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**DEMAND FOR AND ACCESSIBILITY TO FAMILY  
PLANNING SERVICES IN SUBSAHARAN AFRICA**

by

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## EXECUTIVE SUMMARY

Over the past decade fertility preferences in Africa have undergone substantial change. The percent of women who want to stop childbearing is rising toward the fifty percent level found in Asian and Latin America. To date only Kenya has reached that level, but other countries could well be there in the early 1990s. These conclusions are based on data for five African countries that have carried out two or more surveys during the past decade or so: Botswana, Ghana, Kenya, Senegal, and Zimbabwe.

Africans have traditionally practiced a form of childspacing. Women often abstain from sexual relations for a year or longer after childbirth. The surveys found that large percentages of women wanted to wait before having a baby. Those percentages are declining to levels typically found in other regions, that is, 25% to 30% of married women of reproductive age.

Currently, between two-thirds and three-fourths of married women of reproductive age say they either do not want a future birth at all or they want to wait two years or more before having a baby. In Asian and Latin America between 75% and 80% of women do not want to be pregnant, at least for now.

To a substantial degree, husbands, at least in Ghana, share their wives' interest in fertility regulation. Half the couples in Ghana agreed that they did not want a baby, at least for now. Another 12% agreed that they wanted a baby within the next two years.

Knowledge of family planning methods has also spread. In Zimbabwe virtually all women know at least one modern family planning method and virtually all know at least one source for family planning information, services, and supplies. More than 90% of women in Botswana and Kenya know at least one method and source. The three countries have very active family planning programs and strong support from senior levels in the government.

In Ghana only 77% know a modern method. That figure is higher than a decade ago, but it is disappointing since Ghana has had an official family planning program for nearly two decades and has received substantial external resources for its program. Mismanagement and a lack of strong leadership in the program coupled with serious economic and political problems in Ghana have seriously hampered the program. Senegal has the lowest level of knowledge among the five countries, although it experienced the sharpest, from 20% in 1978 to 68% in 1986.

Thirty six percent of Zimbabwean couples were using modern contraceptives in 1988, the highest in Sub-Saharan Africa but only half the levels found in Northern American, Europe, Japan, and more advanced developing countries such as Singapore, Thailand, Brazil, and Colombia. Botswana had the second highest level (32%) and Kenya the third (18%). Ghana and Senegal reported five percent and two percent, respectively.

Data on contraceptives shipped by AID indicate that Botswana has been swamped by contraceptives. Between 1984 and 1989 Botswana received enough contraceptives to support a use rate of nearly 100 percent for the entire period. Zimbabwe has also received large quantities of contraceptives, enough for 45% of reproductive age couples to be supplied for the entire period 1984 to 1989. The other countries received more modest quantities.

Kenya has probably received about the right level, particularly considering the fact that the commercial sector supplies most of the Oral Contraceptives and that other donors are also providing contraceptives, but as contraceptive use spreads, the supply from whatever sources must be increased.

The other nations for which commodity flows were examined, Burundi, Ghana, Senegal, Togo, and Uganda, received more modest quantities. Substantially larger supplies than they have been receiving from AID will be needed if they are to significantly expand contraceptive availability to satisfy the latent demand indicated by survey data.

At one time AID had a policy of "Programming for Success," which called for countries with very low levels of contraceptive use to have enough Pills on hand to supplied 10% of the

married women of reproductive age and enough condoms to supply five percent for a year. As family planning use increases, the supply needs to increase accordingly. A similar policy may be needed now for Africa.

Data on numbers of people from seven countries trained by AID indicate that Botswana received a disproportionate share of training, 250 trainees per million population compared with 38 per million for Kenya. There may be a sound reason why Botswana received such a large share of the training and for the more modest levels provided to the other countries.

The training data cover three AID contractors, JHPIEGO, INTRAH, and AVSC as well as training provided through the Office of International Training.

## OVERVIEW

Although Subsaharan Africa has some of the highest fertility rates on record as well as some of the world's poorest people who can least afford large numbers of children, it has lagged behind Asia and Latin America in family planning availability and use. In a number of countries in Asia and Latin America contraceptive use rates have reached or are near levels found in Northern America, Europe, and Japan (65 to 75 percent of currently married women of reproductive age), but the highest documented level of use of modern contraceptives in Subsaharan Africa is about half that level (36 percent in Zimbabwe in 1988).

There are a number of indications that at least in parts of the Continent couples do want to control the number and spacing of their children, that family planning services are available to a much greater extent than they were a few years ago, and that couples are using those services. However, the picture is very spotty. In parts of the Continent family planning knowledge, use, and availability are still minimal.

While there is a need to acknowledge the accomplishments, there is also a need to recognize that Africa's population problem remains very serious.

Reductions in fertility to date have been modest at best and non-existent for most of the Continent. African women still average 6.5 births during their reproductive lifetimes and the region is growing at an annual rate of 2.9%. If Subsaharan Africa continues to grow at this rate its 1989 population of 500 million will double to one billion by 2012 and double again to two billion by 2035 and again to four billion by 2058. That is an eight fold increase in less than a human life time.

Slowing this jet express takes time. In addition to the massive task associated with reducing the fertility of individual couples from six children to two or fewer, African nations have very large populations of children. There is a guaranteed substantial increase in the future number of potential parents and consequently substantial upward pressure on the future NUMBER of births, even in hand of dramatic drops in the fertility of individual couples. Even after a country achieves fertility rates of two children or fewer per couple, a country's population can double or triple.

The United States may be used to illustrate a basic demographic fact. American couples have NEVER had fertility levels as high as those found today in many African nations, not even in the 18th or 19th centuries. But the United States did have a baby boom which pushed the Total Fertility Rate to a peak of 3.8 births per woman in the 1950s. The baby boomers are now producing the next generation of Americans at about half the rate of their parents.

Currently, American couples average about 1.8 children during their reproductive lifetimes, a level that has prevailed for a decade or more. Yet, because there are so many baby boomers, last year about 3.5 million babies were born to American women while only two million Americans died, leaving a surplus of births over deaths of 1.5 million. If couples continue to average 1.8 children, the U. S. population will eventually stop growing and begin to decline, but that will not happen for some years.

Third World countries have much greater upward pressures on births. Often half their populations are children under the age of 18. As these young people reach childbearing ages, the number of potential parents will double every 20 to 30 years.

Moreover, the large number of young people puts substantial DOWNWARD pressure on the number of deaths. Most deaths occur at the two extremes of life, infancy and old age. But Africa has relatively few old people.

### A Possible Strategy for Maximum Impact

Given the large numbers of young people, African countries would be well advised to focus their family planning efforts on young people. If women postpone their first child until they are in their mid to late twenties and their second until they are in their thirties, the

demographic impact will be substantially greater than a strategy focusing the same resources on older women. First, by increasing the intergenerational span, it is possible to reduce the number of generations per century. For example, if the median age at which a woman gives birth is 20 years, there will be five generations per century. If the median age increases to 25 years, there will be only four. The net effect is a progressive reduction in the growth rate and in the size of the population from the date the transition to the older pattern begins.

Second, from a demographic perspective, the births "lost" during the transition from a young pattern of childbearing to an older pattern will never be made up even if the women concerned ultimately have the same number of children.

The social, economic, and health benefits of the strategy are also significant. Teenage pregnancy is a serious problem. Babies born to teenagers typically experience higher rates of infant and children mortality than babies born to women in their twenties and early thirties. Girls who get pregnant while they are in school often drop out of school and thus lose the opportunity for a meaningful education and an opportunity to escape the poverty into which they were born.

Of course, family planning services should be available to all couples regardless of age. But past strategies that have placed emphasis on reaching couples that already have several children and might wish to terminate their childbearing should be reexamined.

## DEMAND FOR FAMILY PLANNING

Five African countries, Botswana, Ghana, Kenya, Senegal, and Zimbabwe, have taken two or more surveys in which data on family planning knowledge, availability, and use as well as fertility preferences were collected. For these nations it is possible to examine trends.

### Preferences for Children

When data from surveys carried out in Asia and Latin America became available in the mid 1970s, they revealed that half the married women of reproductive age in those regions did not want a future birth, providing definitive evidence that women in those Third World nations have a strong interest in gaining control over their fertility.

### Women Who Do Not Want a Future Birth

When data for the early African surveys became available at the end of the decade, they revealed a rather different story. Very low percentages of women expressed an interest in stopping childbearing. In fact, in many cases women in their late forties who were likely to be physically incapable of conceiving a child stated that they wanted a future baby.

Data for three countries with surveys in the late 1970s are shown below:

Kenya 1977/78	Ghana 1979/80	Senegal 1978
15%	12%	8%

Data on women who do not want a future birth for all years for the five countries are presented graphically in Figure 1.

Are African women different? Did they really want an unlimited number of children? Or were other factors operating? Were their expressed fertility preferences so fix in culture and tradition that they would resist change?

Surveys carried out in the early 1980s found significantly higher percentages as not wanting a future birth.

Kenya 1984	Botswana 1984	Zimbabwe 1984
32%	30%	24%

By the late 1980s there was a further evolution. Kenya became the first documented case where half the women in an African country wanted to stop childbearing. In Botswana and Zimbabwe 38% and 33%, respectively, reported a desire to stop. While a higher percentage of women in Ghana and Senegal said they did not want a future birth, the percentages were still low.

Kenya 1989	Botswana 1988	Zimbabwe 1988	Ghana 1988	Senegal 1986
52%	38%	33%	23%	19%

## Women Who Want to Wait

Fertility choices are not limited to the dichotomy of wanting or not wanting a future birth. Childspacing is an important aspect of family planning, and Africans have a strong cultural foundation in it. Many African women abstain from sexual relations for extended periods following the birth of a child. They often do not resume sexual relations until they wean their babies. Breast-feeding may continue for a year or more. Thus, the period of postpartum abstinence is often 12 months or longer.

