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Research Article

**Global knowledge/local bodies:
Family planning service providers'
interpretations of contraceptive knowledge(s)**

Lisa Ann Richey

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Global knowledge/local bodies: Family planning service providers' interpretations of contraceptive knowledge(s)

Lisa Ann Richey¹

Abstract

Contraceptive technologies and the knowledges that are constructed around them are simultaneously global and local. Family planning methods in the context of international development interventions are interpreted and understood as part of the relationship between meanings that are at once embodied and remote. While quality of care issues have been raised over nearly two decades, the interactive relationship between policy/program, supply, and interpersonal relations in forming identities has not been analyzed. This paper is based on two years of qualitative fieldwork conducted in Tanzania over a period between the mid-1990s and the mid-2000s. It examines Tanzanian service providers' perceptions of contraceptives to shed light on questions of local level dissemination of population knowledge(s) and shaping of identities. The findings suggest that the family planning program serves in a process of differentiation between two groups of "local" women: the service providers and their clients. This differentiation subsequently shapes the implementation of the family planning program.

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1. Introduction

African population policies are implemented through donor-funded family planning programs that promote modern contraceptives. This type of development “intervention” (Ferguson 1994) arises out of the view that overpopulation is a fundamental development obstacle in African countries (Richey 2008). A discourse of global population knowledge is constituted by academic and policy debates over the conceptualization of population “problems” and the implementation of “solutions.” While these debates have been ostensibly resolved by the post-Cairo agenda of reproductive health, fundamental assumptions linking controlled fertility and “development” as neoliberal modernity persist and there is no seamless flow of information from global to local. Furthermore, as demonstrated by recent scholarship (Ali 2002; Browner and Sargent 2008; Maternowska 2006; Richey 2008), the remoteness of global population knowledge from the realities of the local women who are its subjects requires skillful translation in the context of local and global political economies.

Issues of quality of care remain central in debates about family planning and provision of reproductive health services (Adeokun 1991; Blaney 1993; Brown et al. 1995; Bruce 1992; Hardon 1997; Katz et al. 1993; Lane 1994; Rogow 1987; Schuler et al. 1985; Simmons and Simmons 1992; UNFPA 1994; Veney et al. 1992). Some have argued that without sufficient attention to quality, “we will neither see a sustained increase in the contraceptive prevalence rate, nor succeed in lowering birth rates through voluntary means” (Jain 1992, xi). Others emphasize quality as a means of providing services that address the reproductive needs of women in a way that upholds their rights and enables them to gain control over their reproductive capacity. As suggested by the concept of quality of care, the critical juncture between the global discourse and policy, on one hand, and local level receptivity, on the other, takes place in clinic interactions, but these are never simply “local” affairs (see Maternowska 2006). Family planning service providers act as translators between global population knowledge and local bodies. Interpretation takes place within a process of an ongoing construction of subjectivities: what is the identity and role of the provider *vis a vis* the client and vice versa? As members of local communities, these providers embody and interpret scientific knowledge for themselves and for their clients. This article will explore some meanings and negotiations of contraceptive technologies in Tanzanian family planning clinics.

I would like to suggest that the family planning program serves in a process of differentiation between two groups of “local” women: the service providers and their clients. This differentiation subsequently shapes the implementation of the family planning program in ways that create identities and thus, go beyond simply “gate-

keeping” in which providers use access to enhance their own control. Understandings about method appropriateness come from the juxtaposition of a global population discourse that holds poor women responsible for the “problem” of high fertility together with local biases based on class, education, gender and ethnic divisions. Yet this global knowledge is not intentional, singular or even exclusively “top-down,” and in fact, it is in the diffuseness of its power and the absence of overt force that we see one modality of bodily governance (see Brigg 2002). A global notion of poor women as “disempowered” intersects with local prejudices and reinforces social fissures. These identities constructed by service providers for themselves and their clients affect the meanings of contraceptives with implications for important issues of “informed choice” and access to contraception. Therefore to understand and improve “quality,” identities must be taken into account.

Ideas about planning one’s family and using a variety of devices and practices to control fertility are not new to Tanzania. However, the large-scale introduction of modern family planning methods nationwide dates back to the early 1990’s implementation of Tanzania’s National Family Planning Programme. If an indigenous Neo-Malthusianism is prevalent in African communities but concern about the safety of modern contraception is prominent, as Watkins (1998) argues from the Kenyan case, then the way that service providers perceive methods is a vital link between global population knowledge and local understandings. Yet, these perceptions cannot be characterized as simply appropriating or resisting the official knowledge transmitted through training courses, as “right” or “wrong.” The discourses of accommodation are often intertwined with those of opposition (cf. Ginsburg and Rapp 1995).

This article will examine Tanzanian service providers’ perceptions of contraceptives to shed light on questions of identity and local level dissemination of population knowledge(s). The next section will describe my methodology in the case study. Section three will give a brief overview of the international and national context of family planning in Tanzania. Then I will explore the ways in which a modern identity for service providers plays out in the clinic setting, including the interpretation and negotiation of various contraceptive methods. The final section offers some concluding ideas and potential programmatic suggestions.

