

Financial Resource Flows for Population Activities

Report of a case study in India

The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.

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Preface

In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS activities;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analysing population data will cost US\$ 17.0 billion in 2000, and increase to US\$ 21.7 billion in 2015. Two-thirds should be paid by the recipient countries, one-third will be paid by the international donor community.

The case study in India was conducted from 24/08/1998 to 16/09/1998, and forms part of the UNFPA-NIDI project which measures global financial resource flows for population activities. For this purpose, questionnaires have been mailed in 1998 to public and private donor organisations in developed countries, and to government departments and national NGOs in

developing countries. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. To better understand and resolve these problems, seven case studies take place during 1997 and 1998. The case studies will complement our knowledge about financial flows for population activities which were obtained through the mail enquiry. The India case study coincided with the domestic data collection period there (for 1997 data).

Data for this report were gathered in August and September 1998 by three persons: Mr. Ernst Spaan, Ms. Marja Exterkate, both from the UNFPA/NIDI Resource Flows Team, and Dr. Barun Kanjilal, Associate Professor Health Economics, from the Indian Institute of Health Management Research. Valuable help was provided by Mr. Wasim Zaman, UNFPA representative and Mr. Dinesh Agarwal, Technical Support Unit at the India UNFPA office.

Due to the complexity of international and national resource flows in population assistance, and the relative short duration of the study, it is possible that this report contains significant omissions or errors. The authors will welcome any comments or corrections.

Marja Exterkate and Ernst Spaan
April 1999

1. Demography of India

With an estimated 969 million inhabitants in 1997, India is home to one-sixth of the world's population. It has the world's second largest population after the People's Republic of China. India is a country of ethnic, cultural, economic, and demographic contrasts. The federation consists of 26 States and six Union Territories. Table one provides some basic national demographic indicators for India during the last 45 years.

Table 1. Basic national demographic indicators.

	1951	1971	1991	1996
Population (million)	361	548	846	934
Average annual growth rate	1.25	2.2	2.12	1.98
Per cent urban *		19.9	25.71	
Crude birth rate	39.9	41.1	32.6	28.3
Crude death rate	27.4	18.9	11.1	9.0
Total fertility rate	5.96	5.94	4.2	3.6
Infant mortality rate	148	129	96	74
Sex ratio	946	930	927	927
Life expectancy at birth*				
Male	55.4	57.7	58.6	61.5
Female	55.7	58.1	59.0	62.1

Sources: K. Srinivasan: Demography of the Nation, Population Foundation of India, 1997.

* UNFPA: Towards Population and Development Goals, 1997.

The population of India has been growing rapidly. In 1996, the average annual growth rate came since long under the two per cent. The major reason for the rapid growth is the decline in mortality: the death rates decreased from 27 in the fifties to nine per 1,000 in 1996. The maternal mortality rate was 437 per 100,000 live births in 1991 (National Family Health Survey 1992/93). Birth rates have declined as well, but at a much slower pace. Fertility rates have dropped substantially: from almost six children per women in the fifties to 3.6 children per woman recently.

In almost all countries in the world there are 1,050 females for every 1,000 men. India is one of the few countries in the world where males significantly outnumber females: from 946 females for every 1,000 males in 1951, it only went down towards 927 females per 1,000 males in 1991. The adverse sex ratio can be attributed to women's lower status in Indian society.

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These national averages don't show the considerable variations among the 26 states however. For example, Uttar Pradesh alone has a population of 157 million people (1996), whereas the state of Sikkim has only 490,000 people (1996). The sex ratios vary from as low as 859 (Arunachal Pradesh) to as high as 1036 in Kerala. The same is true for the other demographic figures. Broadly speaking, one can notice a contrast among the Southern States, which have more favourable health or demographic indicators, and the northern Hindi speaking states, which are pretty much worse off. This latter group of states is often referred to in Hindi as *Bimaru*, which means "sick" states: Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh.

2. Methodological issues

The specific objectives of the case study in India are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail inquiry;
- as benchmarks for studying the quality of data gathered through the mail inquiry in other countries;
- to investigate the roles of Government, NGOs, private sector and the international community in the field of population activities;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Programme of Action (PoA) influenced the population policy and programmes within the country? And how?

The Indian case study was planned during the global data collection period to gather data on financial flows for population activities for 1997. During the week before the arrival of the international consultants questionnaires were sent to six government departments and five Indian NGOs.

Interviews were held with representatives from ministries, international donors (bilateral, multilateral, private), and national and international NGOs in Delhi. Annex 1 provides a list of all persons and organisations contacted during the case study.

With a few exceptions, the co-operation of all respondents was very positive. Concerning the questionnaires, none of the six government departments which received a questionnaire provided information and four out of five NGOs filled in the questionnaires.

To optimise the quality of the information, the team followed as much as possible a standard strategy:

- data were collected through the questionnaires;
- questionnaires were scrutinised and internal and external quality checks were done;
- during the interviews with representatives from the organisation, inconsistencies and uncertainties in the data were clarified;

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- if necessary, information was corrected or adapted, and in some cases a second visit was made to the organisation;
- written documentation about activities and the financial situation of the organisation were collected as much as possible;
- in-depth oral information was gathered about various activities of the organisation such as: historical overview of funding, implementation of the ICPD Programme of Action, future plans and activities, future financial outlook, *et cetera*.

The team is confident that the information obtained in the case study is of high quality. The fact that many of the organisations provided official financial overviews for 1997 has certainly improved the quality of the data. In many cases respondents had to invest considerable amounts of time and effort to come up with exact figures on financial aspects of their operation.

During the case studies it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years:

- the four population activity groups, as defined in paragraph 13.14 the ICPD PoA, which are used to categorise financial flows, are not completely mutually exclusive. This is particularly true considering that more and more projects are integrated development projects. Therefore, expenditures for the four separate categories are fairly often rough estimates.
- indirect national expenditures on staff, housing, utilities and so forth are often ignored, as well as other indirect financial mechanisms like for instance television and radio broadcasting time for messages on population and family planning;
- the institutional framework for public financing in India is highly complex with Central level and State level plan, non-plan categories and, in addition, a large number of budget heads. Government expenditures in this report are confined to expenditures of the Central level, and exclude State level expenditures.

3. Official Population Policy and Programmes

3.1 | Family Welfare Programme

In 1951, India was the first country in the world to launch a national Family Planning Programme as an integral part of its Five-year plans. The Family Planning Programme in India's first Five-year plan (1951-55) started as a purely demographic programme. The objective was stated as "reducing the birth rate to the extent necessary to stabilise the population at a level consistent with the requirement of the national economy" (MOHFW, 1996/97, p. 5).

The approach during the first and second Five-year plans was mainly "clinical" under which facilities for provision of services were created. A Family Planning Board was formed during the second Five-year plan period (1956-61) to advise the Health Ministry on matters relating to family planning (UNFPA, 1996, p. 8). Similar State Family Planning Boards were also established (*ibid.*).

In 1961-1965, the programme was expanded by offering a wide choice of contraceptives (UNFPA, 1990, p. 11). Later, a system of incentives was introduced, providing monetary payments to people who agreed to be sterilised, and to service providers and motivators who assisted them (*ibid.*). In 1966, a separate department of family planning was created in the Ministry of Health (*ibid.*) to give it administrative and political visibility.

During the fourth Five-year plan (1969-74), high priority was accorded to the programme. The fifth Five-year plan (1974-78) adopted the Minimum Needs Programme, to which the existing infrastructure for Health and Family Welfare is geared (UNFPA, 1996, p. 8/9). The programme was driven by method-specific contraceptive targets. During the seventies, the Family Planning Programme was focused mainly on permanent methods. There were also charges that implementation of the Family Planning programme had acquired a certain degree of coercion (UNFPA, 1990, p. 11). IEC and advocacy are important in India's population programme: although awareness has greatly increased during the 1970's, the aggressive family planning and sterilisation campaign led to a decrease in popular support. In a revised population strategy (1977), the voluntary nature of the Family

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Planning programme was stressed, family planning services became more integrated with Maternal and Child Health, and the programme was renamed into Family Welfare Programme (FWP).

In the sixth Five-year plan (1980-85), the National Health Policy (1983) set a long term demographic goal, which is to achieve a Net Reproduction Rate of one by the year 2000 (MOHFW, 1996/97, p. 5). Table two gives the corresponding demographic figures.

Table 2. Demographic goals for the year 2000

Indicator	Goal for 2000
CBR	21 per 1000
CDR	9 per 1000
Annual natural population growth rate	1.2 %
IMR	< 60 per 1000
Couple Protection Rate	60 %

Source: MOHFW: Annual report 1996-97, p. 5.

Since the seventh Five-year Plan, implemented during 1985-90, the FWP has evolved with the focus on the health needs of the women in the reproductive age group and of children below the age of five years, on provision of contraceptives and spacing services to those people in need (MOHFW, 1997, p. 1), and securing maximum community participation.

