
THE WILLOWS REPRODUCTIVE HEALTH PROJECT

REACHING POOR WOMEN IN TURKEY





For additional copies of this report, please contact:
Population Reference Bureau
1875 Connecticut Ave., NW, Suite 520
Washington, DC 20009-5728
202-483-1100 | 202-328-3937 (fax) | www.prb.org
prborders@prb.org

© 2008 Willows Foundation. All rights reserved.

Cover photo courtesy of Willows Foundation.



THE WILLOWS REPRODUCTIVE HEALTH PROJECT

REACHING POOR WOMEN IN TURKEY

Preface

When the Willows Reproductive Health Program began its activities in Turkey in 1999, its founder, Dr. Turkiz Gokgol, asked me to join its board of directors. I agreed, thinking that I would stay on the board for two or three years because I had no idea then how well the program would succeed. Now almost 10 years later, I am the chairperson of the board of directors and proud to be so. The program has succeeded beyond anyone's expectations; an independent evaluation has documented its remarkable progress.

This booklet tells the story of how Dr. Gokgol's dream became a reality. I wrote it because the program represents a successful model that could be adapted and scaled up to help poor women and their families in other countries. Indeed, the Willows model has now been introduced in Ghana and Pakistan. I received no compensation but the great satisfaction of telling a story that needs to be told.

I dedicate this booklet to Dr. Turkiz Gokgol, founder and director of Willows from 1999 to 2005, and to Dr. Demet Gural, who directed the program from 2005 to 2008.

Elaine M. Murphy
Chair, Willows Foundation Board of Directors, and
Bixby Visiting Scholar, Population Reference Bureau
August 2008

Introduction

Because the Willows Reproductive Health Project reaches out to poor women in many communities in Turkey, no one will know precisely the identity or location of the 1-millionth woman served. However, by the end of 2008 it is likely that a new client in one of Willows' sites will represent that magical number. The statistic itself will not be an estimate: within nine years, the project will have reached over 1 million women, contacting each woman individually and keeping records on her demographic profile, health status and reproductive history, and fertility intentions and needs.

Officially entitled the Willows Foundation Community-Based Reproductive Rights and Health Information, Education and Referral Services Project, this remarkable community-based program is commonly known as the Willows Reproductive Health Project or more simply, the Willows Project. Because the project appears to unfold so seamlessly, many people who have come to Turkey to observe its operation are unaware of the behind-the-scenes planning, monitoring, and local adjustments it requires. It has taken not only a grand vision but also practical, efficient management to coordinate its many moving parts: extensive baseline research; recruitment and training of community volunteers to do outreach; working with local political leaders, government health officials, and clinic staff to gain support for the project and improve services at clinics; partnerships with universities and other agencies; monitoring and evaluation; and a detailed recordkeeping system. The results are impressive: a significant rise in contraception and other reproductive health behaviors, improved health services, increased use of those health services, and empowered field workers.

This booklet describes the origin and development of the Willows Project—a successful, sustainable, and replicable model for improving reproductive health.¹

The Beginning

The story begins long before Dr. Turkiz Gokgol initiated the Willows Project in 1999. Sixteen years earlier, she had started the first Turkish community-based services project in the slums of Izmir when she was Pathfinder Fund's Turkey Representative. Later, as Pathfinder Fund's vice president for Asia and the Near East, she observed

Among poor and less-educated Turkish women, use of modern methods was only 28 percent.

Photo courtesy of Willows Foundation



Women who recently migrated from rural areas to cities are pleased to learn that contraceptive services are nearby.

and helped to establish other community-based projects appropriate to local conditions in various countries. When she was approached by a large foundation that offered to support an expanded community-based model in Turkey, she was able to apply not only new ideas but lessons learned from these countries and the Turkish program. The result was the Willows project. Dr. Gokgol and her colleagues who began the new project were convinced that the new model could improve the health and well-being of poor women throughout Turkey—and perhaps one day elsewhere in poor countries. This small band of pioneers reflect anthropologist Margaret Mead's encouraging words: "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

Did Turkey Need This Project?