2. Data and methods

This article draws on qualitative data collected during 18 months of fieldwork in Kilimanjaro, Morogoro and Ruvuma regions of Tanzania in 1995-96, and on follow-up research and visits conducted in Kilimanjaro from June-December 2000 and in January 2004. Using contraceptive prevalence as a rough proxy for acceptance of the ideas and

practices of “modern” family planning, I selected regions of study on the basis of Demographic and Health Survey data to represent areas of high, medium and low rates of contraceptive use and approval (Ngallaba et al. 1993). All of the regions were involved in implementing the National Family Planning Programme, and all clinics in my sample had at least one officially-trained service provider. I collected data during participant observation in 10 urban and rural family planning clinics in the three regions, and from interviews with 47 family planning service providers. I spent no less than three weeks of observation at each site, and in some urban sites and at one village I was able to visit regularly over a period of seven months.

I was made to feel quite welcome in the clinics, and many of the persons with whom I worked were interested in my research. I believe that I was able to make clear that I needed to understand what different kinds of things happened in family planning clinics. I always emphasized that I was not conducting any sort of supervision, nor was I in any way affiliated with the government or any donor. Still, as a white person who arrived at the clinics in a private car, I am sure that some personnel thought that I might have had access to resources that would come their way if they met the evanescent criteria for bringing in development projects.

My participant observation time was spent observing whatever it was the service providers were doing which did not invade the physical privacy of the clients themselves.² In urban clinics, a typical day might involve listening to the health education lecture given before services began, observing one or two groups of new clients being counseled for “informed choice,” following along with two or three of these women as they talked individually with a service provider, observing the service provider who was doing re-supply for returning clients, sitting in the check-in area while clients were being processed in and out of the clinic, and talking informally or conducting interviews with service providers after all the clients were gone. In rural villages, because of the smaller number of family planning clients, a typical day might consist of observing the counseling and method selection from start to finish for every family planning client, observing prenatal visits, immunizations, and sick patient care, and engaging in informal discussions as well as interviews with Maternal and Child Health/Family Planning (MCH/FP) staff and clinic officers in-charge.

Both the participant observation and interviews with providers were conducted by me in Swahili. My language proficiency was fluent enough to understand not only the responses to my questions, but also to “eavesdrop” on other people’s conversations. This was extremely important in participant observations between one service provider and another, and between service providers and clients. Direct quotations from interviews come from notes written during the interview itself, while participant

² This was my own choice, as I was regularly offered the chance to observe physical exams, and insertions of Norplant and IUDs.

observation or casual conversation quotes come from notes written from memory. These quotations are almost always from spoken Swahili and then translated into English and as such involve the limitations of both memory and translation. Also, many of the quotations include my own interpretation of unspoken interactions, silences, and body language. This highly interpretive part of the work is impossible to verify, but serves an important purpose in conveying the realities of local clinic life. In the following section, I will describe the context of family planning in Tanzania.

3. The context from above: The state, the body and the national population policy³

Tanzania has an ambivalent history with issues of family planning and population. In 1959 it was one of the first countries to introduce family planning services through what would become the Family Planning Association of Tanzania (UMATI), yet it was one of the last countries in Africa to prepare a comprehensive national population policy. Tanzania's historically socialist government was known since independence as a leader among Third World countries in advocating an alternative path to development that promoted "African solutions" to "African problems." In spite of Tanzania's reluctance to sign on to the global population agenda, its current population policy and National Family Planning Programme are comparable to those in most other African countries. Acceptance of a national policy is a strong indicator of a nation-state's entry into the arena of population players and is a symbolic statement to the international community that it recognizes that it has a population "problem" as defined in a particular way, and that it is a candidate for development assistance in the realm of family planning programs (see Barrett and Tsui 1999).

The shift in the government's stance on population issues was related to its international context. During the 1980's, changes began to take place in the perceptions of Tanzanian officials about their population "problem" and appropriate solutions. Of course, this shift did not come out of nowhere. It was embedded in a changed way of thinking about Tanzania's overall approach to development which involved the intersection of government, donors, lenders and international organizations. Diverse organizations with different but convergent goals gained influence in Tanzania simultaneously. While this did not have the overt intention of a common front organized to bombard the government with anti-natalist propaganda, it did have that outcome. After five years of negotiations and revisions, the National Population Policy was adopted in 1992, and the National Family Planning Programme developed as its

³ A far more in-depth analysis of the policy and politics can be found in Richey 2008.

primary implementing arm. In light of the economic crisis and structural adjustment reforms, “the national population programme is mainly financed by multilateral and bilateral assistance” (United Republic of Tanzania 1994, 28). Therefore, the discourse of donors and lenders set the tone for both the conceptualization and the implementation of solutions to the population “problem”.

The timing of the policy proved auspicious, and the language of “women’s reproductive health” which had entered the mainstream discourse at the 1994 International Conference on Population and Development in Cairo could be superimposed with Tanzania’s historical emphasis on maternal and child health issues. In Tanzania, the rhetoric of family planning (*uzazi wa mpango*) was quickly replaced by that of reproductive and child health (*afya ya uzazi na mtoto*).

Photo 1: The Ministry of Health Unit for Reproductive and Child Health housing also the NGO-run service-provision clinic (UMATI)



Whether the so-called “Cairo consensus” on the importance of women’s reproductive health has actually shifted the ends to be achieved by international family planning or not, the responsibility for this achievement still rests in the bodies of the women who are to be “modern” family planners. Attempts to integrate HIV/AIDS care into reproductive health have only served to exacerbate peer struggles and global to local incongruities. It is not my point to assess the efficacy of the Tanzanian family planning program but instead to argue that whatever its effect on demographic goals, there are important limitations on reproductive rights and client choice that are embedded within the program from the international to the local levels. Clinic examples later in this article suggest that “quality of care” issues are still distant in provider-client interactions, and the needs of clients, particularly regarding access (Speizer, Hotchkiss et al. 2000) and informed choice are left behind as distinct identities are being negotiated and hierarchies established. In the next section, I will describe how ideas about “modernity” frame identities that have repercussions for the implementation of the National Family Planning Programme at the clinic level.

