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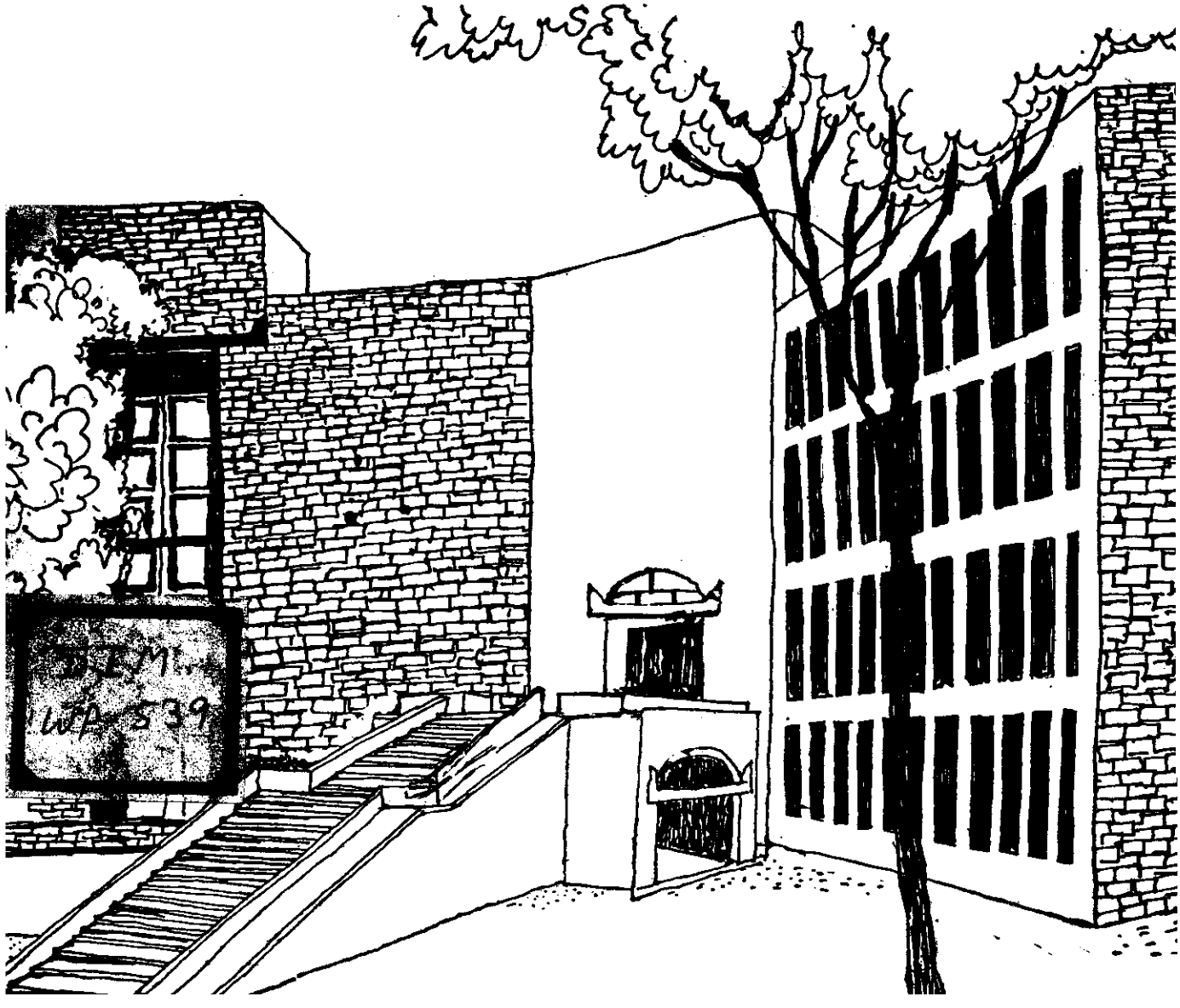

INCENTIVES AND DISINCENTIVES IN THE INDIAN FAMILY PLANNING PROGRAMME: A CASE STUDY

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INCENTIVES AND DISINCENTIVES IN THE INDIAN FAMILY WELFARE PROGRAMME : A CASE STUDY

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I. INTRODUCTION

In view of the national goal to reach a net reproduction rate of 1 by year 2000, there is a growing debate in India about the type of incentives and disincentives for promoting the practice of family planning. The Government of India currently provides compensation for lost wages and other expenditures (for drugs, diet, transport and miscellaneous purposes) to acceptors of sterilization and IUD. About 10 per cent of the total expenditure on family welfare programmes by the Government of India is estimated to be for such compensation and another 5 per cent for other expenditures.* About 25.9 per cent of couples have been effectively protected by contraception by March 1983, 90 per cent of which are by sterilization. The estimated mean number of living children at the time of acceptance remain high and are about 3.4 and 3.7 for acceptors of male and female sterilization respectively. As there is a need to increase contraceptive prevalence rapidly, the family size norm

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* The total expenditure of the Government of India on the Family Welfare Program was reported to be Rs.2,862 million during the year 1982-83. Estimated on the basis of number of acceptors of different methods and the amount of incentive paid to each acceptor, the expenditure on payment to acceptors and other expenses is about 10 per cent and 5 per cent respectively of the total expenditure on the Family Welfare Program. The expenditure on incentives would have increased in 1983-84 because the amount of incentive to acceptors of sterilization was increased by about 50 per cent.

continues to remain high in practice, and a significant portion of expenditure is on direct payment to acceptors, it is worthwhile to review the Indian experience with incentives and disincentives.