Like many other countries, the Turkish government's attitudes toward population growth and fertility regulation have changed dramatically over time. During the period of intense national fervor following World War I and further years of war in the 1920s, Turkey had strong pronatal policies, and even outlawed contraception. By the 1960s, however, an increasing number of policymakers considered rapid population growth a problem and in 1965 the Turkish Parliament passed the first Population Planning Law encouraging small families and mandating universal availability of contraception. The government organized family planning services in both urban and rural areas and intensive communication programs to inform people about contraception and encourage them to use it. Nongovernmental organizations also offered counseling and services. Knowledge of and use of family planning methods increased accordingly over the years. As of 2003, 71 percent of married women were using some form of contraception and the total fertility rate—an estimate of births per woman over her lifetime—had dropped to 2.2.²

But statistics can be misleading. While 71 percent of married women use family planning, only 43 percent use modern methods,³ and modern method use was lower in 1998 (38 percent) during the planning phase of the Willows Project, and even lower among intended beneficiaries. In Turkey, like elsewhere in the world, use of modern contraception is associated with women's higher education and income; poor, less-educated women are less likely to use modern methods. Similarly, the rural population is less likely to use modern contraception than urban residents. This was one reason why Willows decided to reach out to poor rural families who had migrated to cities in search of work as well as other poor, less-educated urban women. In addition, the availability of nearby health services made the urban setting, rather than rural areas, the more strategic location. Willows selected sites where the average woman had more children than desired and focused on women with little or no education who exceeded their desired number of children at even higher numbers. In Willows' sites, 86 percent of women had only an elementary education or less. Almost 40 percent of the women had no formal education at all and 30 percent were illiterate. The discrepancies ranged

Desired and Actual Number of Children in Willows Project Areas*



*12 provinces (completed) out of 16

from Istanbul where women wanted 2.5 children on average but had 3.5, to Van in eastern Turkey where women wanted an average of 3.7 children but had 7.9. Among poor and less-educated Turkish women, use of modern methods was only 28 percent.⁴

What Do Women Want?

Of the many lessons learned throughout the history of the family planning movement, one was paramount: To launch an effective program in a given area, find out what the reproductive health problems are, what women's fertility intentions are, and what obstacles prevent women from achieving their intentions. Then tailor your approach to meet potential clients' needs and help them overcome the obstacles. Thus, Willows began by reviewing the findings of the 1998 Demographic and Health Survey (DHS) conducted in Turkey. These facts were compelling:

- The highest fertility rate was among women ages 20 to 24.
- There were marked differences in fertility rates between the eastern and western regions of the country, although this gap is narrowing.
- There were differences in the age at marriage according to region and education. Women in Turkey's eastern region marry at younger ages, and among women ages 25 to 49, there was a difference of almost six years in the age at marriage between those with little or no education and those who completed at least the secondary level.
- Women who had no education have almost one child more than women who had a primary-level education and almost two children more than women with secondary-level education.
- More than one fourth of ever-married women reported ever having had an induced abortion during their reproductive lives; 62 percent of them had not wanted to have any more children. However, in the month after an induced abortion, 32 percent of women did not use any contraceptive method and 27 percent used withdrawal.
- In the five years preceding the survey, 19 percent of the births were unwanted births and 11 percent of them were mistimed.

Box 1

Willows Project Goals

- Enable women to fulfill fertility intentions: contraception or antenatal care.
 - Increase knowledge of family planning, emergency contraception, antenatal and child care, STIs/AIDS, and reproductive cancers.
 - Increase skills for breast self-exam.
 - Improve quality of reproductive health services.
 - Increase use of reproductive health services.
- The educational level of the mother and the presence of medical maternity care were important correlates of infant and child mortality.
 - High birth order and short birth intervals were the major factors contributing to elevated risks of mortality.⁵

By analyzing these DHS findings and other Turkish studies, Willows was able to identify those who would most benefit from family planning and related health interventions, and where they lived. The intended beneficiaries would be mainly poor young women, living in the slums of large and small cities throughout Turkey—but especially in the eastern part of the country—where they had migrated with their husbands, who were looking for work. The studies also revealed that compared to their more-educated and wealthier counterparts, these women were far less likely to use local public health facilities for family planning and other reproductive health care, antenatal checkups, or immunizations of their children. Willows then selected the neighborhoods in cities where they would begin their operation and conducted a household survey. When the surveys were completed, they had the critically important information that would help them serve each client's specific needs—age, current family members, health status of the family, fertility intentions, use of family planning, use of health facilities for themselves or their children, and reasons why women did not use health facilities. They also ascertained women's knowledge about contraception and their (and their husbands') attitudes toward family planning and other health care options.