For effective community participation, *Mahila Swasthya Sanghs* (women's health groups) were constituted in 1990-91 at village level. During 1992-97, the strengthening of child survival and safe motherhood was emphasised, which included a limited focus on spacing contraceptives. At the start of the Eighth Five-year Plan (1992-97), a Child Survival and Safe Motherhood (CSSM) Programme was initiated. The CSSM programme aimed to accelerate the decline in infant and child mortality and a decrease of maternal mortality.

In 1994, a National Population Policy was drafted by a committee headed by Prof. M.S. Swaminathan, and submitted to the Indian MOHFW, which is still under consideration. One of the recommendations made in this report was concerning the abolishment of the method-specific targets and incentives.

The "target free approach" came into effect from 1st April 1996. This approach envisages replacement of the system of setting contraceptive targets from the top, by a system of decentralised participatory planning at the service provider level (MOHFW, 1996/97, p. 1). The de-linking of the

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FWP from demographic targets implies linking with social policies aimed at improvement of women's (girl's) education, status and health.

The Ministry of Health and Family Welfare developed an action plan to strengthen the CSSM programme and made several recommendations consistent with the reproductive and child health approach. This approach was accepted by the Government of India in the draft Ninth Five-year Plan (1997-2002). This Plan, the RCH Programme, integrates all related programmes of the 8th Plan.

India's Ninth Five-year Plan reflects the ICPD PoA, which links population clearly with broader issues of human development and poverty reduction. Gender inequity (dowry systems, infanticide, property rights, education etc.) is emphasised. The Government works toward establishing client-centred services and offering an essential health package in which family planning is on par with child survival and safe motherhood. In addition, co-operation with national NGOs is promoted as well as improved inter-sectoral co-ordination, in particular between the Departments of Family Welfare, Health and Women and Child Development.

Table 3 gives an overview of some demographic indicators since 1951.

Table 3. Progress of Family Welfare Programme

Parameter	1951	1981	1991	1995
Birth rate	41.7	33.9	29.5	28.3
Death rate	22.8	12.5	9.8	9.0
Total fertility rate	5.97	4.50	3.80	3.50
Infant mortality rate	146	110	79	74
Couple protection rate	10.4 ^a	22.8	43.4	n.a.
Cumulative number of births averted (million)	0.4	43.4	155 ^b	n.a.

Source: Indian Economy Statistical Yearbook 1997, p.95

^a Relates to 1970-71

^b as on 31-3-93

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more attention to urban slums, women empowerment and the role of the private commercial sector for RH services. Currently, some steps are taken to increase the decision-making power of client's communities and grassroots organisations in the Family Welfare programme, by way of setting a process of programme decentralisation in motion. Decentralising programme design and management places responsibility with community level groups, e.g. *panchayats* (village councils) and *Mahila Swasthya Sanghs* (women's health groups). This could help decrease the ineffective use of funds, i.e. support of services that do not cater to the need of clients.

To summarise, the FWP has been changing its direction, emphasis and strategies since its inception to achieve rapid reduction in growth of population as well as to improve the health and quality of life of the people (Simon, p. 205). The first seven Five-year plans (1951-1990) followed the target approach (reducing population). Since the eight (1992-97) and ninth (1997-2002) Five-year plans a change is being made to an integrated Reproductive Health approach.

Contraceptive methods-mix

Although the programme has been effective in increasing awareness of modern contraception, the effect on attitudinal and behavioural change is limited: while 96 per cent of married women are aware of modern contraceptives, only 42 per cent of couples use them (NFHS, 1992-3).

Since 1970, the use of contraceptive methods has risen from about ten per cent to 42 per cent. The National Family Health Survey (NFHS) of 1992/93 show that among the 42 per cent of users, 76 per cent rely on sterilisation and 24 per cent use any temporary method (modern or traditional). Use of specific modern temporary methods is extremely low: one per cent use pills, two per cent IUDs and two per cent condoms.

Here again, differences among states are glaring: in Kerala, Himachal Pradesh, Maharashtra, Punjab, Delhi and Mizoram, more than 50 per cent of married women are using modern contraceptives. On the other hand, in Uttar Pradesh and Bihar, the two most populous states, current use is less than 25 per cent (NFHS, 1992-3).

All methods (sterilisation, pills, IUDs and condoms) are free of costs at the public health care facilities. Condoms and pills are also available at subsidised prices under the social marketing projects. The Family Welfare Programme has used a social marketing approach since 1967 to promote the use of condoms. This was taken over by NGOs since 1986, and besides condoms, oral pills are under the social marketing programmes as well.

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As to injectables, women's groups had raised serious concern about safety and the follow-up mechanisms in the public system. As of yet, injectables are not available through the public sector. They are only available through commercial outlets, albeit at extremely high prices.

Organisation of the Family Welfare Programme (FWP)

The institutional framework for public financing in India is highly complex. The main actors are the Planning Commission, the Ministry of Finance, the Ministry of Health and Family Welfare (MOHFW) and the state governments. Although the State Planning Commission is responsible for the formulation of the Five-year development plans, the final plan of the state needs to be approved by the Planning Commission, which is a central body. The Ministry of Finance allocates the development funds and draws up the budget. The Economic Affairs Department takes care of the co-ordination of external assistance, including bilateral and multilateral funds. The Department of Family Welfare within the MOHFW is responsible for overall programme co-ordination and implementation of the FWP.

In India, social sector programme funding is largely the responsibility of state governments with the Centre supplementing state funds through grant money. While health care funding is totally under the jurisdiction of the states, the FWP is almost entirely financed by the Centre (UNFPA, p. 7). The system of allocating and distributing resources under the central FWP is essentially top-down. The Central Government distributes resources to the states more or less in proportion to population size, and the states in their turn distribute what they receive among their districts. (Measham, *et al.*, p. 95). Attempts are under way to decentralise the programme budgeting, development and evaluation. Although the Ministry of Health and Family Welfare has responsibility for overall programme co-ordination, programme implementation at the state level relies heavily on health facilities run by the state governments. A major anomaly in the current organisational structure is that separate departments are responsible for health and family welfare within the central Ministry, while the administration of family planning and health services is integrated at the state and district levels (Conley *et al.*, p. 24).

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According to India's constitution, family welfare is the responsibility of the Central and state governments, while health is under the jurisdiction of the states. However, by way of national programmes and so-called Centrally Sponsored Schemes, the Central government plays a significant role in the health sector. Thus, family welfare and AIDS control programmes are fully centrally funded, but TB control is only partly funded by the Central government (ODA 1996, p. 21).

Expenditures of the FWP can be classified under three heads (Kanjilal and Shukla, p. 3):

1. Centrally Sponsored Scheme: CSS;
2. Plan: all the programmes under the Health and Family Welfare sector which are additionalities to the existing framework are considered under the *plan*. The Planning Commission approves the state plans and recommends central assistance to finance the plan expenditure;
3. Non-plan: the continuation of the programmes which were initiated in the previous plan are considered as committed liabilities of the state, and the expenditures on such programmes are treated as *non-plan* expenditure. The states submit arrears claims to the Central government to cover their resource gaps. The assistance to fill the *non-plan* resource gap of the state is determined by the Finance Commission appointed by the Central Government.

So, the FWP is a centrally sponsored scheme with 100 per cent central assistance towards the states' plan schemes. It is a plan scheme with some non-plan component (Panchamukhi, p. 120). In practice, approximately 91 per cent of the states expenditure are financed through CSS, roughly four per cent through planned expenditures, and five per cent by non-plan (Kanjilal *et al.*, p. 4).

There is practically no *non-plan* in the budgetary support for family welfare programmes (MOHFW, 1997/98, p. 39). This is peculiar, as for other departments or ministries, part of the maintenance expenditures are transferred to *non-plan*, at the end of earlier plan periods. In the FWP no part of the maintenance expenditures are transferred to *non-plan*, because of the large size of the maintenance expenditures (*ibid.*).

In order to claim the assistance from the Centre within the CSS, the state governments are expected to present their proposals to the Planning and Finance Commission (Panchamukhi, p. 28). The Planning Commission is a non-statutory permanent body to recommend assistance on the new schemes which become part of the plan programme. The Finance Commission is a

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statutory quinquennial body to recommend assistance towards the maintenance of the existing schemes (*ibid.*). The state plans are the outcome of a series of discussions of the Planning Commission with the concerned state governments (*ibid.*). The state plans for family welfare are finalised and endorsed by the State Planning Commission¹. After endorsement, the Ministry of Finance releases funds to the states under the centrally sponsored scheme (MOHFW, 1997/8, p. 39-44). The Finance Commission recommends assistance against the *non-plan* resource gaps of the state governments (*ibid.*). The assistance both on *plan* and *non-plan* accounts is released on a quarterly basis. The first instalment of 1/4th of the assistance approved is released immediately after the programme is initiated (in April). Thereafter, every instalment is released on the basis of performance in the previous quarter (Panchamukhi, p. 31).

