincentives measures continue to be State government strategies to promote small-family norms. Examples of State-level Population Policies with such strategies are Andhra Pradesh, Madhya Pradesh and Rajasthan.

Position of the Constitution of India with regard to family planning and population

Before going into the analysis of the factors contributing to State policy initiatives, it is important to note the division of powers between the Centre and the States afforded by the Indian Constitution with respect to family planning and population. India became an independent country on 15th August 1947 after being under British colonial rule for over two hundred years. In 1950, the Constitution distributed the powers and functions between the Centre and the States. The subjects that fall under the purview of the Central government constitute the 'Union list'. The subjects falling under the jurisdiction of the State governments, on the other hand, comprise the 'State list'. Public health and sanitation, hospitals and dispensaries are subjects of the State list (Srinivasan 1995). 'Population control and family planning' are shared by the Central and State governments and they thus form part of the 'Concurrent list' (Narayana and Kantner 1992, Srinivasan 1995). Listing of subjects in the concurrent list means that their planning and funding rests wholly with the central government. However, the onus of implementation with respect to such subjects rests with the States. As far as family planning and population are concerned, the States implement these subjects as part of their health programmes (Rao 1989, Srinivasan 1995,). However, the Constitution gives the States the freedom to enact laws on subjects that are on both the State and the concurrent lists unless any overruling occurs by a number of States or the Centre (Tandon 2003, Constitution of India 2004).

3.3. Factors leading to State policy initiatives

Based on a literature review, three key contributing factors for State-level Population Policy adoption have been identified: committed political leadership; efficient State administration; and, the presence of international donor agencies working on population and family planning issues, in particular the USAID Policy project. Also, this chapter assesses the impact of the report of the Expert Group of 1994. Moreover, the post-1994 development of State population policies is placed against the context of ICPD. Finally, based on the Evaluation Project framework (Chapter 2), assessment is made of the relevant importance of different factors for the adoption of State-level Population Policies. As mentioned in chapter 2, based on the Evaluation Project model, I identified related indicators for each of these factors. This chapter explores these factors in order to examine why State-level Population Policies emerged in twelve States. Chapter 5 analyses the

research findings based on these themes and indicators to examine the reasons for policy adoption in Madhya Pradesh and not in West Bengal.

3.3.1. State-level political commitment

Commitment to family planning by the political leadership has varied from State to State over time, not least because of changes in the allegiance of the political State leadership to the party that was in power at the Centre. Over the years, all the leading national political parties in India have agreed on the need for fertility control in order to reduce the pressure of population on the country's resources, and population control has featured in their election manifestos (Panandiker and Umashanker 1994). From the late 1960s to the mid-1970s, the leadership of the northern States of Madhya Pradesh, Harayana and Uttar Pradesh belonged to the Congress Party (Gwatkin 1979). As a result, the increase in State incentive and disincentive schemes that occurred was in large part due to an intention to concur with the wishes of the ruling Congress Party at the Centre. It is interesting to note that during the mid-1970s, States with poor performance in terms of the achievement of centrally determined 'acceptor' targets (Jammu and Kashmir, Kerala, Tamil Nadu) were those where the party in power was in opposition to the Congress (Gwatkin 1979). However, due in part to excessive use of compulsion for family planning acceptance during Emergency, the Congress Party lost power in the elections in 1977 in all the northern States (Gwatkin 1979). As a result, for many years there was a significant dip in State governmental measures with regard to family planning (Gwatkin 1979). Whichever party came to power in these States carefully stayed away from family planning in order to gain the confidence of the electorate (Panandiker and Umashanker 1994). As a result, family planning efforts began to be affected, leading to a rise in fertility in the northern States (Conly and Camp 1992). It has been suggested that the better demographic performance to control rates of fertility and mortality by Tamil Nadu, Maharashtra and Kerala has been partly due to the support given by their respective political leaderships to population and family planning efforts (Conly and Camp 1992). Promotion of the small family norm was given priority in the regional party in Tamil Nadu for four decades (Srinivasan 1995). Periodically, the political leadership in this State has used the staff of both the family planning department and other government departments to increase motivation and thereby the acceptance of family planning services (Srinivasan 1995). But prioritisation of family

planning did not occur in most States until the 1990s. Critics (Bose, 1988; Panandiker and Umashanker, 1994) argue that the lack of political dividend generated by support for family planning has been a cause of non-prioritisation by State governments. They suggest that in contrast to other development issues such as education, provision of drinking water and sanitation, the impact of family planning services is subtle and it cannot be detected easily. Accordingly, support for the extension of such services does not generate votes. As a result, analysts have pointed out that if given a choice, many States would divert funds from the Centre for family planning to other issues. Further, it is doubtful whether States would like to be entrusted with the full responsibility of "owning" the family planning programme. (Panandiker 1983; Narayana and Kantner 1992; Panandiker and Umashanker 1994). Bose (1988) suggests that States have perceived the family planning programme as a programme of the Central government, and that their interest in it has sometimes largely been restricted to getting funds from the Centre. It has also been pointed out that because of their dependence on the Central government for funds, until recently the States have been reluctant to generate funds of their own to increase spending on family planning (Conly and Camp 1992, Narayana and Kantner 1992). However, since the mid to late 1990s, seven States - including the three poor performing States of the north - have adopted specific population policies. These policies reflect a high degree of political commitment. In the policy of Andhra Pradesh, the commitment of the State's political leadership is reflected in the Foreword provided by the chief minister. Also, the minister of family welfare in Andhra Pradesh affirmed ownership of the programme by planning to contribute funds from the State funds (Andhra Pradesh policy 1997, Visaria 2002). A similar degree of political commitment from the leadership is seen in the policies of Madhya Pradesh and Rajasthan where the political leaders talked about contributing funds from the State bursaries (Healthwatch 2000, Visaria 2002). For example, the commitment of the government of Madhya Pradesh is evidenced by the following statement:

> "...the State government will allocate Rs 5 crores of its own resources to the programme every year to support the innovative measures like the proposed State Population Resource Centre..." (pp 26, Government of Madhya Pradesh 2000).

Therefore commitment of the leadership at the state level is an essential factor in the adoption of State population policies. A political party's commitment to family planning significantly affected the commitment of the State leadership. That, in turn, led to increase

in population policy measures. This section showed that that was the case with the national Congress party rule prior to 1976 in Madhya Pradesh, Haryana and Uttar Pradesh, and in later years with the regional parties of Tamil Nadu and Andhra Pradesh.

3.3.2. Function of the bureaucracy at the States

Responsibility to implement the State government's policy initiatives and administrative measures rests with administrators at the State, district and block levels. These administrators are also responsible for translating the promises of the State leadership into action. They are the high-level government officers of the Indian Administrative Service (IAS). Over the years, the success of the implementation of the family planning programme has been linked to their efficiency and effectiveness. However, the efficiency and effectiveness of these State-level officials has been questioned by observers because of their lack of specialist knowledge about family planning and because of frequent inter-departmental transfers leading to a lack of accountability and sustainability (Conly and Camp 1992). During family planning programme implementation, tensions have also arisen between these officers and the medical/clinical programme managers leading to inter-State variations in bureaucratic efficiency and effectiveness (Conly and Camp 1992). However, Maharashtra has been able to utilise the potential of these officers significantly by filling 'vacant positions in a timely manner, supervise personnel adequately and ensure rapid disbursement of programme funds' (Conly and Camp 1992, pp 25). Not least, Maharashtra was able to retain an officer-in-charge for family planning for over twelve years, thereby providing continuity in leadership (Conly and Camp 1992). Similarly, the success of Tamil Nadu's family planning performance is attributed to an efficient administration (Srinivasan 1995). The administration helped to mobilise large crowds to participate in the mass vasectomy camps in the 1970s. The impact of an efficient individual officer is also highlighted by the case of the mass vasectomy camp organised in Ernakulam district of Kerala in 1971 (Visaria and Chari 2000, Chaubey 2001). However, behind the adoption of the recent State population policies lies the efficiency of the bureaucracy. The success of these States to procure both financial and technical assistance effectively, and in coordinating the drafting and passing of policies in both the State legislature and the State cabinet in only few months, has been attributed to these officers (IIHMR 2004). There is a sense of urgency on the part of the bureaucracy of these States to rectify their image as poor

performers. This feeling is reflected not only in the adoption of the policies, and in their language, but also in the forewords of the policies that have been adopted so far. For example, it can be seen in the population policy of Uttar Pradesh in the statement made by the Chief Secretary that it:

> ".. is very timely because though in the last few years there have been some positive trends in Uttar Pradesh related to decrease in fertility, increase in contraceptive prevalence and the utilization of private sector for reproductive and child health services, these efforts need to be consolidated, up-scaled and focussed, to have wider impacts. " (pp.x, Government of Uttar Pradesh 2000).

Thus we see that efficiency and effectiveness of State government administrators is another key factor in the adoption of population policy measures. Such instances were found in Kerala and Tamil Nadu in the 1970s, Maharashtra in the 1990s, and in recent years in the States that have adopted State-level Population Policies. Examples are Uttar Pradesh and Madhya Pradesh.

3.3.3. Involvement of donor agencies

Foreign assistance for the implementation of the family planning programme has been available to India since the 1970s when help from foreign donor agencies was used in the setting up of Area Projects in selected States (Rao 1989, Conly and Camp 1992, Visaria and Chari 2000,). From the 1970s onwards, the World Bank and the governments of the United States, Sweden, and Great Britain provided financial assistance to India to help control population growth (Bose 1988, Rao 1989). The World Bank started the Indian Population Projects in two States namely Uttar Pradesh and Karnataka (Rao 1989). However, interest and assistance from the international community regarding India's population has varied over the past four decades. During the era of the coercion-related family planning programme in the mid-1970s during Emergency, donors were wary of involvement. But in the late 1970s and early 1980s, the Central government received international assistance which amounted to almost one-tenth of its family welfare budget (Kocher 1980). At this time the donors included UNFPA (United Nations Population Fund), SIDA (Swedish International Development Agency), USAID (United States Agency for International Development), DANIDA (Danish International Development Agency),

NORAD (Norwegian Agency for Development Cooperation) and the Overseas Development Administration (ODA) of the British government (Kocher 1980). This international involvement was a sequel to the World Bank funded India Population Projects. Over the years, the Central government has extended the India Population Projects in other States. The World Bank and SIDA worked in Andhra Pradesh, while UNFPA operated in Bihar, Rajasthan, Madhya Pradesh and Tamil Nadu. The British ODA (now DFID) has worked in Orissa, and USAID funded family welfare projects in Maharasthra, Gujarat, Haryana, Punjab and Himachal Pradesh (Kocher 1980). However, it has been pointed out that all this financial assistance was used by the Central government to expand its own model of service delivery rather than to develop innovative projects in the States (Conly and Camp 1992). Observers like Bose (1988) and Narayana and Kantner (1992) have criticised the implementation of these projects as being a reflection of the Centre's centrist attitude without considering the reality of the States. However, from the middle of the 1990s things started to change. After the Indian delegation came back from Cairo, having signed the Programme of Action of the International Conference on Population and Development (ICPD) in 1994, the Central government decided to remove centrally determined demographic targets (personal interview, observer, 2004). Post-ICPD there was a surge of spending perhaps from budgets and activity of donor agencies in relation to population and reproductive health. For example, the Reproductive and Child Health Project was started with funding from different donor agencies in 1996.

In 1995, USAID began its international Policy Project to help developing countries implement the objectives of the Cairo conference. One of its objectives was to improve the existing policy environment for family planning and reproductive health care programmes (USAID 2003, 2004). Its operation spread over 36 countries, including India (USAID 2004). Set against the context of the target-free approach adopted by the Government of India in 1996 and the recognised need for decentralised programmatic action, USAID engaged the Population Policy Project in India to assist in the formulation of State-level Population Policies and to increase political support for family planning and population activities (USAID 2003). Initially the Policy Project worked in five States (Uttar Pradesh, Madhya Pradesh, Andhra Pradesh, Maharashtra, and Rajasthan) to help them draft, formulate and disseminate policies (USAID 2004). Later, it was extended to Uttaranchal when that new State was carved out of Uttar Pradesh (USAID 2003). USAID's sub-

contractor for the Policy Project in India was the Futures Group International, which started its work in Andhra Pradesh with the dissemination of the policy (Narayana 2004). In Uttar Pradesh, Madhya Pradesh and Rajasthan, it was fully involved in the drafting and dissemination of the State policies. As part of its operations, Futures Group International provided not only financial, but also technical assistance in bringing together various Indian institutes such as the Indian Institute for Health Management and Research (IIHMR), and international and Indian experts. Currently the Policy Project has wound up its operation in India and is limited to supporting the USAID Mission's major bilateral project in Uttar Pradesh "Innovations in Family Planning Services" (IFPS) (Narayana 2004 and The Futures Group 2004).

Therefore foreign assistance from international donor agencies has been a key factor behind the adoption of State-level Population Policies. In the initial years in mid-1970s these agencies were wary of involvement due to the compulsive government measures of population control. But since the late 1970s donor assistance has played a significant role in the country's spending on population issues. This peaked after the Cairo conference in 1994, and since 1996 the Policy Project of USAID has been instrumental in the formulation of State-level Population Policies of five States.

3.3.4. Role of the Central government

There has been a change in the role and position of the central government with regard to family planning over the years. Before 1995, the Government of India refused to devolve powers to the States. However from 1996, when it abolished the system of determining method-specific targets for the States, the Centre has reminded the States of the need for achieving replacement level fertility. As a result, currently it is encouraging States to adopt population policies - but within the framework set down by the national population policy of 2000.

3.3.4.1 From 1952 to 1996

> "Since 1952, however, the family planning programme has been centrally-sponsored, centrally-financed, centrally-monitored, centrally-evaluated and centrally-directed, though the implementation of the programme is left to the States" (pp 353, Bose 1988).

After gaining independence in 1947, India adopted a federal democratic structure following a combination of elements from both the British and American political systems. The Indian political structure works through an elected government at the Centre in New Delhi, and through twenty-eight States and seven union territories (Panandiker and Umashanker 1994, Government of India 2005). In the federal political systems of America, Canada and Germany, the division of power between the national and State governments is clear cut, and the States have authority to legislate, fund and implement matters relating to their residents. However, in India the central government wields all the policy and decision making powers. The Centre implements these policies through the States and the union territories (Panandiker and Umashanker 1994, Government of India 2005). It does not have its own machinery in each State and therefore it has to depend on the States for actual policy implementation. As a result, there has been a high degree of centralisation when it comes to the design, planning and administration of population policy. The directives of the Centre are very specific and restrictive. According to the Central guidelines, States do not have much flexibility to change their programmes according to their socio-economic situation. Staffing patterns and approaches to service delivery are more or less uniform across the country (Conly and Camp 1992, Narayana and Kantner 1992). For budget allocations to the States, the Centre follows a set formula and that is carried over by the States to their districts (Conly and Camp 1992). Moreover the Central government does not give the States much freedom to use its funds to make changes in the programme in relation to State-specific needs (Narayanan and Kantner 1992). For that purpose, they are required to make use of their own funds. On the other hand, States do not have the freedom to use their resources for amending staffing patterns and so approval from the Centre is required for this (Narayana and Kantner 1992).

This centrist tendency of the Central government in India today has been attributed to the style of governance inherited from the British colonial administration (Narayana and Kantner 1992). To administer the Indian subcontinent (including Pakistan and Bangladesh), the British passed uniform government acts to establish control over the whole population (Narayana and Kantner 1992). However, the top-down attitude of the post-independence government also had its roots in the felt need for developmental planning for the country as a whole (Hanson and Douglas 1972, Panandiker 1983, Narayana and Kantner 1992, Srinivasan 1995). In the initial years after independence, the perspective of policy makers

was more from a national level for the overall uniform development of the country - especially with regard to population and family planning (Rao 1989). As a result, by 1958-59 State Family Planning Boards were formed in order to implement the directives of the Centre and to monitor the family planning performance in each State (Rao 1989).

It was in 1966 that the Department of Family Planning was set up as part of the Ministry of Health (Rao 1989, Visaria 2002,). A special Joint Secretary was appointed to look after the administrative aspects of the family planning programme. Moreover, a Commissioner for Family Planning - taking care of technical aspects - was made responsible for the department's activities (Rao 1989, Visaria 2002). Trying out different approaches with the family planning programme from 'clinic-oriented' to 'extension' approaches, in 1966 the central government decided to adopt a target-oriented approach. For the first time a demographic goal of achieving a crude birth rate of 25 per 1000 population by 1972 was set (Srinivasan 1995, Visaria 2002). In 1966 the national crude birth rate was about 37.8 per thousand population (Visaria and Chari 1998). Under this new approach, every year the central government determined and passed method-specific numerical targets for each State, district and primary health centre (Khan and Townsend 2001, Visaria and Chari 2001, Donaldson 2002,). The calculation of targets in each State was determined on the basis of a formula based on population size, social and economic situation, and previous family planning performance (Gwatkin 1979). There was little discussion with, and participation of, field staff when setting these targets. Therefore 1966 can be considered as the landmark year when centralised population policy making really began in India.

The year 1976, however, was a turning point in the history of India's population policy. In that year the central government made a national population policy statement in which population control was stated as a national priority (Panandiker and Umashanker 1994, Srinivasan 1995). It pressurised the States to rigorously implement the Centre's policy objectives, and gave the States incentives and freedom to fulfil these goals. The main features covered in this population policy statement were the freezing of representation in both the national and the State legislatures based on the 1971 census results, and eight percent of central assistance to the States was to be directed towards family planning activities. It also suggested incentive payments by the central government to male sterilisation acceptors - Rs. 70 with four or more children, Rs.100 for couples with three

children, and Rs. 150 for those with two or fewer children. The population policy statement also laid down group incentives to Panchayati Raj Institutions, teachers, and labour organisations. Furthermore, it gave the States the freedom to enact legislation to differentially promote people having 3 or less children (Gwatkin 1979, Pethe 1981, Chaubey 2001). The year 1976 is also significant as it marked the transfer of power from the States to the Centre over population and family planning issues. Before 1976, population and family planning were 'State' subjects. Carrying on with the centrist tradition, the Central government amended the Constitution as a result of which 'population control and family planning' became subjects of the concurrent list (Panandiker and Umashanker 1994, Chaubey 2001). This meant that the central government got the powers of funding and planning for these subjects - though their implementation rested with the States (Rao 1989, Panandiker and Umashanker 1994, Srinivasan 1995). As a result of this strong centrist attitude of the central government, population policy initiatives undertaken by the States were mostly complementary to central policy initiatives. Whatever measures the States undertook were meant to help in the implementation of the national policy and the national programme.

3.3.4.2 From 1997 to the present

The position of the Constitution has not changed since 1976. Legislative power with respect to 'family planning and population control' still rests with the Centre. However, in April 1996, the central government decided to abolish targets for the entire country (Visaria and Visaria 1998, Reddy *et al* 2000). Therefore after thirty years of centralised planning and administration, the Centre devolved some powers to the States - giving a kick-start to the process of decentralisation. This meant that decentralised planning would start at the primary health centre level, where health workers would set targets for themselves after assessing the needs of their clients (Farrell *et al* 1998, Visaria and Visaria 1998).

Under the ninth plan period of 1997-2002 the central government emphasised decentralised, area-specific micro-planning for the family planning programme (Badri 2004). During this period it renamed the "target free approach" as the "community needs assessment approach". In October 1997 the central government also introduced the Reproductive and Child Health (RCH) programme funded by different multilateral and

bilateral donors (Mathai 1998, Visaria and Visaria 1998, Khan and Townsend 2001). Continuing with the spirit of decentralisation, and a focus on poor performing States, it divided the States into three categories based on their crude birth rate, their total fertility rate, the percentage of deliveries that took place in hospital, and the percentage of deliveries conducted by untrained birth attendants (Mathai 1998, Khan and Townsend 2001). Further categorisation was made of the districts within each State, based on an assessment of their crude birth and female literacy rates (Mathai 1998, Khan and Townsend 2001). The logic behind such categorisation was the prioritisation of work and the provision of more support for weaker performing districts (Mathai 1998, Khan and Townsend 2001). However, in an interesting turn of events, in July 2003 the Supreme Court of India upheld a law put before it by the Haryana government. The law disqualified a person from contesting elections for the local self-help governments – the Panchayati Raj Institutions - based on the two-child norm (Rao 2003). By this time seven States had already adopted their population policies, and all of them contained some form of incentive and disincentive scheme. Realising that such laws and policies were in violation of the 'Cairo spirit' espoused by the National Population Policy, the central government decided to set up the "National Level Resource Committee to facilitate formulation of Population Policies of States" (Government of India 2004). This committee was set up in 2002, and one of its key purposes was to guide States in the formulation of their population policies (Government of India, 2004, Rao 2004).

3.3.5. Emphasis on poor performing States

Although the demographic diversity of India was explicitly noted by a report of the Planning Commission (Rao 1989) in 1971, specific action by the central government aimed at the poorer performing States only really started in the early 1980s. The annual report of the Ministry of Health and Family Welfare in 1982 recommended the adoption of an area-specific approach for the States of Uttar Pradesh, Bihar, Madhya Pradesh and West Bengal, taking their poor family planning performance into account (Banerji 1989). The Seventh Five-Year Plan (1986-91) outlined the development of special schemes for these States in order to improve their programme efficiency (Banerji 1989, Srinivasan 1995, Chaubey 2001). As an adviser to the Prime Minister, Prof. Ashish Bose coined the word *BIMARU* describing the poor demographic performance of the four big northern States. *BIMARU* is

the acronym for these States in alphabetical order (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh). However in Hindi, 'Bimaru' means "the sickly or the ill".

> "BIMARU describes aptly the demographic sickness of these States which account for 40 per cent of India's population, 42 per cent of the growth in absolute numbers and 48 per cent of India's illiterate population" (Bose in *Tribune,* September 24, 2005).

In 1992, the Department of Family Welfare published a report on various weaknesses of the family welfare programme (Chaubey 2001). And as a reaction to this document, the government recommended a twelve-point strategy for the improvement of the programme. One of the recommendations of the 1992 report was to adopt special initiatives in relation to 90 "backward" districts in the northern States (World Bank 1995). Though in 1996 the central government abolished the system of determining demographic target-setting for the States, its eagerness to reduce fertility and population growth rates persisted. In order to streamline its focus and ameliorate the poor performance of the big northern States, in March 2001, the Department of Family Welfare established an "Empowered Action Group" (EAG), to develop specific strategies of action for these States (Government of India 2001). However, realising the significant demographic differences between districts within States, the current government has decided to focus on 150 high fertility districts (Government of India 2004). In order to focus the attention of policy makers and programme managers in these districts on their poor demographic performance, it has convened various regional and national workshops. Thus one such workshop, held in January 1999 by the Department of Family Welfare, was to review performance and help poor performing States to identify their weaknesses (UNFPA 1999). In the proceedings of the first conference of the State Population Commissions held in 2002, a sense of urgency on the part of the central government to stabilise the population growth rate is evident. For example, one of the objectives for convening the conference was to make "population stabilisation a people's programme" (Government of India 2002, pp 1). At the national level, there was an increase in political commitment for population stabilisation after 1996. The former Prime Minister, Atal Bihari Vajpayee, talked about his concern:

> "... in areas of population stabilisation ... what has been worrying me is the big gap between the progress made in other States and the unsatisfactory performance of the four northern States of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. ...since these four States alone account for 37% of India's population, their laggardly performance is pulling

down the socio-economic development of the country as a whole." (Govt of India, Press Release, January 16, 2003).

The Minister and the Secretary of the Department of Health and Family Welfare also made this point publicly (Government of India 2002). Moreover, in the upper house of the national Parliament demographic diversity has been a topic of discussion since 2000 as is reflected in the minutes of the sessions of the Parliament (Government of India 2000). So we see that the role of central government has been significant in population policy measures of the state-level. Until 1996 the Centre had followed a centrist attitude towards the States with regard to family planning. It did that not only by following the four decade long target-oriented approach to family planning, but also in the design, planning and administration of population policy. Instances of severe centrist tendency were seen in 1976 when the central government followed a 'carrot and stick' policy of pressuring the States to implement its policy objectives and in return giving them financial assistance. However since the 1980s, recognition of the glaring inter-State demographic differences led to the Centre's focus on socio-economically, and especially demographically, poor-performing States. Since 1996 it started a decentralisation policy by abolishing demographic setting for the States. Thus the Centre's focus on poor performing States to stabilise population growth, coupled with its decentralisation policy, has played a role in the formulation of State-level Population Policies.

3.3.6. Report of the Expert Group of 1994

A key factor that gave a fillip to the process of adoption of official population policies by the States was the report of the expert group the "Swaminathan Committee", headed by Dr. M. S. Swaminathan, an eminent agricultural scientist. In 1993 the central government appointed the Expert Group to draft a National Population Policy that was to be ratified by both the country's cabinet and parliament for the first time in Indian population policy making history (Srinivasan 1995, Visaria and Chari 1998, Chaubey 2001). The draft of the National Population Policy written by this group was submitted to Parliament in 1994 (Chaubey 2001, Visaria and Chari 2001). Though it was written as a draft, it was the first official document to give the States specific impetus to adopt their own policies (Visaria 2002). Thus the report says:

> "The State Population and Social Development Committee will prepare a socio-demographic charter for the State as a whole ... ." (pp 9, Draft national population policy, expert group, May 21, 1994).

However, it took six years for the central government to announce a National Population Policy. The delay was because of many revisions made to the draft, and several changes of the ruling party at the Centre in Delhi (Visaria 2002). In February 2000 the first official population policy of India was finally adopted. The policy refers to the creation of State Population Commissions as one of its strategies (Nanda 2002, National Population Policy 2000, pp 13). As a result after its announcement, a National Population Commission was formed in May 2000. Along with the Department of Family Welfare, this Commission is encouraging the States to establish State commissions and to adopt population policies within the framework suggested by the national policy.

3.3.7. The Influence of ICPD

One key international event that requires special mention in this discussion is the International Conference on Population and Development (ICPD) that was held in Cairo in 1994 and to which India was a signatory. There are three key linkages to be noted here. First of all, the report of the Expert Group chaired by Dr. M.S. Swaminathan was both influenced by ICPD and was also an influence on the country report of India prepared for the conference (personal interview, policymakers, Delhi, 2004). Secondly, the impact of ICPD can be seen in the Reproductive and Child Health project of 1997, which included area-specific micro-planning and providing need-based demand–driven high quality service. The spirit of the reproductive health care approach is strongly reflected in the wording of the National Population Policy (2000), with an emphasis on voluntarism and the use of informed choice and consent, combined with decentralised planning and the implementation of a policy based on area-specific needs and demands (Rao 2001, Nanda 2002, Visaria and Ramachandran 2002). Thirdly, in order to implement the policy objectives of ICPD's PoA, USAID started its International Policy Project which was instrumental in the drafting of the State population policies.

This section has discussed the factors that have contributed to the adoption of official State population policies since 1997. The commitment of the State leadership to family planning was found to be an important factor as such commitment depended on allegiance to a political party which believed in such matters. Efficient administrators combined with technical and financial assistance from donor agencies such as USAID's Policy Project significantly contributed to policy adoption by States. The Centre's focus on poor performing States since the 1980s, combined with its target-free approach, contributed to the process, together with the recommendations of the Expert Group. Finally, the influence of ICPD conference was a significant influence nationally in bringing about a decentralised attitude of the central government and the start of the Policy Project of which India was a partner.

3.4. Conclusion

Although population measures were undertaken by the States since 1952, it was in 1997 that the first State-level Population Policy – for Andhra Pradesh - was officially adopted. Pre-1997, government measures were incentive and disincentive schemes to promote small-family norms, but they were not ratified by the legislative and executive branches of the government and cannot be regarded as official policies. The first eight State-level Population Policies were formed after the announcement of the Centre's decentralisation policy in 1997. These eight States were quick to adapt to the decentralisation environment and took it upon themselves to include incentive and disincentive measures in their policies to address their respective demographic situations. In 2002 the Centre formed the National Level Resource Committee to ensure that the remaining States adopt population policies in the Cairo spirit. This was a measure to prevent further use of incentive and disincentive schemes. At present, twelve States and five Union Territories have officially adopted policies. In order to examine the factors contributing to the adoption of these policies this chapter examined the role of the political leadership, administrators, and the central government. It also described the effect of assistance from the donor agencies. It showed that the Cairo conference created a global atmosphere involving a 'paradigm shift'. This involved moving from an emphasis on aggregate problems arising from rapid population growth to responding to the reproductive health needs of people. For India it meant the removal of centrally determined demographic targets and the adoption of a bottom-up

'community needs assessment' approach. As has been mentioned, talk of decentralisation had been underway for quite some time. Indeed, one such initiative was the report of the Expert Group in 1994. However, the same central government that took almost thirty years to address State-wise demographic differentials was now proactively reminding and urging the poor performing States to take action. As a result, the States with active political leaders and efficient administrators realised the need to take charge of their own demographic situation. Meanwhile in the post-Cairo environment, USAID started its Policy Project in thirty-six countries. In India, it provided both financial and technical assistance to help States to formulate their own population policies. Those States ready for action collaborated with the Policy Project and adopted policies. The next chapter reviews the literature to examine the evolution and implementation of family planning strategies, both internationally and in India.

