in the rural areas may be seen from Table 3 (for Paira) and Table 4 (for Durgapur). Data for the analyses were collected from interviewing currently married women of reproductive age residing in the sample households. Similar to the urban study site, changes in the number of these women over time occurred mainly due to the combined effects of split-up of households and changes in the composition of the sample women because of marriage, divorce, separation, mortality and crossing out of or entering into the reproductive age bracket. (Although we noted some influence of out- and in-migration, unlike the urban study site, these were not an important factor in the rural study areas.)

The overall contraceptive prevalence rate in both areas was consistently higher throughout the period following the shift in service delivery. In Paira, prevalence increased from 52% to 57% (Table 3), while in Durgapur it rose from 40% to 45–46% (Table 4). In both of these sites, prevalence was notably higher in the base sample than among newly enrolled women, implying that the increase in the overall prevalence did not result from differentially high enrollment of contraceptive users in the subsequent study samples.

The proportions of currently married women of reproductive age who were using temporary modern methods increased considerably in both the Paira and the Durgapur study sites after the shift in service delivery. In the high-performing Paira union, the relative share of pill users rose from 18% to 22%, that of condom users remained unchanged (at 2%) and the proportion of injectable users increased from 10% to 15–16% (Table 3). No such uptake was evident in use of longer-acting and permanent methods, however. In the low-performing Durgapur union, the proportions of women using all modern methods displayed an increase; the most sizable of these was in the use of injectable contraceptives, from 3% in 1995 to 8–9% in 1998 (Table 4).

The relative shares of injectable contraceptives in both rural study sites were notably higher than the corresponding national average of 6% for the rural areas. The remarkable increase in the use of injectable contraceptives has taken place because of the easy availability of this method from trained providers at the cluster spots, which were located within close proximity to women’s residences. Also,