Willows field educators learn about reproductive health and rights.

Photos courtesy of Willows Foundation

Improve Services to Increase Utilization

Since many women simply followed their old rural ways of not being in regular contact with the health system, and others reported not returning to health clinics after having had negative experiences there, it became clear that working with the health system was critically important. Before beginning activities in a location, Willows made sure to visit with and gain the agreement of—and often partner with—local officials, including leaders of the public health system. Then Willows provided training to health workers to improve both clinical services and the quality of interpersonal communication and counseling. The latter is critically important because the quality of client-provider interactions strongly influences health-seeking behaviors everywhere in the world.⁶ Those facilities significantly improving their services were rewarded with financial grants from Willows to be used to further improve their facilities and services. By the end of 2005, the time when an independent evaluation of the Willows Project was taking place, Willows had provided training to improve services at 376 health facilities in 32 sites. The field educators could feel confident that when they referred women to health facilities, the women who went to the clinics would be welcomed and cared for.

Field Educators: The Heart of the Project

The role of the field educators who visit women and sometimes couples in their homes is a crucial one—they are indeed the heart of the project. It was clear from the start that those who would implement this community-based project must be authentically from the community they serve. It is logistically the most feasible plan but more than that, the field educators must know their intended beneficiaries and understand their problems. In turn, the intended beneficiaries are more likely to trust someone who is not an outsider while at the same time respecting their higher level of education.

Thus Willows selected field educators from the communities they will serve. They had to be at least high school graduates because the training requires considerable reading on medical topics, some of it complex. In addition, candidates are interviewed to ascertain their suitability in terms of positive attitudes about reproductive health interventions and about helping poor women in a friendly, noncondescending way. Once the field educators are selected, three weeks of training begins. The training develops skills such as how to work with the community, interpersonal communication and counseling, and how to fill out the forms that make up Willows' detailed management information system. Using interactive, adult

learning techniques, the training aims to—and does— increase new field educators' factual knowledge and understanding of issues they will encounter on the job:

- The male and female reproductive system, and reproductive health, sexuality, and sexual health.
- Reproductive rights.
- Sexually transmitted infections (STIs).
- Early diagnosis of breast and cervical cancers.
- Antenatal care and safe delivery; and postpartum care, breastfeeding, and contraception.
- Miscarriage, safe abortion, and post-abortion care and contraception.
- Healthy birth spacing and contraceptive methods, including their mechanism of action, side effects, and eligibility.

The field workers receive additional training on the needs of their specific community and how best to meet these needs. Once their training is over, the field workers begin their work in a new Willows site by household visits to collect data on the health status of the family, knowledge of reproductive health issues, fertility intentions of reproductive-age women, and whether the husband supports or opposes family planning. They use this information to tailor their educational approach to the needs and interests of each woman. The first priority is to visit women who do not want to get pregnant soon (or ever again) but are not using contraception, are pregnant or lactating, or have recently had a delivery or abortion. Second priority is given to newlyweds, engaged couples, and users of traditional methods. However, all visits reflect the individual woman's specific needs and interests. For example, one woman may need information about the variety of contraceptive methods available—and may need a referral to a health facility for clinical methods such as an IUD—while another is already using a modern method but needs to know about STIs and how to avoid them. Some may need to obtain information privately while others prefer couple counseling. Some women are unaware of emergency contraception and also about screening for breast and cervical cancers. All may need instruction in breast self-examination.

Photo courtesy of Willows Foundation



A Willows field educator explains modern methods of contraception to a young mother.

A field worker who learns that a woman is reluctant to visit the public health clinic will reassure her and frequently accompany her to the clinic to register for services. In each Willows site, a field educator contacts 1,000 women on average during the 18 months or so that the project exists, visiting each woman four to five times. Although they work hard and have many obstacles to overcome, the field workers report being transformed by the project and consider themselves beneficiaries as much as the women and families they visit.⁷ This was also the experience of lady home visitors in the Matlab project in Bangladesh.⁸ When Willows is able to demonstrate that the majority of the women in need whom they have visited have benefited from the information and referrals they provided—for example, that the women can demonstrate proper breast self-examination or have gone to the clinic and now are using modern contraceptive methods—they begin to close down operations in that site. Part of this process includes meetings with local political and health leaders to communicate the results of their collaborative work and to encourage continuing improvements in reproductive health services.