Chapter 4: Family Planning Programmes and their Implementation Strategies

4.1. Background

This chapter is a review of the literature on the evolution of international and Indian population policies and family planning programmes by focusing on the approaches adopted during different international conferences on population. It specifically examines how various family planning strategies have been used by these policies. It focuses on three strategies namely, the provision of different contraceptive methods, the involvement of community-based institutions in the family planning programme, and the use (and non-use) of demographic targets, incentives and disincentives. By examining the historical background of their emergence the chapter locates the discussion of the Indian family planning programme and the use of these strategies over the years in the proper context. As a result, the chapter examines the demographic performance of India. Finally, the family planning programme of India from 1952 till the present time is reviewed, with an emphasis on the use of the three family planning strategies at the national level. Chapter 6 analyses the research findings to examine the use of these strategies in Madhya Pradesh and West Bengal. Therefore the purpose of this chapter is to discuss the conceptual and contextual framework of the thesis.

4.2. Evolution of International Population Policy and Family Planning Programmes

We can trace the debate on population policy emanating from the empires of the ancient world when "greater numbers tended to connote greater wealth and power" (pp 3, Demeny 2003). Traditional societies, either early modern Western European or Indian, witnessed modest population growth rates due to high levels of fertility and mortality. The nineteenth and early twentieth century debate was dominated by the views of Malthus that accelerating population growth rates would jeopardise the capacity of nature to accommodate increasing a population (Cassen 1994). From nineteenth century till the outbreak of First World War, Europe witnessed demographic transition. Rising fertility due to a ban on contraceptive information and abortion was overshadowed by declining parental demand for children as a

result of the limitations of urban life (pp. 8:9 Demeny 2003). However, the inter World War period saw significant loss of life leading to huge fertility decline giving rise to pro-natalist population policies. The debate after the Second World War began with discussion of these policies and voluntary control of fertility in the Western world and how demographic transition had helped in reducing fertility, that is how "modernisation", lessening of familial and kinship ties played a role (Freedman and Berelson 1976). Discussions about the increasing gap between the developed and the developing world due to the rapid increase in population growth in developing countries on the one hand and low fertility and higher income levels in the developed world began in the late 1950s (Sinding, Ross and Rosenfield 1994, Demeny 2003). During the 1960s and 1970s, two main approaches to fertility reduction can be identified. One group comprising of world leaders like the former United States President Lyndon Johnson and World Bank President Robert McNamara wanted family planning programmes to be the primary means for fertility reduction (Sinding, Ross and Rosenfield 1994). The other group, consisting of (predominantly Asian) governments, believed that overall socio-economic development would lead to reduction in fertility and overall population growth in the developing world (Sinding, Ross and Rosenfield 1994). Discussions about population policy reached the inter-governmental level with the major international conferences on population. During the first international conference in 1974 at Bucharest the debate highlighted the divergent views of developed and developing countries. The developing world thought 'development was the best contraceptive' (Singh 1974) whereas the West proposed the setting up of family planning programme to address global population growth. The Bucharest conference helped in the convergence of these thoughts, giving priority to the 'socio-economic development' stance (Korten 1979, Sinding, Ross and Rosenfield 1994). Tables were turned in the 1980s, when the United States administration of the time opposed abortion and favoured socio-economic development to address population growth. Conversely, developing countries opined that family planning programmes were the way to control population growth (McIntosh and Finkle 1995). Consensus among most developing countries was that high fertility and population growth adversely affects efforts to improve standard of living and has negative socio-economic effects (Bongaarts et al 1990). As a result "by 1985, 37 governments had established national family planning programmes and an additional 33 countries had significant non- governmental programmes with direct or indirect support of the government" (pp 299, Bongaarts et al 1990).

The focus changed again in the 1990s, when feminist perspectives gained prominence. ICPD's PoA espoused that individuals should be "able to have a satisfying and safe sex life and have the capability to reproduce and the freedom to decide, if and when and how often to do so" (Programme of Action 1994, Population Bulletin 2001). The main idea arising from the Cairo conference was that population policy should be client-centred and address the reproductive health needs of individuals, abolishing coercive demographic targets at the aggregate level. "Governments should give special attention to the development and implementation of client-centred management information systems for population and development, and particularly for reproductive health, including family- planning and sexual health programmes..." (Action 13.10, Programme of Action 1994). As a result, family planning services should be provided in comprehensive reproductive health care packages including safe pregnancy and delivery services, prevention and treatment of sexually transmitted diseases, information and counselling on sexuality, and targeting vulnerable populations including adolescents and refugees (Ashford and Makinson 1999). As a result, the focus on rapid population growth rate and implementation of family planning programme in developing countries took a backseat (Cleland 1997, Caldwell et al 2002, Finkle and McIntosh 2002). Despite 180 countries agreeing on the importance of the reproductive health approach at ICPD, one of the most contentious issues was the integration of reproductive health care with family planning programmes (Brown 1994, Jain 1994, Cleland 1997, Lush 1997). The core vision of the Cairo agenda is that by responding to the reproductive health needs of individuals, the aggregate problem of rapid population growth will be resolved. But it failed to provide a model for the implementation of its recommendations (Brown 1994, Caldwell 1996, Finkle and McIntosh 2002, White, Merrick, and Yazbeck 2006). As a consequence, the challenges facing the different signatory countries of Cairo were and have been how to expand their family planning programme whilst dealing with which reproductive health service should be given priority in this integration process, how decisions should be implemented to ensure quality of services, and what the cost implications would be for such initiatives (Brown 1994). Studies conducted after Cairo showed that in integrating reproductive health in their family planning programmes, countries like Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru and Senegal were facing institutional constraints such as staff shortages, work overload, lack of trained personnel as part of their newly decentralized management and

financing systems (Hardee *et al* 1999). Moreover, studies by White, Merrick and Yazbeck (2006) mention failure by countries of Central and South America to provide reproductive services to the poor and vulnerable people (pp. 8, 2006). At the turn of the century at the United Nations Millennium Summit, eight Millennium Development Goals (MDG) were identified. Due in part to backlash from the Cairo conference, reproductive health was not identified as an independent MDG (Bernstein 2005, Crossette 2005). As a result, there are major issues regarding the further declining priority on family planning and allocation of resources to it (Blanc and Tsui 2005).

Thus the debate about population policy and the use of voluntary fertility control started in the 1950s. Over the next two decades the argument was whether family planning programmes or socio-economic development would provide the solution for rapid population growth in the developing world. In the 1990s, focus shifted to provision of family planning services with reproductive health services. However, the beginning of the new century saw further declining priority on family planning and reproductive health was not considered a MDG. The next section considers the use of family planning strategies by different programmes in the last century and beginning of the current century with the changing focus on family planning.

4.3. Strategies for the implementation of Family Planning Programmes

In the 1970s, research was focussed on the various strategies that a government could use for the effective functioning of a family planning programme in order to tackle unintended or unwanted fertility. Berelson (1974) identified five family planning strategies that governments used or could use to reduce fertility: (1) communication with people to influence their demographic behaviour, (2) provision of family planning services, primarily different contraceptive methods, (3) manipulation of family size through incentives and disincentives, (4) changing social institutions like marital status, child mortality rate etc. to affect fertility preferences, and, (5) employing coercion to achieve desired demographic objectives. In the 1970s, service providers in many countries provided information about fertility reduction through different media like schools, training courses, community organisations and other mass media. As different contraceptive methods became available, governments started to provide them in a range of combinations depending on availability

and accessibility. There was evidence of use of incentives and disincentives by India, Pakistan, Taiwan, South Korea, and Tunisia (Veatch 1977), and in particular the use of coercion by India and China to meet demographic targets. In 1989 a study conducted by UNFPA identified political commitment, generating demand, increasing and improving accessibility through the private sector, developing adequate personnel and financial bases, as key elements of many programmes (Keller et al 1989). Along with the use of these family planning strategies, the literature discussed the organisational structure of family planning programmes, that is, whether a programme should have a vertical structure or be integrated with other health services (Korten 1979). Also, as part of the evolution of these programmes, different models of service delivery including clinic based, clinician oriented, community based and oriented were identified (Korten 1975, 1979). The premise of this discussion was the level of control a government exercises in administering and delivering family planning services ranging from top-down centralisation to bottom-up decentralisation (Korten 1979). After Cairo in 1994, family planning programmes went through a drastic transition as part of the process of setting priorities and integration with reproductive health services. Family planning programmes that have integrated reproductive health care are called reproductive health programmes. However, three family planning strategies that epitomize a population policy of the pre-Cairo demographic era are the provision of mix of contraceptive methods; the involvement of community-based institutions; and the use of demographic targets, incentives and disincentives. The practice of demographic targets, incentives, and disincentives, availability of family planning services and contraceptive methods based on the priority of the provider, and thirdly, top-down policy making and service delivery based on the principle of maximum coverage to stabilize population growth rate represents an anti-natalist population policy like pre-1996 India. Therefore, to examine the pre- and post-1996 centralised and decentralised environments regarding target-setting reproductive health incorporation and keeping the relevance and practicability in an Indian context, these three family planning strategies were chosen for the study.

4.3.1. Contraceptive method mix

Contraceptives provided initially by family planning programmes in the 1970s included oral pills, condoms, the intrauterine device (IUD), sterilisation (male and female) and abortion (pp 11, Freedman and Berelson 1976). The provision of these different contraceptive methods as part of a family planning strategy has been addressed both from demand and supply perspectives (Kumar et al 1989). The 'quality of care' framework (see Donabedian 1988, Bruce1990) contends that a number of appropriate and acceptable contraceptive methods should be provided to clients based on their informed choice by technically competent providers and depending on the specific reproductive health need of individual clients. Improving quality of contraceptive services leads to satisfied clients which will result in increasing contraceptive prevalence and eventually in fertility reduction (Bruce 1990). The life-cycle approach, based on the demarcation of unmet need over a woman's major life stages[1], matches particular contraceptive methods with the needs of particular reproductive age groups (Sen *et al* 1994, Potts *et al* 1998). Since contraceptives differ in their attributes and because there are variant reproductive health needs among individuals in terms of their sexual life-cycle, health status and specific stage in the life-cycle, the use of contraceptive methods is also different and variable (Ambedgaokar 1997). The rationale behind this segmentation is that each category of woman will need a different type of contraceptive method. Therefore, meeting those particular needs will lead to a reduction in the requirement to provide a wide range of methods in every family planning clinic. This, in turn will not only lead to improved efficiency and effectiveness of care, but will also stimulate an improvement in the overall quality of the services provided (Potts *et al* 1998).

Public health specialists have examined the provision of a mix of contraceptive methods from two main perspectives. One perspective, otherwise termed as the "strategic approach", is based on the aspect of sustainability and utility of introduction of new methods in poor countries (Simmons *et al* 1997). The second perspective (Stewart *et al* 1999, Vernon and Foreit 1999) is from the standpoint of organisational structures - as to which type of structure is suited for offering clinical and non-clinical methods. The emergence of the strategic approach for the introduction of new contraceptive methods can be traced to

[1] Women of reproductive age one divided into 4 categories namely those who are fertile but not yet sexually active; sexually active women who are childless and do not wish to have children yet; women in the maternal phase who are pregnant and have had previous births; and women who are still fertile, but do not want to ever have a child or another child (Ashford 2000).

international organisations such as the World Bank and World Health Organisation (WHO). These organisations argued that instead of introducing new contraceptive methods and technologies in resource-poor settings, it is more cost-effective and efficient to improve the service delivery of already existing methods. This argument emphasizes method-mix and improvement in the capacity to offer reproductive health services with quality of care that reflects the user's needs (Simmons *et al* 1997).

Studies have analysed the impact of different models of service delivery for family planning programmes and the provision of different contraceptive methods mix (Stewart *et al* 1999, Vernon and Foreit 1999). Vertical programmes have single purpose sites, meaning family planning clinics that are with single purpose providers of family planning services. An integrated structure performs a combination of various family planning and health functions and tasks both at the policy and service delivery levels. It is important to remember that the reproductive health approach propagates an integrated programme. Research has shown that an integrated structure is ideally suited to provide a range of contraceptive methods (Stewart *et al* 1999, Vernon and Foreit 1999) because a structure that provides family planning along with other health services is likely to be staffed with medical personnel who will be trained to provide IUD and sterilization, the two clinical contraceptive methods that need medical supervision. Moreover, if located within an area of dispersed population and with less overall demand for family planning, integrated structures can promote the benefits of a range of methods when offered in conjunction with other health services. Keller et al (1989) discuss the relationship between demand and context, and note that providing too many methods may not yield the desired results of fertility reduction and improved health if administrative capacities are not highly developed. Furthermore, an integrated structure can discourage the provision of many variants of each method for reasons of logistics and supply. Thus, dependent on the capability and socio-economic circumstances of a country, improving efficiency in the provision of a combination of already available contraceptive methods might be more efficient than introducing new methods and technology.

4.3.2. Involvement of community-based institutions

Community-based programmes for the distribution of non-clinical contraceptives have been used since the 1970s, especially in rural communities in developing countries where there is shortage of trained personnel, leading to decentralised programme administration (Korten 1985, Allan Guttmacher Institute 1997, Cleland 1997). Examples of successful community-based distribution programmes have occurred in Bangladesh, Sri Lanka, Indonesia, Taiwan and Korea (Alan Guttmacher Institute 1975, 1977, Family Health International 1999). In some countries (e.g. Brazil, Colombia, Honduras), in order to make up for a shortage of personnel, community leaders have become involved (for example, teachers, municipal workers, heads of mothers' clubs, satisfied contraceptive users) (Alan Guttmacher Institute 1975, Korten 1985). International conferences (International Conference on Family Planning, Jakarta, 1981; International Conference on Better Health for Women and Children through Family Planning, Nairobi, 1987) have recommended that in order to increase programme efficiency local communities should be involved both in service delivery and in programme design depending on the specific context of individual countries (Population Council, 1981, Conference Report 1988).

Both needs and rights groups agree on the importance of community involvement for reproductive health integration (Cleland 1997, Stewart *et al* 1999, Hardee and Smith 2000). However, the difference in perspective is that of supply and demand. Rights groups advocate community involvement from a demand perspective. That is, in terms of how a community is responsible for addressing violence and coercion in issues related to reproductive health, thereby making a community sensitive to matters associated with reproductive freedom. On the other hand, proponents of a needs-based approach suggest ways to increase community involvement, thereby increasing contact between clients and the provider. This might include community involvement in service delivery, increasing awareness about contraceptive methods, and involving the community in social marketing of contraceptives leading to a participatory bottom-up system to address the reproductive health needs of the community more efficiently.

Success in involving the community depends partly on the national context. A bottom-up approach is facilitated by contexts where local communities are already involved in

population and reproductive health activities or other social activities, and the political structure is federal and democratic in nature. Vertically structured community-based programmes have proved effective in distributing contraceptive supplies in the countries of Western Africa (e.g. Cote d'Ivoire, Nigeria, Benin, Ghana and Guinea) accounting for a large proportion of the total family planning couple-years of protection that is supplied (Stewart *et al* 1999). Thus, the effectiveness and usefulness of existing community structures should be studied first before implementing an integrated structure. The PoA of Cairo recommends community participation in reproductive health services by decentralizing the management of public health programmes. However the process of devolution of power from central governments to the community level sometimes leads to transfer of responsibility without proper guidelines for implementation and adequate allocation of resources (Hardee and Smith 2000). There is no set formula for determining how the community should be involved, what responsibilities should be devolved, and who in the community should be engaged.

4.3.3. Demographic targets, incentives and disincentives

Discussion on the use of demographic targets, incentives and disincentives as a family planning strategy is premised on the justification of governmental action to reduce population growth over the responsibility of individuals to determine their own family size. Debate on the use of coercive versus voluntary family planning is longstanding (Veatch 1977). Those favouring the use of incentives have proposed different kinds of incentives with different target audiences from individual acceptors, group of acceptors and even the whole community, to motivators, and providers (Enke 1960, Ridker 1969 as referenced in Veatch 1977, Berelson 1974). Others have justified their use with reference to the timing of their use – delayed versus immediate, and also non-coercive or not harming unborn children (Veatch 1977).

The Cairo PoA condemned coercive family planning programmes and stated that family planning goals of governments should be defined in terms of unmet need for information and services (Isaacs 1995). The criticism of use of targets by rights advocates is based on the premise of reproductive choice (Isaacs 1995, Hardon and Hayes 1997). Employing

targets to achieve demographic goals has sometimes been achieved through coercive methods which leads to involuntary choice and clashes between the right to reproductive health care and the right to reproductive self-determination (Boland *et al* 1994, Center for Reproductive Rights 2003). Anti-natalist countries of China, India and Indonesia facing rapid population growth have used this strategy, but no studies have confirmed their direct advantage in increasing long-term contraceptive use and changing fertility behaviour (Keller *et al* 1989). When fertility fails to decline at a desired pace, a country imposes stringent performance targets on service providers and managers, adds incentives for clients, and in some instances employs coercion. It is contended that unless this association between family planning programmes and the societal objective of fertility reduction is removed, poor quality programmes will persist (Jain and Bruce 1994). It has been clearly established that helping women to fulfil their unmet need accomplishes as much, or more, demographically than meeting the demographic targets set by family planning programmes (Sinding *et al* 1994). The discontinuation of target-setting by a reproductive health programme reflects the presence of a client-centred needs-based environment where the client is able to choose a contraceptive method not out of pressure, but rather out of his/her own reproductive health need. This in turn will create a better environment for the implementation of the stage-of-life approach. The removal of targets reflects a bottom-up approach where service provision is decentralized and provision of family planning can be offered either by an integrated or by a vertical programme, or by both. Thus, service provision is based on voluntarism whereby the provider will offer different affordable and easily accessible methods, information about contraindications of each method provided, and make available follow-up care and service if the client needs to discontinue or switch, leading to more choice for clients.

Thus the use of these family planning strategies can be traced in the literature since the 1970s, with evidence of use of incentives and disincentives by Asian countries including India. Provision of different contraceptive methods as a strategy has been debated extensively. The quality of care framework, life-cycle approach, and strategic approach have discussed it in-depth and the benefits of its use have been considered from organisational standpoints as well. On the other hand, successful community based programmes were seen in Asian and Western African countries. However, use of this strategy has been debated from the demand and supply perspectives and also on the types

of programmes. Finally, debate on the use of demographic targets, incentives and disincentives was found to be around the use of coercion versus voluntarism. The Cairo mandate of informed choice of contraception strongly opposed such measures.

4.4. Demographic background of India

India is a country of vast demographic diversity. Although it is the second most populous country in the world, rates of population growth by state are not uniform. States vary greatly in population size, density, and other demographic characteristics including age structure and sex ratio (Srinivasan 1995). According to the 2001 census, Uttar Pradesh was the most populous State with 166.1 million inhabitants and Sikkim the least populous (0.5 million) (Government of India 2001). The major contributors to population growth are the four big northern *BIMARU* States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh, which together constitute almost 40 percent of the country's population (Srinivasan 1995, Government of India 1999, Sharma 2004). However, interstate variation in rates of population growth existed before Independence in 1947 (Srinivasan 1995). States like Kerala and Maharashtra that are currently demographically better performing grew annually at 1.5 percent or more during 1901-51, while the big poorer performing States of the north grew at only at 0.5 per cent per year (Srinivasan 1995). The reasons for such growth rate differences are attributed mainly to differential mortality rates, and to a lesser extent, differences in natural fertility. Compared to the others, States like Kerala and Maharashtra had better public health and sanitation systems and better nutrition levels, leading to earlier reduction in mortality rates (Srinivasan 1995).

Looking at the demographic picture of the country over the last few decades, one sees that some States have been able to reduce their population growth rates while others have maintained high growth rates. During 1981-91, the northern States of Uttar Pradesh (25.55 percent), Bihar (23.38 percent), Madhya Pradesh (27.24 percent) and Rajasthan (28.44 percent) registered high decadal population growth (NIHFW 2003). Comparing these figures to 1991-2001, one sees that these States continued to maintain high growth rates with a decadal percentage increase for Uttar Pradesh of 25.80 percent, Bihar (28.43 percent), Madhya Pradesh (24.34 percent) and Rajasthan (28.33 percent) (NIHFW 2003). But for southern States like Kerala the decadal growth rate reduced from 14.32 in 1981-91

to 9.42 percent in 1991-2001 (NIHFW 2003). Similarly Tamil Nadu registered growth rates of 15.39 during 1981-1991 and that reduced to 11.19 percent during 1991-2001 (NIHFW 2003). Similarly there are vast interstate differences in fertility levels. In the States of the south and west of the country, the total fertility rates are below the national average of 2.6 births per woman (NFHS 3) whereas for the north central States the level is 4 or higher (Sen and Ramachandran 2002). The reason for poor performance in the northern States is often attributed to poor socioeconomic development leading to a higher incidence of poverty, and higher rates of illiteracy (especially for females). Along with these considerations, other causes mentioned are poor quality of health services coverage and high levels of unmet need for family planning services (Ramachandran 1999, UNFPA 2000). The reasons for better performance by the southern States include relatively early onset of socio-economic development, increased acceptance of contraception, higher levels of female education, and greater influence of "cheap books, films and television" in introducing new models of sexual and reproductive behaviour, mostly in urban areas (pp12, Dyson *et al* 2004).

Since the 1950s, there has been uneven population growth across India, attributed to differentials in mortality rate declines, varying degrees of success of the family planning programme, increases in life expectancy due to better health care systems, and removal of social and religious taboos on sexual intercourse (Srinivasan 1996, Dyson 2004). The country is in its fourth or final stage of demographic transition where "the pace of declines in mortality initiated during the early 'fifties has slowed down and there is an acceleration in the pace of declines in fertility since the early 'eighties, leading to a slowing down in the rates of population growth" (Srinivasan, 1996, pp 3). However, some south western States in the country like Goa, Kerala and Tamil Nadu have already reached or fallen below the replacement level fertility of 2.1 whereas the northern States of Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Haryana are lagging behind considerably (Srinivasan 1995, NFHS 1999, Sharma 2004). The contraceptive prevalence rate of the country has increased from 41% in 1992-93 to 48% in 1998-1999 to 56% in 2005-2006 among married women aged 15 to 49 years (NFHS 2005-06). About 13.2% of married Indian women have unmet need and it has fallen from 20% in 1992-93 during NFHS 1 (NFHS 3). Also, there is inter-State variation of unmet need which varies from 7-8% in Punjab, Haryana, and Andhra Pradesh to 25-36% in Meghalaya, Nagaland, Bihar and Uttar Pradesh (NFHS 1999).

4.5. Family Planning Services in India

India was the first country in the world to adopt a Family Welfare Programme in 1952. Based on the United Kingdom's public national health service, primary health care was established as the foundation of the Indian health systems (Peters *et al* 2002). This meant provision of simple curative and preventive care at a clinic and home-setting. As a result the Family Welfare Programme started out as a clinic-centred service delivery system that concentrated on improving the health of mothers and children (Jeejebhoy et al 2004). Since the 1960s the objective of the programme has shifted from human welfare to population stabilisation. The Indian Family Welfare Programme has evolved over the past four decades adopting different approaches to control population growth. These approaches can be traced chronologically based on the Five-Year Plans of the Government of India. Broadly, seven approaches to the Indian Family Welfare Programme can be identified, as seen in Table 4.1 below.

Table 4.1: Family Planning Programme Approaches of Government of India (1952-2006)

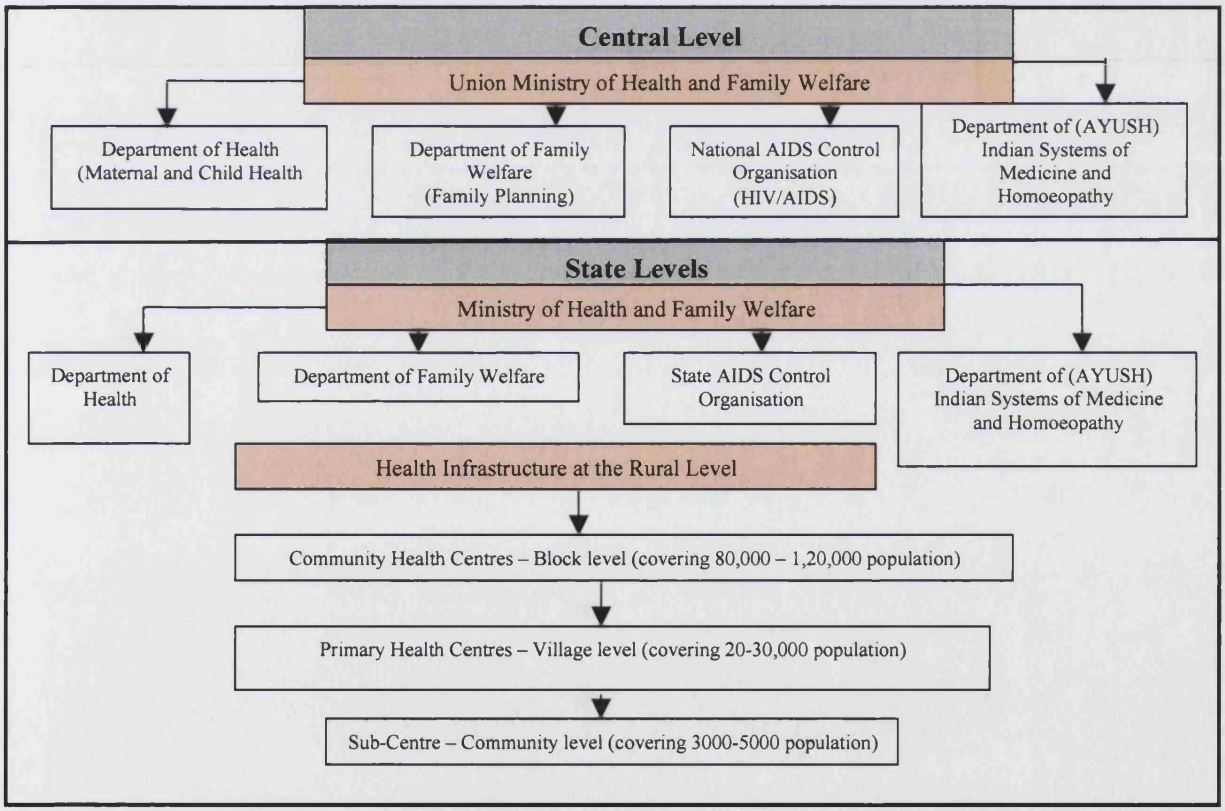
Years covered	Family Planning Approaches	Basic Tenets	Five-Year Plans covered	Demographic data reported over the years
1952-64	Clinic-oriented Approach	• Originated in urban areas; • Outlined integration services • Encouragement of NGOs.	First and Second five-year plans	Crude Birth rate - 41.7 Crude Death rate per 1000 population - 22.8 Total Fertility Rate - 5.97
1964-71	Extension Approach	• Auxiliary Nurse Midwives to visit homes of married women • Family Planning Programme to remain centrally sponsored scheme – Central Government to meet entire expenditure • Policy goals - acceleration of fall of birth rate by speedy contraceptive adoption • Introduction of IUD • Cafeteria approach with emphasis on sterilization • Incentives for sterilisation	Third five-year plan	Crude Birth rate - 37.8 Crude Death rate - 15.4 Total Fertility Rate - 5.2
1969-95	Target-oriented Approach simultaneously along with other approaches	• Contraceptive method-specific numerical targets introduced. • Integration of Family Planning with Maternal Child Health • During 6th plan separate targets for different contraceptive methods and their allocation to the States.	Fourth to mid of Eighth five-year plans	
1971-77	Intensive Approach during Emergency	• Obsession with speedy lowering of crude birth rate • Freezing at 1971 till 2001 of Legislative seats at national and state levels based on population size. • Freedom given to States to legalize compulsory sterilization. • Cases of forced sterilization reported.	Fourth and Fifth five-year plans	Crude Birth rate - 37.2 Crude Death rate - 15.0 Total Fertility Rate - 5.8
1977-95	Development Based Welfare Approach	• Voluntary nature of Family Planning Programme was reaffirmed. • From 1977 Family Planning Programme renamed as Family Welfare programme. • Promotion of non-terminal/reversible contraceptive methods. • Decentralized approach to service provision.	Sixth, Seventh and Eighth five-year plans	Crude Birth rate - 27.4 Crude Death rate - 8.9 Total Fertility rate - 3.6
1996-97	Target-Free Approach	• Focus on clients' needs and to improve quality of care. • Bottom-up approach under which caseloads of workers to be determined after identifying clients' needs. • Lack of guidelines to the States resulting in confusion in implementation.	Eighth five-year plan	Crude Birth rate - 27.0 Crude Death rate - 9.0 Total Fertility rate – 2.98
1997 to date	Community-Needs Assessment	• Recasting of previous approach. • 2 types of Reproductive Health service packages - essential and expanded • Targets to be set by health workers based to Expected level of Achievement after assessing needs of clients in particular areas.	Ninth and Tenth five-year plans	

(Visaria and Chari, 1998, Reddy, Rayappa, Raju, 2000, Visaria, Jejeebhoy and Merrick, 1999, M. Ramakrishna Reddy, P. Hanumantha Rayappa, and K.N.M. Raju, 2000, Panandiker and Umashanker, 1994, Pethe 1978, Narayana and Sangwan, 2001)

As part of the Indian health system the organisation, management and implementation of the Indian Family Welfare Programme is jointly shares by the central and State governments. At the national level, since its inception, the programme has been the

responsibility of the Union Ministry of Health and Family Welfare which is charged with setting policy on reproductive health. Within the ministry, the Department of Family Welfare (responsible for family planning), the Department of Health (responsible for maternal and child health), and the National AIDS Control Organization (NACO) (responsible for AIDS and STDs) implement it. As shown in table 4.2, individual States, on their part, implement the programme with corresponding departments responsible for family planning, maternal and child health, and for AIDs and STDs. The "large public network of health providers" (pp. 3 Peters *et a*l 2002) of the Indian health system at the rural level consists of Community Health Centres at the block level, Primary Health Centres at the village level, and sub-centres at the community level (Annual Reports, Ministry of Health and Family Welfare 2002, 2004).