While reviewing the incentives in family planning(FP) field, Rogers (1971) noted that there had been relatively little behavioural research on the role of incentives in the diffusion of FP. A review of currently available researches in India by us suggests that this situation has not changed appreciably. Surprisingly, only a few studies have evaluated the demographic, economic, psychological, ethical and administrative aspects of offering incentives. The near universal use of similar type of monetary incentives and awards since they were instituted about 20 years ago may have caused a sense of complacency among researchers in India. Admittedly it is also difficult to isolate the impact of incentives from other factors on acceptance of FP except in controlled experiments and such experiments are very difficult to implement.

It is, therefore, not possible to provide definitive empirical evidence on effectiveness and behavioural consequences of various kinds of incentives in India. In this paper, we review the available evidence. To begin with, the type of incentives being given by the government and the organized sector are presented in section II. We review

research studies relating to the impact of these incentives on quantity and quality of FP services in Section III. Several issues regarding method-mix of contraceptive acceptance and administrative feasibility arise and are discussed in Section IV. The Indian programme has not used disincentives in any significant way except for a brief spell in 1976-77. Therefore, while the paper mainly concentrates on incentives, we have briefly summarized the current debate on disincentives in Section V. We conclude the paper by identifying lessons learnt so far and needed future policy directions.

II. TYPES OF INCENTIVES: CURRENT STATUS

Incentives offered by the Government of India

Incentives can be provided to acceptors, motivators and providers of services. Particularly to acceptors, many types of incentives can be offered; individual or group, positive or negative, monetary or non-monetary, immediate or delayed, graduated or non-graduated, and contraceptive-acceptance or birth-prevention. Many of these types of incentives have been tried in India, on small and large scale.

The most prevalent category of incentives offered by the government, however, is that of individual, positive, monetary, immediate, non-graduated incentive for acceptance

of contraception, especially sterilization. This is in the form of monetary compensation for lost wages and other expenditures incurred by acceptors of sterilization and IUD (Table 1). Currently Rs.100 (about US $ 9) and Rs.11 (about US $ 1) is given to an acceptor of sterilization and IUD respectively. While the nature of incentives offered by the government has not changed, the amount has varied (Table 2). In December 1964, an acceptor of sterilization was given Rs.10 as compensation for lost wages, which has now been increased to Rs.100. But the amount given to IUD acceptors has not changed substantially in money terms.

In addition to compensation for expenditure on drugs, diet, and transport, the government gives Rs.30 per acceptor of female sterilization and Rs.40 per acceptor of male sterilization to the state governments as a miscellaneous purpose fund. Some of these funds are used to purchase equipment, but most of it is used to provide a small cash incentive to motivators and awards to various categories of public servants and elected representatives. In addition, the states often supplement the amount of incentives given to acceptors and motivators by using their own funds, funds of local bodies, and various local organizations such as Lion's Clubs and industrial organizations. Since these local efforts vary considerably, it is not possible to provide definitive

data on the exact amount of incentives. However, we briefly discuss below the efforts in four states: Maharashtra, Gujarat, Tamil Nadu and Kerala.

Both Gujarat and Maharashtra have in recent years achieved high performance, atleast partially owing to incentives. Although the Government of India funds incentives through a uniform pattern of expenditure, states like Gujarat and Maharashtra are able to increase the total adopter incentives by mobilizing additional funds from local bodies such as panchayats and voluntary organizations(Annexure 1). When the size of adopter incentives is the same, it is the imaginative character of motivator incentives which make a marked difference. Both Gujarat and Maharashtra have similar structures of local government, but, during the past three years, Maharashtra has forged ahead of Gujarat. One of the important factors in the Maharashtra success is an imaginative package of motivator incentives developed for each and every functionary involved in the programme. All responsible district officials and leaders are sent on a foreign tour if they achieve a certain minimum target for their district. Another example is the "turban" ceremony. In the feudal system before independence, kings used to decorate their loyal supporters with a turban which was considered a very high honour. The Maharashtra government is now honouring village panchayat presidents with a

turban, known as Feta in local language, if they achieve a certain specified level of contraceptive prevalence in their community. (A list of awards and incentives currently being used in the Maharashtra state is given in Annexure 2)Kerala and Tamil Nadu, two other high performance states, also use a similar pattern of incentives and awards. These include a subset of the following: lottery tickets to acceptors, special lottery at a camp, small incentive(about Rs.15)to motivators of sterilization, awards to motivators and officials of the areas having high performance in the form of study tours, cash awards, gold medals and other honours.

The tax system does not directly provide any incentive or disincentive for FP. The income-tax rules do not distinguish between individuals who are unmarried, married, or married having dependent children. However, the amount of rations from the public distribution system available at reduced prices to households below a specified income level directly depends upon the number of adults and children in the household.

Recently several states have issued "Green Cards" to acceptors of sterilization having two or less number of children. The benefits available to the holders of these cards vary from state to state and include one or more of the following: preferential treatment for health

services, allotment of houses, reserved seats for children in professional colleges, and small interest rate remissions on loans.

Knowledge and approval of incentives and disincentives

How widespread is the awareness and knowledge of incentives? Although countrywide information is not available, Srinivasan(1979)reports on a survey of 3371 respondents from Bangalore division of Karnataka State in 1975. In villages, about 72% of the respondents were aware of incentives and 54 per cent could name the exact amount. In towns, the awareness was slightly higher; about 77 per cent were aware of the incentives and 60 per cent could name the exact amount. Another survey of 900 rural couples in 1984 in a district of Gujarat revealed that about 85 per cent were aware of the incentives. Thus, awareness of incentives seems to be fairly widespread.

Do couples approve use of incentives? Again Srinivasan finds that about 58 per cent of the respondents from towns and 61 per cent from villages approved of incentives for family planning acceptors. Indeed, about 63 per cent from villages and about 72 per cent from towns felt that the incentives were insufficient and wanted more. About 70 per cent from villages and about 58 per cent from towns did not have a spontaneous response

to a question on their preferred incentives either for limitation of family size or for spacing of children. But after probing, the respondents from villages preferred incentives in the form of cash or land or livestock, whereas those from towns preferred incentives in cash or house sites or house. It is clear that the respondents preferred such incentives as would meet their felt needs. Bonuses, old-age pensions and other incentives which benefit family planning acceptors at a later date are not preferred, particularly by young couples. Differences in age, sex, religion, caste and type of family make for differences in awareness, approval and preferred incentives.

