

From Family Planning to Reproductive Health: Challenges Facing India

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More than 45 years ago, India became the first country in the developing world to initiate a state-sponsored family planning program with the goal of lowering fertility and slowing the population growth rate. Since the program's inception, fertility levels have declined throughout the country, at varying paces in different regions; overall, the total fertility rate decreased from 6.4–6.6 lifetime births per woman in the early 1970s to 3.4 births per woman in the mid-1990s.¹

Since the 1960s, however, the Indian population has continued to grow by approximately 2% annually and has more than doubled in size, from 439 million in 1961 to an estimated 930 million in 1996.² The population is expected to grow beyond 1.5 billion before it stabilizes.

Despite the decline in fertility, the reproductive health situation in India remains poor: Although the rate of infant mortality declined from more than 200 infant deaths per 1,000 live births in the 1960s to approximately 74 per 1,000 live births in the 1990s,³ maternal mortality ratios (550 deaths per 100,000 live births) remain among the highest in the world.⁴ Moreover, two-thirds of Indian women go through pregnancy and childbirth without seeing a trained birth attendant,⁵ and obstetric and gynecologic disorders are widely prevalent and remain largely untreated and silently borne. The AIDS pandemic has added another dimension to the poor reproductive health scenario; it is expected that by 2005, some one million Indians with AIDS will require medical attention.⁶ Finally, while contraceptive prevalence increased from barely 10% in 1971 to 46% in the mid-1990s,⁷ con-

traceptive choice and quality of care within the Indian program remain problematic.

Since its inception in 1951, the National Family Planning Program has been dominated by demographic goals. The government introduced method-specific family planning targets in the mid-1960s, wherein state targets were set by the central government and then pursued at the local level. The program focused primarily on sterilization, largely obviating client choice and limiting availability to a narrow range of services. The program subsequently evolved into the Family Welfare Program, which currently administers family planning and maternal and child health services through various primary and community health centers and district and subdistrict hospitals.

In April 1996, the Indian government decided to abolish method-specific family planning targets throughout the country. In October 1997, India reoriented the national program and radically shifted its approach to more broadly address health and family limitation needs. The new approach involves a more comprehensive set of reproductive and child health services and a focus on client choice, service quality, gender issues and underserved groups, including adolescents, postmenopausal women and men. The objective of this article is to trace the roots of this change in orientation, document the program's achievements to date and examine the challenges that remain at the policy level, at the implementation level and in the overall socioeconomic environment in establishing a program that truly meets clients' health needs.

Roots of Change Program Stagnation

In 1992, the Indian government published its eighth five-year plan,⁸ and with candor listed several factors that had contributed to the poor realization of its family wel-

fare goals. According to this report, the family planning program, which had been conceived and implemented by the Ministry of Health and Family Welfare, had suffered from centralized planning and target-setting that allowed for little innovation or flexibility.

That same year, the government launched the Child Survival and Safe Motherhood Program to enhance the health of women and children and further reduce maternal and child mortality. The Family Welfare Program, however, continued to emphasize family planning services, and the child survival components of the new program—especially the expansion of child immunization services—were implemented earlier than the safe motherhood components. Therefore, the overall national program still offered little to improve the quality or availability of reproductive health services for women.

In addition, monitoring of the national family planning program entailed only routine reporting of target goals, making it difficult to identify problems in service delivery and therefore impossible to take corrective action. Responsibility for achieving method-specific contraceptive targets was passed to successively lower administrative units. Failure by local health workers to achieve the targets often led to serious consequences, such as reprimands from supervisors, withdrawal of annual salary increments and job transfers to undesirable posts. As a result, providers often overreported the use of reversible contraceptives or coerced couples into accepting sterilization in order to meet program expectations. In short, the program as implemented was insensitive

*The 1992–1993 National Family Health Survey estimated the maternal mortality rate as 437 deaths per 100,000 live births, but the survey was likely to have underestimated maternal deaths. (Source: International Institute for Population Sciences (IIPS), *National Family Health Survey, 1992–93*, Bombay: IIPS, 1995, p. 226.) The rate of 550 deaths per 100,000 is considered more realistic.