Box 2

Community Visits, 1999 to 2006

- 919,137 women (plus many husbands) reached and registered.
- Each married woman visited four to five times.

Box 3

Findings: Contraceptive Use

- 65 percent of women used modern methods at the end of the services vs. 38 percent baseline and 43 percent contraceptive prevalence rate (CPR) for all Turkey.*
- Use of modern methods increased by 68 percent in more developed sites and 136 percent in less developed sites.
- Permanent or long-term methods increased 38 percent in developed sites and 65 percent in less-developed sites.

* Data from: C. Haub, 2006 *World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2006).

Recently, Willows has added a youth component to its work because of the interest expressed by young people in reproductive and sexual issues and because of the need to provide them with accurate information and a safe place to ask questions about topics such as relationships, sexual development, contraception, and protection against AIDS and other sexually transmitted infections. Based on research on how best to reach youth, Willows chose peer education. Now trained young people reach out to other young people at school and religious youth clubs, sporting events, the military, and other venues where young people gather. The peer educators gather regularly and also keep in touch via cell phones to discuss common issues and problems, and effective ways to reach their intended beneficiaries.

Evaluation: Did Willows Work?

All too often after a project ends, the gains made are likely to erode or even disappear. Once Willows had been operating for five years, it was important to measure precisely what the gains were and to what extent the gains were sustainable in communities throughout Turkey after outreach activities had ended. It was also important that an independent organization conduct the evaluation. Consequently, the Istanbul University Institute of Child Health organized a survey of over 2,000 married women, divided into intervention and control groups. The intervention group consisted of women residing in ongoing and completed project sites in the urbanized areas of six provinces of Turkey—Istanbul, Ankara, Gaziantep, Diyarbakir, Van, and Adana, where approximately 300,000 women of reproductive age had received Willows services from 1999 to 2005. These six areas were in both developed and less developed cities and towns and were representative of 32 sites where the project had operated. The main outcome indicators were changes in knowledge and use of effective contraception (modern methods and emergency contraception), and related preventive behaviors such as Pap smears, breast self-examination, and antenatal care. In addition, Istanbul University conducted focus group discussions and in-depth interviews with a subset of clients, field educators, project managers, and health personnel to further gauge the impact of the Willows Project and provide valuable feedback.



Photo courtesy of Willows Foundation

Willows peer educators answer reproductive health questions from other youth.

Impact of Willows Project

Contraceptive Use and Continuation

How did women's contraceptive practices change during the approximately 18 months of Willows' activities in various sites?⁹ Between the first and last visits by field educators, overall use of modern contraceptive methods significantly increased, from approximately 38 percent to 65 percent—more than a 50 percent increase. This rate is also significantly higher than modern method use in all of Turkey at the end of the evaluation period—43 percent. Permanent, long-term method usage increased 38 percent in the more developed areas, where it was higher to begin with, and 65 percent in the less developed project areas. Temporary modern method use more than doubled, from 16 percent to 33 percent, and more than half of women using traditional methods of contraception shifted to a modern method. At the end of the intervention period, average continuation rates for women who reported initially using modern methods were extremely high, 94 percent. At 18 months or more after the intervention period—at the time of the evaluation—continuation rates of modern methods remained high, averaging around 77 percent. About 16 percent of women in more developed areas had discontinued, compared with 32 percent of women in less developed areas. The combined Willows attrition rate of 24 percent is significantly lower than Turkey's national attrition rate of 40 percent.¹⁰ Knowledge of emergency contraception increased from 7 percent to 39 percent from the beginning until the end of project services.

A Diffusion Effect?

The evaluation findings suggest that Willows activities had an effect beyond the period of home visits. About 20 percent of women who had received Willows services but persisted in using traditional methods or no method at all adopted modern methods of contraception in the two years following the end of services in their area. This could be a “diffusion of innovations” or “tipping point” effect: Once a critical mass of people adopts an innovation, others who were initially resistant follow.¹¹ Additionally, women in nearby, more developed areas not directly receiving Willows services reported using modern methods of contraception at almost twice the rate reported by women who had received Willows services at the baseline measurement. This is a significant difference from similar communities farther away, and while some women may have migrated from Willows areas to adjacent localities, the magnitude of the effect suggests a strong influence via word of mouth to relatives and friends.