4. How a modern identity affects service providers as medical “professionals”

4.1 Population as a “modern” development problem

This section will explore how a mutually-reinforcing construction of “traditional” and “modern” identities affects the roles and practices of service providers in their clinic work (see also Richey 2004; Allen 2004). As I have argued elsewhere (Richey 2008), modern family planning is intimately linked to the neoliberal project of “development.” The genealogy of the global population discourse begins when population became a category in which states could begin to conceptualize and thus order their constituents (Foucault 1980; Riley and McCarthy 2003). Simultaneously, population evolved as an area that can be controlled through governance because human reproduction could be controlled by individual restraint. Making modern bodies through female fertility control and sexual restraint has been the basis for the modern body politic (see the seminal works of Douglas 1966 and Lock and Scheper-Hughes 1996). Contraceptives in the clinic are known as “*njia za kisasa*” or “modern methods.” The negotiation between contraceptives and development goals, both “modern” served to create identities for Tanzanian women, not as a singular category, but as a differentiated group in which some women are modernizing others.

Service providers have multiple identities as purveyors of new and somewhat controversial information, employees of the state, medical professionals, and local

women (see Allen 2004; Booth 2004; and Maternowska 2006). Joffe's (1986) work with service providers in an urban American family planning clinic argued that these providers were the mediators between various conflicts over what family planning services should be. One interesting finding from her study was that American family planning service providers wanted the realm of family planning to be expanded beyond the narrow medical definition of contraception to include legitimization of discussions of sexuality (Joffe 1986). In contrast, discussions of sexuality almost never took place in Tanzanian clinics. My understanding is that Tanzanian service providers were not comfortable with discussions of the issue, and wanted instead to be identified as medical *professionals*.

Photo 2: A rural Health Center with a popular family planning clinic in a comparatively wealthy village



However, professionalization in the context of a Tanzanian medical institution resembles less a case of impersonal competence as in a Weberian bureaucracy, and more a type of personal rule or clientelism.⁴ Therefore, the identities constructed for service providers and their clients have more importance for shaping the interactions between them than they would in a more regimented, standardized bureaucracy where functions take precedence over the identities of individuals who perform them. The construction of local women clients as “traditional” women in need of assistance from local women service providers who embody “modern” knowledge effectively shapes contraceptive decision-making and limits choice.

Family planning service provision as an impetus for donor funding has provided a channel for personal and professional gain for one group of “modern” local women. Contrary to my own expectations before going to the field, all service providers with whom I had any contact expressed positive dispositions toward the provision of modern family planning.⁵ The material value of family planning as a resource overpowered any other potential reasons for rejecting it. Service providers want to become trained in family planning because training means attending classes, usually in the regional capital city, where they are given room, board and a *per diem* for the duration of the training period. Completion of this professional training also opens up avenues for further training in the future -- refresher courses, specialized courses, or expansion of basic training all provide another opportunity for increased material and symbolic capital.

⁴ Kaler and Watkins (2001) borrow the concept of clientelism from the study of African politics to describe the “non-modern” features of the personalized and unequal relationship between CBDs and their clients. An exchange of material spoils for allegiance is at the core of such patron-client relationships.

⁵ I had expected resistance on the part of service providers who held personal beliefs against contraception, particularly in highly Catholic areas. I had also anticipated the possibility that the introduction of an increased repertoire of services to the already over-taxed MCH workers would be resented by service providers in busy clinics.

Photo 6: Urban service providers finishing their record-keeping at the end of the day



The official training informs potential providers that population growth and poor maternal and child health are serious problems for Tanzania's development and that family planning is a way to combat these problems. Service providers are then given the tools and the knowledge to assist local women in solving the problems defined by the international community and transmitted into the local context. This is "modern" knowledge now held by a different group of women with different credentials than previous "traditional" knowledges. Legitimacy comes through their roles as medical professionals. Whether motivated by beneficence in aiding their less-educated counterparts, or by a desire to reinforce their own power as gate-keepers, Tanzanian service providers frame method-choice according to their own lenses. These may be biased based on prejudice of education, urbanization, wealth, or ethnicity -- implicitly supported by training that emphasizes the objectives of the National Family Planning

Programme over the rights of its women clients. From the importance that women place on “dressing-up” themselves and their children for a trip to the clinic, and the reluctance I have seen from poorer women when a clinic visit is required, I suspect that local women understand the identities that are being constructed for them in the clinic setting.

4.2 The appeal of provider-dependent methods

In helping women to make “good” reproductive decisions, service providers read the categories of “short-term” and “long-term” methods that are taught as part of their professional training in ways that direct method choice toward provider-dependent methods. Observation in clinics showed that methods were presented to clients as short-term and long-term; yet, for the most part, providers did not consider short-term methods to be a reasonable contraceptive choice for their female clients. Because these categorizations of short and long term also corresponded with user-controlled versus provider-dependent methods, the emphasis on long-term resulted in steering clients toward methods over which the service providers had more control. Thus, service providers, equipped with “modern” knowledge and contraceptives, were potentially allies to help clients control their fertility. At the same time, they were also potentially obstacles to be overcome when women’s desires were at loggerheads with what providers considered being the right choices.⁶

During my interviews with service providers, they regularly responded that they were teaching *all* methods of family planning. However, my participant observation of “informed choice” counseling showed that usually Depo Provera⁷, pills, and the IUD were explained, and Norplant[®], condoms and/or foam were merely mentioned in passing. I never heard LAM⁸ or natural family planning being explained to clients at any clinic, even though providers told me that they taught them. The diaphragm, part of the official family planning program’s constellation of methods, was almost never

⁶ In examining the negotiations over contraceptive technologies between women and providers, I am not assuming that, in the absence of such technologies, women would no longer need to negotiate their fertility. Indeed, contraceptives are ambivalent in their potential for assisting women to control aspects of their bodies and in divesting women of control at a different level. There are also other important local negotiators for reproductive control of women’s bodies including husbands, parents, in-laws, clans, churches and mosques, etc.