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to the needs of clients and discouraged community involvement.

The government report acknowledged other problems as well: Both initial and on-the-job training of service providers had been poor; information and education efforts had been ineffective, presenting family planning as a means to contain population growth rather than as a way to improve a family's economic and social status by limiting births; the infrastructure for extension services in some of the more populous regions was lacking;⁹ the program had few resources for new initiatives or for strengthening health care services; and the government program allowed for little active involvement of the community.¹⁰

As awareness of the existing program's weaknesses was growing, evidence emerged that data from assessments of the program did not correspond with data from population-based surveys: Contraceptive use rates calculated from program statistics were inconsistent with observed fertility levels, and official program-based protection rates were significantly higher than survey-based contraceptive prevalence rates.¹¹

Organized Pressure

Since the mid-1970s, when the Indian government vigorously promoted sterilization as a means of population control, various stakeholders have voiced concern about the national family planning program. Some women's organizations, for example, have viewed the government's approach as a violation of human rights.¹² Additionally, the poor quality of care offered by contraceptive providers has been considered indicative of the government's lack of respect for women's health. Some groups have protested against the government's conducting clinical trials of hormonal contraceptives, claiming that proper ethical procedures were not followed. These protests received some media attention but little notice from official quarters.

After the release in 1985 of the 1985-1990 five-year plan, however, the government itself recognized and publicly acknowledged the inherent constraints in state-administered social-sector programs in general, and the limited impact of the family welfare program on birthrates in particular.

The donor community also played an important role in pressuring the Indian government to change the focus of its family planning program. For example, donor agencies supported field-based research on women's health and quality of care. They also sponsored an initiative that encouraged discussion between women's

groups, primary health care advocates, demographers and family planning service providers in state-level meetings to prepare for the 1994 International Conference on Population and Development (ICPD).

At these preconference meetings, participants reached a consensus that ethical considerations, proper procedures and high quality care cannot be compromised in a zealous pursuit of demographic goals. Attendees identified four key issues that the Indian government needed to address if its family planning program was to effectively meet women's needs: maintaining efficient program management; ensuring quality of care; widening the scope of services to cover comprehensive reproductive health; and using communication and media to disseminate information.¹³ In 1994, national-level meetings were organized by regional nongovernmental organizations in 18 major states to develop specific action points on the first three issues.

The ICPD, held in Cairo in 1994, and the World Conference on Women, which took place in Beijing the following year, generated additional pressure from the global community for changes in the focus and approach of the Indian family planning program. At these meetings, women's groups from around the world shared their experiences and developed a solidarity that empowered them to successfully petition their own governments to better address women's needs.

In December 1994, a small group of individuals involved in the pre-Cairo consultative process formed HealthWatch, a network of like-minded nongovernmental organizations, activists, researchers and concerned citizens, to engage both government and funding agencies in ongoing dialogue about India's population policy. HealthWatch provided constructive criticism, offered alternative strategies and facilitated the development of monitoring indicators.

Forging an active partnership with a network of nongovernmental organizations was a major step for the Indian Ministry of Health and Family Welfare. In a series of consultative meetings organized during 1996-1997 to examine the target-free approach, the Ministry recognized the need to develop and sharpen program evaluation indicators and keep the program focused on women's needs.

A New Approach

Soon after the Cairo conference, the Ministry of Health and Family Welfare proposed that one or two districts with well-performing programs from each of India's major states begin using a target-free ap-

proach to family planning on an experimental basis. The announcement of the new approach, however, was made suddenly and without adequate preparation.

A year later, in April 1996, the government of India took an even bolder step: It announced that the national family planning program would become target-free. This decision also was made without adequate discussion about what would replace the old system and without assessing the experience of several districts that had become target-free in 1995.

The target-free approach of 1996 meant that centrally determined targets would no longer "be the driving force behind the program."¹⁴ Instead, the community's service needs would determine the program's priorities. With the new approach, planning was to be decentralized and responsibilities were to reside at the level of the primary health centers: Targets would be set by local health workers, "in consultation with the community at the grassroots level."¹⁵

At the policy level, the central government's shift to a target-free family planning approach was a necessary first step toward enhancing the quality of services nationwide. At the state and district levels, however, where the new program was to be implemented, program staff were offered little guidance other than receipt of the program's target-free manual to orient them to decentralized planning.

