

Introduction

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In 1952, India became the first developing country to establish a national family planning program to address the issues of high fertility and rapid population growth. In the more than four decades of its existence, the Indian family planning program has been both highly visible and the subject of intensive international interest and analysis. A primary explanation for this interest lies in India's global demographic significance. With a population approaching one billion people, India accounts for almost one-sixth of the world's people. It is estimated that by the middle of the next century, it will surpass China as the world's most populous country.

Over the past four decades, significant growth and expansion of the Indian family planning program have been evident. Starting from virtually no infrastructure, the Indian program has grown to encompass over 150,000 primary health centers (PHCs) and subcenters, employing more than 300,000 family planning personnel. This network of services now extends to almost the entirety of India's people, three-fourths of whom continue to reside in 600,000 often small and isolated communities. As evidenced by the most recent National Family Health Survey in India, knowledge of family planning among reproductive-aged women is by now almost universal, and by the early 1990s 41 percent of couples were currently using a method of contraception (IIPS 1995). Largely as a result, total fertility rates in India have declined significantly over the last several decades, from 6.0 births in the 1950s to 3.4 births by the early 1990s. In addition, the program has gradually expanded the range of services it offers to include immunization, antenatal and delivery care, preventive and curative health care, and, most recently, reproductive health care.

These achievements notwithstanding, it is difficult to escape the conclusion that the Indian family planning program remains characterized by considerable unfilled potential and promise. Its modest progress stands in marked contrast to the progress of a number of neighboring family planning programs in Asia—most notably Bangladesh, Indonesia, and Thailand—which despite having launched their programs much later, have achieved considerable success in raising levels of contraceptive use. Nowhere is this disparity more apparent than in the large and populous northern states, which are home to more than 400 million people, more than 40 percent of India's total population.¹ The reasons for the limited success of the Indian program extend far beyond the service delivery program itself. They encompass a host of other social, cultural, and economic factors—including low levels of female and overall educational attainment, continuing high mortality, low status of women, and extreme poverty—which influence the demand for fertility limitation (Cassen 1978; Satia and Jejeebhoy 1991). In recent years, however, there has been a growing consensus among policymakers, researchers, and informed observers that the program itself—as reflected in its priorities, emphasis, and the implementation of

services—must be accorded primary responsibility for the limited success of family planning in much of India.

Much has already been written about the Indian family planning program. As one of the most ambitious organized efforts to influence human fertility in a country of key demographic importance, the program has been extensively documented and critiqued over the last several decades. Much of this research has focused on the analysis of population and family planning policies within India. One set of studies has described the historical evolution of population and family planning policies in India since the program's inception in the 1950s (Narayana and Kantner 1992; Visaria and Chari 1998). A second constellation of studies has focused upon the impact of the politically turbulent 1976–77 Emergency Period—when compulsory sterilization was introduced in many parts of India—in terms of its immediate and subsequent political and programmatic impact (Basu 1985; Cassen 1978; Gwatkin 1979; Kocher 1980; Pai Panandiker and Umashankar 1994). Other more recent work has sought to describe the major shifts in population and reproductive health policies that have been taking place in India following the 1994 International Conference on Population and Development (Measham and Heaver 1996; Visaria and Chari 1998; Visaria, Jejeebhoy, and Merrick 1997).

A second focus of research on the Indian family planning program has been its organization and resource inputs, in terms of structure (Misra et al. 1982; Narayana and Kantner 1992; Simmons and Ashraf 1978), facilities, equipment, and staffing (ICMR 1991; Satia and Giridhar 1991; Soni 1983), and financing and resource allocation (Berman and Khan 1993; World Bank 1995). Another set of studies has focused on program outputs, as reflected by contraceptive prevalence, acceptance levels for specific methods, and utilization of other maternal and child health (MCH) services (IIPS 1995; Satia and Jejeebhoy 1991; Soni 1983).