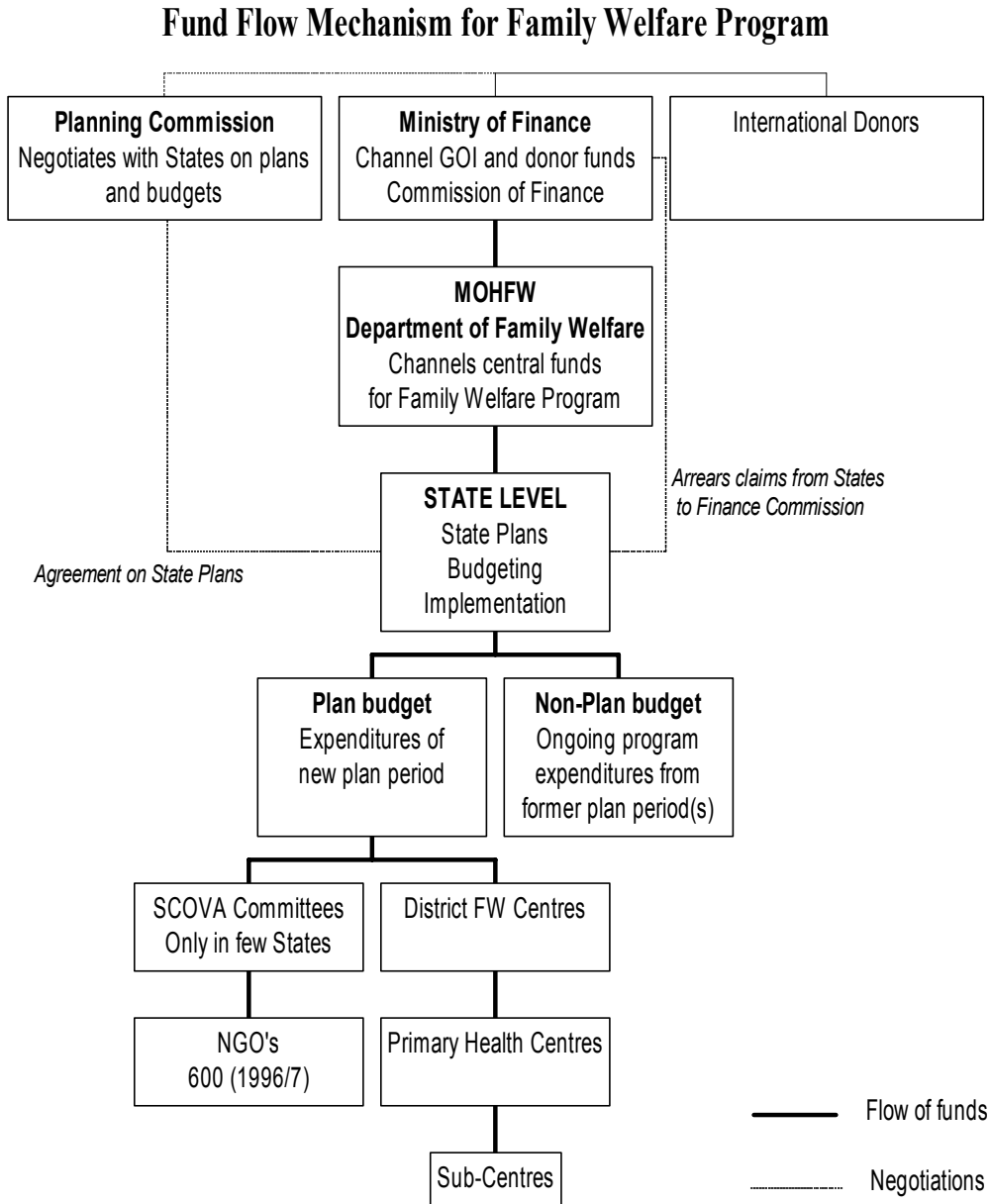
During the Ninth Five-year Plan, starting 1997-98, funding for the RCH programme (which fall under the FWP) to states which have an expeditious utilisation of funds, will be provided funds through Finance Departments, otherwise funds will be channelled through a State Committee On Voluntary Action (SCOVA), which will be a registered society (MOHFW, 1997, p. 8), which will also channel funds to the districts.

At the start of new Five-year Plan period, allocations and expenses are accounted for on the *plan* budget. Program liabilities from the former plan period are in principle transferred to the *non-plan* budget. As maintenance component of the expenditures are larger than additional activities under the programme, the state budgets do not suffice. Thus, these recurrent costs for maintaining the family welfare infrastructure and for salaries, which should be transferred to the *non-plan* component, are claimed by the states at the Finance Commission of the Ministry of Finance. After approval of these arrears claims, additional funding is channelled to the states in compensation. However, these arrears payments are generally delayed and insufficient. The result is that the bulk of the *plan* budget is used for the maintenance of the health infrastructure, while the expansion and improvement of services is endangered.

¹ Planning commissions do not exist in all States.

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Figure 1. Fund Flow Mechanism for Family Welfare Programme



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3.2 | National AIDS Programme

The first case of AIDS in India was observed in 1986. Until July 1998, 78,904 persons with HIV infections have been reported, of whom 6,386 cases have developed AIDS (NACO statistics). The GOI was quick to respond to the threat of HIV/AIDS and in 1986, a National Aids Committee was constituted by the GOI in the MOHFW. AIDS prevention and control activities have started by the GOI since 1987. Activities at that time were focused on HIV screening of the “sexually promiscuous groups” and blood donors (NACO, 1996, p. 11). In 1989 a Medium Term Plan for AIDS control was drawn up, to be implemented in the states and Union Territories, which were mostly affected: Maharashtra, Tamil Nadu, West Bengal, Manipur and Delhi (*ibid.*). In the period 1986-1997, the general emphasis of the National AIDS Control Programme shifted from blood safety and awareness building to control, surveillance and condom programming. Current target groups are pregnant mothers, truckers and commercial sex workers (CSW).

In 1992 the National AIDS Control Organisation (NACO) was created as the executive governmental organisation to oversee AIDS prevention and control efforts in India. In 1991/92 a Strategic Plan for Prevention and Control of AIDS in India was prepared for the five year period 1992-1997. The overall objective of this plan was to establish a comprehensive, multisectoral programme for the prevention and control of AIDS in India. It focussed on prevention of transmission from high risk groups to low risk groups (e.g. drug users, truckers and women in rural areas). In order to meet the medium term objectives, a number of strategies were defined, namely: 1) programme management, 2) surveillance & research, 3) IEC and social mobilisation, 4) STD control, 5) condom programming, 6) blood safety and 7) reduction of impact.

Within the GOI, NACO collaborates closely with a number of Ministries in the field of HIV/AIDS IEC and research activities². In each Ministry with activities in the field of STD and HIV prevention a nodal officer is identified who is responsible for these activities. On the State level, NACO works through a so-called State AIDS Control Cell/ State AIDS Control Society, which is responsible for the implementation of the state action plan for prevention and control of HIV/AIDS. This includes the training of medical practitioners at the Community Health Centre and Primary Health Centre

² Ministry of Welfare, Ministry of Labor, Ministry of Railways, Ministry of Information and Broadcasting, Ministry of Human Resource Development, the Indian Council of Medical Research and the National Council of Educational Research and Training.

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levels. At the grassroots level, the GOI aims at integration of HIV/AIDS prevention with the Reproductive and Child Health programme. Currently, there is a total of 504 STD clinics in India. Each clinic gets Rs. 1 lakh for laboratory support and infrastructure facilities. Funding is by NACO, but the states implement the programme.

NACO has recognised the importance of the role NGOs and Private Voluntary Organisations (PVO's) can play in HIV/AIDS prevention. As of yet, NGO involvement with NACO is still limited. However, NACO does promote condoms via NGOs, with 75 per cent GOI subsidy. In addition, NACO collaborates with the corporate sector (e.g. Tata Iron and Steel Corporation, FICCI) to integrate HIV/AIDS education in their corporate family welfare programmes.

4. Financial Flows

4.1 | Role of the Government of India

Family Welfare Programme

Expenditures recorded under the budget for family welfare include all centrally financed expenditures but generally excludes state-financed expenditures on sub-centres and primary health care centres. However, the states finance a significant share of family welfare services (Measham *et al.*, p. 95).

The Family Welfare Programme is a 100 per cent centrally sponsored scheme since its inception. As can be seen in the table below, allocations and expenditures for the FWP has increased substantially. When we look at the expenditure as a per cent from the total five-year plan, we see that expenditures for FWP have ranged between 0.01 per cent and 1.8 per cent (table 4). This is still far below the NDC Committee on Population's recommendation of three per cent by the end of the Eight Plan (GOI, p. 265). The programme is underfunded since the early eighties, as expenditures exceed allocations. These figures include international assistance to the programme.