The surveys found an interesting pattern when women were asked about the preferred timing of a future birth. For three of the four countries for which data are available, the percent declined during the 1980s. Ghana was the only country reporting an increase.

For Botswana, Kenya, and Zimbabwe, between 38% and 44% of the women interviewed in 1984 stated that they wanted to wait two or more years before having a baby. Four years later, the range was 26% to 35%, a decline of from eight to 15 percentage points. (See Table 1 and Figure 2.)

**Table 1.-- Changes in the Percent of Women Who Want To Wait Before Having a Baby**

Country	Survey	Percent	Change
Botswana	1984	44%	
	1988	29%	-15%
Ghana	1979/80	14%	
	1988	45%	31%
Kenya	1984	38%	
	1989	26%	-11%
Zimbabwe	1984	43%	
	1988	35%	-8%

**Source: National Surveys for the respective countries.**

In Ghana, only 14% of the women interviewed in 1979/80 said they wanted to wait while in 1988 forty-five percent wanted to wait, the same percentage as Botswana and Zimbabwe in 1984.

There may be a rational explanation for this pattern. In Asia and Latin America between 25% and 30% of married women of reproductive age wanted to wait. The declines for Botswana, Kenya, and Zimbabwe brought these countries closer to the pattern in the other regions.

Senegal was not included in the above table because the earlier survey did not collect information on preferred timing of future births, but in 1986 forty four percent said they wanted to wait, the same as the 1984 levels for Botswana and Zimbabwe and the 1988 figure for Ghana.

## Women Who Do Not Want to be Pregnant, at Least for Now

By combining the two groups, those who do not want a future birth at all and those who want to wait before having a baby, it may be possible to gain further insights into changes in

fertility preferences and in the size of the group that are potential users of family planning.

Between two thirds and three fourths of women in the four countries do not want to be pregnant, at least for now. Kenya had the highest level at the end of the decade (78%) and Zimbabwe the lowest (68%). Ghana experienced the largest increase during the 1980s (42 percentage points). Botswana experienced a decline while Zimbabwe remained the same. (See Table 2 and Figure 3.)

In three of the four countries between two thirds and three fourths of the women in both 1984 and 1988 (1989 for Kenya) did not want a baby, at least for now. The shifts in individual countries did not change the basic pattern.

The big shift for Ghana brings it into line with the other three. In 1988, sixty-eight percent of Ghanaian women wanted to avoid pregnancy, at least for now, the same as in Botswana and Zimbabwe.

The earlier Ghana survey was 1979/80, or more than four years before the 1984 surveys in Botswana, Kenya, and Zimbabwe. The difference in time may be significant. Kenya and Senegal also had surveys at the end of the 1970s, but those surveys did not collect information on preferred timing of the births. They did collect data on women who did not want a future birth. Ghana was not very different from Kenya – 12% and 15%, respectively. It was higher than Senegal (8%).

**Table 2.-- Changes in the Percent of Women Who Do Not Want To Be Pregnant, At Least For Now**

Country	Survey	Percent	Change
Botswana	1984	74%	
	1988	67%	-7%
Ghana	1979/80	26%	
	1988	68%	42%
Kenya	1984	69%	
	1989	78%	9%
Zimbabwe	1984	68%	
	1988	68%	0%

**Source: National surveys for the respective countries.**

Data for Senegal are available for only one point in time, 1986. For that date, 63% of married women of reproductive age did not want a baby, at least for now, placing Senegal at the low end of the range for the countries in the above table.

### Women Who Want a Baby Soon

Another way to view fertility preferences is to look at the percent of women who want a baby "soon." "Soon" is defined as within two years, which may be an overly long period since women who want to wait, say, 18 months may be just as desirous of remaining nonpregnant as women who want to wait 24 or 30 months. Nonetheless, the two year period is currently used by the Demographic and Health Survey staff and will be used here.

In Asia and Latin America around 10% typically express an interest in having a child within two years. A much higher percentage of African women say they want a baby within that time period, but the figures are declining. In Ghana, 31% said that wanted a baby soon in 1979/80 compared with only 20% in 1988. (Table 3 and Figure 4.)

For the surveys carried out in 1984 between 17 and 24 percent wanted a baby soon. By 1988/89 only eight percent of Zimbabwean women and 13% of Kenyan women wanted a baby soon. Botswana was the same (24%) for both years.

Thirty-three percent of Senegalese women said in 1986 that they wanted a baby soon, placing Senegal well above the other countries.

**Table 3.— Changes in the Percent of Women Who Want A Baby Within Two Years**

Country	Survey	Percent	Change
Botswana	1984	24%	0%
	1988	24%	
Ghana	1979/80	31%	-11%
	1988	20%	
Kenya	1984	21%	-8%
	1989	13%	
Zimbabwe	1984	17%	-9%
	1988	8%	

Source: National surveys for the respective countries.

## FAMILY PLANNING KNOWLEDGE AND USE

### Knowledge of Modern Family Planning Methods

The five countries have registered significant increases in knowledge of modern methods of family planning and in knowledge of a source during the past decade. Ninety percent or more of the married women of reproductive age in Botswana, Kenya, and Zimbabwe know at least one modern contraceptive method and at least one family planning source. In fact, knowledge of both method and source is essentially universal (98%) in Zimbabwe and approaching universality in Botswana and Kenya.

Knowledge is significantly lower in Ghana and Senegal, but both have registered significant increases in knowledge of both method and source during the 1980s. In 1988 sixty eight percent of Senegalese women and 77% of Ghanaian women knew at least one method while 50% and 73%, respectively, knew a source. (See Table 4 and Figures 5 and 6.)

### Contraceptive Use

Contraceptive use has also increased significantly in three countries, Botswana, Kenya, and Zimbabwe, but levels are still well below those found in a number of countries in Asia

and Latin America. (See Table 4 and Figure 7.) For example, Zimbabwe's use rate for modern methods of 36% is the highest documented rate in Africa, but it is about half the rates found in developed nations and in the more advanced developing countries such as Thailand, Singapore, and Brazil.

If the pace of recent increases continue, Botswana and Zimbabwe could easily achieve use rates equal to those found in developed nations, that is, 65% to 75% and Kenya could reach the level currently found in Zimbabwe, that is, about 36%. Alternatively, Kenya might accelerate the spread of family planning use to the pace recorded in recent years in Botswana. Should that happen, Kenya's use rate could be 50% by the end of the century.

Ghana and Senegal still have very low use rates. Both countries have some practice of traditional methods (8% and 9%, respectively), but little use of modern methods. Since Ghana has had a family planning program for nearly two decades that has consumed considerable external resources, it is hard to imagine how the program could have been so ineffective.

**Table 4.— Changes in the Percent of Women Who Know a Modern Family Planning Method, Who Know a Family Planning Source, and Who Are Using a Modern Method**

Country	Survey Date	Know Method		Know Source		Using Method	
		Percent	Change	Percent	Change	Percent	Change
Botswana	1984	80%		57%		19%	
	1988	94%	14%	94%	37%	32%	13%
Ghana	1979/80	60%		47%		6%	
	1988	77%	17%	73%	27%	5%	-1%
Kenya	1977/78	88%		42%		4%	
	1984	83%	-5%	48%	6%	10%	5%
	1989	91%	8%	91%	43%	18%	8%
Senegal	1978	20%		na		0%	
	1986	68%	48%	50%	na	2%	2%
Zimbabwe	1984	88%		80%		27%	
	1988	98%	10%	97%	17%	36%	9%

Source: National surveys for the respective countries.

### Husband-Wife Comparisons

One other data set provides additional insight into fertility preferences in one of the countries. The 1988 Ghana survey included a husbands questionnaire which collected data on fertility preference, so it is possible to examine the degree to which husbands and wives agree on whether they want a future baby and when they want to have a baby. The data are presented in Table A-4.

Twelve percent of the husbands and wives agreed that they did not want a future birth and 28% agreed that they wanted to wait at least two years before having a baby. In another 10% of the cases, one partner said he or she did not want a future birth while the other he or she wanted to wait two or more years before having a baby. That means that half the husbands and wives agree that they do not want to have a baby at least for now. Another 12% agreed that they wanted a baby within the next two years.

With half the couples in Ghana agreeing that they do not want a baby, at least for now, one searches for reasons why only five percent of the couples are using family planning.

## CONTRACEPTIVE FLOWS FROM AID TO SELECTED AFRICAN NATIONS

One measure of family planning availability is the flow of contraceptives from the donor community. This section deals with AID provided contraceptives to Botswana, Burundi, Ghana, Senegal, Togo, Uganda, and Zimbabwe between 1984 and 1989. The data for 1989 cover shipments through mid-September.

### Methodological Background

The physical volumes shipped are given in Table A-1. For condoms, the number of individual condoms; for oral contraceptives, the number of monthly cycles; for IUDs, the number of individual IUDs; and for foaming tablets, the number of individual tablets.

The numbers of Couple Years of Protection (CYPs) provided by the volume of contraceptives shipped are given in Table A-2. To derive these numbers, it was assumed that Africans average 150 acts of sexual intercourse annually. Thus, since one condom or foaming tablet is supposed to be used for each sex act, CYPs were derived by dividing the number of pieces of each by 150.

Thirteen cycles of Oral Contraceptives are required to protect a woman for one year, so the number of CYPs derived from the Pills supplied is derived by dividing the number of cycles by 13.

IUDs were assumed to be worn an average of 2.5 years, so the numbers were multiplied by 2.5 to get CYPs.

In order to provide a basis for judging the adequacy of the contraceptives vis-a-vis the number of reproductive age couples, potential prevalence rates were calculated by dividing the number of CYPs by the number of married women of reproductive age. These data are presented in Table A-3 and Figure 7.