During the first year, the new approach was met with a great deal of skepticism and confusion, along with several serious concerns: that the target-free policy was a signal to ignore family planning; that the new approach would reverse gains already made toward population control; that target-free would be interpreted as "responsibility-free"; and that program workers would relax and underperform. Moreover, many questions remained: If no targets were to be imposed, how would worker performance be evaluated? What would happen if family planning performance declined, as it very likely would? In their uncertainty over the consequences of the new approach, many states continued to impose targets, setting local goals based on the previous year's centrally assigned targets.

While it is too early to assess how successfully the target-free approach is being implemented or whether it is having an impact on the performance of the family planning program, some early efforts suggest that serious obstacles to full implementation exist: Planning at the local level does not occur; strategies to involve village-level

groups in program implementation remain largely absent; and the manual, while streamlined considerably, still overlooks the need to assess clients' preferences for contraceptive methods and places the decision on method selection with the service providers. Moreover, officials, service providers and other interested parties do not understand what the program shift actually entails and are concerned about whether the shift can ensure high levels of contraceptive use.¹⁶ These and other problems regarding program implementation could undermine the potential of this much-needed change in orientation.

An examination of data on annual acceptors of various methods of family planning, however, indicates that contraceptive prevalence has not declined since the programs's inception: After experiencing some decrease in the absolute number of acceptors during 1996–1997, the acceptance of all methods improved during 1997–1998.¹⁷ In addition, health workers are not reprimanded if they fail to fulfill targets, as in the past, and they are better accepted by the community when inquiring about or providing services for clients' other health needs. These all signal a clear departure from the previous approach.¹⁸

Early Target-Free Efforts

In 1991–1992, as a consequence of the government's effort to capitalize on fertility changes that were already occurring in Tamil Nadu, the state was freed from pursuing method-specific targets, and became the first to adopt a target-free approach. The program emphasized the role of nurse midwives in the provision of contraceptive services, and workers were not pressed to fulfill sterilization targets. Measures of contraceptive prevalence and of maternal and child health in the state indicate that the program has had some success: By 1995, contraceptive prevalence for all four methods offered (female sterilization, the IUD, oral contraceptives and the condom) had increased.¹⁹

Like that of most states, the experience of Maharashtra in implementing the target-free approach is more recent. The state concluded that the term "target-free" was a misnomer, since the new approach did not eliminate targets, but rather, made them a less prominent part of the state's family planning program.²⁰ Therefore, the state's new program was named the "self-determining strategy for work." Expected levels of contraceptive use for each district were estimated using criteria based on birthrates and death rates, and targets were drawn up at workshops by district

level officers and workers. However, as in the earlier system, the community's needs were not considered in these calculations.

Nevertheless, in Maharashtra, attempts are being made to redress some of the limitations of the old approach. For example, training for primary health center staff has been initiated and includes such previously neglected topics as quality of care, informed choice and the assessment of community needs. A sense of optimism now exists among health workers, who welcome the greater interaction with district-level staff fostered by the new approach.²¹

While it is too soon to undertake a rigorous assessment of the program's outcome, indicators for Maharashtra between 1994 and 1997 suggest only a slight decline in contraceptive use.²² Although rates of method use have decreased since the program's inception, a similar level of decline had been observed prior to its implementation and may actually reflect a decrease in exaggerated reporting of contraceptive use. Moreover, levels of child immunization in the state increased marginally. Similar findings emerged from an examination of Satara and Wardha districts of Maharashtra, where the target-free approach had been implemented a year earlier than in the rest of the country.²³

The Next Step

In October 1997, the government launched the Reproductive and Child Health (RCH) Program. The RCH program entails a change not only in program policy but in management and implementation as well. The goals of the RCH program include: removing all targets; phasing out incentive payments to both providers and acceptors of family planning methods; increasing utilization of existing facilities rather than creating new structures; and using the voluntary and private sectors to increase access to services and fill gaps left by public-sector providers.