More than 60 per cent of the respondents from both villages and towns felt that people would adopt family planning if government came out with such disincentives as curtailment of free education to children, availability of foodgrains through fair price shops and imposition of tax on additional children for those exceeding a specified family size. This shows that mild disincentives would make the people adopt family planning if they are nearly convinced of the necessity of limiting their family size or it will help legitimize the small family norm.

Whatever may be the personal predilections of individual researchers, it appears that people by and large approve of current incentives for family planning acceptors.

Incentives - Disincentives in the Organised Sector

The organized sector offers greater opportunities, for both incentives and disincentives, because the organized setting permits it, administrative machinery exists, and the risks of misuse are low. These experiences, therefore, help us understand the role of incentives and disincentives without the attendant administrative problems of large scale implementation.

Many private companies have been offering incentives and disincentives of various kinds to their employees for acceptance of family planning methods. However, no large scale survey of such practices has been carried out. A study of 6 successful programmes(1978)showed that while compensation of some sort was offered by all, the quantum varied from Rs.25 to Rs.500(Murthy, 1983). In addition, there were other benefits with respect to maternity and medical facilities. A few companies also gave preferential considerations for allotment of housing. Significant disincentives were given by only one company which denied maternity leave, admission to company-run school and housing to the parents who had more than three children. The amount of incentives compared to the salaries of workers is usually not large, although one company has been recently reported to be offering about Rs.3,000 to acceptors of sterilization.

Deferred Incentives

The only experiment with deferred incentives was carried out in 18 tea estates in South India during the period 1971-78 (Ricker, 1980). A no-birth-bonus scheme was introduced for couples who limit their family size. In this scheme each female worker within child bearing ages was provided with an account in which the estate would pay Rs.5 for each month the woman was not pregnant. The account could not be drawn upon until the women completed her child bearing years; but would accumulate interest at 5 per cent per annum. Each time the woman became pregnant, payments into the account would cease for a period of 12 months. The forfeited amount increased as the number of children increased and all savings were forfeited upon the birth of the fifth child. A woman would be eligible for the scheme irrespective of family size if the couple accepted sterilization. The scheme had positive impact on acceptance of FP (reported later in section 3.1)but the changes were not dramatic.

Recently Gujarat is experimenting with a scheme of deferred incentives. A savings account is opened for those couples who have one or no children and wish to practise FP. A deposit of Rs.10 per month for the first year and of Rs.15 per month for the second year is made in the account. However,

this account is closed if the wife delivers a child during this period. At the end of two years, a couple will receive the money accumulated in their account.

A different version of a "no-baby-bonus" scheme is under consideration at the Government of India level. Only those couples who accept sterilization after two children will be eligible for such a scheme. It is suggested that Rs.50 per month will be deposited in a savings scheme for five years for these couples. Another scheme under discussion relates to giving a government bond which would mature after 15 years to coincide with the remaining children's entry into higher educational institutions. It is also suggested that the amount of the bond should be higher for couples with only daughters or with one son and one daughter. The bond should yield a substantive sum of Rs.1,00,000 at the time of maturity, although the initial investment may be only about Rs. 3,000. However, some administrators we talked to were of the view that a purely future benefit, however large, may not be attractive to poor parents. Instead, they recommend a small portion to be paid immediately and the larger portion to be invested in a bond.

III. IMPACT ON PERFORMANCE

Do incentives lead to improved acceptance? What is the contribution of incentives in increased performance? We

summarize below the available evidence on these issues. We have analyzed incentive-programme performance relationship in terms of both quantity and quality of FP acceptance.

Level of Acceptance

Rogers (1971) has presented some evidence from earlier Indian studies to conclude that "adopter incentives increase the rate of adoption of an innovation". He cites two examples. First, the Tamil Nadu government was the earliest to offer incentives in 1956 (Repetto, 1968). In 1965-66, it paid the highest sterilization diffuser incentive among the Indian states. It had 3.42 sterilizations per 1000 population while other states averaged only about 1.00.

Rogers (1971) provides a second example from the organized sector(Research and Marketing Services, 1970). The FP adoption rates in four factories of the Tata Industrial Group which gave high incentives were compared with five factories of similar size at nearby locations which either offered no incentives or paid only small amounts. Consistently high adoption rates were observed in factories where incentives were paid.

Khan and Prasad(1980)carried out another study to assess the role of incentives in motivating the workers when other variables are also simultaneously influencing the rate of acceptance. They interviewed about 4000 workers from

eight industries; four Tata companies giving heavy cash incentive (Rs. 200) to acceptors of sterilization and four matching companies which gave little or no incentives. By 1976 the cumulative sterilization rate (sterilization per cent among eligible couples) was 34.4 in the two east zone Tata companies as compared to 32.3 for the matching non-Tata companies. The difference was not significant. However, an analysis of the west zone data indicated that the two Tata companies continued to maintain a relatively higher rate (41.6) than the matching non-Tata companies (35.1). This difference was statistically significant and was mainly because of incentives and motivation work. However, multivariate analysis of the data indicated that the role of incentive in promoting sterilization among the industrial workers was only marginal. It was further observed that the most important factor in predicting acceptance of sterilization was the level of motivational facilities in the companies. Incentive was an effective tool in the hands of extension workers. A change agent with a heavy cash incentive scheme was more effective in his motivational effort and was able to motivate workers to adopt sterilization at a relatively early age and at lower parity than one without incentive. It was also observed that the incentive scheme had stimulated discussion among the workers about FP and particularly about sterilization. The incentive scheme, therefore, can be effective only with well designed extension.