Table 4. Total allocation and expenditure under the FWP, 1951 - 2002

Five-year plan	Period	Allocations (Rs. in crores)	Expenditures (Rs. in crores)	Expenditure as per cent of total five-year plan	Expenditure as per cent of allocation
First Plan	1951-56	0.65	0.14	0.01	21.54
Second Plan	1956-61	5.00	2.15	0.05	43.00
Third Plan	1961-66	27.00	24.86	0.29	92.07
Inter plan	1966-69	82.90	70.46	1.06	84.99
Fourth Plan	1969-74	285.80	284.43	1.80	99.52
Fifth Plan	1974-78	285.60	408.98	1.26	143.20
Inter Plan	1978-80	228.00	226.12	1.00	99.18
Sixth Plan	1980-85	1,309.00	1,425.73	1.04	108.92
Seventh Plan	1985-90	2,868.00	3,105.21	1.81	108.27
Inter Plan	1990-92	1,424.00	1,872.41	1.32	131.49
Eighth Plan	1992-97	6,500.00		1.50*	
Ninth Plan	1997-2002	11,016.00			

Source: MOHFW Annual report 1992/93 and 1996/97. GOI, 9th Five-year Plan, Vol. II, p. 245.

* allocation as per cent of total five-year plan

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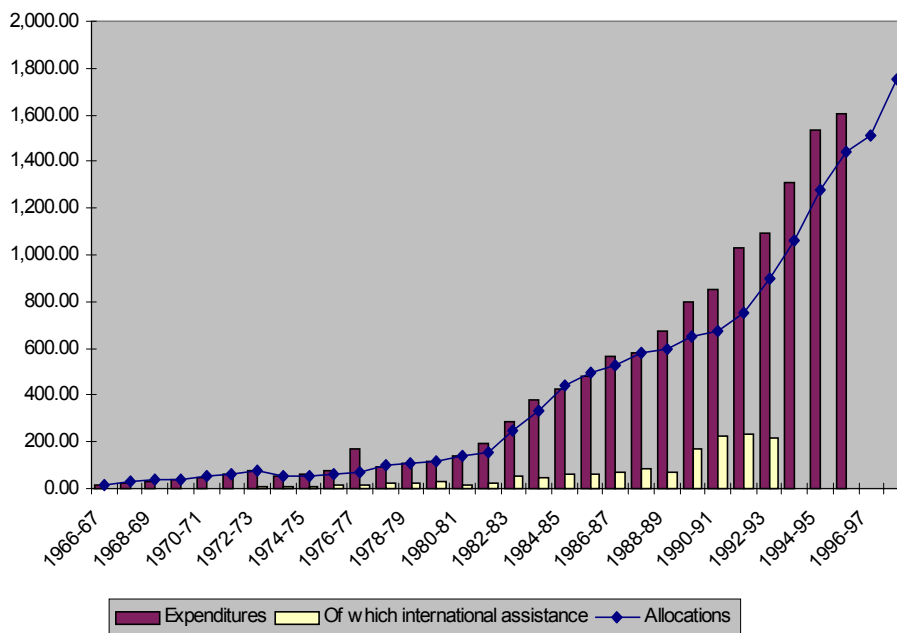
In the last ten years, the amount of external assistance for India's Family Welfare Programme has been significant and varied between ten per cent and 25 per cent of total committed funds. Annexes IIa and IIb, and figures 2a and 2b give more detailed information on annual allocations and expenditures under the FWP, both national and international.

In annex IIa and figure 2a, we can see a dramatic increase in allocations and expenditures for the FWP, and that since 1971, expenditures have been consistently higher than allocations. Since the beginning of the nineties, the international assistance has been at a level of over 20 per cent.

With the Indian population increasing from 548 million in 1971 to 920 million in 1996, per capita expenditures increased from Rs 1.13 per capita in 1971 to Rs 17.4 per capita in 1995.

Even though the expenditures have increased from Rs. 48.9 crore in 1970 to Rs. 1,602 crore in 1995, we can see a different picture emerging from annex IIb and figure 2b, where the expenditures are presented in US\$ as well.

Figure 2a. Annual allocations and expenditures for the FWP, 1966 – 1998 (Rs. in crores)



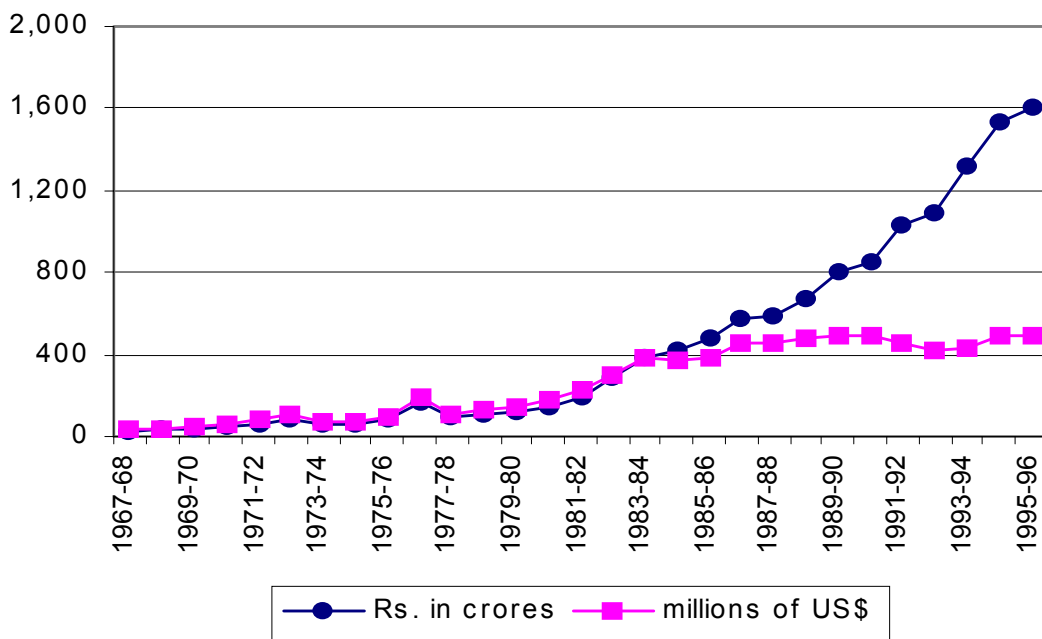
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Now, the increase is less spectacular: from US\$ 65 million in 1970 to US\$ 494 million in 1995. Especially, since 1987, expenditures have stagnated between US\$ 450 and 500 million. Per capita expenditures were US\$ 0.15 per capita in 1971 and increased to US\$ 0.50 in the mid eighties, and have been pretty stable at a level between US\$ 0.50 to US\$0.60 since then.

So in US\$ terms, not more resources have been mobilised, even though the population is growing, and more activities are included in the FWP.

The Department of Family Welfare of the MOHFW also provided funds for Family Welfare programmes of other ministries such as the Ministry of Defence and the Ministry of Railways. These funds have been decreasing over the years however, as is shown the table below. In 1998-99 no funding is provided anymore to these ministries.

Figure 2b. Expenditures for the FWP, 1967 – 1996 (Rs. in crores, and millions of US\$)



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Table 5. Assistance provided by MOHFW to FW programme of other ministries, Rs. Lakhs, 1991-98

Year	Min. of Railways	Ministry of Defence
1991-92	310.00	184.00
1992-93	425.00	274.00
1993-94	338.00	212.00
1994-95	190.00	70.00
1995-96	100.00	70.00
1996-97	160.00	70.00
1997-98	160.00	77.00

Source: MOHFW Yearbooks 1991/2-1997/8.

HIV/AIDS

AIDS prevention and control activities have been supported by the National Budget of the GOI since 1985, when the first pilot screening activities took place. At the inception of the National AIDS Control Programme (NACP) in 1987, the main funding came from the GOI. Additional assistance has come from the World Bank and through WHO since 1989 and particularly for the implementation of NACO's Strategic Plan for Prevention and Control from 1992 on (NACO, p.89). During 1987-1992 a total of Rs. 23,5 crores was allocated for the National AIDS Control Programme which was used for HIV screening (49 per cent), blood safety (36 per cent) and IEC activities (15 per cent). Total NACO funds for 1992-97 are about US\$ 100 million, of which 13 per cent from GOI.

Table 6. NACO expenditures 1992-95 (in Rs. Crores)

Financial Year	Projected expenditure	Actual expenditure
1992-3	56.84	29.44
1993-4	44.61	32.65
1994-5	46.18	43.41
1995-6	40.47	51.26
1996-7	39.12	118.88*
Total	227.22	275.64

* Expenditure estimated up to 31 March 1997.

Source: National AIDS Control Programme India. Country Scenario Update 1995, NACO, December 1996, p. 82.