The RCH program utilizes district-level planning and monitoring to make it more responsive to local needs, and it focuses on improving the quality of care by emphasizing the needs of the client, involving the community, improving the client-referral system and providing local oversight for female health workers. The program strives to revitalize the existing network of rural health facilities by improving supplies of drugs and equipment and enhancing training so workers can provide better information and counseling to clients and communities.²⁴

Under the RCH program, the government is implementing national initiatives

for information, education and communication activities, for training and for program monitoring while also introducing reproductive and child health interventions in selected districts. This approach allows districts to gain experience in limited areas, track the program's progress and identify problems prior to larger scale expansion. In addition, 24 districts or cities with weak social indicators are implementing focused interventions to increase access to health care for particularly disadvantaged groups, such as scheduled castes, tribes and the urban poor.

Besides addressing quality of care and informed choice, the RCH program also promotes the creation of a forum for policy dialogue and for periodic program reviews. The program also stresses that states should have flexibility when implementing recommendations emanating from evaluations and reviews. While the details of the RCH program can be debated and discussed, it does attempt to address several issues that have thus far been neglected in India's Family Welfare Program.

Considerable doubt exists about the new program's potential for success, however: The approach requires a degree of skill and training that may stretch the limits of available resources; it may be unrealistic under current conditions in rural India to upgrade facilities and services at the local level; meeting other program goals might mean that women's contraceptive needs could be ignored; and the costs of expanding services are formidable.²⁵

Model Programs

Few models exist that can serve as guides for the provision of comprehensive reproductive health services. However, the experiences of a small but growing number of nongovernmental organizations demonstrate that many concerns about the implementation of the RCH program could be allayed.

Local programs vary in their approach, but they are similar in their emphasis on comprehensive services for women and children and in their focus on women's rights and choice. These programs include attention to clinical services and counseling; a focus on health promotion; expansion of services to unmarried women, men, adolescent girls and boys and postmenopausal women; reliance on local women as community health workers; innovative and repeated training of workers using folk and other media; and nominal fees for services.

One example of such a program, located in Tamil Nadu, is the Rural Women's So-

cial Education Center, a grassroots women's organization. In response to the community's needs, the program gradually shifted its focus from health promotion, education and women's rights to include clinical services. It now offers a wide range of educational and clinical services involving local women both as health workers and in the management of the program.

Other organizations, like the Society for Education and Action Research in Community Health in rural Maharashtra, and Swasthya in New Delhi, have had a strong clinical component from their inception. Each of these projects has demonstrated that it is possible to enhance quality in community-level programs through the training of health workers, a focus on informed client choice in service delivery and an emphasis on mechanisms whereby workers monitor service provision and provide feedback to enhance quality of care.

Assessments of the performance of local nongovernmental organizations are generally positive. For example, in the case of several Tamil Nadu centers, data maintained by the organization, along with reports from health workers, suggest that health awareness, health-seeking behavior and health status have improved significantly over time among community members: Women have learned to recognize danger signals during pregnancy and the symptoms of reproductive tract infections, and the proportion of deliveries that are assisted by a health care provider has increased dramatically.

Child immunization is almost universal, there were no diarrheal deaths or maternal deaths between 1989 and 1994, and morbidity and malnutrition decreased among children, adolescent girls and women. The evidence also suggests that contraceptive prevalence has increased among women and condom use has risen among men.²⁶ Moreover, the community appears willing to pay for services, allowing for a greater range of services to be provided without costs becoming prohibitive. However, programs run by local nongovernmental organizations continue to depend quite heavily on external funding.

Challenges Ahead

Expanding Services

Women remain one of the most underserved segments of the Indian population. The almost singular focus of the Indian Family Welfare Program on female sterilization resulted in the neglect of many areas of women's reproductive health.