Because Botswana had a potential use rate of 275% for 1985, most of the other countries were compressed near the bottom of the chart. Figure 8 shows the same data as Figure 7, excluding Botswana.

The CYPs and potential use for all contraceptives were attributed to the year in which the commodities were shipped. Another way to represent the data is to spread the CYP over several years. That approach would be particularly appropriate for IUDs since a woman receiving an IUD in, say, January 1985, would be protected during all of 1985 and 1986 and half of 1987, assuming she kept the device in situ for 2.5 years.

To properly evaluate the adequacy of AID supplied contraceptives, it would be helpful to have data from other donors as well as data from the commercial sector, but these data were not available at least in the time frame required for this report.

### Potential Use Rates from AID Supplied Contraceptives

AID supplied contraceptives to Botswana between 1984 and September 1989 and enough to yield a use rate of 99% for the entire 5.75 years. The use rate for modern contraceptives in 1984 was 19% and in 1988 it was 32%, so that about four times as many contraceptives were

shipped to Botswana by AID affiliated organizations that would be required for the actual levels of use.

A large share of the surplus contraceptive coverage was provided by IUDs, but considerable numbers of Oral Contraceptives were also supplied to Botswana by AID. The number of CYPs provided by IUDs depends on the length of time the devices remain in situ. If, for example, they remain in situ for only 1.5 years rather than the assumed 2.5 years, the potential prevalence provided by IUDs shipped in 1985 would be 122% rather than 204%. The potential rate for the period 1984 to 1989 would drop from 99% to 78% – still much higher than the actual use rate.

Zimbabwe also received a large supplied of contraceptives, enough for a use rate of 45% for the entire period 1984 to 1989. The use rate in that country was 27% in 1984 and 36% in 1988. Most of the contraceptives shipped to Zimbabwe were Oral Contraceptives. Since each cycle will provide protection for precisely 28 days, the formulas for conversion to CYPs and to potential use rates are fixed.

Kenya received enough contraceptives to provide a use rate of 6.5% for the period 1984 to 1989. Very few Oral Contraceptives were provided by AID because the private commercial sector does a good job in providing them. Kenya's use rate was 10% in 1984 and 18% in 1989. In the absence of data on commercially provided contraceptives and contraceptives provided by the United Nations and other bilateral donors it is hard to judge the adequacy of AID supplied contraceptives.

Contraceptives shipped to other countries listed in the tables are adequate for only single digit use rates. The actual use rates in these countries range between 1% and 5%. AID supplied contraceptives are generally adequate for current minuscule use rates, but they are not adequate for an expansion of services.

At one time AID used the concept "Programming for Success," which generally meant for countries with low levels of use enough condoms to produce an annual condom use rate of 5% and enough pills to provide a years supply for 10% of reproductive age women at risk of pregnancy. That formula might not be so bad for the early 1990s if Africans are to have access to the supplies they need to control their fertility. As use levels rise, the formula can be changed to keep ahead of use.

### **Personnel Trained by AID Contractors**

During the period 1984 to 1989 AID trained 2,026 nationals from the seven countries listed in Table 5. The training was provided by JHPIEGO, AVSC, INTRAH, and directly through PIO/Ps handled by the Office of International Training.

The peak years for numbers were 1986 and 1987, due largely to large numbers of Kenyans trained those years. In fact, 46% of the trainees were Kenyans, 17% were Ugandans, 15% were Botswanans, and 13% Ghanaians.

On a population bases Botswana had by far the largest number of trainees – 250 per million population. Kenya came in second at 38 per million followed closely by Togo with 34 per million (See Table 5.)

### **Data From Community Surveys**

In Uganda, Togo, and Burundi the Demographic and Health Survey used a community module to obtain information about services available in the communities from which people selected for individual interviews lived. This section deals with one of these countries, Uganda.

In Uganda 72% of the women interviewed said they knew a source for family planning and 28% said they did not know a source. However, the community survey found a family planning source in only a little over one third of the communities where respondents said they knew a source. There was no source in just under two thirds of the communities where individuals said they knew a source. (See Table 6.)

**Table 5.— Number of People From Seven African Countries Trained by AID Between 1984 and 1989**

Country	Population (Millions)	Number Trained	Trainees per Million Population
Botswana	1.2	300	250.0
Burundi	5.5	19	3.5
Ghana	14.6	266	18.2
Kenya	24.1	923	38.3
Togo	3.4	116	34.1
Uganda	17.0	338	19.9
Zimbabwe	10.1	64	6.3

Source: Population data are from the Population Reference Bureau's World Population Data Sheet and number trained from Table A-4.

**Table 6.— Existence of a Family Planning Source by Perceived Knowledge of Source: Uganda 1989**

From Community Survey	Women's Perceived Knowledge		
	Knew Source	Did Not Know Source	All Women
<b>Total</b>	<b>72%</b>	<b>28%</b>	<b>100%</b>
<b>Source Exists</b>	<b>26%</b>	<b>10%</b>	<b>36%</b>
<b>No Source Exists</b>	<b>46%</b>	<b>18%</b>	<b>64%</b>

Source: Special tabulations for the community and individual surveys.

Since the individual survey did not collect information from individuals on where the source they knew was located, people who knew a source in a distant community would be recorded as knowing a source. However, the community survey only recorded family planning outlets within a prescribed distance.

A little over one third of the individuals who said they did not know a source lived in a community that actually had a source according to the community survey. Evidently, the information program operated by the program had failed to make everyone aware of existing outlets.

The community survey collected information on the travel time to source. (See Table A-6.) Of the 36% of all women who lived in a community with a family planning outlet a majority would have to travel more than an hour to reach an outlet. Most women going to an

outlet would walk there, including those who must travel for more than an hour.

Table A-7 shows the year in which various family planning outlets began offering specific contraceptive methods.

In 1988 twenty nine percent of Ugandan women lived in areas served by hospitals that offer Oral Contraceptives. Eighteen percent lived in areas served by health centers that offer the Pill, and 11% lived in area served by private clinics offering the Pill. These data are not mutually exclusive. That is, an area may be served by all three of the service facility types.

The cumulative columns in Table A-7 shows the progression of program coverage. For example, by 1978 ten percent of the Ugandan women lived in areas serviced by hospitals that offered the pill. By 1984 twenty two percent were covered.

The expansion of IUD, Injection, Vaginal methods, and condoms spread at the same pace, although the populations covered at various points is somewhat lower than that for the pill.

About a fifth of the population has access to a hospital that offers tubectomy and eight percent had access to vasectomy services.

## ANALYSIS

The picture that emerges for the five countries is that there is a significant interest in fertility control, both in childspacing and in limiting family size. With the exception of Kenya, the levels do not yet match those of Asia and Latin America, although the direction of the change is toward the Asian/Latin American pattern.

In Asia and Latin America, about half the married women of reproductive age said they did not want a future birth while another 25 to 30 percent said they want to wait before having a child. Thus, 75% to 80% do not want to be pregnant, at least for now. About 10% wanted a baby soon, that is, within the next two years. The other 10% to 15% were undecided about whether they wanted a future birth or when they wanted it.

For all five of the countries discussed above, substantially fewer than half of married women of reproductive age reported earlier that they did not want a future birth. All experienced significant increases, with Kenya reaching the 50% mark.

On the other hand, Botswana, Kenya, and Zimbabwe reported high proportions as wanting to wait in 1984. All three reported declines by 1988/89, putting them closer to the Asia/Latin America pattern.

Ghana reported a very low level (14%) as wanting to wait in 1979/80. Its huge increase in the 1980s placed it at the level found in Botswana and Zimbabwe in 1984.

Ghana's survey of husbands demonstrates that men as well as women want to control their fertility. Half of Ghanaian couples agree that they do not want a birth, at least for now.

The surveys in Asia and Latin America were carried out at a much later stage of family planning development than those in Africa. Many Asian and Latin countries started family planning activities in the 1960s. By the mid to later 1970s people in some countries had been hearing about family planning for a decade or more.

Although some African countries adopted population policies and announced programs almost as early as the pioneers in the other two regions, the programs saw little activity.

In Ghana, for example, the family planning program was announced with great fanfare in 1970, but, for years it was plagued by mismanagement and political and economic turmoil.

Ideology played a significant role in retarding family planning in Africa. Some of the advisors sent to Africa under the guise of population/ family planning held strong personal views about the appropriateness of the programs they were paid to promote.

Some thought it evil to spend money for family planning until the many other pressing problems of the region could be taken care of. They failed to understand one of the basic reasons why family planning was essential, namely, that there was little hope of solving the monumental health, economic, and social problems in poor countries whose populations are doubling every 17 to 25 years.

Funds provided to African social scientists for studies of the population problem were often counterproductive. The funds were often used for studies that involved the application of outmoded demographic theories to Africa rather than helping African governments understand the implications of rapid rates of population growth.

Efforts by expatriates to convince governments to adopt population policies often succeed in getting governments to issue flowery statements announcing population policies, but these statements often failed to get governments to take practical action to provide contraceptives to their citizens.

The medical profession did not do any better. Gold plated health and family planning delivery systems purported to show that family planning was unacceptable to Africans outside the context of a full service health system. But the demonstration systems did not carry out objective research and the gold plated health care systems they established in small areas collapsed as soon as outside funds and personnel were withdrawn.

Some Africans viewed family planning as genocidal programs push on black people by white governments. Some foreign advisors did little to counter these views and may have shared them.

The most advanced family planning program in Africa is in Zimbabwe. That program was established without external support. By the time the international community decided to provide resources to Zimbabwe, the program was well established with strong support from Prime Minister (now President) Robert Mugabe. The head of the family planning program is Ester Bohene, sister of First Lady Sally Mugabe.