In view of this extensive body of research on the Indian family planning program, it is therefore surprising how little is actually known about how the program is implemented at the field level—at the interface between the program and its clients. Although frequent references are made to the serious gaps in quality of family planning services provided by the Indian public sector (Conly and Camp 1992), empirical evidence on this issue remains limited, unsystematic in nature, and largely unpublished and inaccessible to the research and policy communities.² Little has been published on how existing policies and program inputs translate into implementation practices at the field level. Even less is known about the nature and content of interactions that take place between family planning program personnel and current or potential clients on a day-to-day basis. Limited evidence also exists on how service providers themselves define, prioritize, and carry out their mandated responsibilities, as well as the barriers they face to providing high-quality services. And perhaps most importantly, little is known about the perspectives, perceptions, and direct experiences of Indian women themselves—both among users and especially among nonusers—in terms of the quality and adequacy of services they have received through the public-sector family planning program. Finally, we know remarkably little about how current standards of care inhibit or deter women from seeking or continuing to utilize family planning and other services offered through the Family Welfare Programme.

Recognizing these significant information gaps, the Population Council organized a three-day workshop entitled “The Quality of Services in the Indian Family Welfare Programme” in Bangalore, India, in May 1995, with support from the Ford Foundation and the United States Agency for International Development. The workshop brought together for the first time a diverse mix of policymakers, social scientists, public health physicians, members of nongovernmental organizations, and women’s health activists to consider a countrywide perspective on the nature and quality of services provided by the Indian family planning program. The collective picture that emerged from the workshop provided an unprecedented ground-level view of quality of care within the national program.³

No a priori attempt was made to define the dimension of quality of care for workshop participants. Yet, as is evident from the present volume, the focus of almost all of the studies is upon what Donabedian has defined as the two critical elements of quality of care: technical care and the interpersonal relationship between the practitioner and the client (Donabedian 1988). Many of the studies presented also draw significantly upon the six elements of the quality-of-care framework developed by Judith Bruce specifically for family planning services (Bruce 1990).

The issue of quality of care was evaluated from multiple service delivery levels—clinical services, PHCs, and outreach services—and from multiple perspectives—individual women clients, community outreach workers, medical personnel, and program managers. The studies also employed a range of innovative research methodologies to examine the issue of quality of care—including respondent and workers surveys, client exit interviews, client-provider interaction observations, focus-group discussions with both clients and providers, and situation analysis. The diversity of approaches and methods generated an unprecedented wealth of information on a wide range of quality dimensions of the Indian program, including service access and availability, information provided to clients, choice of methods, interpersonal relations, technical competence, and follow-up and continuity of care.

The present volume consists primarily of selected edited papers from the Bangalore workshop, augmented by several additional studies that were unavailable at the time of the original workshop. The volume is organized into four main sections: (1) evidence from community-based surveys and in-depth, qualitative research on clients; (2) qualitative and quantitative studies of service provider perspectives on quality of care; (3) studies of clinical quality of care provided in sterilization camps; and (4) programmatic evidence and policy issues associated with improving the quality of care.

In Chapter 2, T. K. Roy and Ravi K. Verma present findings from their four-state study of quality of care in India, which included two North (Bihar and West Bengal) and two South (Karnataka and Tamil Nadu) Indian states. The study highlights the significant differences (frequency of outreach visits, availability of physicians and medicines) that characterize the Indian program, with the program in southern states performing consistently higher in most areas. The study also outlines quality-of-care concerns that appear to cut across almost all programs—including dominant emphasis on sterilization and limited information to clients on method use and side effects—and suggests that the contraceptive choice provided to clients might be no wider, and possibly even more limited, in the South Indian states, which have high contraceptive prevalence.

In Chapter 3, Nirmala Murthy provides further evidence on coverage levels and perceived quality of public sector health and family planning services, based upon detailed analysis of a sample survey of women in the western Indian state of Maharashtra. The study highlights the important role of geography in determining service access, and finds that respondents residing in more remote communities are less likely to have been visited by health workers, to have been visited for adequate lengths of time, and to have received other MCH services. The study also finds that workers may make selective decisions about providing contraceptive choice and information, with women residing in more remote communities and poorer women substantially less likely to have been informed about spacing methods of contraception and method side effects.