Photo courtesy of Willows Foundation



Rain or snow, Willows field educators make their community visits.

Surprising Impact on Younger Women

The project has had an especially significant effect on younger women and women married for fewer than four years (largely overlapping groups). In all project areas, these women had much higher modern method use than among women married for the same length of time in the Turkish general population (46 percent vs. 28 percent). This differs from patterns of contraceptive adoption among poor women in many other countries, where interest in using modern methods is highest among women married for a longer time, after they have had the number of children—and male children—they desire).¹² There was roughly a 40 percent increase in modern method adoption for women married for one or two years and 35 percent for women married for three or four years. Women married for five or more years increased their contraceptive use by 20 percent.

Other Outcomes

Exposure to the Willows program dramatically increased women's knowledge and use of preventive behaviors including obtaining Pap smears, mammography, and obtaining or conducting breast examinations. Depending on the site, 50 percent to 60 percent of women had

received training on breast self-exam (baseline: 20 percent) and knew to seek medical follow-up if a lump was found. From the beginning to the end of project services, the proportion of women going to a doctor or hospital for a mammogram increased from 8 percent to 25 percent in more developed project areas and from 1.5 percent to 10-15 percent in less developed areas.

The average number of antenatal visits to health services during the last pregnancies of women surveyed was six in developed areas and three in less developed areas (the World Health Organization recommends a minimum of four antenatal visits¹³). Although all of Willows clients were poor, it is not surprising that those living in more developed areas were better able to access services than those living in less developed areas. Apart from Willows field educators, the most frequent sources of information on reproductive health were the women's spouses, neighbors, female relatives, and friends. Most women said that their husbands were important influences in deciding what contraceptive method to use.

Impact on Field Educators

The field educators had applied the skills or attitudes that they had acquired during the Willows training to their own lives: They controlled their fertility, used reproductive health services, and practiced preventive measures such as breast self-examination. They increased their knowledge of reproductive health issues and reported gaining self-reliance and improved communication skills through their work with the project. The field educators stated that major challenges of their work were difficulty in communicating with women with low levels of education; adverse weather conditions making it difficult to travel; and, in some cases at least initially, poor relations with health facilities' staff. They also noted the harsh economic conditions that make it difficult for women in the community to access reproductive health services. The field educators felt that referring women to health facilities was an important service and one they enjoyed providing. Although the health facilities were conveniently located, relationships with the staff of the facilities were often difficult in the beginning. Initially, health service providers in many communities did not accept the field educators, the women referred by Willows staff were treated poorly, and there were insufficient supplies. Over time, partnership with and training of health staff led to improved services and increased mutual respect among all parties.

Investing in the Future

Comparing the costs of different reproductive health projects can be misleading because most projects have a specific outcome in a specific time period while others may produce behavior changes not only for the given period but far beyond. Thus, while costs may be similar, interventions that lead to sustained behavior change are far more cost-effective. The evaluation shows that Willows' investments in educating individual women about their reproductive health options and connecting them to—and improving—local health services paid off in terms of long-term use of contraceptive and other reproductive health services. Hundreds of thousands of poor women who had not previously used these services changed their behavior on a sustained basis.

Obtaining these long-term results required equal parts planning, organization, and hard work. The project trained 1,353 field educators, 89 supervisors, 56 program assistants, and 47 managers during the seven years of services (1999 to 2006) covered by the evaluation. Willows set up operations in 32 sites throughout Turkey where its field educators reached 920,000 women, visiting each four to five times on average. More than 320,000 women were referred for clinical services. Through partnerships, training, and awards, Willows improved reproductive health services at 376 health facilities where the women they reached would be served.

Willows estimates that it takes four to five visits per beneficiary to help women gain access to and continue use of publicly provided reproductive health services, including family planning, prenatal and postnatal care, cancer screening, and safe abortion. The average cost per beneficiary is around \$19; this includes all management expenses, the baseline surveys, introductory and follow-up visits, accompanying beneficiaries to health facilities, and working with health providers to improve providers' treatment of clients. Willows typically completes its work in a locality in about 18 months, after having successfully connected poor women to improved services. Evaluations show high continuation rates even two years after Willows has left and significant word-of-mouth demand creation for family planning and other services in adjacent areas. Depending on the length of sustained behavior change, the average yearly cost per beneficiary is quite low. For example, in the case of a young woman who benefits from the program in her early 20s and continues to make effective use of services through her late 40s, the annualized cost of the initial behavior change investment is less than a dollar a year. It was, in fact, young women who were most responsive to Willows' messages about

contraceptive use, both for health and as a woman's right. It is still too soon to measure the longer-term impact of the Willows program, but the evaluation results provide strong support for the view that the investments are indeed being sustained after the program leaves a locality.