Kenya's program was greatly assisted when President Daniel arap Moi took a strong public stance on the necessity to slow population growth.

## THE CONCEPTS OF FAMILY PLANNING AVAILABILITY AND ACCESSIBILITY

### Background

While many factors may impact upon the decisions of individual couples to use family planning, it is axiomatic that before people can practice family planning, they must know at least one contraceptive method and they must have access to reliable information, services, and supplies needed to use the method.

But what constitutes access?

Many Africans no doubt know that doctors in London and Paris or indeed in their own national capitals provide various contraceptive methods to their patients, but unless they have the means to travel to these distant places, that knowledge will have little impact on family planning use.

Contraceptives may be available at one or more outlets in an African community, but unless reproductive age couples who live in or near that community know about the outlet, they can not visit it and consequently family planning use will not increase as a consequence of opening the outlets.

Thus, two essential, although not necessarily sufficient, elements of accessibility are that family planning outlets located within a "reasonable" distance from where prospective users live or work must exist and that people must be aware of the existence of the outlets and the services they provide.

The definition of "reasonable" may vary with different methods of contraception, different levels of motivation to use family planning, and different levels of income. For example, people may be willing to travel a great distance and incur considerable expense to obtain a tubectomy or vasectomy because those methods are ordinarily permanent and trouble free.

They may also be willing to travel considerable distances to obtain other long term methods such as the IUD or Implant. Because these methods require a single once in a life time visit or visits every two to five years, people can afford an extra effort and expense. But they may not be willing or able to travel far or incur substantial expense for supply method contraceptives such as pills and condoms since these methods require frequent resupply and thus repeated trips to an outlet.

Accessibility may involve other factors as well: Location of the outlet vis-a-vis other places frequented by prospective family planning users (e.g., shops, farm markets), available mode of transportation to the facility, transportation cost, cost of services and supplies, conveniences of bus schedules, hours of service at the outlet, wait time for transportation and for service, friendliness of the personnel in the outlet, and so on.

Sometimes the term "availability" is used to denote knowledge of an outlet without regard to where the outlet is located while "accessibility" takes account of the convenience of the outlet.

Data on availability and accessibility are ordinarily collected via sample surveys. Surveys of individuals (usually married women of reproductive age and sometimes their husbands) collect what is sometimes referred to as "perceived" availability or accessibility. That is, what respondents believe to exist rather than what actually exist. Since the information may or may not be correct, it needs to be checked against hard information on what actually exist.

In order to obtain hard information on family planning facilities in the community, survey personnel generally start by making a tentative list of family planning outlets based on information obtained from community leaders, government officials, family planning organization, and the people interviewed in the individual survey. Visits are then made to all outlets within some prescribed radius of the sampling clusters used in the individual survey to obtain information on the services provided by the outlet, number and types of

personnel, hours of service, charges to clients, common modes of transportation to points in their service area, etc.

With these two sets of data, program managers can match what people believe against what actually exist. If people do not know about existing outlets or if the information they have is inaccurate, education programs need to be launched to make people aware of the outlets and the services they provide.

If significant numbers of people lack access to family planning, under utilized outlets need to be relocated and new outlets opened. Incidentally, "outlet" need not be a fix site. Family planning services may be provided by field or extension workers who makes periodic visits to a community or to individual homes. Sometimes clinics move from place to place, using schools, community centers, private homes, tents, vans, or an outdoor area.

The term "source" is sometimes used to describe family planning distributors because it conveys less of an image of a fix physical site.

Surveys carried out in the mid to late 1970s and in the early 1980s usually included questions on the individual schedule relating to knowledge of a family planning source, travel time to the source, and mode of transportation. Some surveys asked qualitative questions such as satisfaction with the services provided through the outlets.

Sometimes respondents were ask a general question regarding knowledge of a source that provides any method of family planning while others asked whether the respondent knew sources for specific methods.

By the mid 1980s all questions relating to accessibility were dropped. Respondents were asked only whether they knew a source for the methods they knew. Thus, no distinction was made between people who knew a source next door and those who knew a source 20 miles away.

Three very recent surveys, Burundi, Togo, and Uganda, included community components designed to determine what family planning outlets existed in the communities, their hours of service, number and type of personnel, family planning methods offered, etc. The Uganda survey also collected information from outlets on the year they first offered specific methods. The individual questionnaires contained only the general questions relating to knowledge of sources for specific methods but not travel time and other items relating to accessibility.

There is a need to restore questions on accessibility to individual questionnaire and to develop additional questions to measure quality of services and to identify program related factors that impact on decisions to use family planning.

There may be a need for another type of information: gathering to supplement survey data. One possibility is to use anthropological methods. In depth, opened ended interviews with a small number of people might reveal a great deal about problems in service delivery programs.

Another approach may be to solicit more information from program personnel. They know a great deal about problem areas in the programs and many are motivated to improve service delivery if given an opportunity.

Figure 1.-- Percent of Women Who Do Not Want a Future Birth

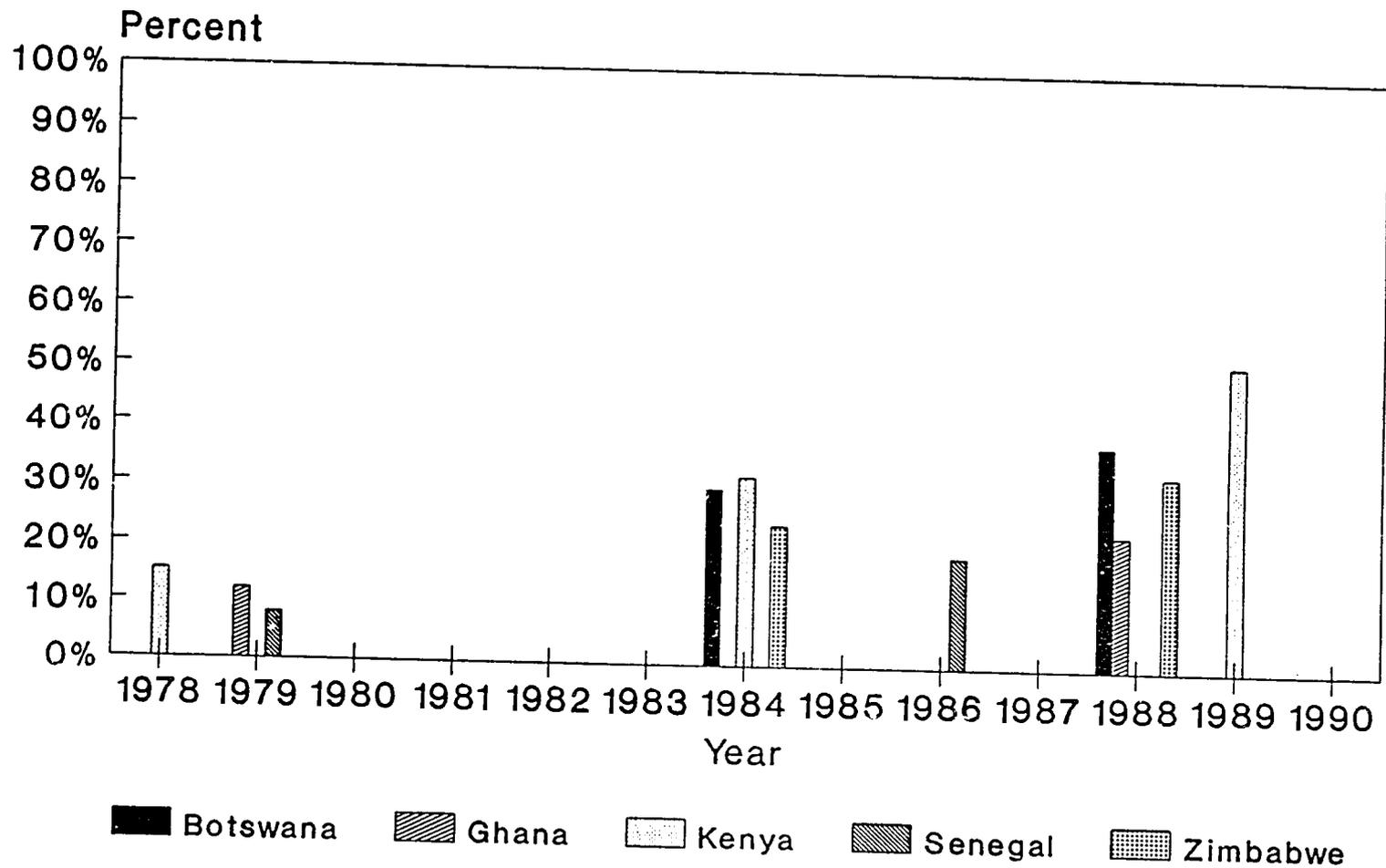
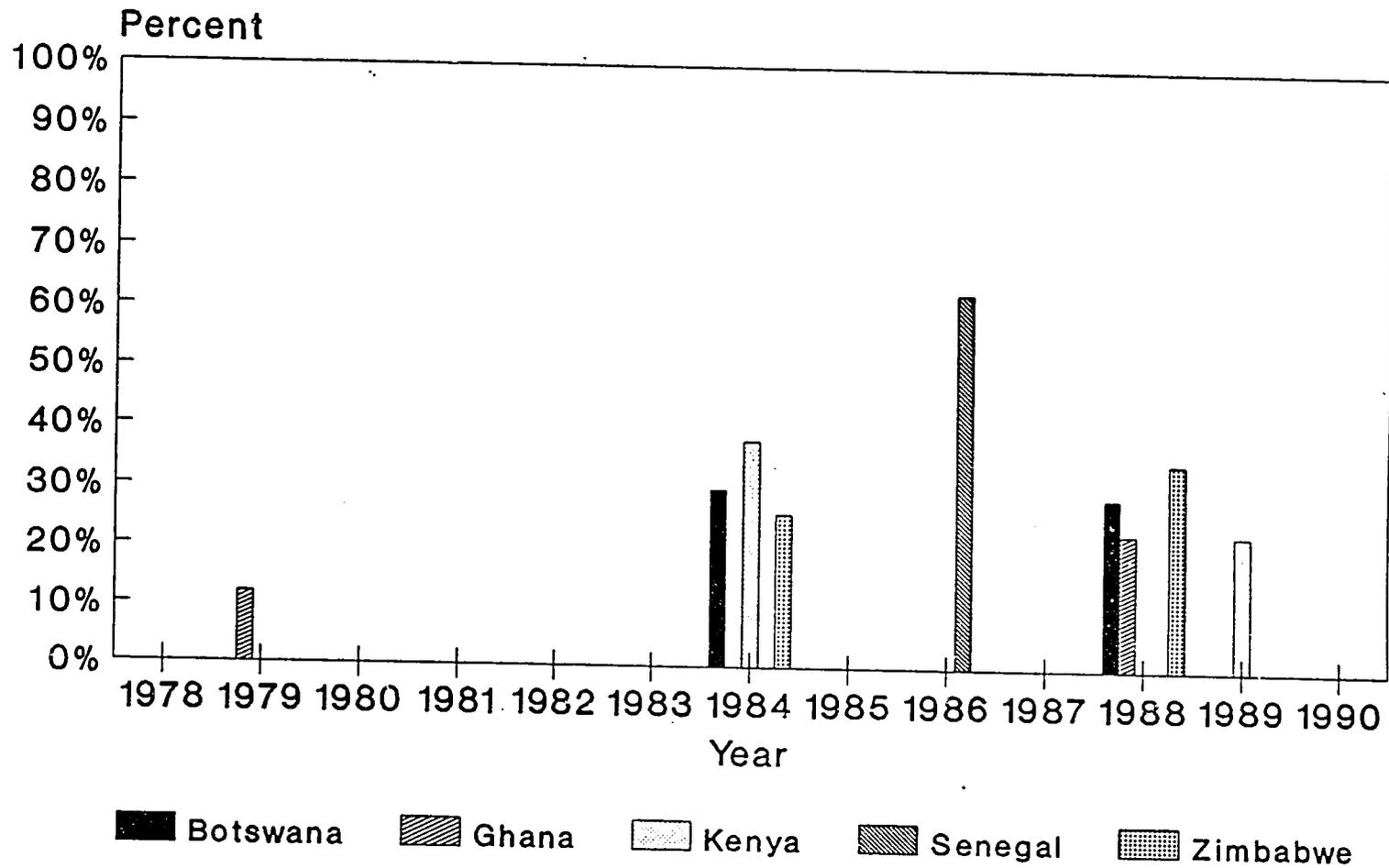