The case studies of six successful programmes in private companies (Murthy, 1983) found that both the quantum and type

of incentives differed. Since all programmes were successful (couple protection rate among the acceptors was estimated to be more than 60 per cent in all the six companies)Murthy concluded that, for a successful programme, incentives were neither necessary nor sufficient. However, they were a useful programme component to be used judiciously depending upon the environment.

The no-birth-bonus scheme in tea estates was discussed earlier. For experimental purposes, the eighteen estates were divided into three groups with approximately the same number of child bearing woman in each group. In Group I estates the birth-bonus scheme was implemented along with a comprehensive labour welfare scheme. In Group II estates only the comprehensive labour welfare scheme was implemented and neither scheme was present in Group III. By 1975, the proportion of eligible couples accepting sterilization was 22, 19 and 10 per cent in Groups I, II and III respectively. The experiment indicates that such schemes could be implemented at an average per capita cost of about Rs.100 per member per year and would yield modest results.

Usually extra incentives are offered when FP camps are organized.(Ghosh and Khan, 1976). In the mass campaigns in Ernakulam(Krishnakumar, 1972)higher incentives were offered to adopters along with other measures such as involvement of other agencies and large scale publicity. In the first camp when Rs.85 (normal payment earlier was Rs.20)was paid as adopter

incentive, 15,000 vasectomies were reported. In the second camp, when Rs.100 was paid, 63,000 more vasectomies were reported. However, to what extent this difference owes to increase in incentives is not known.

In 1972, a survey of 140 vasectomized cases conducted in Kerala(Gopalakrishnan,1981)arrived at the following findings: Twenty five per cent of acceptors admitted that but for incentives they would not have come for the sterilization camp. As regards the influence of incentives nearly 23 per cent said "not at all", 43 per cent said "to some extent", and 30 per cent said "very much". In contrast, Pai Panandikar(1978)based on his study during the emergency period of 1976-77 reported that most people felt that higher incentives were good but that alone would not induce people to undergo sterilization. Not a single respondent admitted that he had undergone sterilization for the sake of money nor anyone cited any case where money had played a motivating part.

Thus, what emerges is a mixed picture of the impact of incentives on level of acceptance.

Quality of Acceptors

Rogers(1971)also generalized that although adopter incentives increase the quantity of adoption of an innovation, the quality of such decisions to adopt may be relatively low. This generalization was based on a few studies conducted in 1960s. Later studies also support this generalization

especially in terms of high age and parity of the sterilization acceptors. However, the high age parity profile of acceptors may be owing to the prevailing family size norm. For example, generally very few couples with less than three children would be willing to accept sterilization. Despite increase in incentives over the last two decades, the average number of living children a couple has at the time of acceptance of sterilization has gradually decreased. Similarly, all IUD acceptors have consistently lower age-parity profiles than sterilization acceptors. Thus, differences in the quality of acceptors may be method specific rather than because of incentives. When we discussed this issue with programme administrators from a few Indian states, they felt that quality of acceptors as well as services were related more to management of the programme than to incentives.

The graduated incentives were offered for a brief period during the mid-1970s. During this period, incentives were given according to the number of living children at the time of sterilization, thereby giving higher incentives to couples with two or less children. Some programme administrators feel that it did lead to considerable falsification of records. There was a strong tendency on the part of the acceptors to declare less number of children.

Is there a considerable wastage because of misreporting? Unfortunately, there are no large scale studies in this area.

One estimate is provided by Reddy and Raju (1976)in their study of six districts of Karnataka. The study covered 607 sterilization acceptors, of whom 220 were males and 387 were females. They examined the rate of wastage caused by the acceptors who were either ineligible for sterilization or who underreported the number of living children at the time of sterilization. The total wastage rate was found to be between 13.66 and 15.38 per cent; among male acceptors it was between 24.51 and 27.19 per cent and among female acceptors it was between 6.44 and 7.54 per cent. Ineligibility of acceptors contributed 11.79 per cent whereas underreporting of living children contributed only between 1.87 and 3.59 per cent. Among ineligible acceptors, those with(or whose wives had)an open birth interval of 72 months or more(i.e. those who were secondarily sterile)contributed about 10 per cent wastage.

The study revealed that wastage due to male acceptors was more than that due to female acceptors; implying that male acceptors should be screened more thoroughly then female acceptors. The study has also revealed that it is not the acceptors who underreport living children at the time of sterilization but rather ineligible acceptors who are responsible for much of the wastage. From among ineligible acceptors, those who or whose wives are secondarily sterile contribute preponderantly to the wastage. In order to minimize the wastage, the programme personnel would do well to refuse

sterilization to those with(or whose wives have)an open birth interval of 72 months or more. Much of the wastage in the administration of enhanced and graded compensation for sterilization can be reduced if target couple registers are regularly updated and acceptors adequately screened. However, the researchers conclude that it is neither possible nor perhaps even necessary to eliminate the wastage completely.

IV. INCENTIVES : IMPLEMENTATION ISSUES

The Indian experience with incentives has highlighted the following implementation problems:

Quality of services

It is generally believed that incentives lead to neglect of quality of services. We do not have definitive evidence to substantiate this observation. Indian experience with FP camps using higher monetary incentives indicates that the quality of services are affected more by organizational arrangements rather than by incentives per se. For example, an FP camp organized in 1972 in Gorakhpur district of Uttar Pradesh, although modelled on a previous successful pioneering camp experience in Kerala, failed to provide good quality services (Bhende et al., 1976, 101-104.) The Gujarat government later adapted the approach and organized smaller camps all over the state instead of organizing one big camp in a district(Thakore and Patel, 1972). These examples suggest that the administrators

must take added precautions to meet pressure of additional demand. This would involve additional resources, appropriate organisational arrangements, and in-built quality control.