Table 4.2: Division of Responsibility of the Family Welfare Programme at the Central and State Levels



4.5.1. Contraceptive method mix in India

For the past five decades the Indian programme has provided clinical (vasectomy, tubectomy) and non-clinical (oral pills, condoms and IUD) contraceptive methods. The programme has used different techniques of both vasectomy (scalpel and non-scalpel) and tubectomy (abdominal tubectomy, ligation, mini-laparotomy and laparoscopy), but not all States have been able to provide them all due to a lack of trained doctors (Personal Interview Munshi 2004). In the 1960s, the recruitment of IUD acceptors, together with condom use, was emphasised (Merrick 1996). However "unanticipated popular reaction" and promotion of the method "without a full appreciation of its medical side effects" (Gwatin 1979: 32) led to a sharp fall in acceptors from "900,000 in 1966-67 to 300,000-400,000 in early 1970s. In the 1970s, the programme primarily depended on sterilization as part of its target-oriented approach (Srinivasan 1996). The emphasis then was on vasectomy, but following the backlash of the Emergency, the emphasis has been on tubectomy ever since. However, due to its irreversible nature, acceptors of sterilization tended to be older, high parity women (Srinivasan 1995). Despite the increase in contraceptive prevalence rate among this reproductive group, the needs of younger couples who want contraception for spacing births are being ignored (Srinivasan 1995, 1996). In addition to high parity couples, the target audience for the programme has been married women who are pregnant and have had previous births (Narayana and Kantner 1992). The family planning programme is inadequate in dealing with the needs of young unmarried women and married women who are childless and do not wish to have children yet (Conly 1992). On the other hand, in an Indian context, currently married women who are not using any contraceptive method but who do not want any more children or want to wait two or more years before having another child are defined as having an unmet need for family planning. Since 1972 induced abortion has been legalized in India with the Medical Termination of Pregnancy Act. But due to many practical reasons, the Family Welfare Programme has not offered it as a form of regular contraception (Narayana 1992). First of all, access to safe abortion services is problematic in rural areas. Only government gynaecologists and doctors trained in MTP based in block primary health centres can

perform such operations. Furthermore, approval of two doctors is needed for abortion of pregnancies between 12 and 20 weeks (pp. 97, Jejeebhoy 2004). Therefore lack of trained doctors in government establishment forces acceptance of services from private and in most cases lay practitioners or 'quack' doctors. Secondly, despite the introduction of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act of 1994, the practice of sex-selective abortion has been quite rampant especially in the Northern part of India. (Due to the lack of data at the field-level, this study has not looked at abortion.) Hence, there is a significant proportion of the Indian population who have a high demand for contraception requiring reversible methods such as IUD, oral pills and condoms.

Uttar Pradesh's population policy talks about ensuring availability of a choice of modern methods with a stress on both tubectomy and vasectomy and promotion of the indigenously developed non-hormonal, once-a-week pill 'Saheli' by providing marketing support under the contraceptive social marketing programme (Uttar Pradesh Population Policy 2000). Andhra Pradesh government's strategy is the provision of a mix of contraceptive methods (both temporary and permanent, with a particular promotion of vasectomy) with a focus on couples with two children, and an enhanced role for private medical practitioners (Andhra Pradesh Population Policy 1997). The State launched in 1998 an intensive clinical skills training programme for government doctors and private practitioners in "double-puncture" laparoscopy and "no-scalpel" vasectomy techniques (IIPS 2000). The government of Madhya Pradesh, on the other hand, stresses sterilization, and in particular the no-scalpel vasectomy method to increase male participation in family planning. As for spacing methods, the State talks about new technological advances like non-hormonal oral contraceptives, and new IUD devices (Madhya Pradesh Population Policy 2000, pp 27).

4.5.2. Involvement of Community-based Institutions – The Panchayati Raj Institutions

As mechanisms for decentralization, Panchayati Raj Institutions, the locally elected rural self government institutions, have a long tradition in India. The Constitutional 73rd (1992) Act, known as the Panchayat Act, laid down a three-tier administrative system below the state-level, consisting of Zilla Parishad at the district level, the Panchayat Samiti at the block level, and the Village Panchayat at the village level. The role of the community in the

family planning programme both for service delivery and monitoring is considered of critical importance in those Indian States like Karnataka, West Bengal, Madhya Pradesh where the system of Panchayati Raj is well developed. There has been a differential speed in their development in different States, but they can present a good opportunity for local communities to define their needs and make local government accountable for both the quality and quantity of reproductive health services (Merrick 1995, Swaminathan 1996). These institutions are a key alternative to the decade-long uniform centralized implementation of the family planning programme in States with different demographic profiles and uneven patterns of socio-economic development.

The draft West Bengal population policy talks about decentralisation of "population stabilisation efforts...at all tiers of the Panchayat and Municipalities with identified responsibility" (draft West Bengal Population Policy, pp 11). The Panchayat are linked with the grass-roots level health service delivery system in the State starting from the sub centre. Also the draft policy talks about the creation of committees called District Health and Family Welfare Samiti comprising representatives of different departments in "addressing all district specific population stabilisation issues " (draft West Bengal Population Policy, pp 12). On the other hand, in Madhya Pradesh the need for community participation in programme design and implementation was identified out of a needs-based, client-specific approach for both service delivery and improving demand for and access to services. As part of decentralized planning, the State believes that "decentralized decision making is the hallmark of administration in Madhya Pradesh" (Madhya Pradesh Population Policy 2000), including extensive use of Panchayati Raj Institutions. Initiatives involve training of members of Panchayat on reproductive child health issues, better involvement of women members in these institutions, and the use of already established District Planning Committees (*Zila Sarkar*) for family planning and reproductive health issues. The State has also decided on the involvement of these institutions in implementation and monitoring of registration of births, deaths, marriages and first trimester pregnancies.

4.5.3. Discontinuation of demographic targets, incentives and disincentives

From 1966 to 1996 the Indian family planning programme employed the demographic goal for crude birth rate of 25 per 1000 population as a strategy for monitoring decline in the

rate of population growth (Srinivasan 1995, Visaria 2002). Under this approach, every year the central government determined contraceptive method-specific numerical targets for each State, district and primary health centre (Khan and Townsend 2001, Visaria and Chari 2001, Donaldson 2002). The calculation of targets was determined on the basis of a formula based on population size, social and economic situation, and the previous family planning performance of each State (Gwatkin 1979). There was little discussion with and participation of the field staff when setting these targets. Post-1976, incentives and disincentives were employed to achieve the targets. During the 1975-77 Emergency, the government forcibly promoted vasectomy and used incentives including payment to acceptors, motivators and providers and disincentives. (Gwatkin 1979; Pethe 1981; Chaubey 2001). Although the national government removed the use of targets, incentives and disincentives in the National Population Policy 2000, some States like Andhra Pradesh, Uttar Pradesh, Madhya Pradesh and Rajasthan have retained them. Since targets for both terminal and spacing methods were fixed by the States, as a top-down system it resulted in inflated reporting and poor quality of services. So instead of discontinuing it altogether, Andhra Pradesh's policy fixed targets from the Panchayat and upwards in consultation with the grass-roots levels workers and the community (Andhra Pradesh population policy 1997, pp 13). It divides targets into three types, those targeting the community, individuals and the service-providers. For the community, incentives will reward good-performing districts by giving them additional funds and coverage under different government schemes. For individuals, incentives include monetary awards to couples with maximum of two children following the adoption of permanent methods of contraception (Andhra Pradesh Population Policy 1997, pp 9). The incentives for service providers "in the shape of cash awards" will be given "to motivate teamwork among primary staff" (Andhra Pradesh Population Policy 1997, pp 20). In Madhya Pradesh and Rajasthan, population policies include disincentives to promote a two-child norm, e.g. couples marrying before the legal age at marriage will not be eligible for government employment (Madhya Pradesh Population Policy 2000, pp 16 and Rajasthan Population Policy 1999, pp 8). "Persons having more than 2 children after January 26, 2001 would not be eligible for contesting elections for panchayats, and other local bodies in the State. In case they get elected and in the meantime they have a third child, they would be disqualified for that post" (Madhya Pradesh Population Policy 2000, pp 17).

Thus, the stress of the Indian family planning programme has changed over the years from the IUD in the 1960s to vasectomy in the 1970s and tubectomy in 1980s. Stress on permanent contraception can be found in the State-level Population Policies of Andhra Pradesh, Madhya Pradesh and Uttar Pradesh with a mention of "double-puncture" laparoscopy and "no-scalpel" vasectomy in combination with other methods indigenously developed non-hormonal, once-a-week pill 'Saheli' in Uttar Pradesh. Panchayati Raj Institutions have been working effectively in Karnataka, West Bengal and Madhya Pradesh so the State policies of Andhra Pradesh, Madhya Pradesh and West Bengal consider them as alternatives to decade long centralised implementation of the family planning programme. Despite the national removal of both demographic target-setting and the use of incentives and disincentives, these measures still appear in the policies of Andhra Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh.

4.6. Conclusion

Despite the shift in emphasis on family planning in international population conferences over the years, family planning strategies have been used by programmes across the globe. As a result their effectiveness has been debated extensively in the literature. The quality of care framework, life-cycle and strategic approaches have discussed the provision of different contraceptive methods in-depth and benefits of its use have been considered from the organisational standpoints as well. Community involvement in family planning service provision, on the other hand, has been debated from the demand and supply perspectives and also as regards the types of programmes. Finally, debate on the use of demographic targets, incentive and disincentives revolved around the use of coercion versus voluntarism. In the Indian family planning programme, the programmatic stress changed from the IUD in the 1960s to vasectomy in the 1970s and tubectomy in the 1980s. Emphasis on permanent contraception can be found in the State-level Population Policies of Andhra Pradesh, Madhya Pradesh and Uttar Pradesh.

The chapter shows that due to the effective functioning of Panchayati Raj Institutions in Karnataka, West Bengal and Madhya Pradesh some of the State policies consider them as alternatives to decade long centralised implementation of the family planning programme. Despite the national removal of demographic target-setting and use of incentives and

disincentives, they still appear in the policies of Andhra Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh. Therefore this chapter provides the conceptual framework on which the research is based. It analyses both the international and national literature on population policy and use of family planning strategies by different programmes to locate the research. By doing so it provides a conceptual background to the choice of the three family planning strategies, namely provision of different contraceptive methods, involvement of the community in the family planning programme and use and non-use of demographic targets, incentives and disincentives. This in turn helps to link the conceptual framework with the analysis of the data on provision of family planning services. Chapter 6 examines the research findings for Madhya Pradesh and West Bengal to examine the family planning service based on these three family planning strategies. The next chapter scrutinizes the research data to examine the evolution, and historical origins of population policy of Madhya Pradesh and the draft policy of West Bengal. It also discusses the process of policy adoption in both States.

Chapter 5: Analysing adoption of State-Level Population Polices: Madhya Pradesh and West Bengal

5.1. Background

This chapter examines the historical and contemporary factors leading to the adoption of a State-level Population Policy in Madhya Pradesh, and the development of a draft policy in West Bengal. It also examines their historical origins and the process of their adoption. To date, no studies have looked at the evolution of, and reasons behind, the adoption of State-level Population Policies. The chapter is divided into five main sections. Firstly, it outlines the state of knowledge in both Madhya Pradesh and West Bengal at the time of State-level Population Policy development. The next section investigates the factors that contributed to policy adoption in Madhya Pradesh, but not in West Bengal. It includes an examination of the demographic scenario of both States followed by a discussion on their relations with the Centre. Moreover, an analysis of the commitment of both the political leadership and the administration are outlined as reasons behind the adoption of State policies. The influence of major donor agencies is also assessed as a factor of policy adoption. In the fourth section, the historical origins of the State population policies in both States are highlighted. The final section explores the process of policy adoption in Madhya Pradesh and is followed by a discussion of West Bengal's attempts at policy adoption.

Around the time of the launch of the Madhya Pradesh State-level Population Policy in 2000, the State's policy environment was assessed using the Evaluation Project indicators (Ranjan 1999; Chaurasia 2000; Chaurasia 2004). But these studies looked neither at the evolution of the policy nor at the various causes contributing to the policy, nor did they shed light on the policy formulation process. The government of Madhya Pradesh published two reports, 'Madhya Pradesh Family Welfare Programme Evaluation Survey 2003' and 'Madhya Pradesh: The State of Population 2003', both examining the Family Welfare Programme in the State. These reports were based on analysis of secondary data from the National Family Health Surveys (NFHS). Moreover, none of these studies discussed the use of different family planning strategies and the reason for their use. In terms of literature on West Bengal on the other hand, very few studies exist on population, family planning and the policy

environment. The Child in Need Report (1999) analysed the impact of the target-free approach on the Family Welfare Programme when the Reproductive and Child Health project was started in 1996. This study concluded that due to the familiarity with four decades of demographic target-setting, it would be difficult to bring about changes in the attitudes of the health workers. The annual reports published by the West Bengal Health Department provide district-level information, including data on family planning. But these reports are statements of annual performance and are not analyses of family planning performance. Several studies (Nag 1985, Nossiter 1988, Desai 2001) have compared West Bengal with Kerala, due to the presence of a Communist government in both States. These studies have attempted to explore the reasons for the relative failure of West Bengal against the success of Kerala. Both Nag (1985) and Desai (2001) cite a lack of political will towards reforms and lack of political awareness of the rural population as the causes of West Bengal's failure when compared to the success of socio-economic development of Kerala. This chapter sets out to fill the gap in the literature relating to the process of population policy formulation and adoption in Madhya Pradesh, and West Bengal.

5.2. The contributing factors

Chapter 3 examined the contributing factors for State-level Population Policy adoption for the entire country. This chapter scrutinises them more in-depth in the context of Madhya Pradesh and West Bengal. It focuses on five areas: State demographic performance; the role of the Centre; State-level political commitment and administrative efficiency; the involvement of donor agencies; and, the impact of the Cairo Programme of Action. Eleven indicators were identified to study these five topics, drawing on the frameworks of USAID's Evaluation Project (1994) and the POPTECH project (1997) (Chapter 2) (Table 5.1). This section analyses the available data based on these themes and their related indicators.

Table 5.1

Research Question	Themes	Related Indicators
What are the various arguments and socio-economic consideration s specific to a State that have given rise to a State-level Population Policy?	Demographic trends	Did the values of key demographic indicators such as population size and distribution, population growth rate, fertility, mortality and morbidity rates show that they placed undue burden on the state?
		Was there any recognition by the State government of the interaction between population growth and availability of natural and economic resources?
	Role of the Centre	Formal population policy addressing fertility and family planning at the national level
		Is the (Central) government committed to economic and social development (of the States) manifested both in frequent, influential, public pronouncements?
	Political Commitment	Were key State-level political leaders/high-level government officials visibly supportive of population growth rate reduction and family planning?
		Number of statements made by high-level government officials at the state level – voicing the need for a State-specific policy
	Attitude of the Administration	Quality of programme leadership
		Civil bureaucracy used
	Presence and involvement of Donor agencies	To what extent do bilateral donor and multilateral lending institutions exert particular influence over policy development?
		Specialised technical expertise from donors. Including funding, research and policy dialogue
	Impact of Programme of Action of Cairo	To what extent have declarations emerging from international meetings like Cairo influenced the development or amendment of policy?

Each of these themes and their associated indicators will now be considered in turn.

5.2.1. Demographic trends

Table 5.2

	Madhya Pradesh		West Bengal		India	
Indicator	**1991**	**2001**	**1991**	**2001**	**1991**	**2001**
Population	66,181,170	60,384,023[2]	68,077,965	80,176,197	846,302,688	1,028,610,328
Population Density (persons per sq. km)	149	196	767	904	267	324
Decadal Pop. Growth rate, per cent[3]	26.8	24.3	24.7	17.8	23.8	21.3
Natural Growth rate, per cent	22.0	20.8	18.7	13.6	23	17
Crude Birth Rate	35.8	31.7	27.0	20.6	29.5	25.4
TFR[4]	4.6	4.2	3.2	2.4	3.6	3.1

Sources: Census of India 1991, 2001, National Population Commission 2004, World Population Data Sheet 2005, Department of Family Welfare, and Government of West Bengal, 2003 and Government of Madhya Pradesh 2004.

[2] On 1 November 2000, bifurcation of Madhya Pradesh and Chhatisgarh resulted in transfer of 7 districts with a total population of 17,614,928.
[3] For the period 1981-1991 and 1991-2001.
[4] For all women aged 15-49.

Demographic trends of the States have influenced policy decision making at the State and national levels in India since 1971 (Rao 1989) because of the relationship between population growth and socio-economic development. According to the 2001 census, Madhya Pradesh was the seventh most populous State, while being the second largest geographically. Prior to November 2000, when Chhatisgarh was carved out of it, it was the largest State in area in the country (Chaurasia 2004). On the other hand, until the 1980s, the Centre banded West Bengal with the *BIMARU* States because along with Madhya Pradesh, it accounted for 16 per cent of the country's population (Srinivasan 1995). As a result, it was included for the Centre's special schemes to improve the efficiency and effectiveness of the family planning programme (Srinivasan 1995). But over the years its performance has been impressive, as the following quote suggests:

> "In the context of high population density in the State, the extent of reduction of the decennial growth rate of population in West Bengal has been quite impressive at nearly 7 per cent as compared to the Indian average of 2.5 per cent" (pp 119, West Bengal Human Development Report 2004).

As seen in table 5.2 the reduction of the decadal population growth rates of West Bengal between 1981-1991 (24.73 per cent) and 1991-2001 (17.84 percent) has been significant compared to the growth rates of the previous decades of 1951-1961 (32.80 percent) and 1961 -1971 (26.87 percent) (Government of West Bengal 2003). For Madhya Pradesh the annual growth rate was most rapid at 2.87 per cent in 1961-71 (Bose 1988, Chaurasia in Wadhwa et al 2003). The average annual growth rate of the Madhya Pradesh population was 2.27 per cent per year between 1951 and 2001 (Chaurasia in Wadhwa et al 2003). Also its population growth rate of 2.28 per cent is higher than the national average of 1.93 per cent (Census 2001). As a result, of the high rates of population growth, fertility (Table 5.2) received high priority from policymakers of that time resulting in the policy adoption. This view was shared by all the policymakers actively involved in the policy formulation process who I interviewed, one of whom said:

> "If we look at the geographical location of Madhya Pradesh, Uttar Pradesh, Rajasthan, and Bihar, they are the neighbouring northern States with very high population growth rate compared to other States. ... The problem of population growth rate was analysed in a workshop where analysts and population experts of national repute and experts from international agencies participated. This was an eye-opening workshop that played a decisive role and then the need was felt to bring down the fertility rate to the replacement level of 2.1 by 2011. That's how the work for population policy was started" (personal interview, health official, Public Heath and Family Welfare Department, Madhya Pradesh, 2004).

West Bengal has also been successful in reducing its fertility level at a faster pace than the decline in its mortality levels (Srinivasan 1995). The infant mortality rate (IMR) of the State has reduced from 71 per thousand births in 1991 to 51 in 2001. Also maternal mortality ratio (MMR) has reduced significantly from 458 per 100,000 live births in 1991 to 266 in 2001 (Government of West Bengal, 2003). This success has been attributed to the success of the Family Welfare Programme (Chaubey 2001, Srinivasan 1995, Basu and Amin 2000). But for Madhya Pradesh along with population growth and fertility, values of other demographic indicators are among the highest. IMR reduced from 117 per 1000 live births in 1991 to 86 in 2001 (Government of Madhya Pradesh, 2005) when nationally IMR reduced from 80 in 1991 to 66 in 2001 (Census 2001). Also, the values of MMR are one of the highest for the State (498 per 100, 000 live births) in 1997 in comparison to 408 for India as a whole (National Commission on Population 2004). Further, there are significant inter-district differences in maternal deaths ranging from 1295 per 100,000 live births in Sidhi district to 202 deaths per 100,000 live births in Indore district (Chaurasia 2004). These values also drew high priority for formulation of the policy, as was confirmed by another key policy maker who said:

> "With the IMR and MMR, we were among the worst performing States. Therefore, the State government taking these issues into consideration decided to take up a comprehensive policy covering all these aspects. Therefore the policy was formulated. TFR, IMR, MMR, immunisation whole gamut of activities were taken into consideration" (personal interview, health official, Public Heath and Family Welfare Department, Madhya Pradesh, 2004).

The population-development interaction was at the forefront of people's thinking when developing State-level Population policies. For example, an important policy maker in Madhya Pradesh confirmed this in his interview:

> "You see the government felt it absolutely necessary to have a policy on population because we considered population fundamental to development. If you want to develop fast you must have a certain policy on population, how much it should grow because it is a feeling and I think it is a right perspective that if the population increases too much then it becomes very difficult to increase the level of quality of life and living standard of the masses because whatever resources you have are not unlimited, they would be spread over a large population" (personal interview, health official, Public Heath and Family Welfare Department, Madhya Pradesh, 2004)

Furthermore, interactions between population growth and the availability of natural and economic resources were recognised not only by the government but by the print media as well....

> "... population explosion will tarnish the progress made so far. It is understood now that for a growing population to live comfortably it is difficult to enjoy the benefits of economic and natural resources in the coming decades" (*Dainik Jagran Bhopal*, September 23, 1999).

By contrast, West Bengal's demographic trends were a source of satisfaction as reflected in the excerpts of a speech made by Asim Dasgupta, the Finance Minister of West Bengal, at the Conference of State Population Commissions and Councils held in New Delhi in September 2002:

> "With the background of progress of Family Welfare Programme in the State, it is possible to set the target of stabilisation of population of West Bengal by the end of Tenth Five Year Plan, i.e. by the year 2007 which may be ahead of the national level target. It may be noted that the total fertility rate has already come down in the State to 2.3 in 1998-99 as against 3.3 for the country." (Asim Dasgupta 2002).

Hence it can be seen from the analysis of the data, that in contrast to West Bengal, for Madhya Pradesh, poor demographic performance was a serious cause of concern and therefore can be considered one of the primary contributing factors for the adoption of a State-level Population Policy.

5.2.2. National Government's Role

Prior to 2000 at the national level, the draft Swaminathan Committee Report of 1994 was the first national document that recommended State-specific action regarding population

growth. However, after its launch the National Population Policy 2000 recommended the formation of State Population Commissions to implement its objectives. The Department of Family Welfare at the Centre sent letters instructing States to develop State-specific population policies, but within the framework laid out by the National Population Policy. The first letter (April 2000) was sent by Mr. N.T. Shanmugam, the former Union Minister of Health and Family Welfare, and was followed by a letter from Mr. Shatrughan Sinha, the then Union Minister for Health and Family Welfare in July 2002 which read:

> "... I would therefore, request you that while formulating State specific population policies, the State government may kindly keep the conceptual framework of National Population Policy in view. In this regard, you may like to take the help of National Level Resource Committee constituted by this department. ... As Population Policy is an issue of vital concern for the overall socio-economic development of the States and is not merely a health related issue, I would request you to assume a leadership role in formulation of the policy framework" (Ministry of Health and Family Welfare, Government of India 2002).

The recommendation of the Centre with regard to the implementation of the objectives of the National Population Policy 2000 was uniform for all the States, as was the encouragement to adopt State-specific Commissions and policies. These recommendations did not affect Madhya Pradesh because by then it had already adopted a policy unlike West Bengal. The Centre's relationship with individual States varied considerably over the years due to the presence of different political parties in power. Madhya Pradesh is one of the States that has an amicable political relation with the Centre due the presence of the same political party (Congress Party) at the Centre and the State. Most of the time it was the Congress Party that was in power in the State, and later on came the Bharatiya Janata Party (BJP). Depending on which party has been in power, the relation between West Bengal and the Centre, on the other hand, has changed over time, but most of the time it can be described as lukewarm. When the Congress party was in power both at the State and at the Centre, quite understandably relations were amiable. Over the years the Left Front dominated by the Communist Party of India (Marxist) has been extremely critical of the Centre's policies and positions (Roy Choudhury 1985, Nossiter 1988, Mallick 1993). Despite the unfriendly relationship between West Bengal and Centre, due to its better demographic trends, the State was never a major cause of concern for the Centre. This was not the case for Madhya Pradesh, a *BIMARU* State, with poor socio-economic development

and worrying demographic trends. Concern for the *BIMARU* States featured in the Independence Day speech of the Secretary of Family Welfare, Government of India.

> "Within the country, Tamil Nadu, Kerala, Goa, Sikkim, Mizoram, Pondicherry and Chandigarh have attained replacement level of fertility rate viz. the total fertility rate of 2.1; while Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan which together account for more than 45 per cent of the country's population are still lagging far behind in this regard" (Government of India, August 2002).

This national concern acted as a source of significant pressure for Madhya Pradesh policymakers, acknowledged by one official I interviewed. She said:

> "When you have a national policy and there are targets it is better to have your own policy. The national target is not for 2011 and we have taken a concession of 3 years and even after that we can't achieve TFR of 2.1 by 2011 then we should be prepared for the brickbats at the national level" (personal interview, health official, Public Heath and Family Welfare Department, Madhya Pradesh, 2004).

Thus the Centre's concern with regard to Madhya Pradesh's poor demographic performance had significant impact on the policymakers to adopt a State-level Population Policy. While for West Bengal there was no added pressure on it from the Centre. The formulation of the draft State-level Population Policy in West Bengal was in response to the national guideline meant for all the States and was not out of specific pressure as applied in the case of Madhya Pradesh.

5.2.3. Political commitment

Between 1947 and 2003, the Indian Congress Party ran the administration of Madhya Pradesh (with the Janata Party in power briefly in 1977). The Bharatiya Janata Party (BJP) formed the opposition in Madhya Pradesh from the 1980s to 2004 until it took over the administration in 2004 (Ramshanker 2004). In contrast, communist government has run the administration of West Bengal continuously for the last thirty years, preceded by the Congress party (1947-1966 and 1972-1977) and a coalition (1967-1972). The coalition government was composed of all the left parties of West Bengal, as well as the Congress (Roy Choudhury 1985, Mallick 1993). During the Congress rule from 1993 to 2003 in Madhya Pradesh, Digvijay Singh was the Chief Minister. He is known to be a better politician, more astute, and free of corruption than his competitors in the State (Kela 2003).

During his tenure for ten years, his policies especially his development agenda and political decentralisation through Panchayati Raj Institutions earned him popularity (Manor 2004). So it was not surprising to find his visible support for population policy formulation.

> "Lack of access to family planning methods and other RCH services is resulting in higher fertility and mortality. I felt that even the pressure of present population of 7-8 crores is rendering the resources, services and the system futile and a two-fold increase in population will make our efforts meaningless. This very concern motivated me to provide a Population Policy... " (Digvijay Singh, in the foreword, Madhya Pradesh Population Policy, Government of Madhya Pradesh, 2000).

Administrators who were actively involved in policy formulation confirmed that without his backing it would have been difficult to develop the policy.

> "That time the then Chief Minister, Mr. Digvijay Singh had a very liberal outlook. He did realise that the ways the replacement was on and IMR, MMR was going on we need to have a policy in place. So he backed it up once the draft of the policy was ready. His backing was the anchor on which we could move around. You need a policymaker to back up a policy because bureaucrats can't do it themselves" (personal interview, health official, Public Heath and Family Welfare Department, Madhya Pradesh, 2004).

Digvijay Singh's involvement was also acknowledged by external observers:

> "When we were drafting the policy, our then Chief Minister was very keen. So whatever external activities were going on they got the support at least from the highest level of the government, that is the Chief Minister" (personal interview, an observer, Madhya Pradesh, 2004).

However, along with Singh, other ministers and politicians also expressed their support with respect to population issues. Thus prior to the launch of the policy, the former Health Minister, Mr. Subhas Sojatiya frequently spoke of "population control as a necessity for the speedy development of the State" (*Swadesh Bhopal,* Bhopal, March 13, 2000). Also, in a public meeting, Laxman Singh, a Member of Parliament from Rajgarh district, highlighted the importance of "effective network of the facilities...throughout the remote areas" for successful implementation of the RCH project (*Chronicle Bhopal,* January 21, 2000).