An expanded reproductive health program must include access to safe, effective

and affordable methods of family planning for both women and men, informed choice in contraception and high-quality supplies. It also must promote safe motherhood and the prevention of sexually transmitted diseases, and make efforts to reduce violence against women. It must provide access to safe and affordable abortion services, as well as services for the infertile, and comprehensive and accurate information about reproductive health care, including the risks and benefits of different contraceptive methods. Programs must have well-trained service providers with good interpersonal communication and counseling skills, and must offer appropriate follow-up care and regular monitoring and evaluation of performance, incorporating the perspectives of clients and beneficiaries.²⁷

An expanded program also must offer services to a wide range of clients, not just to married women of childbearing age. Unmarried women, adolescent girls and boys and postmenopausal women all have distinct needs for information and services. Perhaps most important, an expanded reproductive health program must address men, both in terms of their own health needs and in terms of their role in ensuring reproductive health and choice for their wives.

These changes cannot be accomplished without major shifts in the delivery of services. In order to address women's health concerns in a timely manner, for example, weekly visits to primary health centers by a gynecologist will be necessary. Strategically placed emergency obstetric services and access to specialists will be required, as will attention to overcoming obstacles to accessing facilities, such as transportation to and from remote locations. In addition, counseling capacity and referral chains also will need to be strengthened.

Informed Choice

Although the target-free approach espouses informed choice in contraceptive selection, the experience of program planners, health care workers and clients indicates that there is still little choice among contraceptive acceptors in method selection.

Even in the revised target-free manual, for example, a system called "client segmentation" is used to guide a client's method choice. Client segmentation, however, appears designed simply to place a woman into a category that will determine which method she is to be offered: A woman who either desires no more children or already has two or more children will be encouraged to accept sterilization, while a woman who has recently married

or who prefers to postpone childbearing will be offered a nonpermanent method of contraception.

This approach still assumes that service providers know what is best for an individual client. For example, a woman who reports that she does not want any additional children but would prefer a nonpermanent method will still be offered sterilization. While some health workers reportedly have taken a more client-centered approach to their work,²⁸ the needs-assessment tool provided in the manual does not address which method a woman intends or prefers to use, nor does it request information regarding a woman's preference for switching methods. Future revisions of the manual should provide for the collection of information on women's actual contraceptive preferences. Moreover, women who accept sterilization, particularly those living in rural areas, often do so having only minimal information about the procedure, about after-care and about possible complications.

Women's Access to Quality Care

More attention has been paid in the Indian Family Welfare Program to physical infrastructure, personnel and equipment than to standards of care. In addition, expanding the scope of services is a necessary but not sufficient step toward improving women's access to quality health services.

The health care delivery system has been largely insensitive to the needs of women and the constraints they face in expressing their needs—let alone the obstacles they face in obtaining services.²⁹ Extension services, essential for secluded women, are rarely undertaken, and health workers are poorly informed about reproductive morbidity. There is little understanding of the perceptions, beliefs and attitudes that workers may need to address in order to enhance clients' compliance and confidence. Accordingly, workers may not ask important probing questions, and they may also fail to recognize symptoms.

Service delivery strategies have not addressed the serious constraints that women face in acquiring good health care: Vulnerability, lack of autonomy, unequal social status and limited access to economic resources inhibit a woman's capacity to seek health care and may even limit her ability to recognize that she is in need of services.³⁰ Even when a problem has been identified, women may not be able to obtain proper treatment because accessing the service is too difficult or because the expense is deemed unnecessary. Con-

straints on women, and therefore on their health-seeking behavior, operate through social beliefs, norms and practices that are dismissive of women, through segmented markets for land, labor, credit and technology that deprive them of independent resources, and through discriminatory legal practices and government insensitivity that limit their rights.³¹

The empowerment of women to gain greater control over the circumstances of their own lives is a necessary condition to overcoming these obstacles. Women must be encouraged to recognize and articulate their health needs and concerns and to access services with confidence. At the same time, they must be prepared to challenge service providers and program managers to make them more accountable.³² Full access to appropriate care for women requires the creation of an environment that supports women's efforts towards self-determination.

Training

The training currently provided to health care workers will not be adequate to address the needs of an expanded reproductive health program. Field workers now spend a good part of their training period in relatively well-equipped hospitals, leaving them unprepared for the rather primitive conditions that prevail in the primary health centers and other facilities where they will be delivering services. A longer period of preparation in the field would be a better training strategy. In addition, the mode of training and the focus of the curriculum need to better reflect the new program's orientation, and the program must equip workers to better communicate with clients and address motivational issues.