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For the period 1992-1997 the GOI-MOHFW obtained a soft loan of US\$ 84 million from the World Bank for the NACP. This period saw a total expenditure of Rs. 275.64 crores (US\$ 85 million), which was distributed over the following activities: IEC (40 per cent), blood safety (35 per cent), surveillance (12 per cent), STD control (eight per cent) and programme management (five per cent). In the past, NACP has suffered from delayed disbursements of IDA credit due to the slow pace of implementation by some states, by delays in the submission of reimbursement claims and procedural delays (NACO, 1996, p. 83).

The NACP is also supported by external funding from the WHO regular budget, the WHO extra-budgetary AIDS Trust Fund and from bilateral funds (e.g. SIDA and USAID) which are channelled through WHO. Part of these funds are designated for IEC of the State Medium Term Plan Programmes. USAID and SIDA funding is mainly destined for IEC activities and blood centres (USAID). The following table provides an overview of external support for India's NACP for the period 1990-1997. Since 1996/7 the WHO extra-budgetary funding is replaced by UNAIDS but WHO regular funding continues.

Next to bilateral funds channelled through the WHO, additional donor support for NACO has been provided in the past through direct bilateral funding as is shown in the following table. The largest programme support in terms of money came from the British ODA (now DFID) for HIV/AIDS prevention activities among high risk groups in West Bengal, Gujarat, Kerala, Orissa and Andhra Pradesh, and from USAID for the APAC project in Tamil Nadu.

In September 1998, Phase II of the National AIDS Control Programme was still being negotiated with donors such as UNFPA, UNAIDS, World Bank, European Union, DFID and NORAD. GOI funds will account for about 15 per cent of total resources for this phase.

In the following paragraphs, the role of the International Donor Community, and other major players will be discussed in more detail.

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Table 7. WHO regular and extra-budgetary resources in support of the GOI-NACP, 1990-97 (US\$)

Period	Details	WHO Regular	WHO Multi/bi	WHO Global	TOTAL	Remarks
1990-91	MOHFW	525.850		515.000	1.040.850	
	Maharashtra			445.424		
	Manipur			62.856	62.856	
1991-92	MOHFW		245.985		245.985	SIDA
	DGHS/NACO		1.860.000		1.860.000	USAID
	Tamil Nadu		247.621	39.883	286.904	SIDA
	West Bengal		367.412		367.412	SIDA
	Delhi U.T.		93.407	48.961	142.368	SIDA
1992-93	MOHFW	306.200		2.417.603	2.723.803	
	AIDS Int. project		542.492		542.492	SIDA
1994-95	MOHFW	323.900		1.546.850	1.870.750	
	NACO Tech. ass.			600.000	600.000	
	STD Intervention		542.495		542.495	SIDA
	Tamil Nadu		82.809		82.809	SIDA
	West Bengal		142.671		142.671	SIDA
1996-97	Total 1996-7	22.500	Not Available	2.724.933	5.972.366	
Grand total					16.483.761	

Source National AIDS Control Programme India. Country Scenario Update 1995, NACO, December 1996, p. 84.

Table 8. Bilateral Funding for National AIDS Control Programme.

Source	Amount in US\$	Details
ODA	35,000	1991/2 NE States
	2,500,000	Activities West Bengal 1993-5 and Truckers AIDS, NGO AIDS Cell
NORAD	28,000	NGO AIDS cell
	110,000	Calcutta AIIH-CPH intervention project 1992-3
	300,000	NACO/CMAI training 1993-4
USAID	10,000,000	IEC/condom promotion (APAC-project), Tamil Nadu
Ford Foundation	110,000	MCGB intervention via condom promotion/ with PSI
UNDP	18,000	Railway Corporation workplace education programme
UNDCP-UNICEF	15,000	Street children pilot intervention HIV/AIDS

Source: National AIDS Control Programme. Country Scenario Update. Dec. 1995, p. 93.

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4.2| Role of the International Donor Community

The International Donor Community contributed 12-14 per cent of governmental health expenditures during 1991-95. When one takes the Family Welfare Programme, this percentage comes to roughly 20 per cent. The major donors are the World Bank and DFID.

The **India Consortium Meeting** is the forum of exchange of views between GOI and bilateral and multilateral donors and is convened by the World Bank. Participants are GOI, World Bank, IMF, 12 bilateral donors, OECD/DAC, ADB, Nordic Investment Bank, IFAD and the UNDP.

Donors focus their current support to specific sectoral programmes or specific states. The activities of some of the most important donors are described below.

World Bank

Implementation of the first Bank financed population project was initiated in 1972. Up to 1988, the Bank funded five projects involving US\$ 245.7 million. While that constituted 28 per cent of the Bank's population portfolio to that date, it was a small fraction (3.6 per cent during the 1980-88 period) of the total expenditures of India's Family Welfare programme (World Bank, 1992, p.35). A Child Survival and Safe Motherhood Project (CSSM) was funded for US\$ 214.5 million from 1991 to 1996. Currently, there are four ongoing population projects, which together amount to a total of US\$ 373.8 million. All of these projects share the same objective: to strengthen the capacity of the family welfare and health systems to deliver better quality services more equitably. Since the sixth population project (IPP6), the projects have an increased focus on training.

In October 1997, the national RCH project was launched with support by the World Bank. This project would assist the GOI to improve the performance of its FWP in reducing maternal and infant mortality and morbidity, and unwanted fertility.

In the area of HIV/AIDS prevention and control, World Bank support for the National AIDS Control Programme amounts to US\$ 84 million.

Table 9 gives an overview of the IDA credits from the World Bank since 1972.

Table 9. Overview of World Bank programmes by state and budget.

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Population project	State	Period	Amount of IDA credit (in million US\$)
First Population Project (IPP1)	Karnataka (5 districts), Uttar Pradesh (6 districts)	1972-80	21.2
IPP2	Uttar Pradesh (6 districts), Andhra Pradesh (3 districts)	1980-88	46
IPP3	Karnataka (6 districts), Kerala (4 districts)	1984-92	70
IPP4	West Bengal (4 districts)	1986-94	51
IPP5	Bombay and Madras, urban areas in Maharashtra and Tamil Nadu	1988-96	57
Child Survival and Safe Motherhood Project	National, with emphasis on districts where maternal and infant mortality rates were higher than the national average.	1992-96	214.5
IPP6	Rural areas in Andhra Pradesh, Madhya Pradesh, Uttar Pradesh	1990-97	124.6
IPP7	Rural areas in Bihar, Gujarat, Haryana, Punjab, Jammu and Kashmir	1991-98	81.6
HIV/AIDS	National	1992-97	84
IPP8	Slum areas of Bangalore, Calcutta, Delhi and Hyderabad	1994-2001	79
IPP9	Family Welfare in poor, remote and tribal areas in Assam, Rajasthan, Karnataka	1994-2001	88.6
RCH	National	1997-2003	248

Sources: data from the WorldBank; the Internet (www.worldbank.org); UNFPA PRSD 1996, p. 83

DANIDA

DANIDA's involvement in Reproductive and Child Health in India is as of yet limited to some integrated primary health care projects, including family planning. The main emphasis of DANIDA's programme in India is aimed at Primary Health Care, TB, leprosy and blindness. The projects are concentrated in the states of Madhya Pradesh, Tamil Nadu, Orissa and Karnataka. In 1997 total planned Danish aid to India amounted to DKK 190 million (US\$ 28,766,000). The annual budget for DANIDA's health package in India is US\$16.6 million.

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Department for International Development

The British Department for International Development (DFID)³ programme in India, is Britain's largest in the world, covering projects in the field of health and population, water and sanitation, urban poverty, education and forestry, and with a total budget of £100 million annually (US\$ 163,770,000 in 1997). All DFID bilateral assistance is on grant terms. DFID projects are concentrated in Orissa, Andhra Pradesh and West Bengal. DFID's main focus in the health and population field is on MCH, reproductive health services, STD prevention (including HIV/AIDS) and social marketing of contraceptives. The fund flow mechanism is basically from DFID directly to the MOHFW for the RCH related projects. In HIV/AIDS projects, DFID works together with the National AIDS Control Organisation (NACO), and funds have been flowing through NACO to the (former) State AIDS cells. Only in the case of relatively small projects (e.g. truckers project), DFID can channel funds to national NGOs. Joint funding of projects with British NGOs for Indian NGOs (about 10) is only done by the UK headquarters but not by DFID field offices.

According to UNFPA (PRSD, 1998) DFID is currently involved in the following activities:

1. Reproductive Health, Orissa (1996-2001, US\$ 7.5 million);
2. Social Marketing, Orissa, (1995-98, US\$ 2 million);
3. School health project, Andhra Pradesh (1992-97, US\$ 15 million);
4. HIV prevention of Commercial Sex Workers, West Bengal (1994-99, US\$ 6.6 million); HIV/AIDS through NGOs and truckers organisations, Kerala, Gujarat, Orissa, Andhra Pradesh, national (1996-98, US\$ 5 million).