⁷ A commonly-used three-month hormonal contraceptive injection.

⁸ LAM stands for lactational amenorrhoea and refers to the use of regular breastfeeding to prevent pregnancy.

included.⁹ Thus, no methods were promoted that were user-controlled and non-hormonal.

Photo 3: An urban service provider writes the return date on a client's card



⁹ While there has been a long international debate over the efficacy of the diaphragm as a viable option for women in the Third World (see for example, Ortayli et al. 2000), there was little knowledge of the method in Tanzania, much less debate on its merits.

The following example is a description of my observations of two women making “informed choices” in a popular urban clinic:

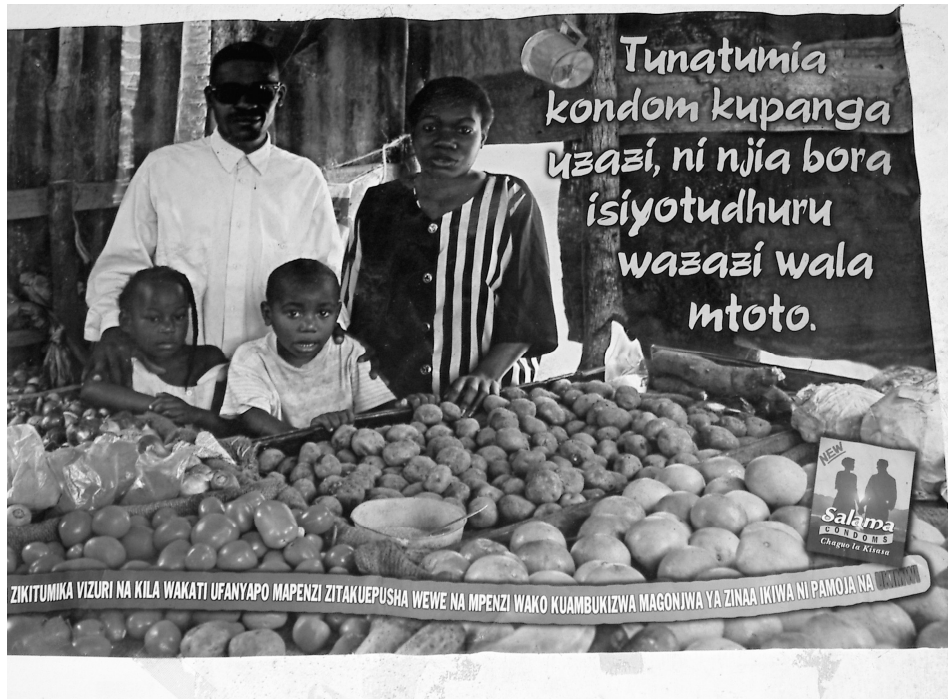
After the counseling for “informed choice” no one had any questions, so each was asked which method she wanted. The 40- year old woman from a nearby village with a toddler and [I think] five other children wanted Depo Provera. She said that she had asthma and couldn’t take pills. . . . The service provider was at a loss as to what to do since Depo Provera is contraindicated for asthmatics. . . . She told the woman to get an IUD, but the woman did not respond positively. The nurses all agreed that she should get an IUD, but the woman was still not enthusiastic. They also told her that the person trained in insertion was out, so she had to come back on Friday when she was back in the office. The woman was obviously distressed at wasting her time for nothing, but left. The “temporary” methods were not even considered for her.

The other younger woman chose spermicidal foaming tablets. Everyone (the service provider and other nurses in the room) erupted in laughter, mocking her. “Do you want to work all the time, every day?” “Don’t you have a man at home? These are for those other men (wahuni)—Choose another method that won’t bother you. You will be really irritated by this one.” . . . All three of them were unable to believe that this woman would want to use the foam. Of course, she “changed her mind” and got pills. Everyone agreed that this was a much better decision. They took her weight and blood pressure and got a short birth history and her name and address. No questions were asked regarding her health conditions, and she was told only how to take the pills. No explanation of the side effects was given.

In the scenario with the first client, we see that a client who was contraindicated for hormonal methods was only given the “choice” of having an IUD inserted. She was not offered the other methods available at the clinic -- condoms and foam --because the service providers themselves did not consider these to be legitimate choices, irregardless of their inclusion in the official family planning program. This attitude was confirmed by their responses to the second client who requested foam. While the service provider in the previous example received “on-the-job” training in family planning skills, similar biases were observed even with highly-trained service providers. They would offer all “modern” methods, but quickly recommend hormonal methods or the IUD. In a majority of the counseling interactions I observed, service providers often left out explanations of nonhormonal contraceptives, or explained them cursorily

without noting which advantages they might offer. This is in spite of the public education posters for condom promotion found on many family planning clinic walls.