Figure 2.-- Percent of Women Who Want to Wait Before Having a Baby



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Figure 3.-- Percent of Women Who Do Not Want a Baby, At Least For Now

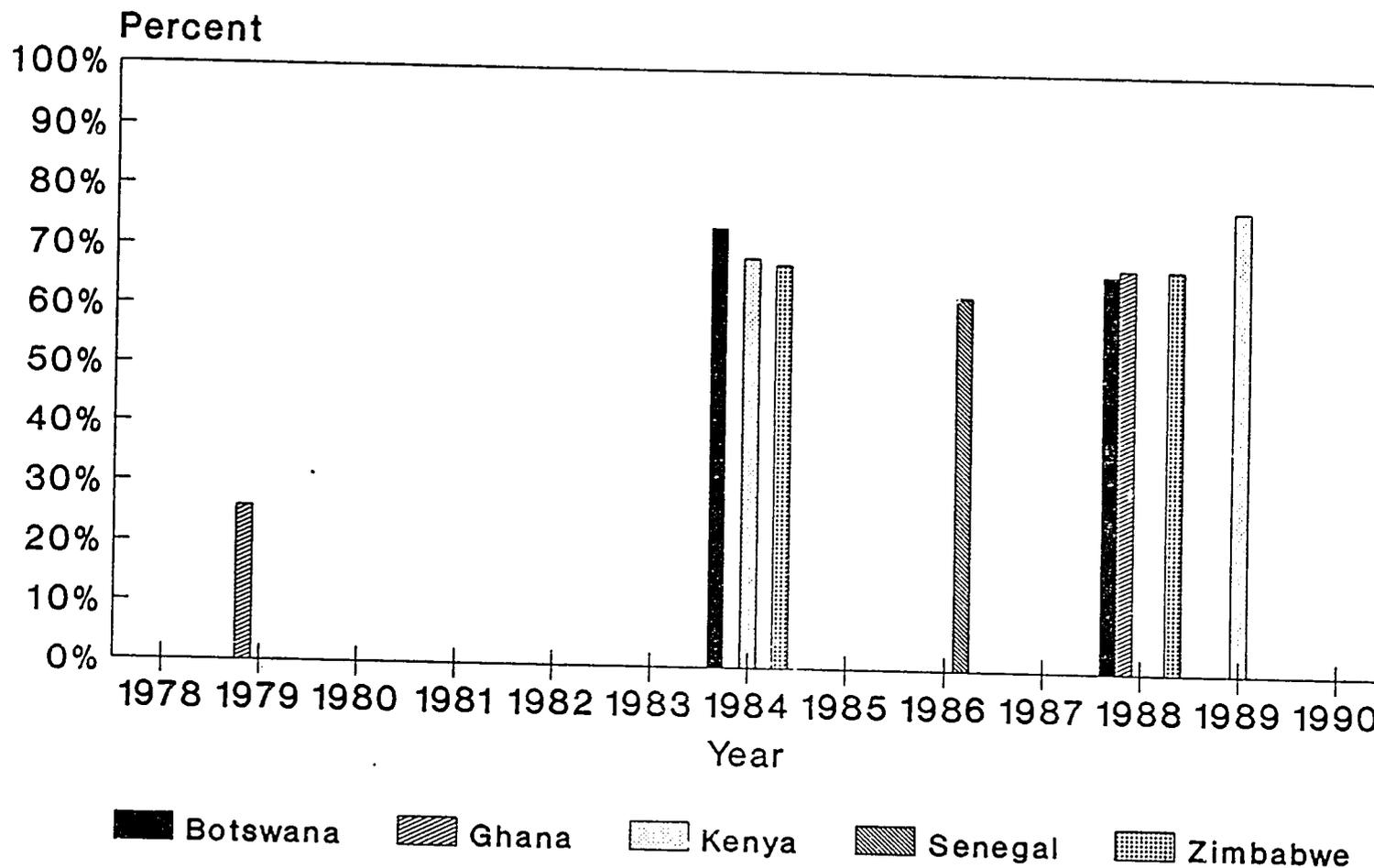


Figure 4.-- Percent of Women Who Want a Baby Within Two Years