UNFPA

UNFPA assistance to India started in 1974. Since then US\$ 220 million has been spent under four programme cycles (UNFPA, 1996, p. xvi). The 4th country programme (1991-1996), budgeted for US\$ 70 million emphasised primary health care infrastructure, MCH/FP service delivery and IEC. Most funding went through the MOHFW and Ministry of Education (UNFPA, 1996, p. xvii).

Since the last few years, UNFPA's support has become more multisectoral and supports income-generation, women's empowerment, female literacy and community participation (*ibid.*).

³ Formerly known as Overseas Development Administration (ODA).

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Current activities of the UNFPA in the field of RH consist of projects on the national and state levels. UNFPA currently supports the following activities in India:

- Integrated population and development projects (IPD) in Maharashtra, Madhya Pradesh, Rajasthan, Kerala, Orissa and Gujarat. In each state 4 to 6 districts are selected for these activities. The projects emphasise a package of quality reproductive health services in order to create supportive environment and advocacy/IEC;
- District reproductive health projects: in one district of five states;
- Logistics project in five states;
- Supporting of HIV/AIDS prevention and control under ambit of district reproductive health and integrated population and development projects;
- UNFPA has also supported the procurement of medical equipment for HIV prevention;
- UNFPA has supported advocacy activities and IEC projects on FP/RH and HIV/AIDS including a 26 episode radio serial and advocacy video production in Hindi on HIV/AIDS.

A four year UNFPA budget of US\$ 50 million for the states, and US\$ 50 million for the national level has been established. For the integrated population and development projects between Rs. 30-40 crores for each state has been envisaged.

USAID

USAID's attention to population issues in India was developed since the late 80s. The National Family Health Survey (NFHS) in 1992/93 was financed by USAID, the second NFHS is due to start in November 1998.

USAID's largest family planning programme focuses on the north Indian state of Uttar Pradesh, the most populous state (the Internet, www.info.usaid.gov). The major goal of this project which started at the end of 1992, is to reorient and revitalise the family planning services in Uttar Pradesh. In order to manage, administer, and monitor this "Innovations in Family Planning Services" project an autonomous institution was established. The institution, the State Innovations for Family Planning Services Agency (SIFPSA), became operational since 1994. SIFPSA has successfully established support for improving government services and has bought in the participation of a wide range of NGOs. USAID is to provide US\$ 325 million for the project (until 2002), out of which US\$ 225 million is to be spent in Uttar Pradesh for specific activities, and US\$ 100 million is to be spent on equipment, services and training for the project.

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Through the Private Voluntary Organisations in Health-II (PVOH-II), USAID supports 85 NGOs in northern India in providing maternal and child health and family planning services (1987-97, US\$ 20 million) (the Internet, www.info.usaid.gov).

The aim of the Programme for Advancement of Commercial Technology project's Child and Reproductive Health component (PACT/CRH) is to develop new technologies and approaches in the private commercial sector (production, distribution and marketing of child survival and reproductive health products in India) (1995-2000, and budgeted for US\$ 20 million).

A new activity, Women and Child Health (WACH) in selected districts in Madhya Pradesh, is currently under design, 1997-2004, US\$ 20 million.

In the area of HIV/AIDS Prevention and Control (APAC), USAID supports Tamil Nadu to control the spread of HIV/AIDS (1992-2002, US\$ ten million). Support goes to NGOs as both funds and technical assistance to design and implement community based prevention programmes which target high-risk groups (the Internet, www.info.usaid.gov).

A HIV/AIDS prevention project in Maharashtra and Bombay is currently under design.

European Union

The European Union has only recently started activities in the field of RCH in India. The EU programme has been influenced by the ICPD Conference and is in line with its recommendations. The EU India programme focuses mainly on support for sectoral reform and strengthening of the management and planning capacity of the GOI in the field of RCH.

The EU sponsored RCH/FW programme has only recently been approved by the GOI and is due to commence in October 1998. The RCH programme is planned for five years and will be supported by the EU with 200 million ECU. The first preparatory programme phase (one year) is aimed at establishing criteria, mechanisms and proper management systems for the whole project. The second phase is planned to expire in 2002. The EU is programme focused and not project focused: mainly bilateral support for improving/strengthening of GOI programmes in RCH. The EU sets up the programme in consultation with the GOI and major foreign donors (e.g. World Bank, DFID, USAID) so as to avoid duplication of programmes.

In addition, the EU aims at providing management support to small NGO projects (HIV/AIDS), but this is done through Europe based international

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NGOs with counterparts in India (through the “NGO Co-financing budget”), so there is no direct funding to Indian NGOs in this field. The EU has earmarked 500,000 ECU for support of HIV/AIDS/STD prevention activities by NGOs in a number of states. The funds will be channelled through the Voluntary Health Association of India (NACO 1996, p. 23). These regional projects are done in collaboration with the UNFPA and are based on tender proposals by European NGOs. This programme is still under consideration and has not been approved by the GOI as of yet.

Ford Foundation

The Ford Foundation established its regional office in Delhi in 1952. Besides India, Nepal and Sri Lanka are also under the jurisdiction of the Delhi office. The Foundation has functioned mainly by giving grants to research institutions, NGOs, government agencies and universities. The programme in the area of reproductive and sexual health focuses on the social, cultural and economic factors that affect women. Funding is concentrated in the states of Gujarat, Maharashtra, Rajasthan, Tamil Nadu and West Bengal.

The Reproductive and Sexual Health Programme in India supports four main areas of work:

- 1) Reproductive health advocacy: support for activities that stimulate public discussion and debate to define priorities in reproductive health issues:
 - a) public policy and programme change
 - b) public education and awareness building
- 2) Reproductive health research and interventions : fill gaps in social science research, and interdisciplinary research:
 - a) social science research
 - b) reproductive health interventions
- 3) Sexuality and HIV/AIDS prevention: support for applied research, training and public education.
- 4) Violence against women: support efforts to create an understanding and enhance recognition of gender-based violence, particularly domestic and sexual violence, as a health issue.

Mac Arthur Foundation

The MacArthur Foundation, an independent grant-making foundation, started its population programme in 1988. The population programme in India concentrates its efforts on reproductive health and rights:

- 1) improving women’s reproductive health: focus on adolescents, missing services, quality of care, filling in gaps in research, and on bridging gaps.

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- 2) enhancing communication and popular education in health and reproduction: focus on conveying messages to rural women, sex education, networking between groups working in the population area.

It supports critical work in the NGO sector (“watch groups”, NGOs, network support groups, grants, fellowships, research, etc.). One of the major items is sexual health (sexual violence, mental illness, STDs, RTIs, menstruation, lack of awareness, HIV/AIDS, commercial sex workers, abortions). Over the last ten years they have supported about 75 NGOs, mostly 1 or 2 year grants. Currently 40 grants are approved.

Funding for population in Mac Arthur has increased over the years. All the money comes from Headquarters. They channel money to NGOs or individuals.

Population Council

The Population Council Regional Office for South and Southeast Asia was established in 1995. This regional office is responsible for projects in India, Bangladesh, Indonesia, the Philippines, Thailand and Vietnam. Its programmes aim at improving the well-being and reproductive health of current and future generations. The annual budget for the South and Southeast Asian Regional office is US\$ 5 million.

The Population Council’s work in India mainly focuses on research, capacity building and advocacy on reproductive health and gender issues. Special emphasis is laid on broadening the population agenda, the expansion of contraceptive choice, media advocacy, safe abortion and reduction of unwanted pregnancies, safe motherhood, HIV/AIDS prevention, adolescents and men, the translation of RH ideology in government policies, assessment of the potential role of the private sector and the furthering of research capacity on relevant reproductive health issues, such as rite’s and safe abortion. The Population Council works at involving policy makers, parliamentarians, NGO programme managers, women’s health advocates and media workers. Many of the Population Council’s projects are global and address issues that have global significance, e.g. the recently initiated Horizons project on AIDS 4. The Population Council in India has played an important role in helping the GOI translate the ICPD agenda into the

4 *Horizons* is a world-wide, five-year (1997-2002) operations research project designed to identify components of effective HIV/AIDS programs and policies, test solutions to problems in prevention, care, support, and service delivery, and disseminate and utilize findings with a view toward replication and scaling-up of successful interventions. Horizons is directed by the Population Council under a cooperative agreement USAID.

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national population policy and in shaping the current GOI Reproductive and Child Health programme.

In the future the Population Council aims at pursuing the research agenda set out earlier and will put priority to: assistance to GOI in implementation of RH programme; integrating RH approach in family planning; HIV/AIDS prevention; adolescent behaviour and male involvement in RH; expansion of contraceptive choice and emergency contraception; cost-effective safe motherhood; safe abortion; creative media advocacy strategies aimed at increasing RH literacy.

Future donor assistance for India's FW Programme

In the wake of ICPD donors have adjusted their programmes to the reproductive health approach. Main elements of future support are (UNFPA 1996, p. 87):

- policy support, intersectoral linking of RH;
- strengthening role of local governance institutions (*Panchayati Raj*);
- RH needs of adolescents;
- improvement of RH data collection and use;
- expansion of contraceptive choices;
- upgrading of logistics management;
- girl child education;
- women empowerment, income generating.