Method-mix

The Indian programme, as is widely known, has favoured sterilization as the major method although all methods are made available. The incentives given also clearly favour sterilization. For instance, three IUD acceptors are considered equivalent to one sterilization acceptor, but the incentive given to a sterilization acceptor is about 15 times the incentive given to an IUD acceptor. This is partly due to differences in the opportunity cost. Incentives are given as compensation for loss of wages and other expenses and IUD acceptors do not incur any significant expenditure or lose in wages.

How does this differential incentive policy affect the method-mix preferred by the clients? Would an increase in amount of incentives for non-terminal methods, specially IUD, improve its acceptance? When we discussed this issue with a few programme managers from Uttar Pradesh, Tamil Nadu and Kerala, they argued that any substantial increase in IUD incentives will lead to malpractices. Specially, they feared that many acceptors will remove existing IUD and return for repeated insertions. The recent Maharashtra experience of

increasing IUD acceptance is not based on any large increase in the incentive given to the acceptors. Three factors may have played an important role in improving IUD acceptance. First, all targets are conveyed in equivalent sterilization, thereby reducing bias against IUD. Second, special awards are given to promoters of IUD(See Annexure 2). Third, IUD performance including quality of follow-up is given high priority and monitored closely.

Deferred incentives

While one time incentives are ideal for promoting sterilization, deferred or repeated incentive payments are necessary for non-terminal methods. Also, wherever follow-up is essential, such as in the case of IUD, even one time incentive payment should be broken up into two instalments, one at the time of insertion and the other at the time of follow-up. Deferred incentives are far more difficult to implement than one time incentives. The major problem is with the continuous monitoring of the use of method or of the pregnancy status of the mother. The no-baby-birth-bonus scheme mentioned earlier is feasible within organized industry and government establishments, but it would be extremely difficult to implement among the rural masses. Falsification of age at marriage, mis-reporting of family income, suppression of birth events, etc. are most likely problems in implementing such incentives. A more effective and widespread system of

registration of births, deaths and marriage is an important pre-requisite for implementing deferred incentives. If the compulsory registration policy cannot be enforced, it would be essential to provide incentives for registering marriages and births in rural areas.

Motivator incentives

Some have argued that incentives for motivators tend to result in coercive methods of communication to clients. When pressure was brought up on the government functionaries during 1976-77 to achieve assigned targets, it did result in use of coercive methods. It should be realized that during this period positive incentives were combined with negative sanctions for public servants. But the more recent experience of widespread use of incentives for various government functionaries in Maharashtra indicate that judicious design of team incentives and multiple criteria for award of incentives can minimize such dangers. Thus, the evidence suggests that positive moderate incentives for motivators, particularly public servants, used imaginatively and carefully would result in improved performance.

At times motivator incentives have resulted in a unhealthy conflict between workers from different departments competing for the same acceptor. This problem is now largely solved by registering all new acceptors in the name of the FP worker but giving away the incentive money to other department

workers who may have motivated the new acceptor. Others have tried team incentives for functionaries in the same area to avoid such conflicts.

V. DISINCENTIVES

Except for a brief period of 1976-77, the Indian government has never endorsed a policy of disincentives for FP. Even during the emergency of 1976-77, the central government had left the decision regarding incentives and disincentives to various state governments*. Annexure 3 lists a set of disincentives adopted by a few state governments during this period. Many of these disincentives led to coercion and eventual backlash during the general elections held in 1977. Since then both the ruling party and the opposition have been reluctant to consider any fresh proposal for disincentives. However, the 1981 census showed that the growth rate during the decade of 1971-81 had not declined even slightly as compared to the previous decade of 1961-71. This disturbing finding led to some public debate on desirability of both incentives and disincentives for controlling population growth. This debate

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*Under the Indian constitution, the federal system allows enough initiative for state governments to adopt their own policies in the field of health services.

is very well presented in two recent reports; one by a national Task Force appointed by the Family Planning Foundation, a non-profit voluntary organization, and the other by a Working Group of the Central Council of Family Welfare. Henceforth we shall refer to the former as the "Task Force" and the latter as the "Working Group".*

The Task Force was divided on the question of disincentives. "One view was that it might infringe basic rights of individuals as disincentives can be punitive in nature. At the same time, it was felt that the child should not suffer the consequences of the irresponsible fertility behaviour of the parent and that some 'preventive disincentives' were desirable..., Yet another view was that if incentives are themselves made powerful, their absence would be a disincentive. But it was argued whether more absence of reward could produce results without punishment." (Family Planning Foundation, 1982; p-6). It was also argued that disincentives, if linked to basic necessities of life, may adversely affect the quality of life of the poorest sections of the population.

In view of the above mentioned legal and ethical implications of disincentives, the Task Force recommended the

*The Task Force consisted of 14 eminent jurists, educationists, parliament members, social scientists and medical specialists. The Working Group was a much smaller group consisting of two administrators, a demographer, a member of parliament, and an economist. We have drawn heavily on both documents, especially the Task Force report. One of the authors was a member of the Task Force.

following two criteria for formulating incentives and disincentives:

1) Any scheme of incentives should be more personal to the parents and should not affect the rights of the children. An example of such an incentive is to charge the mothers progressively for maternity assistance.

2) The incentive must not infringe the fundamental rights.

If, as a disincentive, a third or fourth child is denied educational rights, such a consequence for the child is open to question. Thus, any action by the state would be judged not only in terms of intentions but also of the consequences. The Task Force was of the opinion that "in devising a scheme of incentives and disincentives, emphasis should be on affirmative action with a reasonable margin". For example, instead of denying education to a third or fourth child, the first two children can be given preferential treatment for a certain percentage of seats in educational institutions.