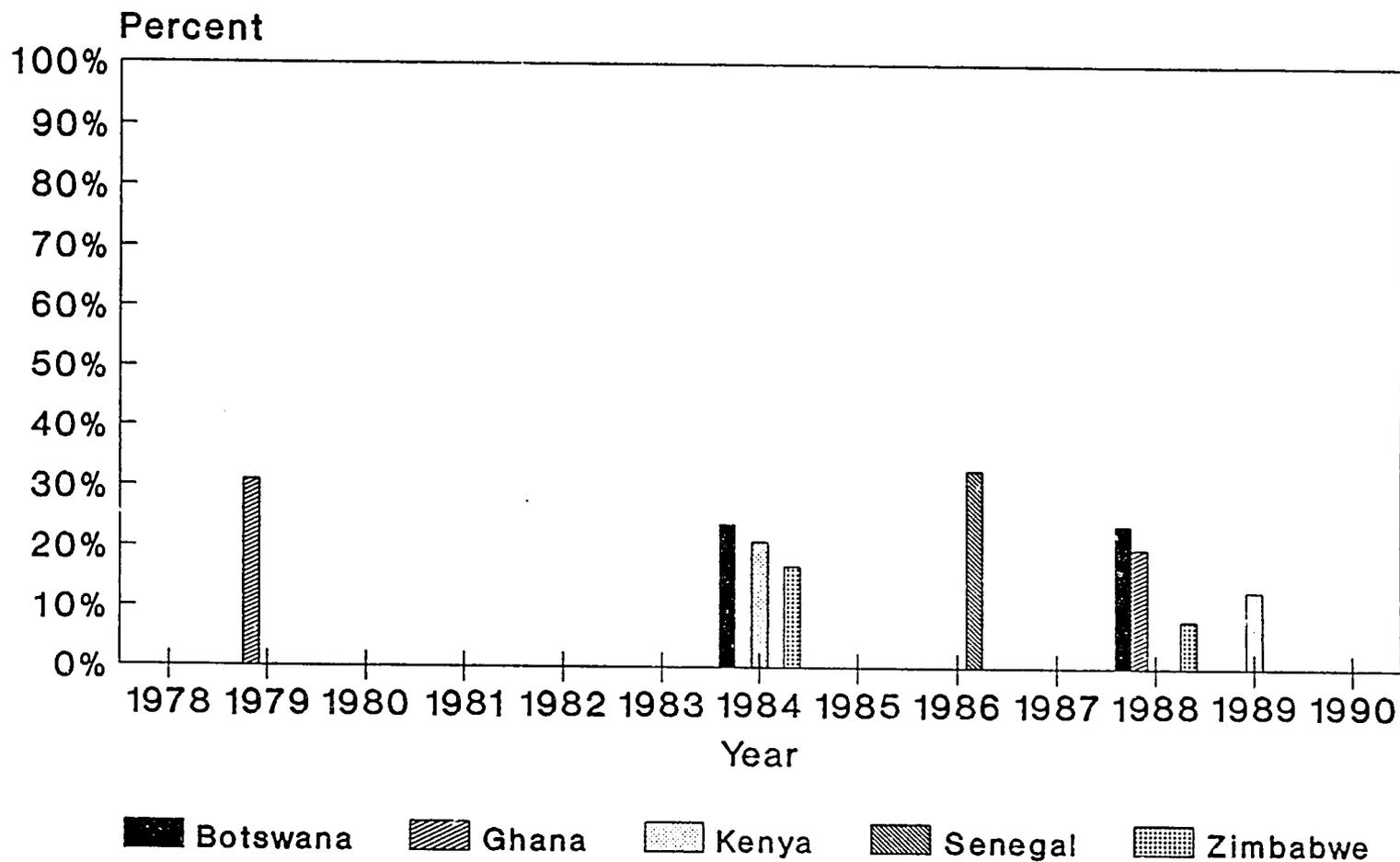


Figure 5.-- Percent of Women Who Know a Modern Contraceptive Method

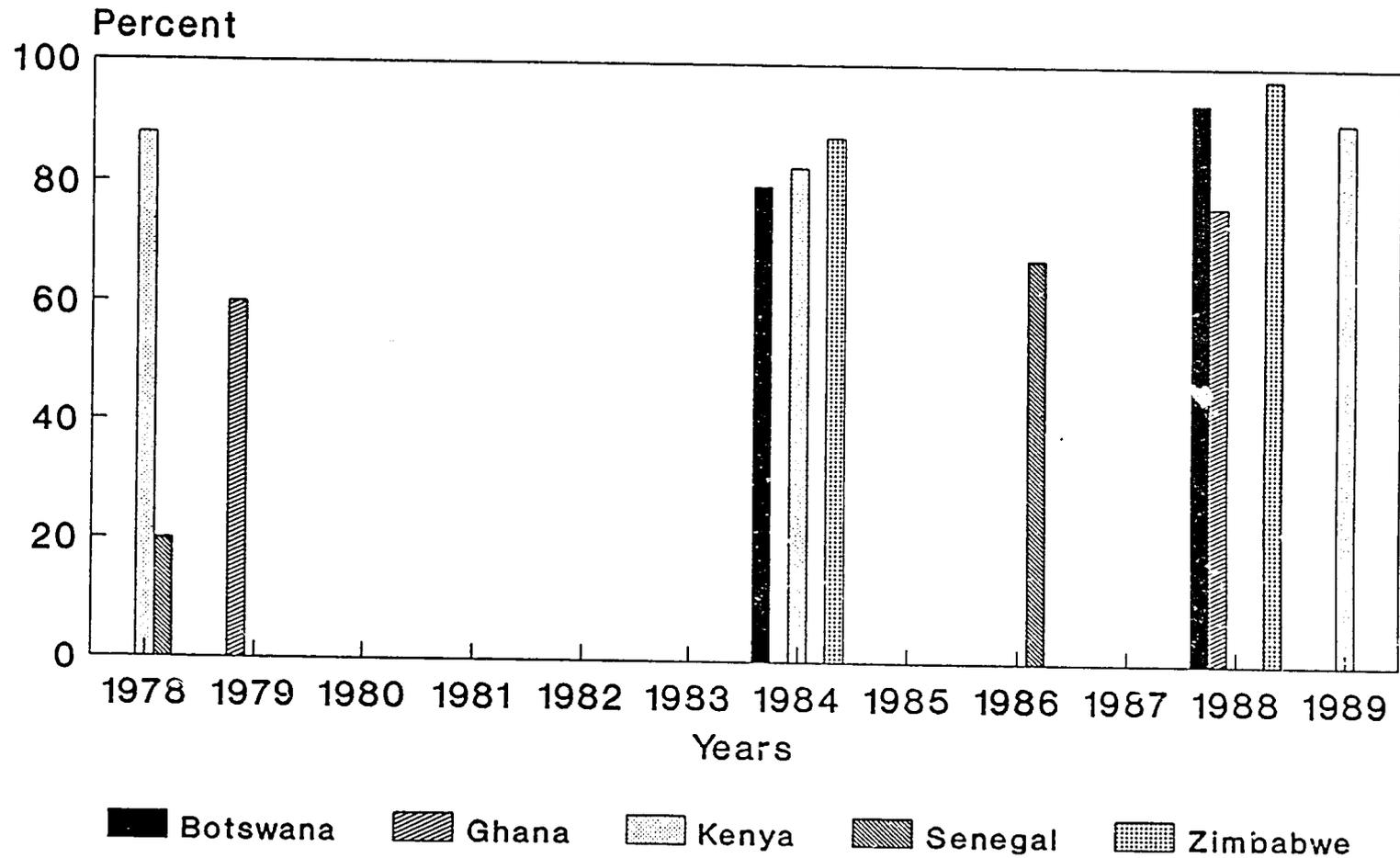


Figure 6.-- Percent of Women Who Know A Family Planning Source

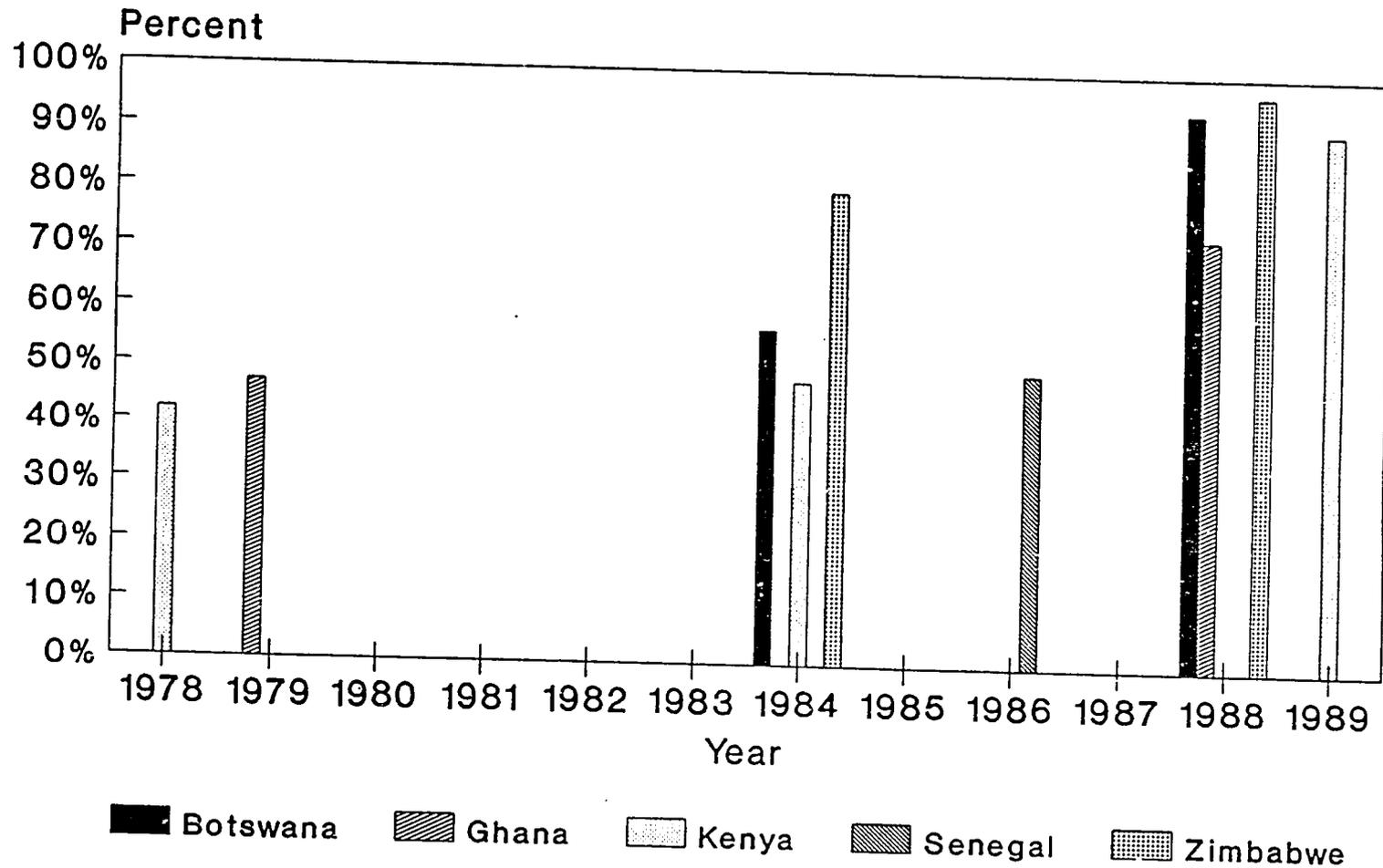