In Chapter 4, M. E. Khan, R. B. Gupta, and Bella C. Patel present the results from a large statewide survey of Uttar Pradesh in North India. Their results underscore an important but frequently overlooked point: In difficult settings such as North India, basic access to services by clients may often take precedence over quality concerns. The authors found that only a small minority of respondents reported any recent contact with family planning outreach staff, a level that does not appear to have changed appreciably over the last two decades in Uttar Pradesh. This minority of women who were visited, however, expressed generally favorable views about the services they received and the further interaction they had with program staff. The study also found that significant numbers of acceptors of sterilization and the intrauterine device (IUD) were unwilling to recommend these methods to others, perhaps not surprising in view of the significant rates of reported method-related complications and low levels of follow-up by program staff after acceptance.

The final three chapters in Part I consider client perspectives on quality of care, based on qualitative evidence. In Chapter 5, T. K. Sundari Ravindran takes an in-depth look at rural women's experiences with the family planning program in Tamil Nadu, widely regarded as a demographic success story, with fertility having reached replacement levels. A series of case studies highlights important gaps in such service dimensions as voluntary and informed contraceptive choice and the technical standards and competence of program personnel; it also points to widespread corruption among program staff and frequent insensitivity to clients' needs. Despite Tamil Nadu's reputation as having a strong and well-run family planning program, the results of this study indicate that considerable scope exists for improving the overall quality and client orientation of public sector services.

In Chapter 6, Sandhya Barge and Lakshmi Ramachandar present findings from an in-depth observational study of service provider-client relations in a rural area of the northern state of Madhya Pradesh. The study provides considerable insight into the nature and importance of interactions between female paramedical staff and women clients. Case studies highlight the systemic problems of access and quality that characterize outreach services in this challenging service environment: nonresidence and abbreviated working hours of female paramedical staff; irregular and infrequent outreach visits, especially to more remote communities; chronic shortages of equipment and supplies; and an overriding programmatic emphasis on sterilization. Yet, despite these systemic problems, the overall picture presented is one of reasonable quality services at

the level of the PHC, and generally positive interpersonal relations between female paramedical staff and their clients.

In Chapter 7, Manisha Gupte, Sunita Bandewar, and Hemlata Pisal explore women's perspectives on quality of health and reproductive health care through an innovative ranking approach carried out as part of focus group interviews with a small sample of women in rural Maharashtra. Their study makes the important point that there may be no single fixed perspective on quality of care. Women instead appear to be highly pragmatic, prioritizing quality of care dimensions differently according to specific health care needs and marital situations. The authors find that the aspect of service delivery to which women give priority for general health care is the doctor's full attention. For delivery care, client priorities are availability of support staff to clean up and convenient location and timing. For abortion within marriage, women give priority to the absence of a requirement for the husband's permission. For abortion outside of marriage, the assurance of confidentiality is ranked highest. For abortion services in general, women appear willing to trade safety and quality of care considerations for assured confidentiality, which helps explain why the private sector is the preferred source for this service.

Part II presents results from quantitative and qualitative studies of the service providers' perspectives on quality of care. In Chapter 8, Leela Visaria presents findings from surveys with female paramedical staff, their client populations, and contraceptive acceptors in the western state of Gujarat. Visaria finds that the Gujarat program has the capacity to provide high-quality services: a high proportion of staff resident in the communities in which they work; few shortages of key equipment and supplies; and high levels of staff training and technical competence, outreach and follow-up, and client - satisfaction. At the same time, her study highlights the potential drawbacks of a system characterized by undue emphasis on method-specific contraceptive targets. One important consequence is significant discordance in terms of program priorities, with supervisors assigning highest priority to family planning, in contrast to outreach workers who accord highest priority to maternal health needs. The study delineates other detrimental consequences of the target emphasis, including limited contraceptive choices offered to most long-term method acceptors, the entry of non-health personnel into the contraceptive recruitment process, and significant overreporting of acceptance levels for most temporary contraceptive methods.