Exporting Willows

It is not surprising that other countries would be interested in an effective, sustainable reproductive health model once an evaluation had documented its successes. Beginning in 2007, Willows has been working in Ghana, partnering with the Population Council, Marie Stopes International, Ipas, EngenderHealth, the Family Planning Association of Ghana, and the Ghanaian organization, Center for Development of People (CEDEP). Willows is working in two urban districts, adapting the model to the Ghanaian culture and context. Willows has also formed a partnership with the Marie Stopes Society in Pakistan and expects work to start there within a year.

In Sum

A program that began in 1999 as one woman's dream now involves thousands of workers and has reached almost 1 million Turkish women. By forming partnerships with local political and health leaders to improve poor women's reproductive health, the Willows Project has been accepted in diverse locations throughout Turkey. Through home visits, trained community-based field educators informed women about contraception and other reproductive health issues and connected them to public health services. At the same time, Willows improved the quality of those services—improving health staff's interpersonal communication and counseling skills and increasing privacy for clients. Adoption of modern methods among Willows clients increased dramatically, especially among young women married for fewer than five years. Those who were already using modern contraceptive methods and those who adopted modern methods during the 18-month course of Willows activities had unprecedented continuation rates, even two years after the project had left the area. In addition, adoption of modern methods has spread into adjacent areas and now the model is being tried in other countries. Like its namesake, Willows has sent out its roots.

References

- ¹ Demet Gural et al., "Adapting, Scaling Up, and Sustaining a Family Planning & Reproductive Health Model: The Willows Foundation Outreach Program in Turkey," paper presented at the Annual Population Association of America meeting, March 29, 2007.
- ² Ayse Akin, "Emergence of the Family Planning Program in Turkey," in *The Global Family Planning Revolution: Three Decades of Policies and Programs*, ed. Warren Robinson and John Ross (Washington, DC: The World Bank, 2007): 85-102.
- ³ Carl Haub, *2007 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2007).
- ⁴ Gural et al., "Adapting, Scaling Up, and Sustaining a Family Planning & Reproductive Health Model."
- ⁵ Hacettepe University Institute of Population Studies and ORC Macro, *1998 Turkey Demographic and Health Survey* (Calverton, MD: ORC Macro, 1998).
- ⁶ Elaine M. Murphy and Kristina Gryboski, "The Importance of Client-Provider Interactions: Evidence from Family Planning Programs," in *Global Public Health Strategies*, ed. Muhiuddin Haider (Sudbury, MA: Jones and Bartlett Publishers, 2005): 199-216.
- ⁷ Gural et al., "Adapting, Scaling Up, and Sustaining a Family Planning & Reproductive Health Model."
- ⁸ Ruth Simmons, Rezina Mita, and Michael A. Koenig, "Employment in Family Planning and Women's Status in Bangladesh," *Studies in Family Planning* 23, no. 2 (1992): 97-109.
- ⁹ The data presented are drawn from Istanbul University's 2006 Willows Project evaluation report and from Demet Gural's presentation at the annual meeting of the Population Association of America, March 29, 2007.
- ¹⁰ Hacettepe University Institute of Population Studies and ORC Macro, *2003 Turkey Demographic and Health Survey* (Calverton, MD: ORC Macro, 2003).
- ¹¹ Elaine M. Murphy, "Diffusion of Innovations: Family Planning in Developing Countries," *Journal of Health Communication* 9, supplement 1 (2004): 123-29.
- ¹² Judith R. Seltzer, *The Origins and Evolution of Family Planning Programs in Developing Countries* (Santa Monica, CA: RAND, 2002): 1-44.
- ¹³ Carla Abou-Zahr and Tessa Wardlaw, *Antenatal Care in Developing Countries: Promises, Achievements and Missed Opportunities* (Geneva: World Health Organization, 2003): 3.