Although certain observers (e.g. Kohli 1987, Nossiter 1988) have praised West Bengal for its success in agricultural performance, land reform and the institutionalisation of the Panchayati Raj Institutions, the overall achievement of the Left government leadership in the State has largely been considered as below the national average (Mallick 1993,

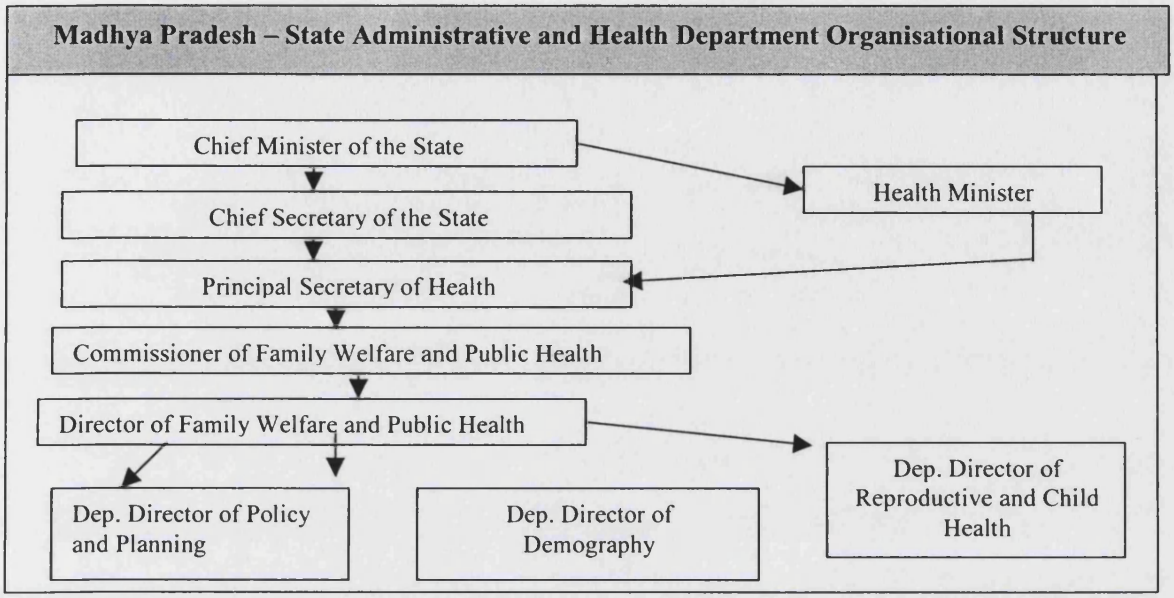
Banerjee 2000, Banerjee et al 2002). Over the years, the State had been synonymous with administrative inefficiency, industrial unrest, and poor infrastructure (e.g. in relation to roads, electricity, communication) (Mallick 1993, Banerjee et al 2002). The health sector has also been fraught with "lacunae, lapses and problems" as has been admitted by Chief Minister Buddhadeb Bhattacharjee (*Telegraph India, Calcutta, November 16, 2005*). My fieldwork did not reveal any evidence of support for population and family planning from key political leaders, including the State's Chief Minister. Also, I was unable to locate any public statements or pronouncements by them supporting family planning.

Thus it can be concluded that in Madhya Pradesh there was visible support for the State-level Population Policy from both the Chief Minister and other politicians. This was manifested in statements which can be assumed to have catalysed its adoption. But the above-national average demographic performance of West Bengal coupled with strong electoral support of thirty years has allowed that State's government to be complacent about health sector reform. As a result, there is little evidence of significant political support for family planning and population issues in West Bengal, in general.

5.2.4. Role of Administrators

Being high-level government officers of the Indian Administrative Service, administrators of a State bear the sole responsibility to implement a State government's policy initiatives and administrative measures. These IAS administrators are also accountable for translating the promises of the leadership into action.

Diagram 5.1



For six years before and after policy adoption, Madhya Pradesh had a group of proactive and efficient administrators at various levels, from the Chief Secretary of the State to officials at the Department of Family Planning and Public Health (Diagram 5.1). The list of all interview respondents is attached in Appendix 4. All of these officials were actively involved during the whole process of policy formulation, making it an effective department. A relevant quote is:

> "You cannot imagine this kind of working environment in the government sector. If the director was around I could send files directly to them and they didn't have any objections for following the protocol. After one hour we got the files back which is very unusual" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

This statement reflects group effort and a sense of responsibility from the senior administrator of the department. The commitment of such administrators is also reflected in the quote below:

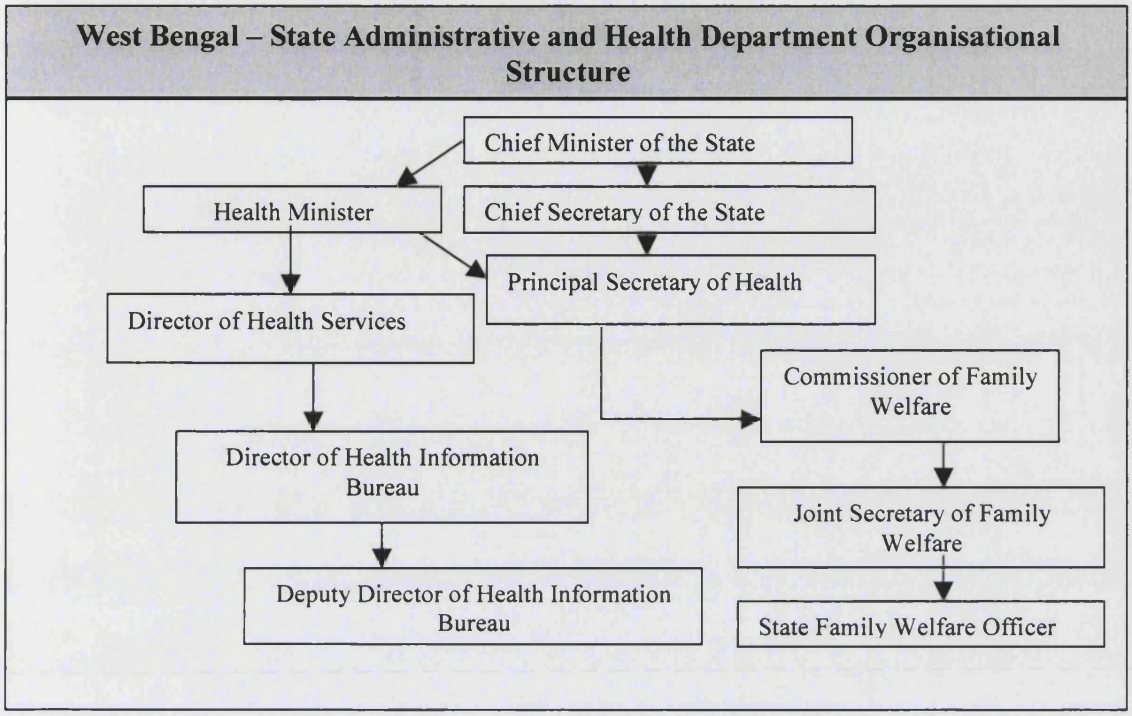
> "We worked a lot on it and lived on sandwiches on holidays and were commuting between Delhi and Bhopal. We had a very good group and jelled well. This must have been October -November 1998" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

Therefore, in Madhya Pradesh's case, the quality of programme leadership was characterised by commitment, a sense of responsibility and efficiency, and effectiveness of the top level administrators to take charge. On the contrary, in West Bengal the State administration has been manipulated by the Communist party as and when it wished (Mallick 1993, Mukhopadhyay 2000). Thus:

> "...the administration is an instrument in the hands of the ruling party which can be used by the Communists for implementing significant changes, if they so desire" (pp. 171, Mallick 1993).

There is a substantial support base for the Communist party among officers at all levels of the Indian Administrative Services (IAS) in West Bengal (Kohli 1987, Mallick 1993, Mukhopadhyayay 2000). As part of this symbiotic relationship, administrators use their party connections for promotion and transfers (Mallick 1993, Mukhopadhyay 2000). The State's bureaucracy is known for its lethargy, lassitude, corruption, and poor timekeeping (Nossiter 1988, Mallick 1993). In spite of talking about administrative reforms, the government is unable to change the inefficiency of its employee due to the fear of losing its supporters and sympathisers from among these officials and their subordinate officers (Nossiter 1988, Mallick 1993). One of the reasons cited by Mallick (1993) for the lack of funds for development reforms is "4/5ths of the State budget going to pay the salaries of government employees whose support has been fostered by Left Front pay increments" (1993: 4). Therefore, thirty years of Communist rule in West Bengal has manifested itself in high rates of administrative inefficiency, corruption, poor time-keeping, and high rates of absenteeism (e.g. see Roy Choudhury 1985, Mallick 1993).

Diagram 5.2



My fieldwork involved contact with the Commissioner of Family Welfare, Director of Health Services, Director of Health Information Bureau, Joint Secretary of Family Welfare, Deputy Director of Health Information Bureau, and the State Family Welfare Officer as seen in diagram 5.2. A list of all the interview respondents in West Bengal can be found in Appendix 4. During the fieldwork of nine months, the Commissioner, and Joint Secretary transferred to different departments, and the Director of Health Information Bureau and the State Family Welfare Officer both retired. Out of these six high-level officials only three were fully aware of the draft State-level Population Policy of the State and out of them only the author of the draft, the Joint Secretary of Family Welfare had copies of the draft policy and documents related to the State Population Commission. Therefore, it can be concluded that the quality of programme leadership was low in the State as there was no free flow of information within the department. Commitment and sense of responsibility among officials was not high due to frequent transfers and the overall negative work culture of the State. In contrast, commitment, sense of responsibility and efficiency and effectiveness of

the top level administrators to take charge characterise the quality of programme leadership in Madhya Pradesh, which in turn significantly helped in the population policy adoption.

5.2.5. Donor Involvement

A range of donor agencies are present in Madhya Pradesh, including DANIDA (since 1979), UNICEF (since the 1980s), compared with the more recent arrivals of UNFPA (since 1999) and DFID (since 2000). In West Bengal, on the other hand, they were hardly present up until the late 1980s. First of all, the Communists had "denounced foreign multinational penetration of the Indian economy" (Mallick: 1993, 182-183) and as result the Left Front followed the same strategy when it came to power in the State in the 1970s and early 1980s. Furthermore, donor agencies found the State less attractive because of its industrial agitation in the form of frequent striking by the workers' unions, chronic problems of electricity supply and distribution, poor infrastructure and administration (Nossiter 1988, Mallick 1993). As a result, the World Bank only started working in the State in 1986 in a few selected areas under the India Population Project IV (personal interview, health official, Department of Family Welfare, West Bengal, Calcutta, 2004). Its presence increased post-1996 with the Reproductive Child Health Project. However, recently many bilateral donor agencies including DFID, KfW (the German Development Bank), and UNICEF have started working in the State. Though DFID has been working in small projects in the health sector since 1996, recently the Government.

During State-level Population Policy formulation in Madhya Pradesh most of these bilateral agencies (UNFPA, UNICEF, DANIDA) were involved, but the degree of their involvement varied. UNFPA participated in the workshops and provided inputs during formulation of the population policy (spokesman, UNFPA Madhya Pradesh, Bhopal, 2004) DANIDA's involvement was indirect and restricted to participation in the workshops only (personal interview, spokesman, DANIDA Madhya Pradesh, Bhopal, 2004). However, USAID never had any other projects in Madhya Pradesh. Its involvement in the State was brief but vital as part of the Policy Project. And without its financial and technical assistance, Madhya Pradesh's population policy would not have been developed, as outlined by one of the active members of the policy formulation team.

> "I wouldn't have been able come up with the policy without the backing of USAID because I needed funding because the awakening wasn't there in the State" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

USAID, through its Policy Project, was the driving force in State-level Population Policy formulation in Madhya Pradesh. Through one of its subcontracting partners in India, IIHMR, USAID initiated the policy dialogue in Madhya Pradesh (the details are discussed in the following section). It also provided both financial and technical assistance.

In contrast, in West Bengal the formulation of the draft State-level Population Policy, having essentially fallen to the responsibility of one person, was not shared with external observers like the donor agencies until it was finalised. Therefore, in West Bengal there was no involvement of donors with regard to the development of State-level Population Policy.

5.2.6. Impact of ICPD

When the Swaminathan Committee Report (1994) was being drafted, the Country Report for the Cairo conference was also being formulated, with significant exchange of ideas between the two reports. Furthermore, provisions like the integration of family planning services with other health services at the grass-roots level, espoused by Cairo, were already being implemented in India as part of the Maternal and Child Health Programme (personal interview, an observer, New Delhi, 2004). Therefore for Madhya Pradesh, the PoA of Cairo seemed to have played an indirect role though its sentiments were clearly reflected in the Madhya Pradesh State-level Population Policy document. Its indirect influence was acknowledged by one policymaker.

> "We had at the back of our minds the Cairo conference on population... . When we compared the figures we realised that we were woefully short of the benchmarks. So Cairo changed the stance from conjugal sex a concern for public policy becoming a responsibility of the family. That is very much reflected in the population policy" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

In West Bengal the draft policy did not explicitly acknowledge the influence of Cairo. However, the language of the draft policy reflects the same spirit of the National Population Policy which incorporated the reproductive health approach. Although, like the national

policy, it talks of demographic goals of reduction of birth rate, IMR, MMR, among other things, it also covers themes like child and maternal health, immunisation, food and nutrition, adolescent sexuality, and male involvement in family planning. Furthermore, there is no mention of any incentives and disincentives, leading to the conclusion that the draft reflects the spirit of Cairo.

5.2.7. Comparison of Madhya Pradesh and West Bengal State-level Population Policy process

Analysis showed that the first five themes (demographic performance, Centre's role, commitment of the political leadership and the administration at the States and the function of the donor agencies) have more significant effects on policy adoption than the last one (influence of Cairo). Furthermore, there was considerable causal relation among these factors. First of all, demographic performance of a State substantially influenced the attitude of the Centre towards it. Demographically, if a State has been lagging behind the rest of the country there has been implicit pressure from the Centre through different means (brand of a *BIMARU* State, mention of poor performance in public speeches etc). Subsequently, this acted as a catalyst for State policy adoption. Moreover, commitment from the political leadership and the presence of efficient administrators highly increased the chances of a donor agency's presence in a State. This, in turn, created better chances for a State receiving technical and financial assistance from donor agencies to adopt a policy.

Below is a table that summarises the findings for Madhya Pradesh and West Bengal based, on the chosen indicators.

Table 5.3

Indicator	Madhya Pradesh	West Bengal
Did the values of key demographic indicators such as population size and distribution, population growth rate, fertility, mortality and morbidity rates show that they placed undue burden on the country?	Yes	No
Was there any recognition by the State government of the interaction between population growth and availability of natural and economic resources?	Yes	No
Formal population policy addressing fertility and family planning at the national level	Yes	Yes
Is the (Central) government committed to economic and social development (of the States) manifested both in frequent, influential, public pronouncements?	Yes	Yes
Were key State-level political leaders/high-level government officials visibly supportive of population growth rate reduction and family planning?	Yes	No
Number of statements made by high-level government officials at the State level – voicing the need for a State-specific policy.	Yes	No
Quality of programme leadership	High	Low
Civil bureaucracy used for policy formulation and adoption	Yes	No
To what extent do bilateral donor and multilateral lending institutions exert particular influence over policy development?	Great extent	None
Specialised technical expertise from donors that includes funding, research and policy dialogue	Yes	No
To what extent have declarations emerging from international meetings like POA of Cairo influenced the development or amendment of policy?	Indirect	Indirect

Analysis of the research findings in this section shows that the values of all of the indicators are positive for Madhya Pradesh, whereas for West Bengal they are often negative. For Madhya Pradesh, high values of demographic indicators have been a cause of concern for both the national and State level policymakers. However, when the Centre's worry got manifested in repeated mention in public speeches, conferences, and the branding of the State as *BIMARU*, it pressurised Madhya Pradesh. Furthermore, the committed political leadership and efficient administrators of the time decided to remedy the situation, and coincidentally technical and financial assistance was at hand from the Policy Project. All these factors therefore seem to have resulted in the State population policy formulation in Madhya Pradesh. On the contrary, West Bengal formulated the draft policy keeping in view the "overall national policy statement in view" and recommendations of the National Commission on Population for a "State relevant population policy" (pp.1, draft State-level Population Policy, Government of West Bengal, 2003). The values of the demographic indicators of West Bengal are comparatively better and therefore never drew any negative attention from the Centre. Furthermore, the rule of the Communist government for thirty years has led to a climate of complacency and inaction, manifested in inefficiency of the

administration. This, in turn, kept the donors away for many years. Therefore, none of these factors merit any consideration in the formulation of the draft policy in West Bengal. After a discussion of the socio-political factors for State-level Population Policy adoption, the next section explores the historical origins of the adoption of policy in Madhya Pradesh and West Bengal, based on three indicators of the Evaluation Project (1994).

5.3. Historical Origins of State-level Population Policy of Madhya Pradesh and West Bengal

The analysis used three qualitative indicators derived from the handbooks of the Evaluation Project (mentioned in Chapter 2) on which research findings were examined to locate the historical origins of the State-level Population Policy of Madhya Pradesh and the draft policy of West Bengal (Table 5.4). They were modified and reworded for the purpose of the study. For example, the indicator "number of appropriately disseminated policy analyses" provides a quantitative measure of activities undertaken as part of the policy development process. Since it was physically impossible to find out the actual number of policy analyses, it has been reworded so that it provides a qualitative measure instead. However, the purpose of the indicator remains the same, which is to find the existence of "analyses of the development impact of rapid population growth" that provided "actionable" information to policymakers (pp. 30, Bertrand et al 1994). Moreover, the second indicator 'existence of a policy development plan' is a qualitative one, designed to measure "progress made in developing a plan for policy development" (Bertrand et al 1994). A policy development plan is one that evaluates the current policy environment for population stabilisation, and identifies and recommends strategies for population stabilisation efforts (Bertrand et 1994, Chaurasia 2004). It is also a plan needed to monitor the existing policy environment. But since the purpose of this indicator here is to examine the historical origins of State-level Population Policy, it was used strictly to find evidence of data prior to policy formulation. Finally, 'existence of a strategic plan for setting up a committee to form State specific population policy' has been redesigned for the purpose of the study to examine historical origins of a policy.

Table 5.4

Research Question	Indicators
What are the historical origins of State-level population policies?	Existence of reports or policy analyses at the national or State levels prescribing for State-specific actions related to population growth, fertility and mortality
	Existence of a policy development plan
	Existence of a strategic plan for setting up a committee to form State specific population policy.

1. Existence of reports or policy analyses at the national or State levels prescribing for State -specific actions related to population

Analysis of data from the fieldwork provides no evidence of documentation prescribing for State-specific actions specifically for Madhya Pradesh or West Bengal. However, the Swaminathan Committee Report of 1994 recommended that States should develop their own policies in matters of population (see Chapter 3). Though the impact of this report was not directly acknowledged by Madhya Pradesh policymakers, observers (personal interview, observers, 2004) do note its influence. This is evidenced in the following statement:

> "The Swaminathan Committee recommended that States could have their policies. India is a large country in which each State is bigger than most countries in the world. So given that there are large differences across States, States could have their own policy even before the NPP was released" (personal interview, an observer, New Delhi, 2004)

Also, a report titled "India's Family Welfare Program: Toward a Reproductive and Child Health Approach", sponsored by the World Bank, came out in 1995. This espoused decentralisation for India's family planning programme in which initiatives and plans could be developed at the State and district levels. It said:

> "Progress in decentralizing family welfare planning to the district level has been slow. Lessons from these (State) initiatives should be collated and disseminated in the form of planning guidelines. Most importantly, the role of local people in program planning and management needs to be more clearly defined and strengthened" (pp. 23, World Bank 1995).

Moreover, existing literature on India's population policy (Narayana and Kantner 1992, Srinivasan 1995) has recommended devolution of powers to the States and has encouraged State-specific actions specifically for population stabilisation. For Madhya Pradesh, Ranjan (1999) proposed the formulation of "a formal population control policy for the State ... must specify the State specific goals to be achieve(d) in the area of population control" (pp. 29, Ranjan 1999). However, it is not clear whether this study was conducted before or after the policy formulation process began in Madhya Pradesh.

In West Bengal, there are no available records of any research or policy analysis recommending State-specific action. Hence, it can be observed that the value of the above mentioned indicator is negative for both States.

2. Existence of a policy development plan

When the Futures Group agreed to assist the Madhya Pradesh government in policy formulation, it followed the same plan that it used in all the States where it operated. As part of this policy development plan, it evaluated the current policy environment by "scanning through the entire literature not only on demographic status but also on health factors, status of women, and other socioeconomic factors" (personal interview, representative of Futures Group, 2004). In order to identify strategies for a State, the Futures Group organised workshops with representation from different stakeholders. The following quotation is relevant in this context:

> "...We invite representation from local NGOs, women's groups, people for Indian medical association, education institutions, people from different departments particularly representatives from education and ICDS. Then they discuss and debate and identify issues" (personal interview, representative of the Futures Group, New Delhi, 2004).

So when the policy of Madhya Pradesh was being formulated there was a policy development plan to review the existing policy environment although it was initiated by the Futures Group.

With regard to West Bengal, there is a 2 page government memoranda titled "West Bengal Population Action Plan: 2004-2005" which mentions various plans of the government based on the draft policy. It states:

> "In order that population stabilization efforts are transparent and meaningful and that all sectoral initiatives do converge appropriately to produce the desirable outcome, a cell at the State Population Commission would be set up to monitor sectoral initiatives, its efficacy and the extent of convergence in a given situation" (Department of Family Welfare, Government of West Bengal, 2004).

Therefore it can be seen that there exists a policy development plan for both the States.

3. Existence of a strategic plan for setting up a committee to form State specific population policy

As part of its planning for policy formulation, the Future's Group has a strategic plan to set up a committee. After the agreement is signed and initial groundwork is done to evaluate the policy environment, the Futures Group requests the government of a State to form a Committee (personal interview, representative of Futures Group, 2004). The chairman of the Committee is the Principal Secretary of Health. Other officials and people from outside the government are requested to become members (personal interview, representative of Futures Group, 2004). So even though the Madhya Pradesh government did not have a plan, one was developed by the Policy Project through the setting up a committee in the State. After the launch of the National Population Policy 2000, the Centre had asked all the States to constitute a State Population Commission. Therefore following repeated reminders from the Centre, the West Bengal government order no. HF/FW/924/4C-6/2000, reveals plans by the State government to set up a State Population Commission. The State Population Commission was formed to review the implementation of the objectives of the National Population Policy 2000, taking State-specific objectives into consideration. It was not set up to formulate a State-level Population Policy but rather to implement the national policy objectives taking the State's context into consideration. Thus we see that Madhya Pradesh constituted committees to formulate a State-level Population Policy, whereas West Bengal's commission was not formulated for that purpose.

The Evaluation Project framework was first used by Ranjan (1999) before the Madhya Pradesh policy was adopted. Later it was applied by Chaurasia (2000, 2004) after the policy was launched. All of these studies have analysed the policy environment of Madhya Pradesh by employing ten policy level indicators suggested by the Evaluation Project framework. They found that Madhya Pradesh has an average policy environment, neither strong nor weak (pp. 121: 2004) that is unsuitable for efforts towards population stabilisation. Though this thesis uses the same framework, unlike Ranjan (1999), Chaurasia (2000) and Chaurasia (2004) (who use it to examine the current policy environment), it analyses the causes of policy adoption and historical origins of policy by comparing Madhya Pradesh with West Bengal. Furthermore, Ranjan (1999), Chaurasia (2000, 2004) did not differentiate the policy environment based on the time of the policy adoption. This study found that the Evaluation project framework is more suited to examine a policy environment prior to the actual policy adoption. For example, the indicators like 'existence of a policy development plan', 'number of appropriately disseminated policy analyses', 'number of awareness raising events targeted to leaders' and 'existence of a strategic plan for expanding the national family planning program' examine a policy environment to understand whether it is conducive for policy adoption. They are not suitable for examining a policy environment where a policy already exists. Further, a significant weakness of Ranjan (1999), and Chaurasia (2000, 2004), is that their analyses are based on very little evidence. They used "information that is available and is primarily subjective in nature" (pp. 131, Chaurasia 2004) and does not cite any source of information and data used. Therefore their scoring of the Madhya Pradesh policy environment can be considered baseless. Finally, these studies did not take into account the involvement of the Futures Group in their analyses, which is also a reason of difference between these studies and this thesis.

Table 5.5

Indicators	Madhya Pradesh	West Bengal
Existence of reports or policy at the national or State levels prescribing for State -specific actions related to population	No	No
Existence of a policy development plan	Yes	Yes
Existence of a strategic plan for setting up a committee to form State specific population policy.	Yes	No

Thus, analysis of the data revealed a positive value for Madhya Pradesh and a negative value for West Bengal, because of the different purposes behind the formation of the State Population Commissions. Both the Madhya Pradesh policy and the draft policy of West Bengal had historical origins in reports, policy development plans and committees. However, there are differences between the two States because of the timing of their adoption and context. For Madhya Pradesh, the State-level Population Policy was launched simultaneously with the National Population Policy 2000. Therefore its origins were not affected by the national recommendations to constitute State Population Commissions and State-level Population Policy. Unlike West Bengal where formation of the State Commission and the policy development plan was undertaken by the State government, in Madhya Pradesh, the Futures Group did everything. The State government just followed the instructions of the Futures Group.

5.4. Process of State-level Population Policy adoption

The process of policy adoption is characterised by the degree of importance attached to the policy issue, the involvement of actors within and outside the government, the degree of risk involved, and the context within which a policy is formed (Lee et al 1994). Consequently, the level of priority attached by policymakers is determined by the level or tier of government officials involved in the process, and the urgency expressed in formulating a policy (Grindle and Thomas 1991). This section analyses the process of policy adoption that Madhya Pradesh underwent and the process that is currently underway in West Bengal.

5.4.1. Process in Madhya Pradesh

High population growth rates and values of TFR, IMR and MMR were pressing problems for Madhya Pradesh (personal interview, policy makers in Madhya Pradesh, 2004). Hirschman defines pressing problems as the ones "that are forced on the policymakers through pressure from injured or interested outside parties" (1981:146). There was significant, although implicit, pressure on Madhya Pradesh from the Centre due its poor demographic performance. The concern of the central government for *BIMARU* States (like Madhya Pradesh) was reflected in many ways e.g., letters, government orders, mention in

public speeches, and in the organisation of conferences. One such manifestation of the Centre's concern was the organisation of a workshop called "Innovations for Population Stabilisation in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh" that was held in January 1999 by the Department of Family Welfare at the Centre (together with UNPFPA and the Indian Institute for Health Management and Research (IIHMR)) (UNFPA 1999). The purpose of convening this workshop is highlighted in the quote below:

> "While most of the southern States have achieved or are in the process of achieving replacement level fertility required to initiate the process of population stabilisation in the next few years, the four large north Indian States have a long way to go before they can achieve it. ... It was thought that this was an opportune moment to take stock of the situation, identify key issues and critical areas of action, and exchange experiences for suitable strategies for propagating total reproductive and child health, including family planning, in these States as a means to population stabilization" (pp. 1, UNFPA 1999).

Along with the pressure from the Centre, there was outside interest in Madhya Pradesh's demographic performance which may have also added to the momentum for the development of a State-level Population Policy. The outside pressure came from the IIHMR, subcontracted by the Policy Project of USAID, to initiate the policy dialogue in the State. IIHMR sent an offer letter dated 6/8/1998 to Madhya Pradesh's Chief Secretary, to find out if the State was interested in formulating a policy (Government of Madhya Pradesh, August 6, 1998).

Furthermore, along with external pressure, one other characteristic of the policy process is its timing (Grindle and Thomas 1991). If policymakers attach high priority to a policy issue then the process can be relatively fast, showing urgency on their part. In Madhya Pradesh the policy process took one year, and the agreement between the Government of Madhya Pradesh and USAID was finalised in May 1999 as is seen in the excerpt from the agreement letter below:

> "...an agreement has been signed with Indian Institute of Health Management Research, Jaipur to provide you technical assistance to develop population/RCH policy for Madhya Pradesh. The policy development process will involve a series of consultative meetings with stakeholders and particularly with senior administrators of the Government of Madhya Pradesh." (Government of Madhya Pradesh, May 11, 1999).

There were various consultations, meetings and discussions held between May 1999 and January 2000 (Table 5.6).

Table 5.6

List of Preparatory Meetings, Consultations and Discussions leading to launch of the Policy		
Type of Meeting	**Date of Meeting**	**Place of Meeting**
First Preparatory Meeting	1-3 June 1999	Bhopal
Steering Committee Meeting	3 July 1999	Bhopal
First Pre-workshop consultation with youth groups, women's groups, NGOs, and PRI representatives	12-15 July 1999	Bhopal
Workshop on Population Policy for identification of issues	30-31 July 1999	Bhopal
Discussion on First Draft	7 October 1999	IIHMR, Jaipur
Discussion on Second Draft	20-21 October 1999	Bhopal
Discussion on Third Draft	1 November 1999	New Delhi
Workshop to finalise details and thrust areas	16 November 1999	Bhopal
Discussion on final draft with the Chief Minister	9 December 1999	New Delhi
Approval of final draft by the Cabinet	11 January 2000	Bhopal

On 11 May 2000 Madhya Pradesh's State-level Population Policy was launched officially (Government of Madhya Pradesh, 2004). However, whether one year was 'fast' in terms of the time needed for policy adoption, is debatable. It has been pointed out by external observers that the policy process was hurried and without exhaustive research and groundwork. The following statement illustrates this.