The experience of the voluntary sector in training its workers may offer clues on how to revamp the process. Nongovernmental organizations have successfully designed appropriate, women-sensitive and need-oriented training modules for health providers and have helped grassroots workers adopt the new approach.

Monitoring and Evaluation

Method-specific family planning targets were considered essential for evaluating the progress of the Family Welfare Program. Thus, it is fundamental that the revamped program develop a simplified monitoring and evaluation system that is useful both to service providers in the field and to those who are concerned with the overall performance and impact of the program.

The target-free manual suggests that simple performance indicators be creat-

ed to record the activities completed by the grassroots workers. Unfortunately, the system espoused in the manual has not succeeded in condensing unwieldy data requirements. Providers still must record a wide variety of unnecessary data on program achievement and provider performance, an exercise that is cumbersome, time-consuming and unproductive. In addition, the health workers are required to keep identical client information in at least three different registers, a futile exercise that requires extensive copying. Every day, workers spend an average of two hours on record maintenance,³³ which often requires the help of family members or supervisors.

Not surprisingly, health workers may not comprehend the need for all of the collected information, which may have little or no relevance for their ability to reach or understand the needs of their clients. Clearly, there is also an urgent need to understand the demands on and the conditions of the grassroots workers, and to develop a more reasonable schedule. The recording system should be completely reorganized so that workers collect only information relevant to the health needs of the women and men in the communities they serve.

The monitoring system described in the manual should be considered a model that can be adapted for each state or region, while only key information is uniformly collected and compiled by all regions and states. Given the regional diversity of the country, each region or state should then have the flexibility to decide its own priorities.³⁴

In addition, indicators measuring the program's overall performance should be unlinked from those measuring the performance of the local service providers. The impact of the program should be measured through periodic population-based surveys, using quantitative research methods. However, the performance of health care providers should be measured not only in terms of quantitative indicators, but also in terms of the quality of care they provide and of their clients' satisfaction.

Message Development

The new reproductive health orientation requires major changes in both the content and delivery of information, education, and communication programs. Messages communicated to the public about family planning and reproductive health must go far beyond raising awareness about contraception and the small family norm.³⁵ Local norms, perceptions and beliefs in the area of reproductive health

need to be assessed, with messages tailored to differences in culture, language and community needs.

For example, there is a glaring need to convince educators and nongovernmental organizations about the prevalence of sexual activity among young people and about their ignorance of the human body, sexual behavior and sexually transmitted diseases. Educators must gain access to youths both in and out of school so as to meet their information needs. Moreover, sex education for young men and women must be both culturally sensitive and locally relevant.

The challenge lies in reorienting communication and education activities to incorporate this wider interpretation of reproductive health, to focus attention on the varying information needs of women, men and youths and to utilize the media most suitable to convey information to these diverse groups. This kind of reorientation requires a fresh look not only at messages and media, but also at the training of communicators.

Conclusion

In the 1990s, the Government of India has taken several bold steps towards a more comprehensive, woman-sensitive health program. Method-specific family planning targets have been removed, a new reproductive and child health program has been initiated and there is a greater openness to working with, and learning from, nongovernmental organizations. What is important now is that the momentum not be lost and that the shift in orientation be reflected at the implementation level and in the mind-set of service providers, program implementers and policymakers on the one hand, and among clients on the other.

In this article, we have outlined the process through which India has shifted its priorities from a narrow family planning focus to a broader reproductive health orientation in which quality and informed choice are prominent features, and we have identified the tasks that lie ahead in making this shift a reality. Altering the perspective of stakeholders to more fully accept the new approach, though, remains an overarching challenge that cannot be underestimated. It is somewhat naive to expect that well-entrenched practices and messages established over 25 years will change on their own, without resistance, simply because of a centrally sponsored policy change. Indeed, service providers, program implementers and policymakers at all levels need to grasp, and be convinced of, the rationale underlying the

shift in priorities and delivery strategies. Clients, equally, need to grasp that health services are their due and to demand accountability from the health system. It is critical that changes in priorities and programs be translated and communicated effectively and convincingly.

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