A policy of incentives and disincentives should not only be fair but must appear fair in the public view. Thus, the pre-requisites of any incentives and disincentives scheme is a broad based, easily accessible and effective information and education programme concerning the action proposed by the state and a clear indication of the options that are available.

Unlike the Task Force, the Working Group did not discuss in detail the legal and ethical implications of incentives and

disincentives. Nevertheless, it did suggest that disincentives should not interfere with the fundamental rights, nor should they impinge on the welfare of the child. It was further recommended that disincentives should be made applicable to lower income groups only after three children. In the case of others, disincentives should come into force if the couple has more than two living children. Also, all future disincentives should come into force after a gap of one year from the official announcement of disincentives. This provision is to avoid hardship to those who already have more than two or three children. The Working Group suggested a few examples of disincentives which are listed in Annexure 3.

The present policy of the government re-emphasizes voluntary nature of the FP programme and does not endorse any specific disincentives. The government is, however, willing to consider preferential treatment in various public services for acceptors of the small family norm. The recent introduction of the Green Card scheme in selected areas is an example of this policy trend.

VI. SUMMARY AND FUTURE DIRECTIONS

Summary

The review of available literature in India suggests that the experience with respect to incentives and disincentives is rather limited. Some types of incentives such as community incentives, incentives in kind, and disincentives

have not even been experimented. Definitive statements about behavioural consequences of one time monetary compensation to acceptors of sterilizations, the most commonly used incentive, are also not possible because of the difficulty in isolating such consequences from effects of other factors.

However, the following observations emerge from the experience so far:

a) There is a widespread knowledge and approval of incentives currently offered.

b) Incentives to acceptors help in increasing level of acceptance. Researches show, and most programme personnel concur, that incentives, especially in camp setting, help in increasing performance.

c) However, incentives alone are not enough. Most of the research shows that incentives should form an integral part of motivational activities.

d) Incentives do not seem to have any direct adverse effect on either the quality of acceptors or on the quality of services. Rather, service setting and prevailing family size norms seem to be major factors.

e) Differences in the size of incentives by itself does not seem to influence preferences for various methods; the more important factor may be the priority attached by the programme to a particular method.

f) Positive moderate incentives for motivators, particularly

public servants, used imaginatively and carefully would result in improved performance.

g) Deferred incentives are suitable for non-terminal methods but they are difficult to administer. The experience suggests that it is comparatively easier to implement such schemes in the organized sector. But experimentation is necessary to design appropriate implementation strategies for the general population.

h) The limited experience with disincentives during 1976-77 indicate that punitive aspects of disincentives to public servants tend to result in coercion. However, the recent public debate has focused attention on the desirability of disincentives to acceptors which do not impinge on the fundamental rights and adversely affect the welfare of children.

Future Directions

The current debate centers around the questions: What should the package of incentives and disincentives be which can help the nation to achieve the desired fertility goals. There is a general agreement that one time payment to the acceptors of sterilization should be increased and will help improve performance. The Working Group on incentives and disincentives set up by the Family Planning Foundation recommends a range of Rs.300 to Rs.500 as compared to Rs.100 paid now. However, only about 25.9 per cent of eligible couples are estimated to have been protected effectively by March 1981 whereas about

60 per cent of eligible couples need to practise contraception to achieve a net reproduction rate of 1, the national target for year 2000. This goal implies a projected birth-rate of 21 per 1000 as compared to an estimated birth-rate of 33.3 in 1981. The questions, therefore, are: How large should the quantum of incentives be? Should they be offered for birth prevention or for contraceptive acceptance? What should be the proportion of immediate and deferred incentives? Should there be differentials in incentives offered? Should they be also offered to motivators, and if yes, how large should these be? Should disincentives be offered? To whom and how?

The incentives have been in the form of compensation for lost wages; they have not formed a coherent part of population policy. More than half of the births are of the third and higher orders. If desired fertility goals are to be achieved, measures will have to be taken to reduce desired family size. One of the reasons for a desire for large families is that an additional child is perceived to be contributing positively to the economic situation of the family. However, at national level, a birth averted is estimated to result in a substantial positive increase in per capita income level. For a marked reduction in fertility, a congruence between national and family level benefit-cost relationship is necessary(Rangarajan and Satia, 1976). Any package of incentives and disincentives should, in the long run, help to reduce this lack of congruence

to be effective. To the extent that lack of congruence varies among different population groups, the package would have to be selective and differ for different segments.

Contraceptive prevalence in the country varies widely. For instance, the number of couples effectively protected by March, 1983 was 40.0 per cent in Maharashtra and 13.1 per cent in Uttar Pradesh. As most of the protection is due to sterilization, the states with high levels of protection would have to emphasize non-terminal methods. A package of incentives for this purpose would have to include deferred incentives for birth prevention. (The difficulties in implementing such a package was discussed earlier.)On the other hand, states with low performance may offer increased incentives for sterilization acceptors.

A segmentation of different categories of population will also be necessary to maximize the effectiveness of incentives and disincentives. The Working Group set up by the Government on incentives-disincentives(1983)recommended the following segmentation of target groups: (1) employees of the government and public sector undertakings, (2) employees in the industrial sector (3) residents of urban slums, (4)landless labourers agricultural workers and peasants in rural areas and (5)others. It may be possible to offer some disincentives to employees of the government and public sector undertakings by curtailing some of the benefits currently received. On the other hand, community

incentives may be most appropriate for landless labourers and agricultural workers.

Activities of the many ministries affect fertility behaviour and, therefore, each of them could design a package of incentives and disincentives. To illustrate, the Ministry of Education could offer adult literacy programmes in those areas which perform well in FP and the Ministry of Labour could introduce effective measures to prevent child labour(Task Force, 1983).