Photo 4: A poster promoting the use of condoms for family planning and prevention of sexually-transmitted diseases; clearly aimed at married couples and noting that condoms cause no harm to the parents or the child



When condoms and foaming tablets were explained, these “short-term” methods were commonly given to clients who were waiting for their menstruation. In these interactions, there was often the unspoken assumption by providers that clients would not actually use the methods. Many service providers required that women prove themselves not pregnant by beginning hormonal methods only when menstruating – a practice also described by Maternowska (2006) and which Speizer et al. (2000) calls an “inappropriate process hurdle” for the provision of hormonal methods.

The varying rates of contraceptive effectiveness were never mentioned, so it was not as if clients were choosing hormonal methods because they wanted a more effective method of preventing pregnancy. From my observations, the way that service providers explained “short” versus “long” term made it unclear that methods such as condoms or foam could also be used effectively for years. Because women who came for contraceptives wanted to avoid pregnancy for months or years, methods described as “short term” were effectively eliminated from their repertoire of choices.

If we compare the methods emphasized at the clinic level with those prioritized by Tanzania’s family planning donors we see a striking similarity. Women are being offered the “choices” which are most effective, and those over which they will hold as little responsibility as possible. I would like to suggest that this outcome at the local level emerges from congruence between international priorities and local biases. If those most responsible for constructing the discourse and practices, both materially and symbolically, i.e. Tanzania’s donors, wanted to prioritize other methods, such as female-controlled nonhormonal ones, then I expect that we might see those methods being promoted at the clinics.¹⁰ However, local women are often assumed to be irresponsible and unable, or unwilling, to give the ongoing acceptance required for “successful” family planning with a user-controlled method. Furthermore, the training of service providers, and their own understandings about the irresponsibility of their clients lead to a conflation of interests in promoting “long term” methods. This makes the concept of “choice” at the local level purely rhetorical.

4.3 IUD negotiations: Persuasive insertions and resistant removals

The IUD is part of the National Family Planning Programme’s constellation of methods, and training for insertion and removal constitutes the difference between the “basic” and “comprehensive” courses for service providers. The IUD has a mostly-urban clientele, but it was available in most of rural clinics where I worked. During interviews, providers gave diverse interpretations on this method and its utility for Tanzanian women. It was mostly noted for requiring a monogamous relationship – described in Swahili has a person who was “*msafi*” [literally, “clean”], but also identified as a good method for “urban” women, for women with more than one child, and for women who are not young. One possible reading of this identity of the IUD

¹⁰ Yanoshik and Norsigian argue that the selection of methods available and promoted in all contexts is dependent on biases toward control of the female body (as opposed to making men responsible for contraception) and preference for high-tech solutions which require invasive technologies which “stem from the confluence of western medicine, the population control establishment, and the pharmaceutical industry” (Yanoshik and Norsigian 1989, 71).

user is that it protects the service providers' professional status by limiting the likelihood that sanitation or promiscuity would complicate the method's effectiveness. Furthermore, should there be any ill-effects from the method, if a woman has already had at least a couple of children, these are not as severe as the risk of not bearing any children for a nulliparous woman (see Allen 2004). "Good clients" for the IUD hold similar identities to "modern" female family planners in general: they are urbanized, morally-disciplined, and use contraceptives within the childbearing context (as opposed to before marriage or in adolescence). Not surprisingly, one service provider told me that the IUD was a particularly popular method among service providers themselves.

However, the popularity of the IUD becomes suspect when its acceptance and use are understood within the actual clinic context. Many IUDs are inserted during the period when family planning training courses are taking place. While these courses were underway, I observed a marked change in the counseling for "informed choice." Instead of presenting the usual repertoire of contraceptives, service provider/trainers together with their trainees, were using heavy-handed persuasion to convince women to "choose" IUDs so that insertions could be done under supervision. One of the MCH coordinators explained:

When the training is taking place, many women get IUDs because the students have to perform so many for their course. After that, many of the women return to have them taken out. . . . I don't know why. . . . Maybe when they get home they realize they just got them quickly without thinking about it.¹¹

It is ironic that at the very time when service providers were supposed to be learning how to counsel women for "informed choice," the demands of their actual training denied women that choice. The needs of the National Family Planning Programme to train medical professionals were given precedence over the needs of local clients.

In my observations, IUD users were forced to negotiate with service providers for removals. Bruce (1992) recommends that because of the asymmetry involved in heavily provider-dependent methods, family planning program managers should promote the credo "removal on demand." This is "to leave no doubt in providers' minds about who has the right to decide whether a device should be taken out" (Bruce 1992, 45). Instead, women who wanted IUDs removed had to be able to articulate an acceptable reason that was judged against the benefits of family planning use as interpreted by providers from their training knowledge.

¹¹ Interview, 95GM24a.

In participant observations at urban clinics, most women who came to clinics with any sort of method problem or side-effects to be managed were clients with IUDs.¹² The interactions between these women and the service providers suggested a lack of understanding of the rights of women freely to choose to initiate and stop using any method of contraception when they desired to do so. I will describe three clients who came on the same day to a hospital clinic to illustrate this point:

A woman came in crying¹³ and grabbing her stomach. One of the service providers asked her if she was pregnant and she said no, that she had an IUD. Everyone in the clinic area laughed at the fact that she was crying and acted as if she were just making a big fuss over nothing. I have no idea how long she had been waiting in the waiting room outside, or if she had just come in. They did, however, clear out an examination room and take the woman in right away—they seemed frustrated and embarrassed that she would make such a scene in front of other clients (my interpretation). After she left, I asked the service provider if she had had an infection and she said yes and that she had already gone home (implying that it was all taken care of—and not to be discussed, it seemed to me).