For the RCH Programme, which became operational in 1997/98, external assistance has increased (see table 10). The programme is dependent on foreign assistance with 25 per cent donor funding.

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Table 10. International support for FW Programme in India's 9th Plan Period (1997-2002)

	Donor	Period	Amount in millions US\$
Multilateral	World Bank	1997-2002	244,15
	EU	1997-2002	250
	UNICEF	1997-2002	121,5
	UNFPA	1997-2001	100
Bilateral	DFID		77
	DANIDA		33
	KfW		33
	JICA		8
TOTAL			866,65

Note: JICA pledged Japanese Yen 760 million; European Community ECU 200; KfW DM 50 million.

Source: MOHFW, Year Report 1997/8 Chapter 4 "Funding for Family Welfare".

4.3 | Role of national NGOs ⁵

Recognising the complementary role NGOs can play in FWP, the GOI has assisted 600 NGOs (1997) under various programmes. In the 9th Plan (1997-2000) NGOs will be assisted again in the implementation of innovative programmes but not for the regular Government programmes. At village, block and *panchayat* levels NGOs will be involved in advocacy, counselling in RCH. Small NGOs, with little resources, can propose innovative programmes, but not at the Central level, but should propose to mother NGOs (5-10 districts). The role of mother NGOs is to develop other NGOs through funding and technical assistance. Approved mother NGOs with substantial resources will be given Department of Family Welfare grants on a yearly basis. Each mother NGO will have one State representative and one GOI representative on its Executive Committee. These screen and endorse proposals from small NGOs. Mother NGOs train staff of smaller NGOs in management of programmes. In addition to this, a limited number of national level NGOs is assisted by Department of FW in implementing innovative programmes (e.g. mobile clinics for FW services and IUD insertions) and to monitor the enforcement of legislative actions, but not in regular government programmes. National NGOs will be assigned performance assessment of the mother NGOs.

⁵ See Reproductive & Child Health Program, Schemes for Implementation, Department of Family Welfare, MOHFW, October 1997, p. 36-39.

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During the 8th Plan, a number of schemes, aimed at the promotion of small family norm and population control, were devised under which national NGOs were given grant-in-aid from the MOHFW. The MOHFW grant-in-aid allocations for the NGO sector involved in FWP increased since 1990. In 1990/91, 91 NGOs were supported with Rs. 3.29 crores (US\$ 1.9 million), compared to as much as 600 NGOs in 1996/7 supported with Rs. 18.56 crores (US\$ 5.2 million). After the RCH programme was launched, these schemes have been discontinued, except for ongoing NGO grant-in-aid liabilities. In 1997/8, 147 NGOs received second instalments, while 46 new NGOs received funds under the RCH programme. The total funds flowing to NGOs in 1997/8 amounts to Rs. 6.25 crores (US\$ 1.7 million); this excludes assistance through mother NGOs and the States' SCOVA Committees (MOHFW, Annual Report 1997/8, p. 73).

In 1994/95 Rs. 7.5 crores (US\$ 2.4 million) was expended by the MOHFW on grant-in-aid to NGOs. This increased to Rs. 8.5 crores in 1996/7 (but is still US\$ 2.4 million) and to Rs. 18.6 crores (US\$ 5.1 million) in 1997/8 (MOHFW, Year Reports).

National NGOs in the area of health are increasingly incorporating reproductive health and contraceptive services among their activities (Jejeebhoy, p.18). The largest NGO working in the area of family planning is the Family Planning Association of India, whose services reach four per cent to five per cent of the Indian population (*ibid.*).

Women's groups have been active in advocating for women's equal rights in the economic, social and political spheres activities (*ibid.*, p. 19). They also have played a leading role in delaying the introduction of new provider-dependent methods, such as injectables or Norplant, into the family planning programme (*ibid.*).

The major Indian NGOs working in the field of reproductive health are listed below.

Family Planning Association of India

The Family Planning Association of India was established in 1949. In 1996 the major funding was received from the IPPF, GOI, Population Concern, SIFPSA, ODA, and Ford Foundation.

In 1996 and 1997, income received by the FPAI increased slightly from approximately US\$ 7.2 to US\$ 7.8 million. In 1996 four per cent of the income was self-generated, in 1997 this had increased to ten per cent.

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Population Foundation of India (PFI)

The PFI was established in 1970 by a group of industrialists and population activists, led by Mr. Tata. They promote family planning and reproductive health through small NGOs in remote areas with a catchment population of 30,000 to 40,000. The main objectives of the foundation are:

- raise the level of family planning;
- support innovative research;
- to serve as a forum for pooling of experience and sharing of professional expertise;
- to assist public and official agencies to promote human welfare through family planning and other development programmes.

Since its inception, PFI has supported some 300 projects. PFI has made a shift from a family planning focus to a reproductive health approach. Currently, attention is paid to advocacy, women's empowerment, training activities and community mobilisation. In 1997/98, 20 to 30 projects are ongoing, most of them are funded for a two-year period, but can also be extended up to five years. The activities of PFI consist of a wide range of projects, among others policy research studies, IEC programmes, action research projects, awards and conferences/seminars. Recently, PFI was involved in an assessment study of the impact of World Bank projects in India. In addition, PFI has executed a study on India's Population Research Centres for the GOI. Projects can be sub-grouped into certain areas:

- Action Research Projects;
- Reproductive Health;
- Training of *panchayat* members;
- Studies;
- Publications.

Most income of PFI is derived from donations made by the private sector industries as well as return on its investments. In earlier years, PFI has received support for its programmes from UNFPA (collaborative project), the GOI (Study of Population Research Centres) or the World Bank (Impact Study of World Bank population project). PFI has a few co-funded projects, e.g. in Haryana with UNICEF.

The total expenditures of the PFI for population programmes (including overheads) between 1993/4 - 1997/8 is Rs. 77 million (roughly US\$ 2.3 million). Table 11 gives a specification over these years.

Table 11. PFI's total expenditures for population activities, 1993-1998 (Rs.)

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Year	Project expenses, excluding general overhead costs	Project expenses, including general overhead costs
1993/4	5,032,145	8,504,657
1994/5	8,781,846	12,868,993
1995/6	8,190,968	12,422,118
1996/7	11,865,227	18,357,059
1997/8	14,484,849	25,017,842
Total	45,115,180	77,170,668

Project funding has fluctuated over the last years. PFI selects among proposals, which NGO submit, according to 10-12 criteria. The problem is that the rupiah has devaluated, which meant that more and more national NGOs go to international donors for funding instead of national organisations.

Parivar Seva Sanstha (PSS)

PSS was established in 1978 and aims at improving accessibility to quality reproductive health care at affordable costs for women and their families. PSS is affiliated to Marie Stopes International, U.K. The first clinic opened in 1979 in Delhi with focus on quality abortions. Over time the emphasis of PSS widened to a more holistic approach and has integrated its services into three major components:

- 1) Outreach programmes.
- 2) Social marketing of clinical services.
- 3) Social marketing of:
 - contraceptives: three brands of condoms and one brand of oral pills;
 - folic acid tablets.

PSS works in 17 states, and has a network of about 30 Marie Stopes clinics, providing a range of quality family welfare and maternal and child health services. They furthermore have education programmes including family life for adolescents and youth, also through effective outreach programmes.

In 1987, PSS joined government efforts of promoting spacing methods through social marketing of contraceptives. Currently, PSS receives 67 per cent subsidy for their products from the GOI.

58 per cent of their total income in 1997 (Rs. 13.3 crores or US\$ 3.7 million) originated from external sources, the remaining 42 per cent is self-generated. Project expenditures in 1997 amounted to roughly US\$ 3 million.

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Voluntary Health Association of India (VHAI)

The VHAI is a national organisation which was established in 1971 and formed by the federation of 22 State Voluntary Health Associations. VHAI links a network of 4000 grassroots level organisations and community health programmes all over India. VHAI aims at promoting community health, social justice and human rights within the context of the provision and distribution of health services. VHAI is now the main reference point for health education in India. The Association has always advocated a holistic approach to health with a gender focus; their views were already in line with the ICPD. Health is put in broader perspective and linked with issues like environmental degradation, food prices and agricultural policies. VHAI works at the grassroots level, the middle level (training activities) and policy level (advocacy, lobbying). VHAI has participated in almost all GOI health related committees, such as the GOI RCH commission. VHAI has been designated as a 'mother NGO' by the GOI, and is responsible for about 50 NGOs in nine different states.

VHAI activities consist of media campaigns, research on health and policy, need based training programmes, information and documentation services and the production and distribution of health education materials. VHAI pays special attention to RH health areas which receive little attention such social factors of ill health; consequences of infertility; women's literacy and health; STDs/AIDS among migrant populations, and gender violence, including trafficking of women.