Finally, incentives offered could be such that they directly help in improving the quality of life of the acceptors. One of such schemes suggested at individual level is to provide allowance to girls in the 15-19 age group who are not married provided they and their family participate in self-development activities and services to improve health and nutrition status of children. Examples of such incentives, of course, are many at community level. For instance, those communities which have been successful in reducing fertility could be given priority claims on developmental projects.

In conclusion, the information base to assess and design incentives-disincentives schemes is weak. Therefore, there should be a much wider public debate about the desirability and implications of these schemes. Secondly, for optimal effectiveness such schemes should form an integral part of the population policy and programme. Finally, the administrative machinery for implementing such schemes should be carefully designed and tested before it is used on a much larger scale.

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PATTERN OF CENTRAL ASSISTANCE FOR PAYMENT OF COMPENSATION FOR STERILIZATION AS REVISED ON 17th MARCH, 1983.

	Tubectomy		Vasectomy	
	Existing Rs.	Revised Rs.	Existing Rs.	Revised Rs.
Amount for acceptors	70	100	70	100
Drugs and Dressings	25	25	15	15
Diet	30	30	10	10
Transport	15	15	15	15
Misc.(including motivators fees)	30	30	40	40
	170	200	150	180

No change

No change

Source: Govt. of India, Ministry of Health & Family Welfare Circular No.N.11011/5/83-Ply dt. 17th March, 1983.

TABLE 2: HISTORICAL EVOLUTION OF INCENTIVES OFFERED BY GOVERNMENT (RUPEES)

Years	Incentives to Adopter of Male Sterilization			Incentives to Adopter of Female Sterilization			Incentives to IUD Adopter	
	Lost wages	Other* expenses	Other	Lost wages	Other* expenses	Other	Lost wages	Other
December 1964	10	10	..	10	10	..	Total 5	
October 1966	30	Break up left to States		40	Break up left to States		11	
June 1972	35	"	"	45	"	"	15	
April 1974	20	15	..	25	45	..	6	2.00
April 1976: Acceptors with two children	100	20	30** Misc	100	40	10 Misc		
three children	50	20	30	50	40	10		
four children or more	25	20	25	25	40	5		
July 1977	70	20	10	70	40	10		
February, 1983	100	40	30	100	70	30	9	2.50

* Drugs, diet and transport expenses.

** For miscellaneous purposes such as motivator fees, community awards, group incentives, small camps, equipment etc.

Exhibit 3 Annexe I

ADOPTER AND MOTIVATOR INCENTIVES FOR STERILIZATION AND IUD KERALA, TAMILNADU, MAHARASHTRA, GUJARAT, 1984(INDIAN RUPEES)

I Adopter Incentives:	Kerala	T.N.	Maharashtra	Gujarat
Vasectomy:				
Govt. of India	125[a]	125	125	125
State govt.	20	10		50 in bond to agricultural labourer & small farmer.
Voluntary organization/Local bodies.	10	Range of Rs.50-200		
Other	Five lottery/ ticket (total Rs.10/-)			Rs.300/-to landless family for housing
Tubectomy:				
Govt. of India	145[b]	145	145	120
State govt.	20	15		50 in bond to agricultural/ small farmer.
Voluntary organization/Local bodies	10	Range from Rs.50 to 200		
Other	5 lottery tickets of Rs.10/-value.			300 to landless for housing.
Gifts in kind (Voluntary Organization)	Cycle, sewing machines etc given by voluntary organizations.	Utensils Saries etc.,		Utensils, Saries etc.,
IUD		9		3
Motivator Incentive:				
Sterilization	15 per case			20(Vas.) 10(Tub.)
IUD	2 per case	1.5		2

a. This includes Rs.100/-compensation + Rs.15 for transportation & Rs.10/- for diet.
b. Includes Rs.100 compensation + Rs.15 transportation +Rs.30 for diet.
c. Information incomplete.

Annex II

AWARDS TO STAFF MEMBERS AND COMMUNITY GROUPS FOR ACHIEVING HIGH PERFORMANCE IN F.P. 1982-84.

Maharashtra(1983-84)

1. Foreign Tour of District Officers of districts achieving more than 150 per cent performance.

2. Tour of India to district and block level officers who perform above a certain minimum performance standard.

3. Other cash awards. These are announced seperately for each campaign period. For example, for the period September and October, 1983 following cash awards were announced for the best IUD performance.

   1. Target for Award period will be double the monthly proportionate target.

   2. Zilla Parishad first in the state in terms of best performance will be awarded cash award of Rs.10,000/-

   3. Zilla Parishads achieving 60% of the target for award period will get cash award of Rs.4000/-

   4. Primary Health Centre standing first in the state will get Rs.3000/- cash award.

   5. District Health Officers of Zilla Parishads achieving maximum performance subject to 60% of Target will get Rs.750/- Rs.600/-. and Rs.500/-cash awards as I, II & III.

   6. First Primary Health Centre in circle subject to achievement of target will get cash award of Rs. 2,000/-. Rs.2000/-

   7. Primary Health Centre which will stand first in the district subject to achievement of target will get Rs.1000/- cash award.

   8. Sub-centre standing first in each district subject to achievement of target will get Rs.600/- cash award.

   9. Higher IUD insertions rate per 100 deliveries in institutions with atleast 30 deliveries during award period will get Rs.100/- cash award.

10. Medical Officer i/c institution performing highest performance in circle subject to minimum 100 insertions during award period will get cash award of Rs.1000/-.

11. Nursing staff who will perform highest No. of IUD insertions subject to minimum 60 during award period will get Rs.100/- cash award.

12. Promotor who will perform highest No of cases of IUD subject to minimum 40 cases in the circle during award period will get Rs.500/- cash award.

13. Medical Officer i/c of the institution who will perform highest number of cases in the district. Subject to minimum 50 IUD during award period will get Rs.800/- cash award.