> "They haven't analysed the institutional environment or policy environment necessary for policy formulation. Actually they didn't conduct any field surveys or policy level analysis. They organised one or two seminars or workshop type things in which they invited a number of people. I think discussion of 1 day or 2 days is useless and it has no meaning. Both times it was a one-day seminar. Then they presented the policy to the committee of secretaries. There are no procedures for the workshops and these procedures were not circulated" (personal interview, an observer, Madhya Pradesh, 2004).

Also, for Madhya Pradesh, since the formulation of the policy was "totally funded by donor agencies" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004) the time taken to finalise the policy was guided by Futures Group's procedures and guidelines. The Futures Group had also provided technical and financial assistance for policy formulation and adoption in other States (Rajasthan, Uttar Pradesh, Uttaranchal and Jharkhand) and the whole policy process took about 7-8 months.

> "The whole process takes around seven to eight months because we fully concentrate on that and nothing else. But it can take three to one and half years to get it cleared by the government" (personal interview, representative of Futures Group, New Delhi, 2004).

Thus it can be concluded that compared to other policies formulated by the Futures Group (4 months in Uttaranchal, and one and a half years in Jharkhand) for Madhya Pradesh the policy process was relatively fast although it was average based on the Futures Group's criterion. Therefore, the timing of the policy process in Madhya Pradesh cannot be considered as a condition for high importance on State-level Population Policy on the part of the policymakers. However, the level of government officials involved in the process characterizes the level of importance attached, and top level administrators in the State were involved in the policy process. One of the policymakers in the second tier of the Department of Family Welfare also corroborated the involvement of top-level administrators in an interview:

> "We went to Jaipur to finalise the first draft of the policy. We read the draft line by line in a group and we were there for 3 days because the Principal Secretary of Health realised that if we stayed back we will not be able to get work done. The drafting of the policy was a joint effort ...." (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

Therefore the involvement of high-level government officials shows that for the Madhya Pradesh government, at the time, the policy formulation and its adoption was important. One other issue that exemplifies the policy process is the level of risk taken by the policymakers. For Madhya Pradesh, the biggest risk taken was the inclusion in the policy of disincentives for the panchayat members based on the 2-child norm (this will be discussed in detail in Chapter 6). The Chief Minister and his cabinet included such family planning strategies in the policy even though the Futures Group had informed them about Cairo and USAID's stance on such incentives.

> "(In the Cabinet meeting) Digvijay Singh said that they should have disqualification for panchayat members if they have more than 2 children. Others said that they have already conducted panchayat elections and next elections will not come until 5 years. So finally they took a decision that it will be passed as an act in the legislature for introduction of disqualification of panchayat members. They said that when the minutes of the cabinet meeting would be written it should say that the clause should be included in the policy document" (personal interview, representative of Futures Group, New Delhi, 2004).

Madhya Pradesh's policymakers were confident of the success of their venture because of the timing of the policy. As can be seen in the interview quote, they did not fear losing political support because the next assembly and parliamentary elections were five years away. Along with the complete involvement of the government officials in the Department of Family Welfare, it is important to examine if other departments were included in the policy process, why the external actors were involved, and if civil society organisations were excluded to ignore dissent. As far as other departments are concerned, their involvement was primarily to identify key inter-sectoral issues. The following quotation illustrates this point:

> "As for inter-departmental coordination, various departments committed to do their own bits. We got action-plans from urban development administration in 23/6/2001, women and child development. In consultation workshops various departments committed that they are going to have their own plans, the departments will perform certain functions. With regard to the energy department, they had written a letter where they said that it would not be possible for them to keep their earlier commitment to electrify 100%. PHE (Public Health Engineering) department, commercial tax, revenue approved by the principal secretary" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

USAID contributed to the drafting, formulating and dissemination of the policy (USAID 2004). Through its sub-contractors, the Futures Group International, USAID also provided financial assistance and employed IIHMR for technical assistance (personal interview, representatives of Futures Group, 2004). Thus I was told:

> "We had engaged the Institute at Jaipur and it was totally funded by donor agencies. We had assistance in getting the policy formulated" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

It needs to be clarified here that repeated attempts were made during and after the fieldwork to discover the reason for the involvement of IIHMR. But no evidence could be obtained. Therefore, a gap in the research remains as to why IIHMR was chosen by the Policy Project to provide technical assistance for Madhya Pradesh. As far as the involvement of civil society organisations is concerned, both the government and the Futures Group confirmed it. The list of participants in one of the workshops shows that representatives of both international NGOs (CEDPA, AVSC International - both sub-contracting NGOs of USAID) and national NGOs (JANANI, Family Planning Association of India (Madhya

Pradesh), were present during the discussions. As far as the involvement of national NGOs with offices in Madhya Pradesh are concerned, my fieldwork revealed that their involvement was indirect. This was confirmed by the representative of Voluntary Health Association of Madhya Pradesh (MPVHAI). Thus:

> "Yes, we were invited but not 100% involved. Overall they involved us. There was no official letter to offer feedback but we received a copy of the policy" (personal interview, representative of MPVHAI, Madhya Pradesh, 2004).

I also interviewed the representatives of JANANI and the Family Planning Association of India, and their response varied from complete ignorance about the policy (State Director of JANANI) to confirmation of indirect involvement (Monitoring Officer of Family Planning Association of India). Therefore it can be concluded that the policy process was not completely transparent. Instead, the process was a relatively closed one - restricted to the active participation and decision making of top-level government officials and representatives of donor agencies.

Thus demographic trends were considered pressing problems by the Madhya Pradesh policymakers of the time. This resulted in a relatively fast adoption of the policy reflected in the involvement of high level government officials and the risk taken by policymakers to adopt the family planning strategy of disqualification of panchayat members based on a two-child norm.

5.4.2.The draft of West Bengal population policy

In West Bengal, recent trends in demographic indicators (especially the population growth rate) are not considered a cause for concern, and therefore are not a pressing issue for policy adoption. In 2003, West Bengal Government's Department of Health and Family Welfare drafted a population policy, although it has yet to be launched officially. Since its formation in 2003, the State Population Commission has met only once (personal interview, official, Department of Family Welfare, West Bengal, 2004). The fifteen-page draft of the policy followed the format of the National Population Policy 2000, but with no State-specific actions as is shown below in the comparison between the two documents.

The national policy distinguishes its objectives into 3 categories, namely, immediate, medium-term and long-term. Its immediate objective is "to address the unmet needs of contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care". As its medium term objective the national policy aims "to bring the TFR to replacement levels by 2010 through vigorous implementation of inter-sectoral operations strategies" (pp. 2 National Population Policy 2000). On the other hand, the draft West Bengal State-level Population Policy document states:

> "The immediate demographic goal of the State population policy is, therefore, to reach replacement level of TFR of 2.1 by 2005 by addressing unmet needs of contraception and reduction of IMR, specially of the neonatal care. ...The medium term objective may be to reduce TFR at 2.0 by the end of 2007 and IMR at 30 by way of improved health care infrastructure, professional service quality through the basic reproductive and child health care network in the State" (pp. 6 draft West Bengal population policy, 2003).

Whatever State-specific actions this draft document listed are already in place as part of the Central government's directives e.g., the formation of the District Health and Family Welfare *Samiti* (local health societies) to address all district specific population stabilisation issues. Also, there are no provisions in the draft policy that show signs of any assessment of risks being taken by the West Bengal government. Therefore, it shows clearly that the State constituted the Commission and drafted a policy primarily to follow central guidelines and to pay lip-service to the Centre. Furthermore, my fieldwork revealed little participation of external observers in the formulation of the draft State-level Population Policy. The members of the State Population Commission include mostly ministers of different departments, local politicians, academics, representatives from newspapers, and NGOs most of whom are directly associated with the Communist party and the government (Government order no. HF/FW/924/4C-6/2000, Govt of West Bengal 2001). But none of these members were involved in the writing of the draft of the State-level Population Policy (personal interview, Joint Secretary of Family Welfare, Government of West Bengal, 2004, State Women's Commission 2004). However, the draft was discussed in a meeting of the State Women's Commission in January 2004. This Commission vehemently objected to the provisions of the draft policy and the fact that while writing it the Department of Family Welfare did not consult experts and specialists in the field. The State Women's Commission opposed the launch of the population policy

without the introduction of a health policy first. As a result, the State Women's Commission recommended that the:

> "Statement of objectives is extremely narrow and again talks of stabilisation without balance. Objective of a Population Policy is to ensure health and safety for the population rather than mere reduction in numbers. ... [The State Women's Commission] feels that for these reasons the government should go through an exercise in discussions and debates before adopting the policy as mentioned in our earlier memorandum. We feel that the proposal in the draft policy is to hold discussions after the policy has been adopted which would be a futile exercise" (State Women's Commission, 2004).

Furthermore, donor agencies working in West Bengal were not directly involved in the formulation of the draft policy. Thus the West Bengal representative for DFID confirmed that:

> "I am not aware of DFID involvement in the population policy. I am responsible for West Bengal for the last 6 months and I know we have seen it, as there are mentions of the policy in the milestone document. I personally haven't looked at it" (personal interview, West Bengal representative, DFID, New Delhi, 2004).

As it currently stands, the draft was revised following the meeting of the State Women's Commission. The Joint Secretary of Family Welfare, who wrote the draft, was transferred to a different department. Thus, nobody in the Department knows when a policy will be launched officially. Talking to the different officials and secretaries of the department (who did not want to be taped), it seemed clear that the adoption of the State-level Population Policy is not a priority.

5.5. Conclusion

This chapter has shown that the socio-political factors that contributed to the adoption of the Madhya Pradesh State-level Population Policy did not affect the formulation of the draft policy in West Bengal. Compared to West Bengal, over the last decade Madhya Pradesh has not been successful in bringing down its population. Its total fertility rate of 4.2 in 2001 is significantly higher than the national rate of 3.1 (as shown in Table 5.2). As a result, below national-average demographic performance of Madhya Pradesh led to the repeated reminder from the Centre to policymakers in the State to remedy the situation. Also, commitment from the political leadership provided by the then Chief Minister Digvijay

Singh, along with efficiency of the administrators in the Department of Public Health and Family Welfare and the presence of financial and technical assistance from the Policy Project, led to the adoption of the policy in Madhya Pradesh. In contrast, for West Bengal, formulation of the draft was simply a result of their following national recommendations. Further, the historical origins of the Madhya Pradesh policy and the West Bengal draft policy were different, due to the timing of their formulation. The analysis of the policy process in Madhya Pradesh showed that because policy adoption was high on the agenda of the government, the process was comparatively fast, but it was not transparent and did not involve the participation of civil society organisations. On the other hand, in West Bengal, the writing of the draft State-level Population Policy was a one-man act without any involvement of other officials within and outside the government or external experts.

Before starting the fieldwork, I had expected to find a long history and working of different factors behind the adoption of the State-level Population Policy in Madhya Pradesh. But my findings were counter-intuitive. In Madhya Pradesh, the policy environment during and immediately after the formulation of the policy was conducive for policy adoption. This was due to the presence of many favourable factors working at the time. There was no history of a favourable policy environment in the State. Moreover, the formulation of the policy was not really an initiative of the State government itself. The quote below summarises it all:

> "The health department could have done the policy formulation itself. We had the expertise, but it was very time consuming. It required full time attention of a set of people over almost a year. We were not in a position to take out staff to that extent" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

As for West Bengal, since population issues are not high priority for the State the urge to finalise the State's population policy is not there.

> "With this overall national policy statement in view, the need for State specific population policy, its goals, objectives and operational strategies is usually felt. The National Commission on Population is also of the view that demographic diversity, current status of all family welfare related regional issues, regional culture and the perception and shared vision of the State Population Commission (SPC) calls for State relevant population policy" (draft Population Policy of West Bengal, 2003).

Hence this chapter has looked at the phenomenon of State-level Population Policy adoption in detail, focussing on the factors, historical origins, and the policy process in two case study States. The next chapter analyses the research findings to examine family planning service provision in Madhya Pradesh and West Bengal focusing on the three family planning strategies. It also examines causal relationships between the adoption of the population policy and the provision of family planning services in Madhya Pradesh.

Chapter 6: Analysing Family planning performance in Madhya Pradesh and West Bengal

6.1. Background

One of the key research objectives of this thesis is to understand the effect of the adoption of State-level population policies on family planning service provision. Chapter 4 reviewed literature on three elements of family planning programmes: the provision of different contraceptive methods; involvement of the community in the programme; and the use of demographic targets, incentives and disincentives. This chapter describes data collected during fieldwork using indicators from the Evaluation Project framework (see Chapter 2) as analytic tools. The chapter begins with an overview of family planning service provision in the two States, and is followed by an analysis of findings from the two States with regard to these three elements of family planning strategies. Next, the level of incorporation of reproductive health in service provision is assessed. The third section analyses information for both States in order to examine the relationship between family planning service provision and the adoption of State population policies. The concluding section compares and contrasts the findings for the two States. The research covers a timeframe of eight years from 1996 to 2004 – this involves four years prior to the policy adoption in Madhya Pradesh and four years after. This chapter uses both qualitative and quantitative data, including in-depth semi-structured interviews, a literature review, family planning performance data, and secondary analysis of NFHS data.

6.2. Family Planning background for the case study States

The Indian family planning programme is a uniform centralised programme under which the Centre "defines the duties of program workers, fixes manpower norms, ... handles logistics, allocates resources and takes on the task of monitoring and evaluating the performance of the program. For their part, the States are assigned the job of 'program implementation'" (Naryayana and Kantner 1982, pp 81). Through this programme, the population is offered five types of contraceptives, categorised into permanent and temporary. The permanent methods are male and female sterilisation, and the temporary methods are oral pills, condoms and the intra-uterine device (IUD). Officially the programme has claimed to follow a

'cafeteria approach' since the 1960s "whereby clients are provided with a choice of contraceptive methods" (Santhya 2004, pp. 24). In reality, however, the Indian programme has been a sterilisation-centred programme (Naryana and Kanter 1982). Female and male sterilisation together account for about 79 percent of current contraceptive prevalence in India, with female sterilisation being the most widely used method (NFHS 3, Government of India, 2005-06). On the other hand, oral pills, condoms and IUDs account for only 14 percent of current contraceptive use (Jejeebhoy 2004).

6.2.1. Family planning services in Madhya Pradesh and West Bengal

The current level of contraceptive prevalence in Madhya Pradesh is 56 percent (NFHS 3, Government of India, 2005-06) compared to 71 percent in West Bengal (NFHS 3, Government of India, 2005-06), with sterilisation dominating the method mix in both States. Estimates from NFHS 3 (2005-06) (IIPS and ORC Macro 2000), the Madhya Pradesh Family Welfare Programme Evaluation Survey (MPFWPS) of 2003 (Government of Madhya Pradesh 2004) and the Government of West Bengal's publication 'Health on the March 2002-2003' show that female sterilisation is the most used contraceptive method in both States, with 50 percent contraceptive prevalence in West Bengal (NFHS 3) compared with 39 percent (MPFWPS 2003) in Madhya Pradesh. In both States around 1 per cent (1.3 in Madhya Pradesh and 0.7 in West Bengal) of women reported that their husbands were sterilised. In Madhya Pradesh, IUDs, condoms and oral pills together constituted 7 percent of contraceptive prevalence (NFHS 3). The MPFWPS of 2003 found that 13 percent of women reported use of IUDs, condoms and oral pills (Government of Madhya Pradesh 2004). In West Bengal oral pills, condoms and IUD use together also account for 18 percent of contraceptive prevalence (seen in table 6.1 below) (NFHS 3, Government of India, 2005-06).

Table 6.1

Current Contraceptive Use (2005-06)		
Contraceptive Methods	**Madhya Pradesh**	**West Bengal**
Female Sterilisation	39%	50%
Male Sterilisation	1.3%	0.7%
IUD	2%	1%
Condoms	5%	5%
Oral Pills	6%	12%

Source: NFHS 3, 2005-06

The primary objective of the Madhya Pradesh State population policy is to achieve a TFR of 2.1 births per woman by 2011. This is to be realised by raising the contraceptive prevalence rate to 65 percent (pp. 9, Madhya Pradesh Population Policy 2000). To achieve that goal the policy specifies certain demographic objectives, including: reduction in unmet need for contraception by 90 per cent by 2011; increasing the proportion of male sterilisation acceptors from the 2% to 7%; increasing the use of spacing methods to 50 per cent among married women; motivating all eligible couples with two or more children to adopt terminal contraceptive methods; and, the provision that persons with more than two children born after 26 January 2001 will not be eligible to contest elections for panchayat and local bodies, and their disqualification from such posts if they have been elected (Madhya Pradesh Population Policy 2000).

6.3. Trends in Family Planning service provision in Madhya Pradesh and West Bengal

The focus of the research was restricted to rural areas in Madhya Pradesh and West Bengal, and the provision of family planning services by the State government health services. In India rural primary health care is organised according to a three tier system based on population size (Table 6.2).

Table 6.2

Type of Health centre	Population Size
Sub-Centre (SC)	3,000-5,000
Primary Health Centre (PHC)	20,000-30,000
Community Health Centre (CHC)	80,000-120,000

Source: Government of India, 2002

Four districts in both Madhya Pradesh (Betul, Vidisha, Rajgarh, Khargone) and West Bengal (Burdwan, Hoogly, Birbhum, South Dinajpur) were researched, as is shown in table 6.3. In each district in Madhya Pradesh, two blocks were visited and in each block one sub centre or a primary health centre was selected. The same sampling pattern was used in West Bengal, although in each block two sub-centres were visited, due in large part to easier logistics. Key informants in both States included the Chief Medical officer, the District Family Planning Officer, the Block Medical Officer, the Block Extension Educator,

and male and female health workers and their supervisors. I also interviewed panchayat representatives at both block and village levels. In total thirty-four interviews in Madhya Pradesh and fifty-five interviews in West Bengal were conducted.

Table 6.3

	Service Delivery Points Visited in Madhya Pradesh							
District	**Betul**		**Vidisha**		**Rajgarh**		**Khargone**	
Block	Shahpur	Bhainsdehi	Vidisha	Nateran	Beoara	Narsingarh	Gugawa	Barwaha
Sub Centre/ Primary Heath Centre	*No centre could be visited due to transport problem*	Kukru	Pipalkhera	Nateran sub centre attached to Community Health Centre	Suthalia	Narsingarh sub centre attached to Community Health Centre	Gugawa sub centre attached to Community Health Centre	Barwaha sub centre attached to Community Health Centre

	Service Delivery Points Visited in West Bengal							
District	**Burdwan**		**Hoogly**		**Birbhum**		**South Dinajpur**	
Block	Memari I	Galsi I	Tarakeswar	Magra	Sainthia	Ilambajar	Tapan	Khaspur
Sub Centre/ Primary Heath Centre	Gantar	Bharatpur	Baligari	Kodalia	Ahmedpur	Daranda	Balapur	Danga

6.3.1. Range of Contraceptive methods provided

In order to assess the contraceptive methods mix available to the rural population from government health centres, the range of methods available at different centres was examined. Questions were also asked about whether there had been a change in this range of methods, what kinds of family planning methods were provided, and whether any new methods had been introduced. Data to measure couple years of protection (CYP) provided in each district were also collected. This was done in order to examine the level of protection in rural Madhya Pradesh and West Bengal. An overview of the findings of the research in the two States is summarised in table 6.4.

Table 6.4

Range of Contraceptive Methods Provided		
	Madhya Pradesh	**West Bengal**
Range of Methods		
Condom	Available at Sub-Centre level regularly	Available at Sub-Centre level regularly
Oral pills	Available at Sub-Centre level regularly	Available at Sub-Centre level regularly
IUD	Available at Sub-Centre level regularly	If facility available at the Sub-Centre
Tubectomy	Block level camps during non-cultivation period	Block level camps during non-cultivation period
Vasectomy	Block level camps during non-cultivation period	Rarely provided
Laparoscopy	Trained doctors available at block level	One surgeon in entire State trained
Kinds of Each Method	1 kind of condom, oral pill and IUD. Laparoscopy, mini-laparotomy, ligation, conventional technique for tubectomy. Conventional and non-scalpel methods for vasectomy. This is true for all districts.	1 kind of condoms, oral pills and IUD. Laparoscopy, mini-laparotomy, ligation, conventional technique for tubectomy – provided at block level depending on the training of the doctor. Conventional and non-scalpel methods for vasectomy. Very few doctors in the State are trained in the non-scalpel technique.
Introduction of New Methods	None	None
Couple Year of Protection	Inter-district difference as CYP for LTT increased in Khargone and Betul with CYP of CTT decreased. Result of NSVT camp of 2000 was reflected in increase in CYP for the year 2001-02.	Burdwan was only district which performed better than the rest. Drop in total CYP in Burdwan, Hoogly and Birbhum was due to non-payment of incentives for LTT.

The range of temporary non-surgical methods in both States included Mala D (the government branded oral pill), Nirod (the government branded condom), and Copper T (IUD type). At the sub-centre or primary health centre level, health personnel in Madhya Pradesh distributed oral pills, condoms, and performed IUD insertions. But in West Bengal not all sub centres had facilities for IUD insertion. This was due to poor infrastructure and a lack of beds. Therefore, clients were referred to either the block primary health centre or rural hospitals. With regards to permanent surgical methods, both vasectomy and tubectomy were conducted in Madhya Pradesh, but in West Bengal not all districts could perform tubectomies. This was due to either non-payment of the compensation fee to clients or a shortage of staff. The following quote illustrates the point:

> "We have people ready to undergo TT (tubectomy) but it is not happening in the block. Now there is a stop to TT operations this year because they are yet to pay the incentive money to the operations that took place last year and there are 50 such cases. There is no money coming in. (personal interview, health worker, Hoogly, West Bengal, 2004).

In both States there were very few doctors who were trained to do laparoscopic sterilisations. In Madhya Pradesh doctors at the block level were not trained, therefore doctors from the districts visited to undertake these operations. In West Bengal, there was only one surgeon in the entire State who was visiting different health centres in order to do laparoscopic operations. Thus it was stated:

> "A surgeon from Medinipur has performed 5-6 lakhs of lap ligation operations. We will be bringing him again during autumn season. In one camp he does 3000-4000 operations" (personal interview, health official, South Dinajpur, West Bengal, 2004).

In both States, sterilisation operations were not done regularly. In Madhya Pradesh, non-scalpel techniques for vasectomy and laparoscopic tubectomy, and in West Bengal laparoscopic tubectomy, were performed in camps between November and February, for both administrative and physical reasons. Thus it was said:

> "Due to geographic and social reasons, TT operations are held during winter seasons only. The period of October, November, and December and till February is a transition between cultivation of two crops and it's the time when women are free and that's why they prefer to undergo the operations. In those four months we will be able to achieve the target for female sterilisation. The reason for the timing of tubectomies being held only during winter seasons is due to the convenience of the public. These TT operations are held regularly in camps" (personal interview, health official, Rajgarh, Madhya Pradesh, 2004).

Although this study did not look at abortion (as mentioned in Chapter 4) research in both States showed, abortions were conducted mainly at district hospitals, unless there was a female doctor posted at the block level. The following quote illustrates this point:

> "Earlier there was a lady doctor who used to perform MTP (Medically Terminated Pregnancy), but now there are no lady doctors and we are not trained to perform MTP. Unmarried MTP cases come and they refer them to the district" (personal interview, health official, Rajgarh, Madhya Pradesh, 2004).

No new temporary contraceptive methods were introduced between 1996-2004. However, with regard to permanent methods, the non-scalpel vasectomy, a single puncture method, is increasingly used, especially in Madhya Pradesh since 2000. One official of the Public

Health and Family Welfare Department underlined, "it is less time consuming, cheaper compared to laparoscopic tubectomy and other sterilisation operations. Also, the patient goes home in an hour and there are no complications" (personal interview 2004). However, in West Bengal use of the non-scalpel vasectomy technique started in 2004. Few doctors are trained in its use, and it has not been widely used yet. There are four different kinds of female sterilisation done by the government health service: conventional techniques with an abdominal incision; laparoscopic tubectomy; mini-laparotomy; and ligation (Government of India 2002). All four techniques were used in all the study districts in Madhya Pradesh. In West Bengal, however, mini-laparotomy was performed by doctors who had specialisation in gynaecology or obstetrics at the BPHC or rural hospitals. Conventional tubectomy or ligation was performed at the district or sub-divisional hospitals only, depending on both the availability of beds and the back up for anaesthesia. Thus:

> "10-12 gynaecologists with training are doing mini-lap in the district. Lap (Laparoscopy) is conducted in 1-2 camps a year that too if there is a government order. Ligation happens only in district and sub-divisional hospitals" (personal interview, health official, Birbhum, West Bengal, 2004).

Although the family welfare programme is centrally sponsored, State governments have the power to introduce new contraceptive methods. But this must be done on a large-scale, and without there being any contra-indications (personal interview, health official, Department of Family Welfare, West Bengal, 2004). No new types of contraceptive methods were found to be introduced in either State. Methods such as the injectable Depo Povera were provided by non-governmental organisations (e.g.: the Family Planning Association of India in Madhya Pradesh).

Calculation of CYP for each method for each district was based on conversion factors taken from Stover, Bertrand and Shelton (2000) (Oral Pills=15, Condoms=120, IUD=3.5, Sterilisation =10) (see Appendix 3). In Madhya Pradesh prior to 1999, Barwani district included both present day Barwani and Khargone, therefore pre-1999 data for Khargone are unavailable. Inter-State and intra-State differences were found in the CYP provided by the family welfare programme in both States (see Diagrams 6.1 and 6.2). In Madhya Pradesh (1996-2004), CYP was more or less constant but there were significant changes in West Bengal. Data from the four districts in Madhya Pradesh confirmed that biggest contributor

to the total CYP in any district was tubectomy. However among female sterilisation, intra-State difference was found. Data from Khargone and Betul showed that the number of conventional tubectomies started to decline from 2000-01 while on the other hand the number of laparoscopic tubectomies increased. Data also reflected the effect of the non-scalpel vasectomy drive of 2000 mentioned by an official of the Public Health and Family Welfare Department as taking place in all four districts. CYP for laparoscopic tubectomy in all four districts rose with a sharp increase in CYP in 2001-02. But it dropped significantly in the following year. No intra-State difference was found with regard to the CYP provided by temporary methods.

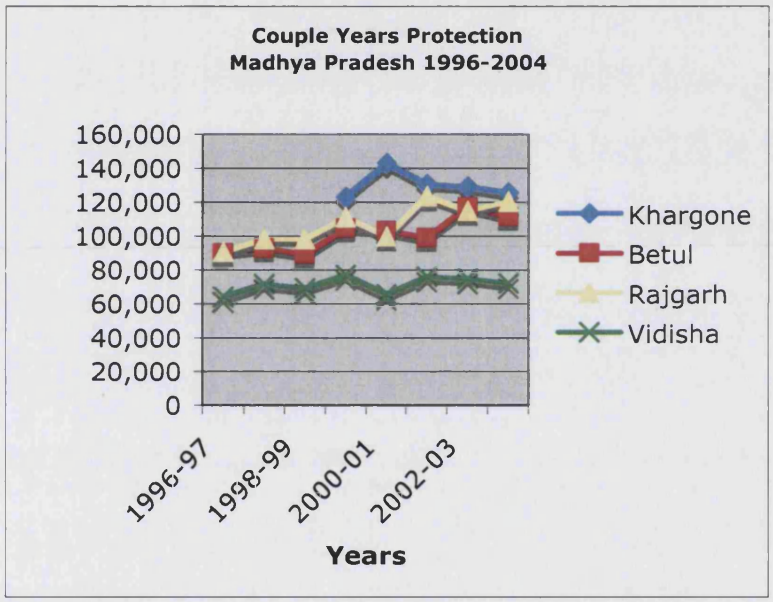


Diagram 6.1

For West Bengal, the CYP for both male and female sterilisation for the year 1996-97 could not be calculated due to a lack of data. Also, there are no disaggregated data for the different techniques of male and female sterilisation.

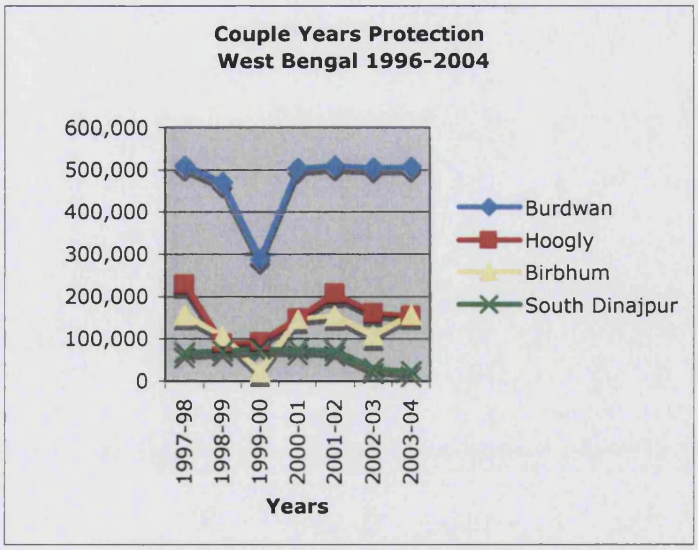


Diagram 6.2

In West Bengal, historically, Burdwan has always been ahead of the other districts with regard to better health care provision, as is evidenced in diagram 6.2. Observers credit this to the residence of high-level State politicians and the presence of the industrial belt which have led to better service delivery (personal interview, an observer, Calcutta, 2005). The fall in total CYP in Burdwan, Hoogly and Birbhum districts was due to the non-payment of incentives for sterilisation.