At present, VHAI receives support from international donors for specific projects (Ford Foundation, Evangelische Zentralstelle für Entwicklungshilfe) as well as the GOI-MOHFW. Since 1996 VHAI has generated its own funds through training and publications. VHAI publications are well-known and include brochures, training manuals, newsletters (translated in 29 local languages and distributed to approximately 100,000 medical workers), posters and video's (RCH, AIDS). VHAI also does commissioned work for the GOI (video's). VHAI operates its own distribution network to keep prices low and distribution high. VHAI publications are also exported to e.g. Africa and other Asian nations. The annual sales amount up to Rs. 40 Lakhs. At present, self-generated income represents about 33 per cent of total funds; VHAI aims at becoming completely self-sufficient in about five to ten years.

VHAI total expenditures for population projects were about Rs. 8.9 million (US\$ 244,000) in 1997, which was spent mainly on reproductive health.

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4.4 | Role of private sector

The private sector provides about 80 per cent of health care in India and is the principal source of curative care. The sector has some distinct advantages such as its outreach, client-friendliness and flexibility of work hours. A disadvantage is the cost of services and contraceptives, particularly for the poorer sections of society. The government is the primary source of preventive and PHC/MCH services such as immunisation and family planning.

Private medical practitioners (PMP) play a significant role in providing MCH and family planning services. One study found that 90 per cent of PMP's in Uttar Pradesh provided family planning advice, while 30 per cent actually provided family planning methods, i.e. reversible methods (World Bank 1995, p. 31).

4.5 | Role of organised labour sector

The organised labour sector serves as an important medium for population activities in the FWP (UNFPA, 1990, p. 47). Family planning activities in the organised labour sector started already in the early 1950s. A major push for the MOHFW's family welfare programme in the organised sector came with the support of international donor agencies (e.g. UNFPA and ILO) in the early 1970s (*ibid.*)

Tata Iron and Steel Company (TISCO)

The population programme of TISCO arose from the initiatives of the Tata Group of Industries, and includes demand creation through effective IEC strategy and provision of quality services. A high rate of incentive is provided to family planning acceptors (UNFPA, 1990, p. 49).

The programme of TISCO covers nearly 600,000 people in Bihar, of which 500,000 are Tata employees and the rest are from the slums and surrounding peripheral areas (UNFPA, 1990, p.49)

Federation of Indian Chambers of Commerce and Industry (FICCI)

Diminishing population growth is on FICCI's agenda and they see a role for the NGO and private sector in this respect. In 1996, income was received from the State Innovations in FP Services Project Agency (SIFPSA) and the Population Foundation of India. In 1996, FICCI's support for FP and RH programmes was limited to about US\$ 50,000.

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5. Concluding remarks

The GOI recognised long before the ICPD that their population policy needed to change. The change in thinking started already in the 1980s. The ICPD has accelerated and consolidated the process.

India's current policy reflects the ICPD PoA, which links population clearly with broader issues of human development and poverty reduction. A client-based approach, sustainable human development and gender inequity (dowry systems, infanticide, property rights, education *et cetera*) is emphasised.

The most noticeable influence of the ICPD on the GOI is:

- The GOI abolished the targets; the policy is now target free;
- Family planning is an integrated part of the RCH programme.

Although the funding is increasing, the scope of work (RH) is also increasing, so actually not more money is available for family planning. Taking into account the great unmet need for contraception, still a lot needs to be done on the quality of family planning services. India is too big (next year there will be over one billion people) to integrate everything, so priorities should be set, starting with good quality family planning services, which includes screening of RTIs *et cetera* (even one per cent of the population means ten million people).

India faces a challenge in integrating reproductive health concepts at the grassroot level. Although this process is already underway, it will take much effort and require many years of work.

As is indicated in this report, the complexity of the institutional framework of public financing in India makes the tracking of financial resource flows a difficult task. In order to provide a realistic picture of funding for family planning, reproductive health and HIV/AIDS prevention activities, one needs to look at state funding at central level as well as at state level. The present trend in decentralisation of health administration and integration of services will make the overall picture less transparent. Any future investigations on resource flows in the Indian health sector need to take this into account.

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Annex IIa. Allocation and expenditure under the FWP (Rs. in crores)

Period		Total		<i>Of which:</i>	
		Allocations	Expenditures	International assistance	National Assistance
First Plan	1951-56	0.65	0.15		
Second Plan	1956-61	5.00	2.20		
Third Plan	1961-66	27.00	24.90		
Inter Plan	1966-67	14.90	13.40		
Inter Plan	1967-68	31.00	26.50		
Inter Plan	1968-69	37.00	30.50		
Fourth Plan	1969-70	42.00	36.20		
Fourth Plan	1970-71	52.00	48.90		
Fourth Plan	1971-72	60.60	61.80		
Fourth Plan	1972-73	76.30	79.70	7.35	72.35
Fourth Plan	1973-74	54.90	57.80	5.63	52.17
Fifth Plan	1974-75	54.10	62.10	7.78	54.32
Fifth Plan	1975-76	63.20	80.60	11.77	68.83
Fifth Plan	1976-77	70.10	173.00	13.27	159.73
Fifth Plan	1977-78	98.20	93.30	20.01	73.29
Annual Plan	1978-79	111.80	107.60	24.48	83.12
Annual Plan	1979-80	116.20	118.50	29.08	89.42
Sixth Plan	1980-81	140.00	140.90	12.79	128.11
Sixth Plan	1981-82	156.00	193.00	25.72	167.28
Sixth Plan	1982-83	245.00	288.30	53.61	234.69
Sixth Plan	1983-84	330.00	383.00	44.62	338.38
Sixth Plan	1984-85	438.00	424.10	58.87	365.23
Seventh Plan	1985-86	500.00	479.70	65.69	414.01
Seventh Plan	1986-87	530.00	568.90	68.26	500.64
Seventh Plan	1987-88	585.00	584.20	82.20	502.00
Seventh Plan	1988-89	600.00	671.80	69.71	602.09
Seventh Plan	1989-90	653.00	800.70	172.28	628.42
Annual Plan	1990-91	675.00	849.90	222.39	627.51
Annual Plan	1991-92	749.00	1,027.50	229.34	798.16
Eighth Plan*	1992-93	900.00	1,090.40	219.13	871.27
Eighth Plan*	1993-94	1,060.00	1,312.60		
Eighth Plan*	1994-95	1,280.00	1,534.90		
Eighth Plan*	1995-96	1,440.00	1,602.40		
Eighth Plan*	1996-97	1,515.00			
Annual Plan*	1997-98	1,750.40			

* :Allocations excluding the provision of arrears

Sources : MOHFW Internet: <http://www.nic.in/MOHFW/finance.htm>
: MOHFW yearbook, 1992/93

Annex IIb. Allocation and expenditure under the FWP (in '000 US\$)

Period	in thousands of US\$			
	Allocations	Total Expenditures	<i>Of which:</i>	
			International assistance	National assistance
First Plan	1951-56			
Second Plan	1956-61			
Third Plan	1961-66			
Inter Plan	1966-67			
Inter Plan	1967-68	41,333	35,333	
Inter Plan	1968-69	49,333	40,667	
Fourth Plan	1969-70	56,000	48,267	
Fourth Plan	1970-71	69,333	65,200	
Fourth Plan	1971-72	80,886	82,488	
Fourth Plan	1972-73	100,474	104,951	9,679
Fourth Plan	1973-74	70,912	74,658	7,272
Fifth Plan	1974-75	66,774	76,648	9,603
Fifth Plan	1975-76	75,454	96,227	14,052
Fifth Plan	1976-77	78,237	193,080	14,810
Fifth Plan	1977-78	112,370	106,763	22,897
Annual Plan	1978-79	136,458	131,332	29,879
Annual Plan	1979-80	142,998	145,828	35,786
Sixth Plan	1980-81	178,049	179,194	16,266
Sixth Plan	1981-82	180,159	222,889	29,703
Sixth Plan	1982-83	259,122	304,918	56,700
Sixth Plan	1983-84	326,765	379,245	44,183
Sixth Plan	1984-85	385,462	373,229	51,809
Seventh Plan	1985-86	404,236	387,824	53,109
Seventh Plan	1986-87	420,268	451,114	54,127
Seventh Plan	1987-88	451,319	450,702	63,416
Seventh Plan	1988-89	431,127	482,719	50,090
Seventh Plan	1989-90	402,441	493,467	106,175
Annual Plan	1990-91	385,626	485,546	127,051
Annual Plan	1991-92	329,347	451,807	100,844
Eight Plan*	1992-93	347,249	420,711	84,547
Eight Plan*	1993-94	347,621	430,459	
Eight Plan*	1994-95	407,981	489,227	
Eight Plan*	1995-96	444,074	494,156	
Eight Plan*	1996-97	427,568		
Annual Plan*	1997-98	482,031		

* : Allocations excluding the provision of arrears

Exchange rates used in order to calculate US\$: IMF, International Financial Statistics, Period Average Exchange Rates