This example of the woman crying in the clinic showed service providers responding to client complaints of side-effects with laughter. While these same providers were well-trained in the official discourse on the “management of side-effects,” nothing in this training made them accept this woman’s complaint as legitimate because her actions challenged the expected submissive and discreet role of the client. Inappropriate crying at the clinic may be interpreted as a resistance strategy¹⁴ that without confronting the norms of proper composure in the clinic setting nonetheless forced a shift in the provider-client relationship to deal with her outburst. The following example is from other clients at the same clinic:

¹² One hypothesis is that since IUDs are heavily pushed by service providers, and clients who have not freely chosen a method would be more likely to experience problems with it, we would expect the numbers of clients returning with problems to be greater. I can not test this claim because the number of clients who returned to the clinic with problems during my observations is too small. Also, I lack cases for comparison (i.e. clinics which had significant numbers of IUD clients but did not push the method).

¹³ This was particularly significant in comparison to other experiences I observed during my 24 months in Tanzania. Women tend to be stoic about pain—to the point that, even when I saw a woman in labor with an obstructed delivery, she did not dare cry out. In general, my experience was that people tend to understate, not overstate their level of pain or discomfort.

¹⁴ This sort of indirect resistance is best analyzed by (Scott 1985; Scott 1990).

Two other women were also there waiting to have their IUDs removed—and it appeared that they had been waiting quite a long time. The first woman had a “legitimate” medical reason — she had pains in her legs (which they assured her were not associated with the IUD) and other less specific abdominal pain (which proved a reasonable means of convincing the nurses to take out the IUD, after much discussion, attempts to dissuade her, and waiting). The second woman was young and had an infant. Apparently, her husband said he wanted her to get the IUD out, and she wanted to get an injection. This proved to be quite an irritation to the nurses who agreed that her husband’s preference was not a good reason. They told her that she would probably get more problems with the injection. They contended that also, as she had demonstrated her lack of conscientiousness by forgetting to bring her client card, she would be unable to remember to come back for repeated injections, and was thus, an unsuitable client for Depo Provera and should keep the IUD. The young woman repeatedly asked them to remove it and give her Depo Provera, and they continued to refuse. Eventually, three service providers were all sitting on the waiting room bench with her, trying to figure out what they would do. Finally, one provider decided that what the client needed was Norplant®. They managed to convince her that her husband wouldn’t know about it. They told her to go home and get her money together (1,500 shillings) [\$2.50] and to go to the NGO clinic the next morning to get them to remove her IUD and give her Norplant.®

The client in the first example was able to produce an acceptable side-effect for demanding the removal of her IUD. However, this interaction required extensive negotiation and required that the client effectively articulate her needs in terms that were defined in the protocols of the national family planning program and acceptable to the local providers. The second woman was less successful in negotiating for method removal, as her justification, that her husband wanted her to remove the IUD was not deemed a reasonable demand by the providers. The second woman faced many obstacles in this interpretation of her “needs” by the providers. First, she would face the issue of payment at the NGO clinic that could supply the recommended method. Second, she was supposed to conceal the new method from her reluctant husband. Finally, she faced the obstacle of the service providers themselves who would not remove the IUD, with or without giving her another method, and who instead referred her to another clinic and another set of providers with whom to negotiate. The providers, as medical professionals, acted as method gatekeepers as they passed judgment on the legitimacy of women’s physical complaints (leg cramps, yes; stomach ache, no) and social demands (husband’s rejection of the IUD is insufficient).

However, their reactions are better understood in the context of the client's identity as "unconscientious" and "forgetful" as demonstrated by their remarks that she forgot her card and thus would not be able to fulfill her part in modern contraception that was in any way client-dependent.

4.4 Norplant[®] negotiations: Cost-effectiveness vs. client rights

Norplant presents similar dilemmas around service provider negotiation, but with the added factors of cost and scarcity of providers trained to insert and remove the method. Norplant[®] must be inserted by a trained physician, and the majority of physicians I interviewed in Tanzanian health facilities were in agreement that it was a woman's right to remove Norplant[®] whenever she chose (although most agreed that clients who choose this method should desire to delay pregnancy for at least three years). However, one doctor trained to perform sterilizations and Norplant[®] whom I asked about the removal of Norplant[®] told me that removals are done "anytime the client wants it out and can't be convinced that she wants to keep it, or if the clients have side effects and want it out."¹⁵ Convincing women to keep Norplant[®] if they come to a clinic to have it removed violates the rights of clients to control their own fertility and contraception. In these situations, interactions which may be intended as "convincing" may in effect be "coercing." As explained by Bruce (1992), because a more prestigious and "powerful" physician is at an advantage in these interactions that almost always take place with less educated and less "powerful" women, it is important that all providers recognize that any woman has a right to stop any form of contraception "on demand" (Bruce 1992, 44,45). However, the primacy of clients' rights to trump any other objective of the family planning program to encourage contraceptive use has not taken priority in implementation.

Furthermore, physicians are not the ones who counsel women coming to the clinic for the insertion or removal of Norplant[®]. Family planning service providers are the method's initial gatekeepers and it is they who refer clients to the doctor. Service providers in the MCH/FP clinics were often unclear on the details of insertion and removal of Norplant[®]. Service providers told me that they are told that Norplant[®] is expensive, so it should be considered a long-term method. This consideration of cost may explain their reluctance to tell women of their rights of removal on demand, effectively forcing clients to keep the implants involuntarily. One example of this comes from my observation of counseling for "informed choice" at an urban hospital clinic where a service provider explained Norplant[®] and noted that there is a doctor who can insert it:

¹⁵ Interview 95GK35, 10/14/96.