Although the Family Welfare Programme is a centrally sponsored programme, as is evident in the supply of similar contraceptive methods to both States, there was a difference in service provision between the two States, and also inter-district differences within West Bengal. Overall the provision of different methods was found to be better in Madhya Pradesh. First of all, Madhya Pradesh was found to be providing a greater range of methods - oral pills, IUDs at the sub-centre level and tubectomy and non-scalpel vasectomy technique at the block levels. Also, more permanent methods were found to be available in Madhya Pradesh than in West Bengal. No inter-district difference was found in Madhya Pradesh with regard to method provision. In contrast, in West Bengal there were significant differences (e.g. Hoogly not performing laparoscopic tubectomies, and poor infrastructure preventing IUD insertions in both Hoogly and South Dinajpur districts).

6.3.2. Reproductive Health considerations

In order to examine if and to what extent, the government health service has incorporated reproductive health considerations in its service provision, the study looked at four aspects of information provided by the service. Firstly, what type of family planning counselling was offered by health personnel to new acceptors? Were there any (non-clinical) restrictions on family planning method choice? What type of Information Education and Communication (IEC) media were used? Was family planning counselling provided to adolescents, given that mean age at first marriage in Madhya Pradesh is 15 years (although the legal age at marriage is 18) (Government of Madhya Pradesh, 2003). Finally, it examined whether, and what sort of, training had been given to health personnel on reproductive health considerations. An overview of the results in both States is given in table 6.5.

Table 6.5

Reproductive Health Considerations			
Indicator	**Research methodology**	**Madhya Pradesh**	**West Bengal**
Counselling of new acceptors	Interviews with health workers at the sub-centre and block levels	New acceptors are only married couples. Counselling depended on the judgement and training of health staff	New acceptors are only married couples. Counselling depended on the judgement and training of health staff
Restriction imposed by providers	Interviews with health workers at the sub-centre and block levels	Spousal consent and consent from in-laws restricting service provision	Spousal consent and consent from in-laws restricting service provision
Type of IEC media	Interviews with health workers at the sub-centre and block levels	Media as provided by the Centre	Media as provided by the Centre
Counselling of Adolescents	Interviews with health workers at the sub-centre and block levels	School health programme in some districts	No programmes
Training of Health staff	Interviews with health workers at the sub-centre and block levels	Partial completion of RCH training for health workers. No training of doctors. State administration spoke about re-training	Partial completion of RCH training health workers
Topics of Training	Interviews with health workers at the sub-centre and block levels	As covered in RCH training	As covered in RCH training

Family planning counselling usually focuses on newly married couples. This begins after these couples are found either from the marriage registers or during weekly home visits when health workers establish contacts. This is illustrated by the following statement:

> "We don't provide anything before marriage. Just after marriage we will advice women to accept condoms, and not OP because if they use OP for long they will suffer from infertility. After first child is born we will ask them to go for IUD insertion within 3-6 months of first birth" (personal interview, health worker, Burdwan, West Bengal, 2004).

An offer of contraceptive methods depended on what the health workers deemed to be right, and they did not ask clients what they wanted. It also depended sometimes on their faulty knowledge about the contraindications of the methods as seen in the above interview. In both States, rural health personnel said that they offered the methods first by finding out the medical history of married women and that they then decided the type of method to be suggested based on the number of children women already had.

> "Women with one child will be motivated for copper T, OP and couples with two or more children will be motivated for LTT. ... When a female client comes to the centre for the first time, her medical history will be asked" (personal interview, health worker, Betul, Madhya Pradesh, 2004).

Counselling of adolescents for family planning varied substantially both between and within the States. Intra-State differences were due to the personal beliefs of individual health personnel and whether the district health administration had adolescent sexuality programmes. Some health personnel, including those medically trained, reported that talking about sex should be left until after marriage, as Hinduism forbids such discussion. This is illustrated by the following statement.

> "According to Hindu religion young boys should have good moral character and not have sex before marriage. So if we talk to them about sex related things then they might start thinking about these things" (personal interview, health official, Betul, Madhya Pradesh, 2004)

Despite personal beliefs, the main difference in adolescent counselling between Madhya Pradesh and West Bengal was in the governmental initiatives. In some districts of Madhya Pradesh (Vidisha and Khargone), there were school health education programmes which gave health personnel the opportunity to talk about adolescent sexuality. The following quote illustrates the point:

> "There is an instruction from the administration that one school teacher from every school was trained. Dai (midwife) training also covered topics like health education and population. Moreover, health workers go to schools to talk to young men. This programme

has started since five years" (personal interview, health official, Vidisha, Madhya Pradesh, 2004).

In West Bengal, there were no such school health programmes and "adolescent males are not covered by the programme. It is not stressed, though they are part of the Reproductive Child Health programme for increasing age at marriage" (personal interview, health official, Department of Family Welfare, West Bengal, 2005). Health workers reported problems with regard to the counselling of male adolescents. Thus:

> "With adolescent girls we sit with them in group meetings. We tell them about personal hygiene and especially menstrual hygiene. When we do combined meetings we ask fathers and boys to come and sit. We can't talk to them about sex education in group meetings. We have to tell them separately. We are facing problems with regards to adolescent boys and we have no orders for involving boys. We don't have any materials to motivate the boys" (personal interview, health worker, South Dinajpur, West Bengal, 2004)

In West Bengal some of the female health staff voiced their concerns about counselling boys, but topics discussed with adolescent girls did not include sexual health. Instead the workers discussed personal hygiene and menstruation. In Madhya Pradesh, however, there was evidence of counselling of adolescent girls.

> "Through ICDS workers we bring young unmarried girls here in the CHC for two days training where we talk to them about adolescent sexuality" (personal interview, health official, Betul, Madhya Pradesh, 2004)

Theoretically, the Indian Family Welfare Programme does not restrict the offering of any contraceptive method, but research shows that in both States, the health workers are imposing restrictions. One major restriction imposed by health workers related to obtaining the consent from a woman's husband or-in-laws:

> "There was a case of one patient who had come to me for IUD insertion without permission of her in-laws. When I inserted it she was happy and everything was fine but next day she came and told me to remove it. Since I didn't have gloves with me I said I will do it some other time. Next day her husband came warning me that how could I insert the copper T without his consent and it is illegal he will file a case against me in the police station. Since there was too much hassle in the household finally I had to remove the copper T." (personal interview, health worker, Vidisha, Madhya Pradesh, 2004)

In West Bengal, no such evidence of restrictions was found in the four districts, although one health official in Birbhum explained that while officially there should not be any restrictions, in fact the matter depended upon the judgement of the health workers.

Media to promote family planning were similar in both States with use made of posters, pamphlets, booklets, and puppet shows, films, and other entertainment shows, organised once or twice a year. All respondents said that the visual shows were organised either through private agencies or by the government because the programme is nationally sponsored and the equipment comes from Delhi. In addition to this, in the four districts in West Bengal, health personnel reported organising a Health Fair. Some health personnel took their own initiative apart from using these media. For example, the Block Medical Officer of Beora, in Rajgarh, said that he used wall writing as a form of IEC, and a health supervisor in Takareswar, Hoogly, said that she makes posters for IEC.

Government training of health personnel to incorporate reproductive health occurs under the Reproductive Child Health (RCH) programme. In both States, some of the districts were unable to complete training of all personnel due to budgetary problems. In West Bengal, officers in the district administration in Birbhum and Burdwan confirmed partial completion of RCH training, whereas South Dinajpur and Hoogly had stopped midway. The health administration in Madhya Pradesh was retraining field staff for IUD insertions. Thus it was said:

> "We are training our ANMs and lady health visitors on spacing methods, particularly IUD. We are retraining them and providing all the logistics which were not available to them" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

No such training programme or similar future plans were found in West Bengal. Hence inter-State differences regarding reproductive health service provision were found in terms of the initiatives made by the district administrations. And district administrations took more initiative in Madhya Pradesh than was the case in West Bengal.

6.3.3. The Involvement of Panchayati Raj Institutions in the Family Welfare Programme

The study examined the participation of locally elected people's representatives in activities organised by health personnel. These activities included participation in the monthly meetings of the Community-Needs Assessment approach, a bottom-up approach which involves the setting of "expected levels of achievement", the demographic objectives by field staff. The Government of India's instructions entail that different members of the community, (especially panchayat representatives), should be consulted while establishing such objectives (Government of India 2003). Other activities might include involvement in the IEC campaigns that are held before and during laparoscopic tubectomy camps, or Pulse Polio (Immunisation Campaign of Government of India to eradicate polio for children under five) activities. Finally, the study examined whether, as part of the Centre's policy of inter-departmental coordination, family welfare committees (including both panchayat members and health staff) were formed. In table 6.6 an overview of the findings in the two States is summarised.

Table 6.6

Involvement of Panchayati Raj Institutions in Family Planning Programme activities		
	Madhya Pradesh	**West Bengal**
Participation in activities of family planning programme	In general, not much involvement, unless asked for by the health staff	In general, not much involvement, unless asked for by the health staff
Formation of family welfare committees	Committees were found to be present	Committees were found to be present.

The study revealed that a majority of the panchayat representatives in both Madhya Pradesh and West Bengal were apathetic to the functioning of the health department. Despite being linked to the Rural Development department, and being elected representatives, these people generally believed that health is a matter for the health department, and therefore they should not be involved. During an interview, one panchayat representative in Madhya Pradesh said:

> "Family planning is done by the health workers, therefore there is no need for the panchayat to do anything" (personal interview, panchayat, Vidisha, Madhya Pradesh, 2004).

This type of perspective was shared by a health official in Bhainsdehi who said:

> "I have gone to quite a few meetings with the PRI members and their attitude is that health is the business of the health department, so we should resolve any health related problems. They try to avoid any health related problems (personal interview, health official, Bhainsdehi, Madhya Pradesh, 2004)

With regard to attendance in meetings organised by the health department, there was evidence of significant non-attendance. In both States health personnel verified this. One block health personnel in Madhya Pradesh said that:

> "They don't attend any meetings organised by us especially CNA (community-needs assessment approach). On paper it is said they should be involved with health, but in reality they are hardly involved" (personal interview, health worker, Betul, Madhya Pradesh, 2004).

In West Bengal this was confirmed by a female supervisor who said:

> "We do all the paperwork for CNA and then take them to the PRIs. They don't attend the meetings, though they are supposed to be present. During the CNA meetings nobody apart from us is present. In reality apart from fieldwork, we should be getting feedback from these people, but what they say is we should fill up, determine the ELA (Expected Levels of Achievement) and do the planning and then take it to them" (personal interview, female supervisor, Birbhum, West Bengal, 2004)

However, these representatives did participate in the IEC campaigns of the health departments, if they were asked to. Thus one health official in Khargone said:

> "At the village level we get help from the PRI representatives, especially during the time of pulse polio and LTT camps. In the initial time of the camps they help but in the later stages their support dwindles" (personal interview, health official, Khargone, Madhya Pradesh, 2004)

But there were some helpful and active panchayat leaders as is illustrated in the following quote from an interview in Madhya Pradesh:

> "During Pulse Polio, we organise camps, we call the guard of the schools and gather young kids in the school building. Also, before the LTT camps we disseminate the information about timing of the camps by sending drummers through the village" (personal interview, panchayat representative, Vidisha, Madhya Pradesh, 2004).

Similarly, there was one energetic panchayat representative in West Bengal who said:

> "We help in the organisation of ligation camps and we disseminate information before the camps. We distribute ORS pouches". (personal interview, panchayat representative, Burdwan West Bengal, 2004)

In their effort to ensure that different programmes reach the rural population, the State governments of both Madhya Pradesh and West Bengal have transferred different rural development functions from government departments to panchayats. As part of this transfer, there are health and family welfare committees at different layers of the panchayat (Government of Madhya Pradesh, 2000, Government of West Bengal, 2003). Information was gathered to determine whether these committees existed, and how they were functioning. In both States, in all four study districts, these committees existed. In Betul, one health officer said:

> "The health committees where BDO (Block Development Officer), BMO (Block Medical Officer), members of the panchayat are members have been working for the past one to two years. The topics that are discussed in the meetings include how to implement the targets that are given by the district, how to decrease birth and death rates, what are and can be methods to decrease them. Discussions are also held on infrastructural issues like conditions of health centres' etc." (personal interview, health official, Bhainsdehi, Madhya Pradesh, 2004)

Similarly in Birbhum district in West Bengal, the district administration confirmed the existence of such a committee. Thus it was said that:

> "Like any other districts we have a District Family Welfare samiti *(committee)* which includes Sabhadipati (PRI head at the district), DM (district magistrate), CMOH (Chief Medical Officer of Health), the member secretary, programme officers like us and representatives of other departments like sanitation, PWD (Public Works Department), PHE (Public Health Engineering Department) etc. The purpose of the committee is to hold discussions relating to health. They are involved in the decision making of the Family Welfare Programme. Usually, different issues and problems relating to health are addressed in these samities. Also, there is a post of health representative at the panchayat. Sometimes we take some issues to this person directly when we don't have time to address issues like boycotting of camps during pulse polio. Then we get full cooperation from the panchayat. To increase inter-sectoral coordination, block level societies are organised" (personal interview, health official, Birbhum, West Bengal, 2004).

Because these committees are just being formed, it is too early to measure their effectiveness. However, there are no central government guidelines as to their functions. This was confirmed by a rural development officer in Madhya Pradesh who said:

> "At every level of the PRI, there are village committees, but there are no written guidelines as to their duties and functions" (personal interview, Rural Development officer, Khargone, Madhya Pradesh, 2004).

In summary, in both States, panchayat representatives were not much involved in the functioning of the family planning programme. Involvement was found to be mostly in the IEC campaigns that were conducted during laparoscopic tubectomy camps and Pulse Polio activities. Where panchayat representatives were involved, this was because they had been asked for assistance by the health staff. However, I observed that the level of involvement and awareness about the programme was greater at the district and block levels, where much of the decision-making takes place. Not all the panchayat representatives at the village level were literate. Consequently, their awareness about the functions of the Family Welfare Programme was found to be low in some cases. The rationale behind the formation of the health and family welfare committees was partly to increase panchayat involvement. But because these committees were formed only three to four years before my enquiry, it was too soon to measure their effectiveness. Overall, no inter-State difference was found regarding their involvement.

6.3.4. The role played by Panchayati Raj Institutions

In order to assess what roles the panchayat representatives play regarding family planning service provision, the study examined the type of communications they produce and disseminate. It also focussed on the type of assistance they provide to health personnel, and whether they monitor the work of health personnel. This information was used to gauge not only the degree of inter-departmental coordination, but also panchayat representatives' understanding about family planning as representatives of the community as a whole. Furthermore, it helped to gauge if the panchayat took any initiatives on their own as part of their rural development activities.

Table 6.7

Role played by Panchayati Raj Institutions in family planning service provision		
	Madhya Pradesh	**West Bengal**
Type of IEC produced/disseminated	Panchayati Raj Institutions are inviting the health staff to the monthly meeting to talk about family planning	Panchayati Raj Institutions are inviting the health staff to the monthly meeting to talk about family planning
Type of assistance provided	Depended on initiative of individual panchayat and funds available	Depended on initiative of individual panchayat and funds available
Monitoring work of health staff	No programmatic action found	Shifting of health centres in the premises of the Panchayati Raj Institutions

In both Madhya Pradesh and West Bengal, the main IEC initiative panchayats took was inviting health personnel to their monthly meeting in order to discuss family planning with the general public. One panchayat representative I interviewed in Gugawa, in Madhya Pradesh, told me:

> "We organise village meetings once a month, where workers from all the department are present, and they inform the people about their activities and the programmes of their departments" (personal interview, panchayat representative, Khargone, Madhya Pradesh, 2004).

Similarly, one health official in Birbhum in West Bengal stated:

> "We have to be present in their village meetings to talk about health and family planning issues. In the meetings they organise at the village level, they talk about their plans and programmes and we are present to tell the people about health. They don't talk about health" (personal interview, female supervisor, Birbhum, West Bengal, 2004).

However, there were exceptions as was pointed out by one health official in Hoogly, West Bengal.

> "They use IEC through local cable TV. They are involved in child health. They help in motivation during LTT camps. Through their sponsorship, we have printed family planning slogans on the prescription pads as well" (personal interview, health official, Hoogly, West Bengal, 2004).

Providing assistance in the form of monetary or infrastructural help varied between individual panchayats and there was no real inter-State difference. If the panchayat leaders were proactive and had enough funds, then they helped health personnel to build rooms for

health centres and sanctioned the creation of health centres when there was a shortage. They also helped in organising laparoscopic tubectomy and Pulse Polio camps. Evidence about this occurred in Betul, where I learnt from one health official:

> "If there are funds available to the PRI members at the Janpad (block) level then they build rooms for the health centres. They also help in sanctioning of sub centres if there are none" (personal interview, health official, Betul, Madhya Pradesh, 2004).

Similarly in Magra in Hoogly district, one health official mentioned the considerable help they got from the panchayat. He said:

> "We are building a new building for health centres. Funding is coming from the panchayat. All the hand-pumps within the campus of the BPHC are maintained by the panchayat. They help in cleaning and clearing of the premises of the BPHC (personal interview, health official, Magra, West Bengal, 2004).

As part of the State government initiative for inter-departmental coordination, since 2003, panchayat offices and sub-centres in West Bengal have been based in the same premises (Government of West Bengal, 2003). In all four districts most of the shifting of the centres had been completed by the time of the data collection. Thus it was said:

> "Now sub centres are going under the gram panchayat as sub centre headquarters. Out of 10 Gram Panchayat, 9 sub centres have moved in" (personal interview, health official, Magra, West Bengal, 2004).

However, this initiative was also taken to ensure the monitoring of field based health staff. In all four districts, I realised that the type of response was reciprocal, meaning that in those places where the health personnel complained about the panchayat members, the panchayat members did not speak positively about the personnel either. One such case was in Ilambajar, where a panchayat representative said:

> "We are getting complaints of health workers not going for visits, and people are not able to meet them. Also, they are not present during the allotted time in the subcentres, and we have found out that this is true to some extent (personal interview, panchayat representative, Ilambajar, West Bengal, 2004).

In contrast, in Madhya Pradesh, where the State government has not taken any such initiative, a panchayat representative commended the health workers by saying:

> "Health workers are working well but they should get more benefits and more pay. They have a big workload and have to cover a big population with a large area. They cover all the villages and are doing proper field visits. Registration of births and deaths are registered in the village panchayat. They get the data from the health workers in the PHCs and the ICDS" (personal interview, panchayat representative, Gugawa, Madhya Pradesh, 2004).

The research did not reveal any independent significant initiative by the panchayat in promoting family planning. The initiative of the panchayat depended fully on the individual panchayat representatives and their degree of enthusiasm. However, in West Bengal, as part of the government policy, most of the sub-centres are now housed in the same premises as the panchayat at the village level. The rationale behind this is to increase inter-departmental coordination. Though this initiative was being implemented during the fieldwork, again it was too early to assess its effectiveness.

6.3.5. Targets, Incentives and Disincentives

In 1996, the Government of India abolished the four decades of target-oriented approach to family planning. In 1997 it adopted a target-free approach renamed the "Community Needs Assessment" (Government of India 2002). However, Madhya Pradesh continues to set targets and to use disincentive strategies. This was corroborated by one of the State officials I interviewed, who said:

> "I do agree at the district level targets are given by increasing 10-20% of the last year's achievement. When the CNA approach was adopted, perhaps it was not properly planned about its operationalisation" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

West Bengal, on the other hand, followed the Centre's instruction and abolished target-setting in 1996. The person responsible for setting targets prior to 1996, an official of the Department of Family Welfare, confirmed this by saying:

> "West Bengal has never liked the targets given by the centre. But when the centre gave targets we followed them and passed them to the districts and when the centre removed targets, we also removed them. Now with CNA, performance is monitored based on the ELA. We take out a bulletin for the whole State on performance of RCH. The process of ELA determination is that they are determined by the sub centres first which are then passed on to the blocks and blocks to the districts and then to the States. Sometimes we do adjust them if we find any discrepancies or inconsistencies. But there is no imposition or dumping of targets on the health workers on top of the ELA they have derived" (personal interview, health official, Department of Family Welfare, West Bengal, 2005)

This section examines the use of demographic targets and (dis)incentives for acceptors of contraceptive methods, panchayat leaders, and those who provide or promote family planning. Table 6.8 below gives an overview of the findings for Madhya Pradesh and West Bengal.

Table 6.8

Targets, Incentives and Disincentives		
	Madhya Pradesh	**West Bengal**
Use of targets	Evidence of use of targets	No evidence of use of targets
Incentives for acceptors of family planning	Same as per Centre's rule	Same as per Centre's rule, but non-payment of acceptor money
Disincentive of Panchayati Raj Institutions representatives	Panchayati Raj Institutions disqualified to contest elections or hold office based on 2-child norm.	No such disincentive found
Incentive and Disincentive for providers	Increment in salary for those State government workers undergoing sterilisation	No such incentive
Community Incentive	Rural Development schemes specially the ones dealing with infrastructure for villages linked to family planning and reproductive health performance	No such incentive

A significant inter-State difference was found regarding target-setting. Research in all four districts in Madhya Pradesh showed that health personnel at the field level were given targets by those higher up in the administrative hierarchy. Contrary to the central policy of a bottom-up approach, in rural Madhya Pradesh, the district administration admitted setting targets for the blocks, and the blocks in turn passed them on to the health centres. Furthermore, some district administrators put pressure on the blocks to fulfil annual targets. One of the health workers I interviewed in Rajgarh district said:

> "We get scolded if performance is down and targets are not achieved. BMO puts pressure to fulfil targets" (personal interview, health worker, Rajgarh, Madhya Pradesh, 2004)

Similarly, members of the district administration in Vidisha district discussed their concern about not being able to achieve their sterilisation targets. Thus one health official said:

> "Progress in achieving targets is going okay, but not fully. The targets for sterilisation that are not being met properly and it is at this point that we are lagging behind and the reason is there is a shortage of surgeons. The administration needs to organise training for the

> surgeons and then numbers of sterilisations would automatically increase" (personal interview, health official, Vidisha, Madhya Pradesh, 2004).

In contrast, in West Bengal the research did not uncover any evidence of target-setting by health personnel, who appear to be following the target-free bottom-up community-needs assessment approach of the family planning programme. That said, many of the administrators doubted whether field-level health workers in West Bengal understood the new approach. A health official in Burdwan was one such administrator, as the following quotation shows:

> "Now the health workers on the basis of their needs determine targets after they conduct some surveys based on their ECR (Eligible Couple Register). We don't give them any targets but what they give us we just consolidate them. Though officially this started in 1996 and on the ground it has started for the last 3-4 years, I can't say that it is working fully well despite having given extensive training" (personal interview, health official, Burdwan, West Bengal, 2004).

Likewise, the district administration in South Dinajpur district complained about the way some of the health workers were setting targets for themselves. One health official said:

> "Now it is CNA. The problem now is that the health workers are not showing the right figure on number of population so that helps them to achieve the targets. They show fewer targets for the year. Also they are not completing the ECR. But despite of all the criticisms, work is being done and it is being done by the health workers. Most of the workers do work" (personal interview, health official, South Dinajpur, West Bengal, 2004).

The Centre has a "Sterilisation and IUD insertion Scheme" under which it provides a compensation package for persons undergoing surgical contraception in all States. The purpose of this package is to give funds to States for expenditure related to drugs, dressings, diet, transportation and cash for compensation payments (Annual Report 2003-04). The central government has been increasing the amount included in this package. In 2002 the compensation provided by the central government for people undergoing vasectomy, tubectomy and IUD insertion was Rs. 200, Rs. 300, and Rs. 16 respectively. However, this amount has been increased recently (as per the Ministry of Health and Family Welfare's Annual Report of 2005-06) especially for the poor performing Northern States, including Madhya Pradesh. The increase is to Rs 400 for both kinds of sterilisation, and to Rs 20 for an IUD insertion. In addition, individual acceptors of vasectomy and tubectomy will be paid Rs 250 and Rs. 200, respectively.

In both Madhya Pradesh and West Bengal, a few health staff were well-informed about the correct amount of money to pay as compensation. Research in Madhya Pradesh showed that the health personnel were unaware of the recent increase in the value of the compensation package, and they continued to follow the old instructions. For example, a district officer in Vidisha said:

> "Compensation for vasectomy is Rs 165 and abdominal tubectomy is Rs 160. LTT Rs 160. From this year, the compensation has increased for VT, it is Rs 265 now, abdominal TT is Rs 210 and for LTT is Rs 210. For surgeons charges per operation for VT is Rs. 25 and for both abdominal and LTT is Rs 20 and it has remained the same. Motivation charge for VT is now is Rs 25 and this is based on the latest notice that has come from the administration on August 7, 2004" (personal interview, health official, Vidisha, Madhya Pradesh, 2004)

In West Bengal there was evidence of non-payment of compensation fees to tubectomy acceptors. Thus, in Birbhum and Hoogly districts there was a huge backlog of payment of acceptor fees, and as a result health personnel were giving 'due-slips', (i.e. acknowledgement of debt) to the clients. Thus it was said:

> "For ligation they get Rs 215. Currently we are giving due slips and there is a huge backlog. We are yet to get money from the district even for the last year" (personal interview, health official, Sainthia, West Bengal, 2004)

The reason for non-payment of acceptor money in some West Bengal districts was financial irregularity, plus the non-uniform release of funds from the central government. In this context this was what a State official said:

> "Money comes from the Centre. There is financial irregularity at the districts. The districts are not showing previous years' adjustment and is the same case at the block level. This leads to non-payment of incentives to the acceptors and as a result they are being given due slips (personal interview, health official, Department of Family Welfare, West Bengal, 2005).

However, there was no evidence of non-payment of compensation fees in Madhya Pradesh. One health officer in Betul stated:

> "Patients undergoing sterilisation are paid money as compensation. Earlier the compensation money was Rs. 170, but a letter has just come in indicating an increase. Surgeon gets Rs. 20. These days payment of motivation money has been stopped" (personal interview, health official, Betul, Madhya Pradesh, 2004).

As has already been noted, as part of Madhya Pradesh's State-level Population Policy, in the year 2000 the State government passed an act in the legislature disqualifying people from contesting elections (panchayat, local bodies, cooperatives) on the basis of a two-child norm. The State Population Policy reads:

> "Persons having more than two children after January 26, 2001 would not be eligible for contesting elections for panchayats, local bodies, mandis or cooperatives in the State. In case they have the third child, they would be disqualified from that post" (pp. 15, Madhya Pradesh Population Policy. 2000).

Research in the four districts showed that the strictures of this Act have been actively practiced in rural Madhya Pradesh, as was corroborated by a health worker in Betul:

> "In total 28 panchayat members have been removed from their posts by the District collector for having more than 2 children after 2001" (personal interview, health worker, Betul, Madhya Pradesh, 2004)

The panchayat representatives I interviewed also gave me the same picture. However, it must be noted that the administration does not have a satisfactory monitoring system in place to determine whether a panchayat representative has more than two children. Therefore only those representatives who are reported as having a third child are being disqualified, meaning that those who report tend to be either in the opposition party or people that have some difference of opinion. Thus one panchayat representative said:

> "In Gram Panchayats some have two children and others do not disclose the third child to be a Panchayat representative. There are some who have been removed from the post. The removal is based on complaints filed by others to the administration. The administration hasn't taken any decision against the members so they are still working in their posts. The government has asked all the Panchayat representatives to certify on paper that they have two children. But people hide the birth of the third child. There are heads in Gram Panchayats who have a third child born but in the birth certificate they write a different name for the father to the child" (personal interview, panchayat representative, Rajgarh, Madhya Pradesh, 2004).

No evidence, either documentary or through interviews, of any kind of disincentive was found with regard to this in West Bengal.

The Government of Madhya Pradesh has an Act of 1976 under which its employees get a salary increment, 7 days' vacation and a green card (easy credit facilities for poor farmers) if they undergo sterilisation. This Act stipulates that employees will get 2 increments if they have 3 children, and 3 for 2 children (personal interview, health official, Khargone,

2004). One health worker confirmed that all of them knew about this policy when they joined the service:

> "Now for the past three-four years one to two children will get one increment. All of us knew about this when we joined" (personal interview, health worker, Khargone, Madhya Pradesh, 2004).