14. Nursing staff who will perform highest number of cases in the district. Subject to minimum 30 IUD will get Rs.800/-cash award.

15. Promotor with highest number of IUD performance in the district. Subject to minimum 20 cases will get Rs.400/-cash award.

4. Innovative Ways of honouring community leaders:

FETA TURBAN AWARD

Sarpanch of Gram Panchayat(Head of Village Council)having population of 500 will be awarded with Feta if 5 sterilisations& 15 IUDshave been performed in the Gram Panchayat during 1983-84. In case of higher population, proportional performance have to be done. Apart from this in this area 12 cases of immunisation under each of the following programme should be completed.

DPT 3 doses.

T.T. to ANC(2 doses + Boostor)

Polio(3 doses + Booster)
B.C.G.(0 - 2)

5. Awards for achieving targets for building construction work:
Award to Executive Engineers.

One Executive Engineer in the Revenue Division will be awarded Gold Medal on the basis of their performance in respect of construction and maintenance of buildings, they would be ranked according to the following criteria.

1. Entire utilisation of grants for construction and special repairs(marks 40)

2. Completion of number of works for which 60% expenditure was incurred as on 1.4.83(20 marks).

3. Expenditure on construction at the newly established Primary Health Centre during 1983-84(15 marks)

4. White washing of all Zilla Parishad Health Facilities(15 marks)

5. Preparation of plans and estimate for new works and actual starting of these new works(10 marks).

Gujarat(1982-83):

Following awards were announced in the Surat district of Gujarat:

Scheme No.1: Rs.250/- each for Block Panchayat President, Block Development Officer, Block Revenue Officer and Medical Officer.

All 13 blocks are divided into four categories based on last years performance.

Category A: One block: Prizes given if 110% of annual target achieved.

Category B: 4 Blocks: Prizes given if 65% of annual sterilization target achieved.

Category C: 4 Blocks: Prizes given if 60% of annual sterilization target achieved.

Category D: 4 Blocks: Prizes given if 50% of annual sterilization target achieved.

Scheme No.2: For Talati-cum-Secretary(Revenue Officer at sub-block level)

	For best performance at block level	At District level
1st prize	Rs. 300	Rs. 1,000
2nd "	Rs. 200	Rs. 700
3rd "	Rs. 100	Rs. 500
4th "		Rs. 300

Similar prizes were announced for Village Level Workers(development)and circle Inspectors(revenue dept.), Principals and teachers & Village Health Workers.

Kerala(1983-84)

Staff:

1.Foreign tour:

Best District Collector, District Medical Officer, State official Secretariat staff-journalist, a representative of Local bodies-given a foreign trip-study cum Sight Seeing tour(Rank holders)

2.Bharat Dharsan(Tour of India)

Those who have achieved maximum no. of cases in each District are selected. All categories of staff are given a chance. The tours are arranged through Kerala Tourism Development Corporation.

Kerala Tours: Places of importance are selected for this. Those who have achieved their targets are selected.

3.Transfer: Good workers are given preference during transfer.

4.Cash Awards: Ranging from Rs.300-100

1st rank - Rs.300

2nd rank - Rs.200

3rd rank - Rs.100

These awards are given to all categories of staff in each district.

Best District Officer:

1st rank - Rs.1200

2nd rank - Rs. 800

Here also all categories of staff are taken into consideration.

5.Special awards are declared by govt. like "good service entry"; cash awards etc.

Annexure 3

Disincentives During 1976-77 and Recent Proposals:

A. Disincentives During 1976-77:

Disincentives applicable to public servants:

1. Disciplinary action proposed to be taken against public servants failing to achieve the quota of motivation for sterilisation etc. allotted to them.

2. Grant of Transfer T.A. to public servants upto 2/3 children only.

3. Free medical treatment or reimbursement of medical expenses to public servants limited upto 2/3 children only.

4. Reimbursement of educational fee to public servants limited upto 3 children only.

5. Grant of maternity leave to female public servants limited upto 2/3 children only.

6. Denial of encashment of earned leave to public servants having more than 2/3 children only.

7. Denial of Government residential accommodation or payment of enhanced rent by public servants having more than 2/3 children.

8. No house-rent allowance to public servants having more than 3 children.

9. Denial of all loans and advances to public servants having more than 2/3 children.

10. Denial of annual increment to public servants having more than 3 children.

11. No allotment of houses built by the Housing Board or L.I.C. or other similar bodies or under M.I.G. Scheme or Rent Control Act to Public Servants having more than 2/3 children.

Disincentives applicable to the public:

12. No appointment to public services for persons having more than three children.

13. Appointment to any public service contingent upon signing a declaration to limit the birth of children to 2 only.

(14) If a person of the eligible category does not undergo sterilization after the birth of upto the third child, he will not be-

a) given any loan

b) granted a licence for fire arms or allowed to renew such a licence

c) allotted a fair price shop

d) allotted a house or plot of land

e) entitled to free medical treatment at Government hospitals

f) granted educational concessions or scholarships except merit scholarships

g) granted any facilities offered by the Harijan and Social Welfare Department.

B. Recent proposals by the Working Group on Incentives and Disincentives:

i) Differential rates of interest on loans.

ii) Low priority in the grant of loans by banks for any purpose if the applicant has more than 3 children.

iii) Low priority in allotment of houses, plots, etc.

iv) A graded increase in the fees charged by hospitals for delivery of babies beyond 3 children.

v) Low priority to the 3rd and subsequent children at the time of admission to educational institutions.

vi) Disqualification from appointment to public service in the case of those already having more than 2 or 3 children.

vii) Disqualification from appointment to public service in the case of those whose wives were below the age of 20 at the time of marriage.

viii) At the time of appointment to public service, a declaration could be obtained from the applicant to the effect that the applicant would limit the number of children to two.

ix) A higher rate of income tax.