Figure 7.-- Percent of Women Who Are Using a Modern Family Planning Method

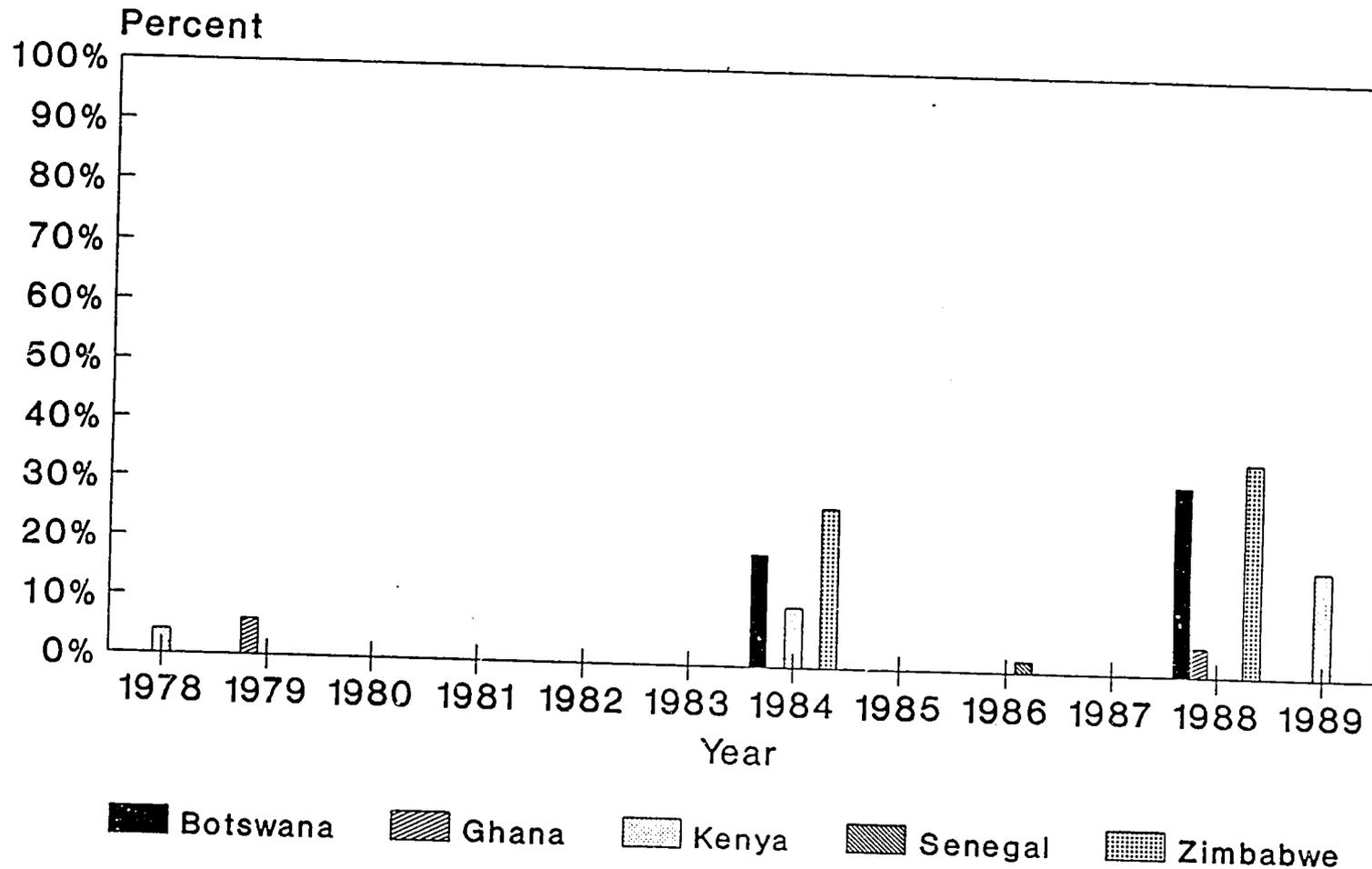


Figure 8.-- Potential Use Rates from AID Supplied Contraceptives: 1984 to 1989

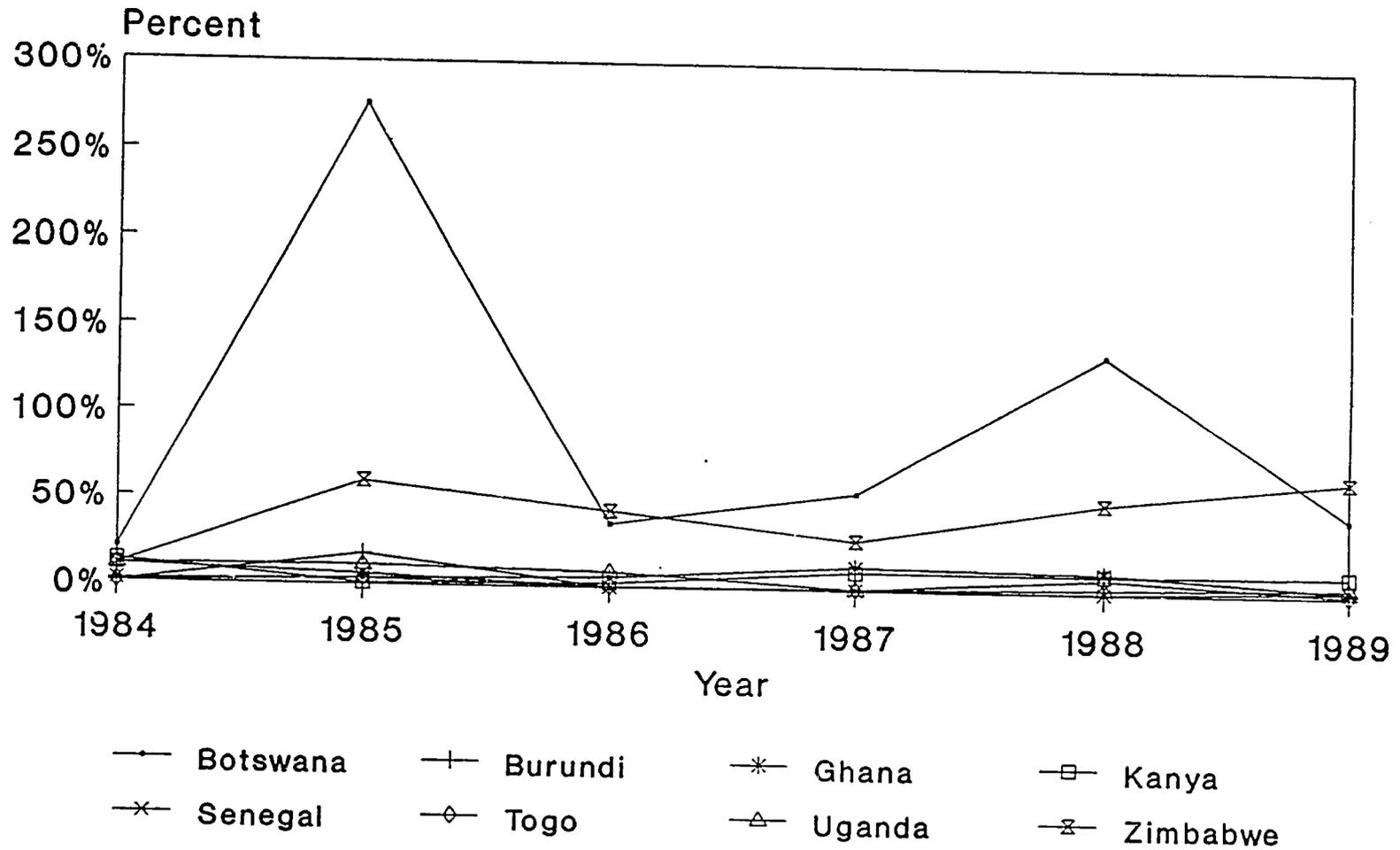
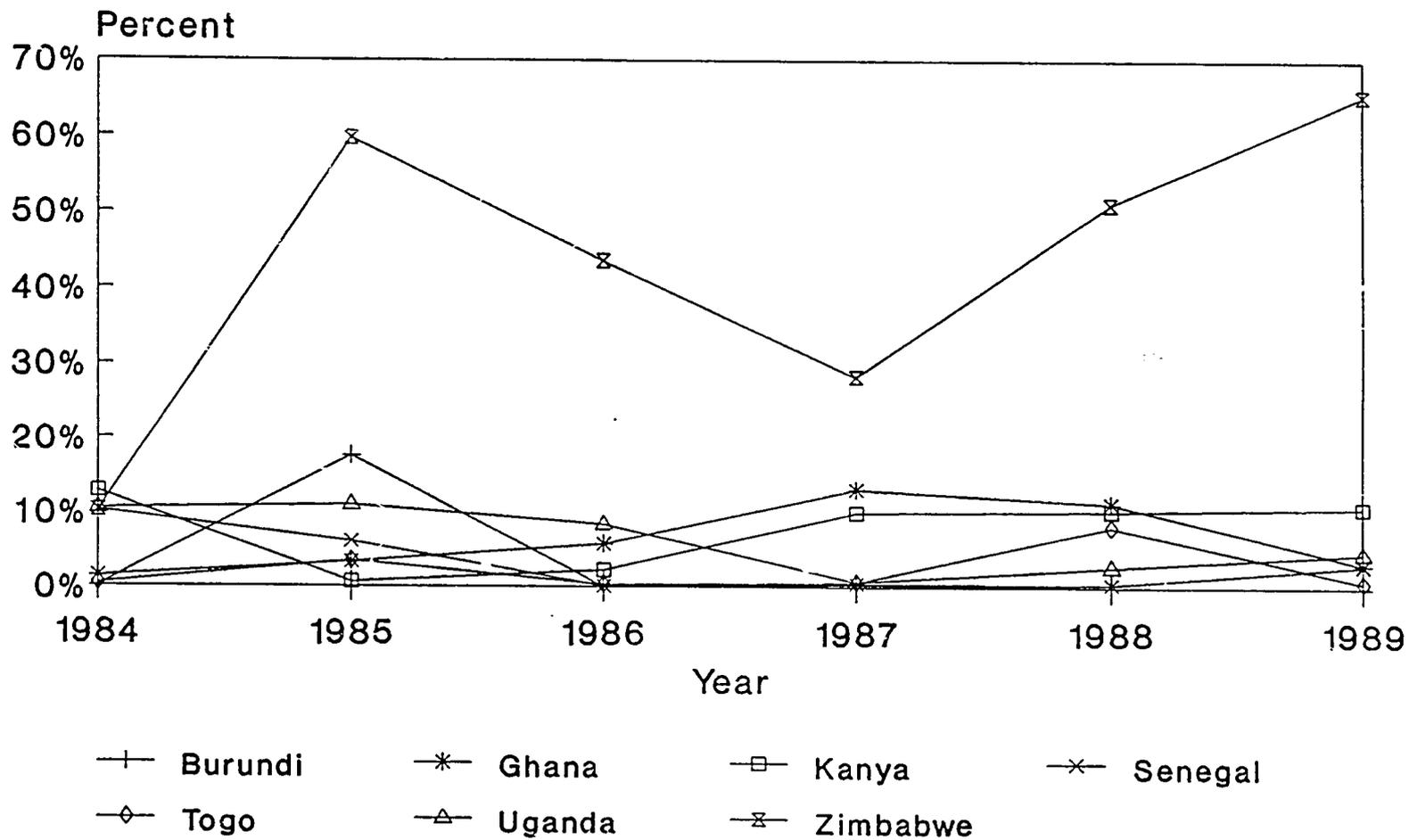