In Chapter 9, Ravi K. Verma and T. K. Roy present findings from a survey of female paramedical workers in their four-state study of the Indian family planning program. Their findings highlight a number of service areas where considerable scope exists for improvement in quality of care in contraceptive information and choice, technical competence, and follow-up. They found, for example, that in most of the states, only a minority of workers discussed clients' reproductive goals, how family planning methods are used, or their potential side effects. In all four states, workers reported choosing the contraceptive method for their clients in a vast majority of cases. The study provides considerable insight into program priorities as viewed by the workers. In all states (but especially in Tamil Nadu), workers reported considerable pressure to achieve their assigned sterilization acceptor targets. They were under significant but somewhat less pressure to achieve their assigned targets for spacing methods, and relatively little pressure to provide follow-up care to current users. The study also found, in most states,

major gaps in workers' technical knowledge of such topics as reproductive physiology. The study points to the supervisory system as an important contributing factor to these gaps in service quality, with only a minority of workers in all four states indicating that their supervisors provided assistance in improving their performance or addressing clients' needs.

Although they employ different research methodologies, the qualitative study by Jagdish C. Bhatia in Karnataka (Chapter 10) and the analysis of worker survey data by Aditi Iyer and Amar Jesani in Maharashtra (Chapter 11) together provide insight into the barriers that service providers face in providing reasonable standards of care to clients. In two states characterized by considerable success in family planning performance, the studies nonetheless describe a range of factors that constrain effective and high-quality service delivery. These include nonresidence of providers due to inadequate housing or schools, inadequate infrastructure, chronic shortages of key medicines and supplies, limited outreach efforts by female workers due in part to frequent sexual harassment and fears for personal security, and institutionalized corruption. The study by Iyer and Jesani paints a particularly compelling picture of the vulnerability of frontline female workers in rural India in attempting to provide outreach services, and the almost complete absence of institutional support for their work. Both studies highlight the central role that numerical contraceptive targets play in shaping program priorities, the pressure placed upon workers to achieve these targets, and how this emphasis often compromises attention to service quality. Interestingly, the study also reports that despite widespread dislike among workers of method targets, a significant percentage believe that their removal would have a negative impact upon program performance, a finding that highlights the complexity of the current shift away from the target system.

In Chapter 12, M. E. Khan, Bella C. Patel, and R. B. Gupta present findings from a qualitative study of quality of care within the Uttar Pradesh family planning program, as seen from the perspective of service providers. The study describes a setting characterized by widespread organizational malaise and an overall absence of readiness to provide high-quality services, and identifies a number of specific contributing factors. One important consideration relates to the personal security of female service providers—a serious concern in much of North India—which contributes both to high rates of nonresidence among female paramedical workers in the communities in which they are assigned to work and to a general reluctance to visit remote communities. Inadequate service infrastructure, systemic shortages of equipment and medical and contraceptive supplies, and poor program management that limits outreach efforts are also identified as constraints. The system of contraceptive method targets once again emerges as a major deterrent to better standards of care, with evidence presented on how pressure to achieve method quotas leads to the provision of clinical contraception despite serious contraindications and how access to abortion is linked with sterilization acceptance. In addition, there is competition between health and nonhealth personnel in recruiting family planning cases and widespread overreporting of numbers of temporary contraceptive method acceptors. The finding that outreach workers in Uttar Pradesh are generally required to fulfill only a fraction of their assigned quota of new sterilization cases also raises - important questions about the overall demographic efficacy of this approach.

Part III presents evidence on the quality of care provided in sterilization camps, where significant numbers of operative procedures are performed en masse. Sterilization camps remain a primary source of clinical contraceptive services throughout much of rural India today. Chapter 13 by Lakshmi Ramachandar and Sandhya Barge on Madhya Pradesh, Chapter 14 by Dileep Mavalankar and Bharti Sharma on Gujarat, and Chapter 15 by John W. Townsend, M. E. Khan, and R. B. Gupta on Uttar Pradesh provide a broad and remarkably consistent picture of the quality of care concerns that characterize this service delivery approach. The capacity of such camps to offer high standards of care appears to vary by location, with the quality of care most problematic in outreach settings. Although surgeons appear to be well-trained, the support systems for providing high standards of technical care are generally inadequate. All three studies note routine shortcuts in the sterilization of surgical equipment and instruments and in overall infection control measures, thus raising serious concerns about potential infection transmission. All observe major shortcomings in the extent of client-centered facilities. Running water and toilet facilities are often unavailable, and services are characterized by extended preoperative waiting times, little preoperative instruction or patient counseling, insufficient concern for patient privacy, and inadequate postoperative recovery facilities and recuperation time. While noting the continued importance of this service approach given the absence of infrastructure in much of rural India, the studies identify a number of aspects through which the quality of care in sterilization camps could be significantly improved.