Norplant[®] is for women who are certain that they don't want to have another child for five years because "up to now, there is no doctor in [the town] who is trained to remove them." [No one asked about this or commented on it, indicating what seemed to me in this context, that it was not perceived to be a big problem.]

Another example from client counseling was that when the service provider explained Norplant[®], she said "doctors will not take it out before two years -- it is expensive!" At one of the NGO-run clinics where Norplant[®] is offered, I discussed the problems of Norplant[®] removal with the officer in-charge.

It is only removed for "medical reasons" before three years. This is because it is so expensive, and is not cost-effective until the patient keeps it for three years. . . . This is violating the patient's rights and we are currently in a tug of war over what to do about removing them early. . . We are free to insert and remove, but the policy is not to remove in less than three years.¹⁶

At the time, the National Policy Guidelines and Standards for Family Planning Service Delivery and Training, "instructions and follow-up schedules" for both IUDs and Norplant[®] stated only that clients should be told when to come back for removal, not that they have a right to removal at any time ((INTRAH) 1994, 14, 15). There is also a tension between the cost of Norplant for the client (most clinics have initiated cost-sharing for this method, making it the most expensive option available for women), the difficulties of finding a doctor for either insertion or removal,¹⁷ and the issue of removal on demand.

¹⁶ Interview 95NO09.

¹⁷ Because sites for Norplant and Minilap procedures often depend on the visit of an itinerant doctor, service providers complained that it was often difficult to manage client needs. For example, at a rural clinic located on a large parastatal farm, a service provider said that the doctor had not come for two months. All the clients had come on the day that he had scheduled, but they just went home again when he did not show up. She said that this was a big problem, and also that if she tells women to go to town the doctor is often not there and they lose even the money they had spent on transport. (from service provider interview 96GMR2)

4.5 Permanent contraception: Irreversible ambiguity

Sterilization, as a permanent, provider-dependent, surgical method presents “special challenges” for informed choice at the clinic level.¹⁸ When I was in Tanzania recently conducting a survey on contraceptive decision-making, I began to notice that a surprising number of respondents had used no method or “traditional” methods (primarily calendar and withdrawal) for childspacing but then had a tubal ligation when the couple had reached their desired number of children. I asked a service provider at a local clinic, if she had noticed that women decide to have all the children they want and then have a tubal ligation. The Rural Provider responded:

Most clients choose a method after being advised by a service provider, particularly those choosing BTL [basic tubal ligation]. When women come for the prenatal clinic or vaccinations for their children we try to advise them. It is not that women plan to have four children and then get BTL, it is that when they come in with five or six children, you advise them to get it.¹⁹

An expatriate obstetrician-gynaecologist at the referral hospital recognized that the line between counseling and persuasion was a difficult balance, and she said during an interview that she has a hard time convincing interns that they are to provide women with information, not to convince them to get tubal ligation.²⁰ Issues of control and choice, while perhaps more striking in the case of a permanent method, permeate the relationship between service providers and their clients for other methods as well. I asked the rural service provider to tell me more about advising their clients on contraceptive methods, and she explained:

¹⁸ These challenges have been recognized for a decade by the largest non-governmental organization for the promotion of permanent methods when a technical report identified the following general barriers to informed-choice on these methods: inadequate information and counseling; provider or institutional biases; limited choice of other methods; targets, quotas and/or incentives for providers or clients; family, provider, or institutional pressures; and unreasonable preconditions or requirements for sterilization ((AVSC) 1999).

¹⁹ (Interview 00GK02). I was told by a doctor at the local Mission Hospital that it was hospital policy to counsel all women with three children or more about tubal ligation (Interview 00NK01). At the Regional Government Hospital I was informed that all women with four or more pregnancies were counseled for permanent contraception (Interview 00GK03).

²⁰ Interview, 00GK01.

*We don't like to intrude (kuingia sana), but if Mama has too much work she can always forget to take pills. Or if Baba is a drunkard she will have difficulties with family planning. If there is a problem then it is necessary to have a method chosen for you.*²¹

Contraceptive choice is regarded as an ideal for women who are sufficiently responsible as individuals and who are in relationships that are conducive to “good” family planning. Other women are in a position of “need” for help by the service providers. The service provider responded to my inquiry about how one would know which women to advise saying:

*If you see a woman, you can look at her and you will know if she is likely to forget and then you should advise her “Why don't you use an IUD. . .”*²²

Service providers are indeed accustomed to “looking over” and “sizing up” their clients to assess their contraceptive “needs.” Indeed, how a client and her children are dressed, her vocabulary, language and accent when she speaks, her posture of confidence or submission, her friendship with someone known in the clinic-- all of these become part of the environment conditioning the service provider-client interaction. These indicators of the client’s identity are interpreted through the lens of the service providers’ professional training.

“Long-term” methods such as the IUD, sterilization, Depo-Provera and Norplant are significantly different from methods such as the condom, diaphragm, or other barrier methods, because they do not require sustained motivation on the part of the user. They also have the additional advantage that women can use them “privately,” without the knowledge of her partner (Watkins, Rutenberg, and Wilkinson 1997, 485). These methods are more effective for achieving demographic goals of large scale fertility reduction than methods which may be used “inappropriately” or ineffectively by women who are unwilling or unable to maintain “sustained motivation.” Of course, while the “couple years of protection” provided by these methods is good for demographic record-keeping, it does not speak to fertility control as defined by the preferences of individual women. I am not arguing here that these methods should not be made available to Tanzanian women, simply that their prioritization from international to local levels reflects an interest in contraceptive continuity, not one in increasing the choice of individual women. Further, I am suggesting that the identities constructed on the bodies of “local” women serve to limit access to certain methods.