As a community incentive, the Madhya Pradesh Population Policy mentions use of "rural development schemes particularly those dealing with infrastructure, will be linked with family planning and reproductive health performance" (pp. 17). Research showed that some district administrators in Madhya Pradesh had taken it upon themselves to enforce the two-child norm on their employees. There is no Act of the State government which prohibits employment based on this norm. In Betul, the district administration had already started sending letters warning personnel to limit the number of births that they have. One health worker in Betul informed me that:

> "Health workers are receiving letters warning them that if they have more than 2 children after 2001 they will face consequences. However, the letters don't specify as to what would happen. But the health workers are speculating that their increment will be stopped or promotion will be blocked. There is one health worker in a sector who has received a letter from the administration because she has 3 children (personal interview, health worker, Betul, Madhya Pradesh, 2004)

Also, for poor performing workers, administrators sometimes caution that increments may be blocked, as was confirmed by one Block Medical Officer:

> "If 80% of the targets are not achieved then we warn the health workers of departmental action like blocking of increment in the salary. Also the information is passed on to the CMO, and he can wish to take it up further" (personal interview, health official, Betul, Madhya Pradesh, 2004).

However, no evidence of warnings based on the two child norm was found with respect to West Bengal. Some of the district and block officials there spoke about scolding health workers because of poor performance. This is shown by the following quote:

> "There is no reward and punishment, though last year the West Bengal government announced that three field workers will be rewarded as best health workers. But I haven't received any instructions and details to implement it. There is no scope for punishment so only thing we can do is to scold. But there are many chronic problems like shortage of staff (personal interview, health official, Burdwan, West Bengal, 2004).

Large inter-State differences were found with regard to the use of demographic targets, incentives and disincentives. In Madhya Pradesh, the administration is actively setting demographic targets, and as a result it is putting pressure on health workers to achieve them. Evidence of the use of disincentives and incentives based on a two-child norm was also found in Madhya Pradesh. Thus, panchayat members in the State are being disqualified on the basis of this rule. The rationale for this initiative is that panchayat representatives should act as role models to the general population. Research showed evidence of their disqualification and removal, although again there is no adequate monitoring system in place. The health workers, as government employees, get increments in salary for undergoing sterilisation.

In contrast, in West Bengal there was no evidence of the use of demographic target setting, or the use of incentives or disincentives by the State government. Since 1996, the West Bengal government has been following the community needs assessment approach to the family planning programme. However, administrators in the State showed concern about its effective implementation by health workers. Inter-State differences were also found in the payment of compensation fees to sterilisation acceptors. In West Bengal the clients were being given due-slips, and health personnel had not been able to pay compensation money for many months. No such non-payment of acceptor money was found in Madhya Pradesh.

6.4. Change in Family Planning service provision due to State-level Population Policy

One of the research objectives was to find a relationship between the adoption of a State-level Population Policy and the provision of family planning services. So far, the chapter has described the family planning service in Madhya Pradesh and West Bengal. During my interviews, I asked health personnel about the State-level Population Policy and whether they had observed any change in the Family Welfare Programme as a result of it. The responses varied from mentioning a change in the quality of the services provided, to a change in the number of service delivery points, and also changes in IEC techniques. However, most of the respondents spoke about a change in the motivation of clients. The following section analyses these responses in order to examine possible linkages between State-level Population Policy and a change in family planning service provision.

Knowledge about the State-level Population Policy in Madhya Pradesh had percolated down to the block level. All the block level health personnel interviewed knew about the policy. Not all of the health workers at the sub-centre level were aware of the policy, but they knew of the target of attaining a TFR of 2.1 by the year 2011. For example, in Barwaha, a health worker told me:

> "We don't know about the population policy. From the top, we are given targets and sometimes they are twice the previous years achievement. When we ask the district they say the targets are from the State. The reason given is that the State will have to reach its demographic targets by 2011. They say that if we do a reasonable number of sterilisations every year then we will be able to achieve the replacement level of fertility of 3 to 2 by 2011" (personal interview, health worker, Khargone, Madhya Pradesh, 2004).

A majority of the respondents in Madhya Pradesh talked about motivation and awareness change as a result of the policy. They said that people are now more aware and ready to adopt contraception. For example, a health worker stated:

> "Earlier we had to go door to door to chase people for motivation which was a big problem, and even then they would not accept family planning. But now that is not the case. Now we just need to tell them the place where TTs are going to take place and they will automatically come. Now motivation has increased quite a bit" (personal interview, health worker, Vidisha, Madhya Pradesh, 2004).

Respondents generally believed that this has been possible due to the increase in IEC campaigns that came after the policy was introduced. Thus it was stated:

> "Basically awareness can be seen among the target couples through information dissemination, as there have been an increase in the number of IEC camps and through PRI there has been camps organised by the 7 Janpad panchayat for the heads of 59 Gram Panchayats to sensitise them about population issues. The results of these programmes are seen in the high attendance in the family planning camps. Motivation for family planning and small family norm has definitely increased (personal interview, health worker, Vidisha, Madhya Pradesh, 2004).

The increase in the IEC campaign was confirmed by one health official at the Public Health and Family Welfare Department in Madhya Pradesh, who said:

> "A very important component of our work is IEC activities for popularising spacing methods and sterilisations. To achieve this, we have made an action plan in our State IEC bureau and are launching the campaign through the BEE (Block Extension Educator) and media officers in the districts, and we are exhibiting film shows in the interior villages, wall

> writing, hoarding, posters, and inter personal communication are developed when the workers want to convince the patients about the different methods. We have developed an IPC module for this purpose and it is in practice. Similarly, we have trained a large number of birth attendants" (personal interview, health official, Public Health and Family Welfare department, Madhya Pradesh, 2004).

Non-governmental respondents also substantiated the increase in IEC campaigns through raised inter-departmental coordination as a result of the population policy. For example, one official of the Family Planning Association of India observed:

> "The ICDS workers of the Women and Child Development department now have training on family planning, and the health and family welfare department is making them depot holders of condoms. So, whenever these ICDS workers go for house visits they carry contraceptives with them so they not only distribute these items, but also counsel their patients not only on safe pregnancy, safe motherhood, but on family planning as well. The ICDS workers get their supply from the health workers, ANMs, male and female supervisors when they go for field visits. The concept of depot holders started 3-4 years back, may be more. Apart from PRI, Women and Chid Development, tourism department, department of youth are also involved. In the youth centres and in schools, they organise youth related programmes to disseminate information on adolescents, youth and how to accept family planning after they are married. They also organise life skill education in schools and colleges" (personal interview, spokesman, FPAI, Madhya Pradesh, 2004).

Many field staff reported that there is pressure from those higher up in the administration hierarchy to motivate clients for family planning. Thus one health worker in Shahpur said:

> "Health workers motivate clients because there is pressure on them to call, but people also motivate one another. They disturb one another, disrespect people with more children, give them names and that's how awareness comes about" (personal interview, health worker, Madhya Pradesh, 2004).

There was evidence to support the increase in IEC campaigns as a result of the adoption of the population policy in Madhya Pradesh. But a direct causal link between the IEC campaign and motivational change cannot really be established. The improved motivation and awareness of family planning clients may be attributed to the many years of IEC and interpersonal communication by the health staff, and not just to four years of implementation of the State-level Population Policy.

One respondent said that after the year 2000, more sterilisation camps have been organised during the non-cultivation agricultural slack season. The administration also organised camps in remote areas by sending in trained doctors from the block level. Thus it was said:

> "Earlier LTT or vasectomy camps were organised only at the districts, but now efforts are being made to organise the camps in the interior areas. Sometimes where there are no trained personnel, trained workers from the block are sent to provide services" (personal interview, health worker, Betul, Madhya Pradesh, 2004)

One health official of the Public Health and Family Welfare in Madhya Pradesh seconded this by saying:

> "Stress is given to sterilisation as the male sterilisation is very poor which is around 2%. We aim to increase this to 10% in the next 3-4 years. We will popularise non-scalpel vasectomy which is less time consuming, the patient goes home in an hour and there are no complications. For this we have organised mega camps in the districts and we have got a very good response. In one camp, we operated more than 30 patients" (personal interview, health official, Public Health and Family Welfare Department, Madhya Pradesh, 2004).

Some respondents also mentioned that they thought there had been an increase in the number of health centres as a result of the policy. Thus one of them stated:

> "There has been a rise in the number of sub centres in the last five years. Earlier there was 1 sub centre for every 5000 to 7000 population. Now there is one sub-centre for every 3000 to 5000 population" (personal interview, health official, Betul, 2004).

Due to the Reproductive Child Health Programme funding from the Centre, the government has also constructed health centres all over Madhya Pradesh. Therefore, this change cannot be considered as being due to the adoption of the State population policy:

> "Under RCH, 4 new CHC s (Community Health Centres) were established and numbers of doctors have increased in these centres. Prior to the RCH, numbers of CHCs were limited" (personal interview, health official, Vidisha, 2004)

This section analysed quotations and data from Madhya Pradesh in order to establish linkages between changes in family planning service provision and the adoption of the State-level Population Policy. Evidence suggested that there has been an increase in governmental efforts in IEC campaigns, and an increase in the number of non-scalpel vasectomy technique camps. However, though many health workers spoke of a motivational change as a result of the population policy adoption, four years was thought to be too short a time to measure such a relationship.

6.5. Conclusion

Thus, we see that this study found programmatic differences in family planning service provision before and after policy adoption in Madhya Pradesh and interstate differences between Madhya Pradesh and West Bengal. Comparing the service provision before and after the Madhya Pradesh State-level Population Policy was adopted, change was found primarily in the initiatives taken by the health administration at different levels. Evidence of programmatic initiatives was seen in the implementation of all three family planning strategies. First, with regard to the provision of contraceptive services, non-scalpel vasectomy has been increasingly carried out since 2000 and the health administration is providing such services in camps in Madhya Pradesh. Moreover, different tubectomy techniques were found to be practiced by the doctors at the block level. In Madhya Pradesh, doctors were already trained to perform such techniques, which was not the case in West Bengal. Since 2000 health administration is also stressing more on spacing methods and vasectomy. An inter-State difference was found in the total CYP estimates for West Bengal and Madhya Pradesh. West Bengal has the second highest contraceptive prevalence in the country of 71 percent, compared to 56% percent in Madhya Pradesh. In both States the biggest contributor of total CYP was female sterilisation. However, looking at the CYP in four districts in Madhya Pradesh from 1996 to 2004, no significant increase can be seen after the year 2000, i.e., after the State-level Population Policy was adopted. In Betul, total CYP increased from 89,859 in 1996-97 to 111,337 in 2003-04. Similarly, in Rajgarh it increased from 90,738 in 1996-97 to 120,317 in 2003-04. However, no change can be seen in the total CYP in Vidisha district (63,686 in 1996-97 to 71,699 in 2003-04). Furthermore, with regard to reproductive health considerations in family planning service provision, no change could be found in Madhya Pradesh pre-and post-policy adoption. But there was inter-state difference as the study found evidence of school health education for adolescent sexuality in Madhya Pradesh. Though theoretically the Indian programme does not inhibit the provision of any family planning service, the fact is that in both States, individual health workers are restricting services either based on personal belief, faulty knowledge or familial pressure from individual clients. Finally, the vigorous use of demographic targets by increasing 10-20% of the previous year's achievement, providing incentives for health personnel, and possible disqualification of panchayat representatives, can also be said to be a result of the population policy in Madhya Pradesh. Unlike West Bengal, the health staff at all levels in Madhya Pradesh are knowledgeable about the demographic target of achieving a TFR of 2.1 by 2011, which is the main objective of the State's policy. Therefore, as the

basic message of the State-level Population Policy has percolated down, so its reflection was indeed evidenced in different programmatic initiatives.

Chapter 7: Conclusion

This study hypothesised that there was a long historical origin of the State-level Population Policies and State-specific reasons behind their adoption. It further hypothesised that these policies have had significant programmatic implications on the services provided by the Indian Family Welfare Programme. This study was designed to fill a gap in the literature about the historical origins of these policies and their impact on services provided. This chapter summarises the main findings of the thesis and this is followed by a section on the limitations of this research and a discussion on the implications.

7.1. Historical Origins of State-level Population Policies

This study is based on the premise that, according to the Constitution of India, a population policy is a government measure to affect a demographic change when it is formulated by the (national or State) cabinet and approved by the (national or State) parliament. Following that definition it has been shown here that it was not until 1997 that the population policy of Andhra Pradesh became the first State-level Population Policy. At present twelve States (Andhra Pradesh, Bihar, Chhatisgarh, Gujarat, Haryana, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh) and five Union Territories (Andaman and Nicobar Islands, Chandigarh, Dadar and Nagar Haveli, Daman and Diu, and Lakshadweep) have adopted a State-level Population Policy (Government of India, 2006, pp 27). It is notable that all of the *BIMARU* northern States (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) now have a State-level Population Policy. Finally, five more policies (for Arunachal Pradesh, Assam, Kerala, Punjab and West Bengal) are under development. Also, moving in the same direction, in 2004, Jharkhand adopted a Population and Reproductive Child Health Policy and Karnataka has an Integrated Health Policy.

The origins of these policies were traced to 1952 in the form of State government measures of incentives and disincentives to encourage small family norms and to limit the increasing population of the country. Prior to the Emergency period, such measures were used by Gujarat, Haryana, Kerala, Maharashtra, Tamil Nadu and Uttar Pradesh. During

the Emergency (i.e. 1975-77), a majority of the States undertook compulsive measures following the prescriptions of the national population policy statement of 1976. The motivation behind such State government measures during the Emergency was meeting the vasectomy targets of the central government and getting financial assistance (an incentive in meeting such targets). At a later stage, evidence of State-specific measures was found when Tamil Nadu was the first State that stopped using the demographic target-setting of the central government in 1991-92 (five years ahead of rest of the country).

The first eight States adopted State-level Population Policies after the announcement of the Centre's decentralisation policy in 1997. These States were quick to adapt to the decentralisation environment when the central government abolished demographic target-setting. As a result, they took it upon themselves to include incentive and disincentive measures in their policies in order to address their respective demographic situations. In 2002, the Centre formed the National Level Resource Committee to ensure that the remaining States adopted population policies by following the 'Cairo spirit'. This was a step to prevent further use of incentive and disincentive schemes.

As a result, out of the seventeen State-level Population Policies, two groups can be identified – the ones that were formed prior to or simultaneously with the National Population Policy 2000, and the others that came about following its recommendations for their adoption. The difference between these groups of policies lies not only in the timing and motivation for adoption, but also in the use (and non-use) of incentives and disincentives. This work chose the Madhya Pradesh State-level Population Policy as a case study because it fell in the former category. In contrast, West Bengal's draft policy belongs in the latter category, formulated as a result of the recommendation of the National Population Policy 2000. The next section highlights the main reasons behind the adoption of the State-level Population Policies, specifically in the case study States of Madhya Pradesh and West Bengal.

Analysis of data collected during the fieldwork showed that the Madhya Pradesh policy and the draft policy of West Bengal had their origins in national reports, State-specific policy development plans and the deliberations of committees. In Madhya Pradesh, the

environment during and immediately after the formulation of the policy was conducive for policy adoption. This was partly due to the presence of many favourable factors working at the time. But there was no previous history of a favourable policy environment in the State. Moreover, the formulation of the policy was not really an initiative of the State government itself, but rather it was an initiative of the Futures Group and Indian Institute of Health Management Research. The origins of the Madhya Pradesh policy were to an extent, not affected by the recommendations of the National Population Policy 2000 to establish State Population Commissions and a State-level Population Policy as both policies were adopted on the same year. Unlike West Bengal, where formation of the State Commission and the policy development plan were undertaken by the State government, in Madhya Pradesh, the Futures Group, the subcontractor of USAID, did most of the work. The State government essentially followed the instructions of the Futures Group. High population growth rates were considered pressing problems by the Madhya Pradesh policymakers of the time. This resulted in a relatively fast adoption of the policy - reflected in the involvement of high level government officials and the risk taken by the policymakers to adopt the family planning strategy of disqualification of Panchayati Raj Institution members based on a two-child norm.

7.2. Socio-economic considerations leading to the adoption of State-level Population Policies

The roles of the State-level political leadership and administrators and the role of the central government were examined as factors contributing to the adoption of the State-level Population Policies. The effect of assistance from donor agencies and the global atmosphere of a 'paradigm shift' created by the Cairo conference were also considered. In India, talk of decentralisation had been underway since the mid 1990s. One document that recommended formulation of State-specific action was the report of the Expert Group headed by the agricultural scientist M.S. Swaminathan in 1994. Moreover, the effect of the Cairo conference was in the removal of centrally determined demographic targets and the adoption of a bottom-up 'community-needs assessment' approach in 1997. In this decentralised atmosphere the same central government that took almost thirty years to address State-wise demographic differentials was now proactively reminding and urging the poor performing States to take action. As a result, the States with active political

leaders, primarily the Chief Minister and officials of the Indian Administrative Service, realised the need to take charge of their own demographic situation. Meanwhile, in the post-Cairo environment, USAID started its Policy Project in thirty-six countries. In India, the Policy Project was implemented by USAID's subcontracted agency, the Futures Group with the Indian Institute of Health Research and Management providing financial and technical assistance. They provided help to the States to formulate their own policies. Those States ready for action collaborated with the Policy Project and adopted population policies.

The below national-average demographic performance of Madhya Pradesh led to repeated reminders from the Centre to policymakers to remedy the situation. Strong commitment and political leadership of the former Chief Minister, Digvijay Singh, together with the efficiency of the officials of the Department of Public Health and Family Welfare of the time against the context of financial and technical assistance from the Policy Project, led to the adoption of the policy. The analysis of the policy process in Madhya Pradesh showed that because policy adoption was high on the agenda of the government, the process was comparatively fast, but it was not transparent and it did not entail much input from civil society organisations. In contrast, in West Bengal, formulation of the draft policy was simply a result of following national recommendations. The writing of the draft State-level Population Policy was a one-man act (that of the former Joint Secretary at the Department of Family Welfare) without any involvement from other officials within and outside the government or external experts.

7.3. Effects of adoption of State-level Population Policies on provision of family planning services

In examining the effects of a State-level Population Policy on the services provided by the Family Welfare Programme, this study focussed on three family planning strategies: the provision of different contraceptive methods, the involvement of the Panchayati Raj Institutions, and discontinuation of use of demographic targets, incentives and disincentives. Nationally, the emphasis of the Family Welfare programme has evolved from the IUD in the 1960s to vasectomy in the 1970s and to tubectomy in 1980s. In recent years, Andhra Pradesh, Madhya Pradesh and Uttar Pradesh the earlier policy States, are

emphasising permanent contraception. As an alternative to the centralised implementation of the Family Welfare Programme, Karnataka, Madhya Pradesh and West Bengal have selected to use the Panchayati Raj Institutions for family planning service provision, based on their effective functioning. Also, Andhra Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh are employing demographic target-setting and incentives and disincentives as family planning strategies despite being criticised by the central government.

The effect of Madhya Pradesh's Population Policy on family planning services was found primarily in the initiatives taken by the health administration at different levels. The comparative analysis of the family planning service provision of Madhya Pradesh with that in West Bengal detected significant interstate differences. Although the national Family Welfare Programme supplies similar contraceptive methods to both States, Madhya Pradesh was found to be providing a greater range of methods - oral pills, IUDs at the sub-centre level, and tubectomy and non-scalpel vasectomy technique at the block levels. This is despite the fact that West Bengal has the second highest contraceptive prevalence rate (of 71%) in the country. At the block level, different tubectomy techniques (laparoscopy, mini-laparotomy, ligation and conventional abdomen cut) were found to be practiced in Madhya Pradesh where doctors were already trained to perform such techniques. In contrast to Madhya Pradesh, in West Bengal there were significant inter-district differences (e.g. Hoogly not performing laparoscopic tubectomies, and poor infrastructure preventing IUD insertions in both Hoogly and South Dinajpur districts). However, in both States the biggest contributor of total CYP was tubectomy. Examining CYP in the four study districts in Madhya Pradesh from 1996 to 2004, no significant increase can be seen after the State-level Population Policy was adopted. Furthermore, in Madhya Pradesh there was evidence of school health education for adolescent sexuality when the study looked at the reproductive health considerations in family planning service provision. In both States, individual health workers were found to be restricting services either based on personal beliefs, faulty knowledge or familial pressures coming from individual clients.

In both States, panchayat representatives were not significantly engaged in the functioning of the Family Welfare Programme. They were found mostly involved in the IEC campaigns

that were conducted during laparoscopic tubectomy camps and Pulse Polio activities. This engagement was because they had been asked for assistance by health staff. Furthermore, the level of their involvement and awareness about the programme was greater at the district and block levels, where much of the decision-making takes place. The study did not detect any independent significant initiative by the panchayat institutions in promoting family planning. Their initiative depended almost entirely on the individual representatives and the degree of their enthusiasm. During the period of the fieldwork, two government initiatives to increase inter-departmental coordination and accountability were implemented. One was housing the sub-centres in the premises of the panchayat at the village level, and the other was the formation of health and family welfare committees. The effectiveness of these initiatives, however, could not be assessed as they had been in operation for only few months by the time of this study's fieldwork.

Large inter-State differences were found with regard to the use of demographic targets, incentives and disincentives. In Madhya Pradesh, the administration is actively setting demographic targets, and as a result, it is putting pressure on health workers to achieve them. Evidence of the use of disincentives and incentives based on a two-child norm was found in Madhya Pradesh during the fieldwork. Panchayat members in the State were being disqualified on the basis that they were not acting as role models to the general population by not following a two-child norm. The study found evidence of their disqualification and removal from office, although there was no adequate monitoring system in place. Furthermore, research showed that in Madhya Pradesh, the health workers, as government employees, got increments in salary for undergoing sterilisation. In contrast, in West Bengal there was no evidence of the use of demographic target setting, or use of incentives or disincentives by the State government. Unlike Madhya Pradesh, in West Bengal sterilisation acceptors were being given due-slips in place of the compensation fees, and health personnel had not been able to pay the compensation money to clients for many months.

The vigorous use of demographic targets by increasing 10-20% of the previous year's achievement, providing incentives for health personnel, and disqualification of panchayat representatives, was considered to be a result of the State-level Population Policy in Madhya Pradesh. Moreover, health staff at all levels in Madhya Pradesh are

knowledgeable about the demographic target of achieving a TFR of 2.1 by 2011, which is the main objective of the State's population policy. Since the basic message of the State's policy has percolated down to health workers at the field level, so it's reflection has been evidenced in different programmatic initiatives.

So this study filled a gap in the literature on historical origins and the socio-economic factors that led to the adoption of State-level Population Policy in Madhya Pradesh and the draft policy in West Bengal. Also, through a cross-State comparison it showed a relationship between the adoption of the State-level Population Policy in Madhya Pradesh and services provided by the Family Welfare Programme during 1996-2004. Furthermore, it analysed the family planning services in West Bengal during 1996-2004. So far, this is the only study that has done so.

7.4. Research Limitations

As noted in Chapter 2, I faced difficulty in getting the current family planning performance data on Madhya Pradesh and West Bengal especially below the district levels as they are only available from the district capitals. Since the study covered the last eight years in comparing the family planning service provision in each State, collection of data from the previous years was problematic. Both in Madhya Pradesh and West Bengal, data from blocks and levels below blocks were sent to the districts that compiled all the data and gave aggregated figures to the States. Moreover, there was no data available for both male and female sterilization for 1996-97 for West Bengal and no disaggregated data for different techniques of such sterilization (unlike in Madhya Pradesh). However, the key part of the research that can be considered a success was getting access to some of the key interview respondents, the high-level officials in New Delhi, Bhopal and Calcutta. As mentioned in Chapter 2, the pilot studies helped to identify people who acted as contacts to set up appointments with the interview respondents. I had back-up plans in New Delhi and Bhopal which was sending letters, and getting their telephone numbers to set up interviews. But in West Bengal I had used these options and had run out of all the possible channels. If I did not have a contact I would not have gotten access to the government officials in the health department who were knowledgeable about the research topics. Furthermore, the experience from this study made me realise the importance of pilot studies and

understanding the feasibility of a project and understanding the realities in the field. Planning ahead is good, but it is only by being in the field that the itinerary of the fieldwork should be finalised. India is very diverse physically and geographically and therefore what was possible in West Bengal - reaching remote health/sub-centres - was not possible in Madhya Pradesh. On a more practical note, next time I would need to financially plan a study, ensure funding for the entire study before commencing it.

7.5. Implication and Future of Research

The findings from this study cannot be generalised to all of the seventeen state-level population policies - due to the vast demographic diversity which exists between the various states. However, they can to an extent be generalised at least to the BIMARU states and those newly formed out of them. These states are Uttar Pradesh, Rajasthan, Uttaranchal, Jharkhand and to some extent Bihar. The justification for this is because of the interplay of similar contributing and conditioning factors in Madhya Pradesh on the one hand, and these five mentioned states on the other. First of all, as the word BIMARU suggests, all six states have similar socio-economic and demographic profiles. As a result, the pressure from the Central Government to improve their demographic performance was a significant factor behind the adoption of population policies by all of these states. That said, perhaps the most significant similarity between Madhya Pradesh and these states excluding Bihar is the availability of assistance from the Policy Project. Had it not been for financial and technical assistance from the Policy Project, these states might not have adopted their policies almost at the same pace and time as happened in Madhya Pradesh. Finally, as several observers confirmed, in some respects at that time most of these states experienced similar levels of political commitment and effectiveness from the bureaucracy in relation to the high priority that they attached to the adoption of a population policy of their own.

This study noted that West Bengal has not adopted a population policy (since a draft policy cannot really be considered as a full policy). However, demographically this state has performed significantly better than Madhya Pradesh. Thus compared to Madhya Pradesh, the health system of West Bengal was established in the early stages of the Indian family planning programme. West Bengal was the first state to develop subsidiary health centres -

which were later upgraded to become Primary Health Centres (personal interview, Banerji, 2005). Also, historically the literacy rate, especially for females, has been significantly higher compared to Madhya Pradesh – a consideration that led to improvements in family planning acceptance and a lower fertility rate. Nevertheless, despite such historical advantages for West Bengal, this research found that Madhya Pradesh experienced positive programmatic initiatives as a result of its State-level Population Policy. On the other hand, when the implementation of the Family Welfare Programme in West Bengal was researched no evidence was found of programmatic initiatives by made by the state's Family Welfare department. Despite the physical disadvantages of having a low population density with second largest area in the country, and non-availability of trained man-power and poor infrastructure, Madhya Pradesh has more primary and block primary health centres (1,151 and 267 respectively) (Directorate of Health Services, 2007) than does West Bengal (922 and 241 respectively) (Health on the March, 2006-07). However, West Bengal has more sub-centres (10,356) than does Madhya Pradesh (8,834). Therefore instead of establishing more sub-centres West Bengal plans to upgrade the existing primary health centres to become Block Primary Health centres, and in turn upgrade Block Primary Health centres to become Rural Hospitals (see Directorate of Health West Bengal, 2007). As was discussed in Chapter 6, the fieldwork revealed unavailability of beds in many sub-centres in West Bengal - leading to referral of clients for IUD insertion. Such incidents were not found in Madhya Pradesh. Furthermore, the share of health sector spending in the total state budget has been declining in both states during the last five years - leading to their shared dependence on assistance from donor agencies and the Central Government (Department of Health and Family Welfare, West Bengal, 2006; Department of Public Health and Family Welfare, Madhya Pradesh, 2007). As discussed in Chapter 5, this research detailed a longer presence of donor agencies working in Madhya Pradesh (i.e. DFID, the European Commission, UNFPA, UNICEF, and the World Bank) than in West Bengal (i.e. DFID, the European Commission, KfW, the World Bank and UNICEF). Therefore the respective adoption and non-adoption of state-level population policies in these two states cannot really be attributed to their differential demographic performance nor to the quality of the existing health systems and their financing. What it may be attributed to is the change in programmatic action by individual state governments (in this case that of Madhya Pradesh).

This research has covered an important timeframe in Indian population policymaking scene – one that has witnessed considerable change. First, the initial part of the study has found that the adoption of the early State-level Population Policies was done primarily because funding and technical assistance from USAID were available. Had this assistance not been available, then the States would not have adopted the policies. In fact, one of the senior administrators in Madhya Pradesh specifically said that the State government would not have adopted a policy without the assistance of USAID (see Chapter 5). However, at the end of the research, it can be seen that a majority of the Indian States and Union territories have now adopted a State-level Population Policy and others are in the process of following. So looking at current developments it can surely be said that Madhya Pradesh would have eventually adopted a policy primarily because of the repeated reminder from the central government about its poor demographic performance. The second development that occurred is the removal of disincentives by some State governments. Since July 2003, when the Supreme Court in India upheld the Haryana government's two-child norm for the disqualification of Panchayati Raj Institutions leaders, the Indian academic community and the print media have highly condemned it. However, since late 2006 some of those States including Madhya Pradesh (two months earlier as confirmed by one interview respondent over email) have dropped use of such a family planning strategy, though there is no official confirmation of this. This governmental move can be considered as a positive step because it broke away from the long history of use of incentives and disincentives.

In the absence of national guidelines for family planning performance for the States, the adoption of State-level Population Policies shows commitment by a State towards improving its demographic performance. Significantly, all of the *BIMARU* States have now adopted State-level Population Policies. The adoption of these policies is a step in the right direction in addressing the concerns of the central government, which motivated their adoption. But the question remains: can they fill the gap left by abolition of the central government's target-setting programme guidelines or are they destined to the same fate like their national policy predecessors, being limited to paper form only? However, their effectiveness can be judged on a longer timeframe as data from the research suggested. This research collected data for just four years after the adoption of the Madhya Pradesh State-level Population Policy. Therefore, if an inquiry is conducted in the future over a longer period of time, more confirmed conclusions can be drawn on the

effects of the adoption of such policies on family planning service provision. Also, as future research topics, the same States can be examined by looking at the rural-urban disparity, focussing more on adolescents and male involvement. Furthermore, using the same family planning strategies, a comparative study on the policy States of Northern and Southern India can be conducted to examine the relationship between a population policy and Family Welfare Programme and its impact on the socio-economic differences of the Northern and Southern parts of the country.