Part IV presents programmatic evidence and policy issues associated with improving quality of care. Of central policy and programmatic importance is the question of how improvements in quality of care affect contraceptive use and demographic behavior. Yet, despite a decade of intensive interest in quality of care within the family planning field, evidence on the impact of quality of care upon contraceptive and fertility behavior remains limited, both in India and in the developing world more generally.⁴ The study by Daxa Patel, Anil Patel, and Ambrish Mehta in Chapter 16 presents some of the first empirical evidence from an intervention project demonstrating how improvements in quality of care may contribute to improved patterns of contraceptive use. Analyzing the experience of Action Research in Community Health (ARCH), a volunteer organization in rural Gujarat, the authors document how small improvements in service approach and quality—such as educating clients on reproductive anatomy, demonstrating how IUDs work, addressing women’s fears and concerns through counseling, and providing information on method complications—resulted in significant reductions in IUD dropout rates.

In the final chapter, Jay Satia and Sangeeta Subramanian Sokhi (Chapter 17) examine the policy and management options associated with the Indian government’s stated policy shift away from contraceptive method targets. The experience gained from six case studies in India, where experiments with alternatives to method-specific contraceptive targets are underway, is initially reviewed. The authors emphasize the critical importance of substituting method-specific targets with other alternative strategic “drivers”—indicators that provide the driving force for the overall program. Potential alternative program drivers include increased client service access and availability, better performance and coverage, and higher quality of care and/or impact indicators. The authors raise a number

of unresolved questions relevant to India's ongoing efforts to shift away from method-specific targets: Should different indicators be employed in different geographical areas depending upon their level of development? Should there be a gradual and phased development of alternative indicators? What requisite changes in supervisory and management information systems must accompany this programmatic shift?

Program Implications

The studies included in this volume collectively provide the most comprehensive and up-to-date picture of the Indian family planning program in terms of actual implementation at the field level. In a study of this nature, some degree of repetition and duplication in findings is perhaps inevitable. It is precisely this overlap and congruency in findings, however, that lends credence to the conclusion that many of the quality of care concerns described in this volume are systemic in nature and characteristic of the Indian Family Welfare Programme as a whole.

While many of the findings reported are by no means novel, collectively they provide a compelling and disquieting picture of the realities of family planning service delivery within India's public sector. The general view that emerges is of a program that has, over time, seriously strayed from its initial mandate to improve the health and wellbeing of Indian women and their families. India's Family Welfare Programme remains characterized by an overriding concern for numbers—as measured by the recruitment of sterilization acceptors—frequently at the expense of higher-quality, client-centered service. While such gaps are perhaps most acute in the large, populous North Indian states, many of the same quality of care concerns are also evident within the Central and South Indian states, the latter now widely recognized as emerging demographic success stories.

The studies in this volume also provide insight into the numerous and frequently reinforcing factors that constrain quality of care within the Indian program, and the links between many of these factors and India's low level of socioeconomic development. Despite government commitment to family planning, resource limitations remain a serious impediment to higher quality services at all levels of the delivery system. Basic buildings and infrastructure are underfunded, especially at the peripheral level. Suitable transportation is lacking, and there are chronic shortages of most basic medicines and supplies. A second set of constraints relates to gaps in program management, as reflected in such areas as inadequate staff training, weak supervisory support, the frequent failure to adhere to acceptable clinical standards, limited accountability among program personnel, and widespread corruption. It is also clear from many studies in this volume that basic program philosophy and orientation—as reflected in the prevailing system of worker targets and program performance indicators and the corresponding low priority attached to the needs of individual clients—has played a central role in shaping current standards of care provided within the Indian program.