²¹ Interview, 00GK02.

²² Interview, 00GK02.

5. Conclusions

The ideology and practices of “modern” family planning reproduce power relations of the international population discourse in the local context. Service providers are, almost always, Tanzanian women. Still, family planning -- as a series of practices embedded in global relations of competing and unequally-funded “development” agendas -- provides a means by which service providers can distinguish themselves from their clients. Family planning service providers are marked or identified at the clinic level by their knowledge of modern methods.

Family planning as the solution for the global “problem” of population growth gives local level service providers legitimacy from above. Their superiors in the Ministry of Health must recognize the important link that they are expected to form between government policy and local women. This affirmation of status is deepened by donor commitment to funding the National Family Planning Programme. At the same time, family planning as the solution to women’s and children’s health problems provides legitimacy from below.

Photo 5: Children in front of rural homes and family gravesites in one of the study villages



Infant and child mortality and morbidity, maternal mortality, poor nutrition and disease are all locally-felt health needs. Therefore, interventions that purport to deal with these important problems are welcomed -- even in communities that lack an indigenous Neo-Malthusian ideology.

Interactions and identities in Tanzanian clinics are intensely gendered, in spite of the fact that most service providers and clients are women (see also Booth 2004).²³ It is a gendered identity of the “good mother” and the “good wife” who takes proper care of her children and home which local women are expected to measure up against. A woman who arrives at the clinic without her child’s vaccination card is not just forgetful; she is a bad mother. Providers act within these gendered norms in ways that reinforce their professional dominance, and while professional dominance over men should not necessarily be excluded, it would be achieved differently.

Issues of identity can help us to understand more thoroughly the interface between service provision and uptake. For example, an analysis of Tanzanian survey data to determine the quality and availability of family planning services found that access to health facilities, facility type, and availability of contraceptives for free do not seem to affect family planning use (Beegle 1995). However, like other studies, this one pointed to levels of female education as the important variable in determining family planning use (*Ibid.*) Given that negotiating the clinic setting may present itself as a difficult task to potential clients, educated women are likely to be better equipped with the skills necessary to face such a challenge in exchange for the service of receiving contraception. Furthermore, because the social distance between the most educated clients and the service providers is minimal, educated clients are more likely to receive more information and be permitted to make their own contraceptive choices with less intervention. If educated women in fact leave the clinic with the method of their choice and have received sufficient information about it, we can expect that their method continuation rates would be higher – an indirect outcome of their educational status.

There are programmatic dilemmas in dealing with the complex relationship between service providers and clients. Rutenberg and Watkins (1997) conclude that while training may be able to convince providers that the government is more concerned about women’s health than about delivering more contraceptives, more training is not likely to reduce the social distance between providers and clients. This is supported by my research in Tanzania; the training that service providers receive and resources that come together with “modern” family planning provide both tools and rhetoric that serves to increase the social distance between service providers and their

²³ I thank Stephen Kunitz for pointing out that professional dominance is exercised also in non-gendered forms, giving an example from his research with counselors and male alcoholics. However, I would suggest that men lose their status in these interactions, not because they are men, but because they are “deviants,” while women lose ground because they are women.

clients. Providers use these devices to ally themselves with the “modern” factions in the constructed battle between “tradition” and “modernity” for Tanzanian development. This side is made up of the “winners” in development: the educated, employed, and economically-advantaged. The women who “need” family planning are placed on the other side of development, and only by the help of their benefactors, the service providers, will they take on the identity of “modern” women.

Photo 7: A rural Deacon proudly holding his newborn for a family photograph with his two wives and children



However, the Tanzania case also suggests that local identities are shaped by global knowledges and agendas: changes in international donor priorities must take place before it is understood at the clinic level that health and choice are the reproductive health program’s priorities -- as opposed to emphasizing fertility reduction. One indicator of a commitment to larger issues of reproductive health would be donor funding of reproductive health interventions that go beyond the provision of contraceptives. Pregnancy testing, diagnosis and treatment of reproductive infections --

both sexually-transmitted and otherwise -- counseling and treatment for infertility, counseling for victims of domestic and sexual violence, family planning services and counseling for men and couples – could provide points of intervention that reach beyond family planning. In contrast, donor interest in Tanzanian reproductive health has waned substantially over the past decade, and while family planning was once a main provider of status and support for service providers, it is not anymore.

Perhaps, if local level service providers received more recognition from “above” for the important role that they play as transmitters and translators of global knowledge, then their needs to procure allegiance, status, and spoils from their “clients” below may not be so great. One important point emphasized by Maternowska (2006) and Rutenberg and Watkins (1997) is that women who become Third World family planning service providers have worked very hard to acquire their professional status in a context of severely limited opportunities. Therefore, these women should not be judged harshly as impediments to “good” quality of care. Instead, if conflicts between “global”/“local,” “traditional”/“modern,” and “efficacy”/“free choice” are acknowledged and discussed within the training context, perhaps the providers themselves would have suggestions about ways that they can work to overcome these dilemmas. Similarly, we should look at the opportunity structures available to them and to the kinds of discourses that create and reinforce locally-held biases.

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