Considering the unsuccessful past impact of many well-written national policy documents in India, many observers point out that the effectiveness of policies can only be judged once they have been implemented for some period of time. As one observer said:

> "Policy will just remain a statement of action if it is not properly implemented" (Personal Interview, An Observer, 2004).

In this context, the reality of population policy making needs to be remembered. First, implementation of population policy in the post-Cairo era is problematic. Jain (1995) asks the question as to who would provide for the implementation and payment for such services. Population policies are not just related to family planning and health. They are interconnected with issues of child and women's development, youth and adolescent sexuality, rural development, transport for access to health care, environmental conservation, water consumption, and the departments that deal with such issues. Therefore, the implementation of the objectives of a population policy does not and cannot be the sole responsibility of the health or family planning department. Secondly, as mentioned in Chapter 3, population and family planning fall in the Concurrent List of the central government whereby their planning and funding rests with the Centre, but the States themselves are responsible for their implementation. Discussion with donor agencies during the fieldwork revealed a reluctance of State governments to fund the implementation of these policies. Therefore, unless and until issues related to funding are sorted, their implementation will be difficult. Thirdly, health and family planning activities are not usually given priority by the political leaders of States as there are no immediate dividends like provision of water or electricity which result in gaining votes from the public (Bose 1988). So unless the chief minister of a State takes an interest in the mandate of a State-

level Population Policy, its considered implementation is going to be in doubt. Though it can be predicted that in the next couple of years all of the Indian States will have adopted a State-level Population Policy, their effectiveness will lie in the manner of their implementation. Therefore the commitment of the political leadership, and the efficiency of the administrators that contributed in the adoption of the early policies like the one in Madhya Pradesh will be crucial to their successful implementation. Equally important will be the financial commitment to fund their implementation, but from where such funds will come is matter for another inquiry.

Therefore this study concludes that State-level Population Policies are indeed positive developments for India. They reflect greater commitment and accountability of state-level policymakers and their responsibility for planning and policy implementation. These policies may also, in the future, force the state policy makers to look wider for possible sources of funding and thus not simply depend on Central or major donor assistance. These policies are definitely a way forward in the current decentralised national environment - where there are virtually no national policy guidelines provided by the Centre. With its increasing demographic and fertility diversity, India cannot tackle many of its problems at the national level. Consequently State-level Population Policies are definitely better alternatives to the uniform national policies – because they are tailored to the specific circumstances and needs of individual states. Furthermore, such policies reflect an individual state's demographic and fertility objectives. Therefore in future it will be easier for either policy-makers or researchers to monitor and evaluate state-level demographic performance based on such tailored policy objectives and goals. That said, the use of strategies like strong incentives and disincentives by some policies to raise family planning acceptance is certainly not justified. Instead, increased involvement of the Panchayati Raj institutions to generate increased awareness is a better family planning strategy. Therefore, in the current demographic situation, State-level Population Policies are indeed positive developments, and they promise to be a fine alternative to previous centralized approaches to family planning in India.

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Appendix 1 – Operationalisation Table

Research Question	***Related Indicators***	***Description of Indicators***	***Data source and data type***	***Where I collected them***	***How I got access to them***
What are the historical origins of state-level population policies (both at the national and state-levels)?	Existence of reports or policy at the national or state levels prescribing for State -specific actions related to population	**Time frame since 1951 when the First Five year plan was announced**	**Documents:** government records, publications in libraries, reference in any books **Interviews:** experts, academics.	Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh	Access established with LSE letter.
	Existence of a policy development plan	**Time frame was 5-10 years prior to 1997**	**Documents:** government records, publications in libraries, reference in any books **Interviews:** experts, academics.	Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi **Future Group:** representatives	Established access through telephone and LSE letter
	Existence of a strategic plan for setting up a committee to form state specific population policy.	**Time frame was 5-10 years prior to 1997** - may be part of policy document of the Planning Commission at the Centre or states.	**Documents:** government records, publications in libraries, reference in any books **Interviews:** experts, academics.	Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi **Future Group:** representatives	Established access through telephone and LSE letter
Research Question	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them***	***How I got access to them***

What are the various arguments and socio-economic consideratio n-s specific to each state that have given rise to such policies?	Were key state-level political leaders/high level government officials visibly supportive of population growth rate reduction and family planning?	**Time frame was 5-10 years before January 2000** (introduction of MP policy). For West Bengal it will last 10 years. **Key political leaders (past and current office bearers) -** Chief Minister, Minister of Health,	**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** officials at Department of Family Welfare in both states	Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning.	Access through LSE letter
	Specialised technical expertise from donors that includes funding, research and policy dialogue.	**Time frame was 5-10 years prior to 1997. Technical expertise** will be in the form of policy experts working for USAID, UNFPA, DFID, DANIA or agencies consulting for them advising or working on need of policies, funding for any research undertaken, dialogue between policy experts and officials of Ministry of Health both at Centre and states.	**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors: Futures Group UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning.	Access through LSE letter

	Did the policy-makers take into account values of key demographic indicators such as population size and distribution, population growth rate, fertility, mortality and morbidity rates, did these values show that they placed undue burden on the country?	**Taking demographic values into account** will be reflected in press releases, public statements, and records of speeches by minister of health, Secretary of Health and Family Welfare.	**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors: Futures Group UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	Access through LSE letter
	Was there any recognition by the state government of the interaction between population growth and availability of natural and economic resources?	**Recognition** will be manifested in press releases, public statements, articles by government officials in peer reviewed journals and magazines, records of speeches by minister of health, Secretary of Health and FW, State Family Welfare Officer.	**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	**State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors: Futures Group UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	Access through LSE letter

	Did the Cairo conference or the POA of Cairo influence the development of such policies	**Extent of influence of Cairo** will be reflected in the language and content of documentation leading to policy and final policy. **Key policy makers -** Minister of Health, Secretary of Family Welfare, Joint Secretary for Policy and Planning, Joint Secretary for RCH, Chief Director for Monitoring and Evaluation, Director for Policy in Health.	**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	**Academics:** Prof. Ashish Bose, Dr. Kulkarni, Dr. Rao, Dr. Vemuri, Prof. Mahendra Premi, A.R. Nanda, Dr. Ranjan **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors:** Futures Group UNFPA, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	I contacted them through telephone with letter from LSE.
	Formal population policy addressing fertility and family planning at the national level		**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished.		
	Is the (central) government committed to economic and social development (of the state) manifested both in frequent, influential public pronouncements?		**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	**Academics:** Prof. Ashish Bose, Dr. Kulkarni, Dr. Rao, Dr. Vemuri, Prof. Mahendra Premi, A.R. Nanda, Dr. Ranjan **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors:** Futures Group UNFPA, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	

	Number of statements made high level government officials at the state-level voicing the need for a state-specific policy		**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	**Academics:** Prof. Ashish Bose, Dr. Kulkarni, Dr. Rao, Dr. Vemuri, Prof. Mahendra Premi, A.R. Nanda, Dr. Ranjan **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors:** **Futures Group** **UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	
	Civil bureaucracy used		**Interviews:** representatives of donor agencies	**Academics:** Prof. Ashish Bose, Dr. Kulkarni, Dr. Rao, Dr. Vemuri, Prof. Mahendra Premi, A.R. Nanda, Dr. Ranjan **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. **Donors:** **Futures Group** **UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	

	Quality of leadership		**Documents:** newspapers, government records, articles on Indian journals, articles by research institutes - published or unpublished. **Interviews:** representatives of donor agencies	**Academics:** Prof. Ashish Bose, Dr. Kulkarni, Dr. Rao, Dr. Vemuri, Prof. Mahendra Premi, A.R. Nanda, Dr. Ranjan **State Government:** Secretary of Health and FW, Commissioner of FP, State Family Welfare Officer, other officers of the department of family planning. Library of Population foundation of India, Library of Women's Commission in West Bengal, Academy of Sciences, Madhya Pradesh, Publication Office, Department of Family Welfare, New Delhi, Publication Office, Public Health and Family Welfare, Madhya Pradesh **Donors:** **Futures Group** **UNFPA**, DFID, DANIDA. Indian Institute of Health Research Management, Jaipur.	
Research Question	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them from?***	***How I got access?***
What is the range of contraceptive methods available to the population of each state and how has this range changed over time?	Range of methods available at SDP of the government or government referred facilities, (over the last 5-10 years).	**Available** refers to those observable at a given SDP, non-expired for which a trained provider is available to administer.	Interview: Health officials at the district and block levels and health workers at the sub-centre levels		Access through authorisation letter from state government and telephone

	Different types of each family planning methods provided		Interview: Health officials at the district and block levels and health workers at the sub-centre levels		Access through authorisation letter from state government and telephone
	Rate of introduction of new contraceptives to the state/local method mix as they become available nationally	**Timeframe was 5 years prior to 2000 (policy adoption date) and 5 years after 2000.**			Access through authorisation letter from state government and telephone
	Standardised Couple-Years Protection	The estimated protection provided by the FWP during one year based on the volumes of pills, condoms sold or distributed, number of IUD insertions and number of male and female sterilisation operations during that period. **Timeframe was 5 years prior to 2000 (policy adoption date) and 5 years after 2000.**	**Documents: Data from district health administration in both states, records from Department of Family Welfare in both states, IndiaStats.**	Visited these offices and during interviews ask about these documents.	Access through authorisation letter from state government and telephone
Research Question	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them from***	***How I got access?***

To what extent can any changes in the range of contraceptive methods available to the population of each state be interpreted as the result of state-level policies?	Change in the number of SDP located within a district	Different contraceptive service and method distribution points that are located within the district. **Timeframe was last 5 years prior to policy and years till fieldwork time.**	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.	. .	Access through authorisation letter from state government and telephone
	Change in the quality of FP methods provided	**Timeframe was last 5 years prior to policy and years till fieldwork time**	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		
	Change in the supply of FP methods provided	**Timeframe was last 5 years prior to policy and years till fieldwork time**	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		
	Number of IEC camps, sessions organised each year since the policy	**Timeframe was last 5 years prior to policy and years till fieldwork time**	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		

	Number and type of activities to improve public image of programme	Quantity of communications via media or activities that try to cast the programme's goals and objectives in a favourable light for the purpose of enhancing institutional image. **Timeframe will be last 5 years prior to policy and years after till date.**	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		
Research Question	***How will I measure them/indicators***	***Definition of Indicators***	***Data source and data type***	***Where will I get/collect them***	***Do I have access to them already***
How much consideration does the government of each state give to the reproductive health needs and preferences of the people (i.e. to what extent do they take a more 'Cairo' approach?)	Rules and regulations that restrict choice of method for reasons unrelated to medical considerations	Requirement for spousal consent for contraceptive method, restrictions on certain methods based on martial status, requirement for multiple visits to receive certain methods, restricted clinic hours.	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government..		Access through authorisation letter from state government and telephone

?	Provider offers all appropriate methods	**Appropriate to the needs of different sections of the population** (pills and condoms for delaying births, IUD for spacing births and male and female sterilisation for termination of capacity to give birth).	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.	.	
	Provider places no unnecessary restrictions on method choice	Restrictions refer to provision of certain methods only on spousal consent, marital status or clinic hours.	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		
	Provider refers client to an existing accessible site for methods unavailable at SDP.		**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		

	Training number and topic of training per year.	**Training** on subject matters pertaining to RH (IUD insertion, male and female sterilisation, advantage and disadvantage of each method to given to the clients and precautions against HIV/AIDS.)	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.		

	IEC: number of communications produced by type during a reference period;	**Communication** can be in the form of messages on electronic, print or radio, poster, brochure, video etc **on need for Family Planning,** family size, advantages and disadvantages of different methods, maternal and child health, adolescent sexuality, HIV/AIDS. **Reference period** will be every year since 1996.	**Interviews: Health workers and health officials at the district, block and sub centre levels.** ANMs in districts, officials of NGOs that are implementing RCH project of government.	.	

	Number of communications disseminated by type during a reference period.	**Disseminated** refers to external transmission or distribution and interpersonal activities or public relations events implemented like IEC camps. **Reference period** will be every year since 1996.			
Research Question	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them?***	***How I got access to them?***
To what extent and in what ways are Panchayat involved in family welfare programme provision in each state?	Participation of panchayat leaders in Family Welfare Programme policy making	Attendance of panchayat members in monthly and yearly Community Needs Assessment (CN.A) meetings of the Central government.	**Interviews: PRI leaders at village, block levels and also health workers and staff at block.**	.	Access through authorisation letter through district administration.

	Participation in any activities/events organised by the Department of Family Welfare				
	Working jointly with the health staff on Family planning issues				
	Awareness of the existence of different village and block committees and societies on health and family welfare				
	Presence in meetings of village and block committees and societies on health and family				
	Number of counselling sessions organised by PRI leaders in which provider discusses all methods;	.		.	

Research Question	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them from?***	***How I got access to them?***
What roles do the Panchayat play in providing family planning services at the village level?	Offering monetary and other assistance for infrastructural and related support to the health staff of village and block levels		**Interviews: health officials and health workers,** state government officials, and PRI leaders, NGO officials.		Access through authorisation letter through district administration.
Research Questions	***Related Indicators***	***Definition of Indicators***	***Data source and data type***	***Where I collected them from?***	***How to got access to them?***
To what extent are the states using (a) demographic targets, (b) incentives of various kinds, and (c) disincentives, in relation to their	Payment of cash by the health staff with acceptance of any particular contraceptive method.	**Clients in this case will be couple with two or more children.**	**Documents:** Reports/records, policy documents from Department of Family welfare about use of targets/incentives/disincentives. Newspaper reports, journal articles. **Interviews: health officials and health workers,** state government officials, and PRI leaders, NGO officials	. .	Access through authorisation letter.

provision of family planning services.	Discussion by the provider with the clients about reward or punishment related to family size.	**Rewards are** tax exemption, salary level, eligibility for government schemes on education. **Punishment** are ineligibility to contest elections, for government employment,	**Documents:** Reports/records, policy documents from Department of Family welfare about use of targets/incentives/disincentives. Newspaper reports, journal articles. **Interviews: health officials and health workers,** state government officials, and PRI leaders, NGO officials		
	Promise by the state government of any benefits to providers if they achieve a target each year.	**Benefits** may be per-case fee, salary hike.			
	Offer by the state government to the PRI any reward or punishment depending on the number of children born after a particular time	**Rewards** may be cash awards, building wells, and better irrigation systems.			
	Types and target audience	The incentives			

	of incentives and disincentives	may be provided to clients, service personnel, communities and districts. The incentives may be in the form of cash awards, eligibility to educational facilities for the couples with two children and who have undergone permanent contraception; additional funds, coverage under different governmental schemes for the districts; cash awards for service providers. Disincentives usually include ineligibility to contest elections, ineligibility for government employment if couples got married before legal age;			
	Use and Purpose of	Use of			

	demographic targets	contraceptive targets for both terminal and spacing methods.			

Appendix 2: Coding Themes used in NVivo

Historical Origins of State level population policies

- **Historical Origins/How**

- Historical Origins/How/Involvement of state government/administration
- Historical Origins/How/Details-Process
- Historical Origins/How/Pre-NPP+post-NPP
- Historical Origins/How/Policy Project
- Historical Origins/How/Current Scenario

- **Historical Origins/Why**

- Historical Origins/Why/Centre-State relations
- Historical Origins/Why/Socio-economic factors
- Historical Origins/Why/Political factors
- Historical Origins/Why/Impact of Cairo

Family Planning Service Provision

- **Family Planning Service Provision/Madhya Pradesh**

- Family Planning Service Provision/Madhya Pradesh/method types
- Family Planning Service Provision/Madhya Pradesh/method kinds
- Family Planning Service Provision/Madhya Pradesh/new methods
- Family Planning Service Provision/Madhya Pradesh/change –Policy
- Family Planning Service Provision/Madhya Pradesh/RH (reproductive health)
- Family Planning Service Provision/Madhya Pradesh/adolescent counselling
- Family Planning Service Provision/Madhya Pradesh/restriction
- Family Planning Service Provision/Madhya Pradesh/IEC
- Family Planning Service Provision/Madhya Pradesh/training-topic
- Family Planning Service Provision/Madhya Pradesh/Panchayat-Involve
- Family Planning Service Provision/Madhya Pradesh/Panchayat-Role
- Family Planning Service Provision/Madhya Pradesh/Targets
- Family Planning Service Provision/Madhya Pradesh/Disincentive-PRI
- Family Planning Service Provision/Madhya Pradesh/Incentive

- **Family Planning Service Provision/West Bengal**

- Family Planning Service Provision/West Bengal/method types
- Family Planning Service Provision/West Bengal/method kinds
- Family Planning Service Provision/West Bengal/new methods
- Family Planning Service Provision/West Bengal/RH (reproductive health)
- Family Planning Service Provision/West Bengal/adolescent counselling
- Family Planning Service Provision/West Bengal/restriction
- Family Planning Service Provision/West Bengal/IEC
- Family Planning Service Provision/West Bengal/training-topic
- Family Planning Service Provision/West Bengal/Panchayat-Involve
- Family Planning Service Provision/West Bengal/Panchayat-Role
- Family Planning Service Provision/West Bengal/Targets
- Family Planning Service Provision/West Bengal/Disincentive-PRI
- Family Planning Service Provision/West Bengal/Incentive

Appendix 3: Calculation of CYP in Madhya Pradesh and West Bengal

Madhya Pradesh

CYP of Khargone															
Year	No. of OP	OP CYP	No. of CC	CC CYP	No. of IUD	IUD CYP	No of VT	VT CYP	No of NSVT	NSVT CYP	No of CTT	CTT CYP	No of LTT	LTT CYP	Total CYP
1999-00	5597	373.1	21934	182.7	8356	29246	34	340	0	0	2854	28540	6422	64220	122901.8
2000-01	4216	281.0	20100	167.5	8950	31325	29	290	9	90	1538	15380	9538	95380	142913.5
2001-02	6699	446.6	22333	186.1	8607	30124.5	24	240	100	1000	988	9880	8845	88450	130327.2
2002-03	7685	512.3	21102	175.8	8143	28500.5	11	110	63	630	665	6650	9228	92280	128858.6
2003-04	7507	564.2	24850	207.0	8037	28129.5	13	130	51	510	778	7780	8779	87790	125110.7

CYP of Betul															
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of NSVT	NSVT CYP	No of CTT	CTT CYP	No of LTT	LTT CYP	Total CYP
1996-97	9101	606.7	33038	275.3	8005	28017.5	13	130	0	0	663	6630	5420	54200	89859.5
1997-98	9728	648.5	27856	232.1	7125	24937.5	10	100	0	0	701	7010	5986	59860	92788.1
1998-99	11414	760.9	29152	242.9	6588	23058	13	130	0	0	582	5820	5896	58960	88971.8
1999-00	10534	702.2	33628	280.2	6662	23317	24	240	0	0	590	5900	7410	74100	104539.4
2000-01	12483	832.2	35168	293.0	6914	24199	22	220	2	20	583	5830	7184	71840	103234.2
2001-02	11977	798.4	24350	202.9	6889	24111.5	6	60	135	1350	517	5170	6721	67210	98902.8
2002-03	12523	834.8	32553	271.2	6147	21514.5	11	110	22	220	403	4030	9013	90130	117110.5
2003-04	11946	796.4	28678	238.9	6052	21182	7	70	27	270	407	4070	8471	84710	111337.3

CYP of Rajgarh															
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of NSVT	NSVT CYP	No of CTT	CTT CYP	No of LTT	LTT CYP	Total CYP
1996-97	8903	593.5	32074	267.2	11745	41107.5	4	40	0	0	4326	43260	547	5470	90738.2
1997-98	13647	909.8	44450	370.4	13437	47029.5	2	20	0	0	4894	48940	68	680	97949.7
1998-99	14573	971.5	37083	309.0	14765	51677.5	3	30	0	0	4510	45100	2	20	98108
1999-00	14409	960.6	36622	305.1	15599	54596.5	3	50	0	0	5514	55140	0	0	111052.2
2000-01	11781	785.4	27684	230.7	11758	41153	11	110	0	0	5151	51510	604	6040	99829.1
2001-02	15137	1009.1	29879	248.9	17140	59990	4	40	6	60	5722	57220	502	5020	123588
2002-03	14925	995.0	34703	289.1	15253	53385.5	10	100	0	0	5871	58710	136	1360	114839.6
2003-04	16428	1095.2	45242	377.0	15953	55835.5	9	90	1	10	6086	60860	205	2050	120317.7

CYP of Vidisha															
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of NSVT	NSVT CYP	No of CTT	CTT CYP	No of LTT	LTT CYP	Total CYP
1996-97	7500	500	48689	405.7	5123	17930.5	7	70	0	0	1084	10840	3394	33940	63686.2
1997-98	9812	654.1	38478	320.6	6555	22942.5	7	70	0	0	1069	10690	3651	36510	71187.2
1998-99	12672	844.8	43203	360.0	6140	21490	8	80	0	0	1030	10300	3571	35710	68784.8
1999-00	14631	975.4	45323	377.6	6287	22004.5	7	70	0	0	1277	12770	4034	40340	76537.5
2000-01	15082	1005.4	46082	384.0	5850	20475	8	80	0	0	839	8390	3489	34890	65224.4
2001-02	14978	998.5	35226	293.5	5906	20671	6	60	67	670	1011	10110	4289	42890	75693
2002-03	12648	843.2	29455	245.4	5167	18084.5	28	280	28	280	819	8190	4642	46420	74313.1
2003-04	12692	846.1	29785	248.2	5170	18095	10	100	0	0	1127	11270	4114	41140	71699.3

West Bengal

CYP for Burdwan											
Year	No. of OP	OP CYP	No. of CC	CC CYP	No. of IUD	IUD CYP	No of VT	VT CYP	No of CTT	CTT CYP	Total CYP
1996-97	30948	2063.2	60183	501.5	13169	46091.5					48656.2
1997-98	32398	2159.8	60218	501.8	13175	46112.5	209	2090	45841	458410	509274.1
1998-99	21184	1412.2	42041	350.3	9812	34342	116	1160	43276	432760	470024.5
1999-00	22074	1471.6	42330	352.7	6778	23723	73	730	26132	261320	287597.3
2000-01	27339	2489.2	43207	360.0	11104	38864	128	1280	45919	459190	502183.2
2001-02	32208	2147.2	37324	311.0	11623	40680.5	111	1110	46402	464020	508268.7
2002-03	33620	2241.3	37336	311.1	11654	40789	135	1350	45977	459770	504461.4
2003-04	47100	3140	27149	226.2	11511	40288.5	102	1020	46125	461250	505924.7

CYP of Hoogly											
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of CTT	CTT CYP	Total CYP
1996-97	21246	1416.4	26924	224.3	5197	18189.5					19830.2
1997-98	24566	1637.7	28359	319.6	5593	19575.5	181	1810	20579	205790	229132.8
1998-99	21201	1413.4	28636	238.6	4572	16002	9	90	7246	72460	90204
1999-00	23007	1533.8	21990	183.25	4495	15732.5	13	130	7523	75230	92809.55
2000-01	25994	1732.9	30230	251.9	5003	17510.5	6	60	12915	129150	148705.3
2001-02	32421	2161.4	29863	248.8	4715	16502.5	10	100	18838	188380	207392.7
2002-03	30764	2050.9	28233	235.2	3888	13608	17	170	14656	146560	162624.1
2003-04	39605	2640.3	20513	170.9	3644	12754	6	60	13923	139230	154855.2

CYP of Birbhum											
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of CTT	CTT CYP	Total CYP
1996-97	11314	754.2	14835	123.6	2283	7990.5					8868.3
1997-98	14655	977	16843	140.3	1750	6125	11	110	14972	149720	157072.3
1998-99	13336	889	16923	141	1870	3545	4	40	10457	104570	109185
1999-00	11111	740.7	9182	76.5	1616	5656	8	80	15019	150190	21572.2
2000-01	12753	850.2	9968	83	1645	5757.5	6	60	14088	140880	147630.7
2001-02	15866	1057.7	9761	81.3	1903	6660.5	1	10	14757	147570	155379.5
2002-03	15018	1001.2	11383	94.8	1438	5033	8	80	10239	102390	108599
2003-04	13775	918.3	18599	154.9	1687	5904.5	3	30	15162	151620	158627.2

CYP of South Dinajpur											
Year	No of OP	OP CYP	No of CC	CC CYP	No of IUD	IUD CYP	No of VT	VT CYP	No of CTT	CTT CYP	Total CYP
1996-97	4887	325.8	2172	18.1	698	2443					3786.9
1997-98	6358	423.8	3217	26.8	494	1729	15	150	6480	64800	67129.6
1998-99	5349	356.6	3431	28.5	603	2110.5	0	0	6858	68580	71075.6
1999-00	6345	423	3688	30.7	402	1407	1	10	7310	73100	74970.7
2000-01	5308	353.8	4131	34.4	450	1575	0	0	7191	71910	73873.2
2001-02	5560	370.6	5210	43.4	241	843.5	3	30	6978	69780	71067.5
2002-03	6018	401.2	5309	44.2	271	948.5	11	110	2701	27010	28513.9
2003-04	9180	612	4667	38.8	383	1340.5	2	20	1942	19420	21431.3

Appendix 4: List of Interview Respondents

Study Sites	Category	
Delhi	Government	o Mr. P.K. Hota - Health Secretary o Mr. N.S. Kang – Additional Secretary – Policy and Planning o Ms Shuvra Singh
	Non-Government	o Future Groups International – Dr. G. Narayana, Dr. Satyanarayana o UNFPA – Dr. Agarwal o DFID – Dr. Ranjana Kumar and Dr. S. Kumar – State representatives for West Bengal o Academics and experts – Dr. P. M. Kulkarni, Dr. Premi, Dr. Vemuri, Prof. Ashish Bose, Dr. Mohan Rao. o Civil Society – Dr. A.R. Nanda, Dr. Ali, Vandana Shiva.
Madhya Pradesh		
State	Government	
	Policy	o Mr. K.S. Sharma – former Chief Secretary o Mr. D.S. Mathur – former Principal Secretary for Health o Mr. Ashok Das – former Commissioner for o Mr. Yogiraj Sharma o Ms. Aruna Sharma, o Mr. Rakesh Munshi,
	Family planning	o Mr. Ashok Sharma o Mr Manoj Jhalani
	Panchayati Raj Institutions	o Mr. Khushiram o Mr. Upadhayay
	Non-government	o Dr. Ranjan, Ms. Nirmala Buch, Shakuntala Sharma o Dr. Dayakrishna Mangal, Dr. Kumar, o Dr. Vinod Diwan o NGOs – Dr. Sinha, Mr. Sudesh Sahni, Dr. Kirti Gupta
District	Family planning	o Chief Medical Officers of Betul, Vidisha, Rajgarh and Khargone o District Family Planning officer of Betul, Vidisha, Rajgarh and Khargone
	Panchayati Raj Institutions	o Panchayati Raj Institutions representative at district level of Betul, Vidisha, Rajgarh and Khargone o District Panchayati Raj Institutions and Rural development officer
Block and levels below	Family planning	o Block Medical Officer (BMO) of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha o Block Education Extension officer (BEE) of of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha o Health supervisors of of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha o Health workers of of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha
	Panchayati Raj Institutions	o Panchayati Raj Institutions rep at block level of of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha o Panchayati Raj Institutions rep at village level of of Shahpur, Bhainsdehi, Beora, Narsingarh, Vidisha, Nateran, Gugawa and Barwaha
West Bengal		
State	Government	
	Family planning	o Mr. Shyam Roy o Mr. Misra o Mr. Alok Mukherjee, Mr. Manas Chakraborti
	Panchayati Raj Institutions	o Mr. Dilip Ghosh o Mr. Dilip Pal o Mr. Rupen Chowdhury
	Non-government	o Dr. G.P. Dutta, Dr. S.L. Banerji o Dr. David Griffith o Mr. Mithun Das
District	Family planning	o Deputy CMO, Family Planning and Reproductive Health of Burdwan, Birbhum, Hoogly and South Dinajpur o District Public Health Nursing officer of Burdwan, Birbhum, Hoogly and South Dinajpur
	Panchayati Raj Institutions	o Panchayati Raj Institutions rep at block level of Burdwan, Birbhum, Hoogly and South Dinajpur o Panchayati Raj Institutions rep at village level of Burdwan, Birbhum, Hoogly and South Dinajpur
Block and levels below	Family Planning	o BMO of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur o Block primary health nurse (BPHN and PHN) of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur o Medical Officers of Galsi o Health supervisors of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur o Health workers of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur
	Panchayati Raj Institutions	o Block development officer of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur o Panchayati Raj Institutions at the block level of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur o Panchayati Raj Institutions at the village level of Galsi, Memari, Tarakeshwar, Magra, Sainthia, Illambajar, Tapan and Khaspur