Despite what might be widely regarded as substandard levels of care, the studies in this volume also highlight the complexity of this issue and the importance of placing findings on quality of care in appropriate perspective. The problems described are clearly not unique to India, but broadly characteristic of health and family planning services in

many, if not most, developing-country settings. In many ways, quality of care represents a set of standards and ideals that few programs—including those in more developed, Western settings—have yet to satisfactorily attain.

Moreover, family planning programs function not in isolation but within the broader context of social relations in a particular setting. Within India, these relations are determined largely on the basis of caste, social class, and gender. Within such systems, the poor, especially poor women, have traditionally been accorded few rights—including the right to receive sympathetic and respectful treatment. Many of the constraints and organizational impediments to better quality of care outlined in this volume are thus systemic in nature, and may characterize public sector bureaucracies in India and South Asia as a whole. There is little evidence to suggest that the efficiency or standards of care are significantly poorer within the family planning program than in other social development programs in South Asia; considerable room for improvement is evident in most sectors.⁵

The results from this volume also highlight the complex and subjective nature of quality of care, and the extent to which this dimension is tied to individual expectations. Despite what could frequently be regarded as substandard levels of care by Western standards, it is striking that significant numbers of clients express satisfaction with existing family planning services, and appear to welcome more, rather than less, contact with program staff. Moreover, the fact that a majority of women in Central and South India have adopted contraception (overwhelmingly female sterilization) may indicate that, under conditions of strong motivation for small families and autonomy among women to make fertility choices, small families may be achieved despite the barriers to fertility regulation presented by poor quality of care.

The findings nevertheless leave the reader with the unequivocal impression that an absence of attention and priority to client needs and poor overall quality of care have played important roles in the disappointing performance of the Indian Family Welfare Programme to date. The potential costs of poor-quality services can also be readily discerned from many of the studies considered—as reflected in lower levels of client satisfaction, a poor image and general distrust of the public sector system, and weak commitment and low esprit de corps among family planning staff. Although, as suggested by Chapter 16, empirical evidence remains extremely limited, poor quality of care may also contribute to high levels of delayed, forgone, or discontinued use of contraception and resulting unwanted pregnancy. Clearly much more attention to this issue is warranted.

The government of India has recently taken the first tentative steps toward addressing many of problems described within this volume, through the reorientation of the current Family Welfare Programme toward greater concern for service quality and clients' broader reproductive health needs. In early 1996, the government abolished the nationwide system of contraceptive method targets, which has dominated the family planning program for much of its existence. In late 1997, the government launched the new Reproductive and Child Health Programme to replace the much narrower programs on MCH and family planning, with the objective of more effectively addressing the broader reproductive health needs of the family. Given the fact these policy changes were

made only recently, their implementation remains uneven and incomplete, and it is too early to assess their impact at the field level.⁶

Nevertheless, the policy shift toward more client-centered services represents a highly significant and positive step, and, if accomplished, is likely to yield substantial dividends—not only in terms of meeting clients' reproductive needs but in terms of India's broader demographic goals. Yet the evidence from this volume attests to the enormity of the task at hand and the uncertainty of success. Progress is likely to be measured more in decades than in years. A clear understanding and recognition of the nature of the problems confronting the Indian Family Welfare Programme represent important first steps toward effectively addressing them. It is hoped that the present volume, by providing a detailed and candid picture of the realities of service delivery at the field level, will make a contribution toward this end.

Notes

- 1 For an analysis of the demographic situation in the northern states, see Satia and Jejeebhoy 1991.
- 2 For a review of existing research on quality of care within the Indian program, see Koenig, Foo, and Joshi 1999.
- 3 For a summary of research findings from the workshop, see Foo 1996.
- 4 See, for example, Pariani, Heer, and Van Arsdol 1991; Mensch, Arends-Kuenning, and Jain 1996; Mensch et al. 1997; and Koenig, Hossain, and Whittaker 1997.
- 5 See, for example, Dutta 1996 on local governance, Rahman 1999 on women's savings and credit programs, Saxena 1997 on forest management, and Weiner 1991 on education.
- 6 For an early attempt at assessment, see Visaria and Visaria 1998.

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