Figure 9.-- Potential Use Rates from AID  
Supplied Contraceptives: 1984 to 1989



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**TABLE A-1 CONTRACEPTIVES PROVIDED BY USAID TO SELECTED  
AFRICAN NATIONS: 1984 TO 1989**

Country	1984	1985	1986	1987	1988	1989
Annual Shipments						
Condoms (units)						
Botswana	1,410,000	678,000	1,170,000	2,076,000	4,494,000	1,206,000
Burundi	0	6,000	0	300,000	0	0
Ghana	828,000	4,422,000	2,010,000	1,662,000	9,102,000	3,018,000
Kenya	306,500	454,300	6,306,000	12,300,000	13,332,000	18,894,000
Senegal	715,000	1,098,000	24,000	756,000	606,000	2,550,000
Togo	24,000	390,000	18,000	372,000	2,004,000	522,000
Uganda	1,076,400	336,000	318,000	2,250,000	5,844,000	3,288,000
Zimbabwe	1,002,000	8,046,000	3,168,000	10,536,000	10,974,000	10,014,000
Total	5,361,900	15,430,300	13,014,000	30,252,000	46,356,000	39,492,000
Oral Contraceptives (Cycles)						
Botswana	4,800	772,800	336,000	328,800	912,000	0
Burundi	0	1,500,000	0	0	0	0
Ghana	198,000	409,200	742,800	2,505,600	1,192,800	226,800
Kenya	42,000	76,800	72,000	0	0	0
Senegal	216,000	548,400	0	1,200	0	73,200
Togo	3,600	14,400	6,000	3,600	3,600	0
Uganda	1,866,000	1,572,000	1,357,200	3,600	200,400	1,094,400
Zimbabwe	1,401,600	7,368,000	6,645,600	3,770,400	7,398,200	10,807,200
Total	3,732,000	12,261,600	9,159,600	6,613,200	9,707,000	12,201,600
IUDs						
Botswana	3,200	72,600	0	3,400	14,800	15,000
Burundi	0	400	0	0	0	0
Ghana	1,300	500	1,300	28,200	32,600	10,000
Kenya	132,400	2,800	1,900	82,400	83,800	82,000
Senegal	32,800	5,000	0	0	0	5,000
Togo	400	4,020	200	0	3,000	0
Uganda	27,000	46,600	32,200	200	3,600	3,800
Zimbabwe	0	32,600	0	0	11,800	1,000
Total	197,100	164,520	35,600	114,200	149,600	116,800
Foam Tablets						
Botswana	0	0	0	0	0	4,800
Burundi	0	0	0	0	0	0

(con't)

Country	1984	1985	1986	1987	1988	1989
<b>Foam Tablets</b>						
Botswana	0	0	0	0	0	4,800
Burundi	0	0	0	0	0	0
Ghana	0	43,200	6,129,600	19,200	1,641,600	1,060,800
Kenya	19,200	53,000	1,540,800	1,732,800	3,244,400	3,133,700
Senegal	0	38,400	177,600	0	14,400	0
Togo	0	86,400	4,800	4,800	2,457,600	0
Uganda	0	0	489,600	4,800	336,000	96,000
Zimbabwe	0	100,800	0	100,800	422,400	86,400
<b>Total</b>	<b>19,200</b>	<b>321,800</b>	<b>8,342,400</b>	<b>1,862,400</b>	<b>8,116,400</b>	<b>4,381,700</b>

## Cumulative Shipments

## Condoms (units)

Botswana	1,410,000	2,088,000	3,258,000	5,334,000	9,828,000	11,034,000
Burundi	0	6,000	6,000	306,000	306,000	306,000
Ghana	828,000	5,250,000	7,260,000	8,922,000	18,024,000	21,042,000
Kenya	306,500	760,800	7,066,800	19,366,800	32,698,800	51,592,800
Senegal	715,000	1,813,000	1,837,000	2,593,000	3,199,000	5,749,000
Togo	24,000	414,000	432,000	804,000	2,808,000	3,330,000
Uganda	1,076,400	1,412,400	1,730,400	3,980,400	9,824,400	13,112,400
Zimbabwe	1,002,000	9,048,000	12,216,000	22,752,000	33,726,000	43,740,000
<b>Total</b>	<b>5,361,900</b>	<b>20,792,200</b>	<b>33,806,200</b>	<b>64,058,200</b>	<b>110,414,200</b>	<b>149,906,200</b>

## Oral Contraceptives (Cycles)

Botswana	4,800	777,600	1,113,600	1,442,400	2,354,400	2,354,400
Burundi	0	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Ghana	198,000	607,200	1,350,000	3,855,600	5,048,400	5,275,200
Kenya	42,000	118,800	190,800	190,800	190,800	190,800
Senegal	216,000	764,400	764,400	765,600	765,600	838,800
Togo	3,600	18,000	24,000	27,600	31,200	31,200
Uganda	1,866,000	3,438,000	4,795,200	4,798,800	4,999,200	6,093,600
Zimbabwe	1,401,600	8,769,600	15,415,200	19,185,600	26,583,800	37,391,000
<b>Total</b>	<b>3,732,000</b>	<b>15,993,600</b>	<b>25,153,200</b>	<b>31,766,400</b>	<b>41,473,400</b>	<b>53,675,000</b>

## IUDs

Botswana	3,200	75,800	75,800	79,200	94,000	109,000
Burundi	0	400	400	400	400	400

(con't)

Country	1984	1985	1986	1987	1988	1989
Ghana	1,300	1,800	3,100	31,300	63,900	73,900
Kenya	132,400	135,200	137,100	219,500	303,300	385,300
Senegal	32,800	37,800	37,800	37,800	37,800	42,800
Togo	400	4,420	4,620	4,620	7,620	7,620
Uganda	27,000	73,600	105,800	106,000	109,600	113,400
Zimbabwe	0	32,600	32,600	32,600	44,400	45,400
<b>Total</b>	<b>197,100</b>	<b>361,620</b>	<b>397,220</b>	<b>511,420</b>	<b>661,020</b>	<b>777,820</b>
<b>Foam Tablets</b>						
Botswana	0	0	0	0	0	4,800
Burundi	0	0	0	0	0	0
Ghana	0	43,200	6,172,800	6,192,000	7,833,600	8,894,400
Kenya	19,200	72,200	1,613,000	3,345,800	6,590,200	9,723,900
Senegal	0	38,400	216,000	216,000	230,400	230,400
Togo	0	86,400	91,200	96,000	2,553,600	2,553,600
Uganda	0	0	489,600	494,400	830,400	926,400
Zimbabwe	0	100,800	100,800	201,600	624,000	710,400
<b>Total</b>	<b>19,200</b>	<b>341,000</b>	<b>8,683,400</b>	<b>10,545,800</b>	<b>18,662,200</b>	<b>23,043,900</b>

Source: Data on contraceptive shipments were obtained from the NEWVERN data system maintained by JSI, Inc., Family Planning International Assistance (FPIA), and Pathfinder. The JSI system contained data from the other two organizations, but the data from FPIA differed significantly from data labeled as FPIA shipments in the JSI system. JSI personnel stated that the FPIA data in their system did not include data shipped to FPIA affiliates and that there were other differences that they had not been able to reconcile. Therefore, data from JSI were used for non-FPIA shipments and from data from FPIA were used for FPIA shipments.

TABLE A-2.-- COUPLE YEARS OF PROTECTION (CYP) PROVIDED BY USAID SUPPLIED CONTRACEPTIVES TO SELECTED AFRICAN NATIONS: 1984 TO 1989

Country	1984	1985	1986	1987	1988	1989
CYPs From Annual Shipments						
All Contraceptives						
Botswana	17,769	245,466	33,646	47,632	137,114	45,572
Burundi	0	116,425	0	2,000	0	0
Ghana	24,001	62,495	114,652	274,446	244,878	69,638
Kenya	336,402	16,290	62,600	299,552	320,009	351,851
Senegal	103,382	62,261	1,344	5,132	4,136	35,131
Togo	1,437	14,334	1,114	2,789	37,521	3,480
Uganda	218,214	239,663	190,284	15,809	65,615	116,245
Zimbabwe	114,495	702,581	532,320	360,943	674,568	901,159
Total	815,701	1,459,514	935,961	1,008,304	1,483,842	1,523,076
Condoms						
Botswana	9,400	4,520	7,800	13,840	29,960	8,040
Burundi	0	40	0	2,000	0	0
Ghana	5,520	29,480	13,400	11,080	60,680	20,120
Kenya	2,043	3,029	42,040	82,000	88,880	125,960
Senegal	4,767	7,320	160	5,040	4,040	17,000
Togo	160	2,600	120	2,480	13,360	3,480
Uganda	1,176	2,240	2,120	15,000	38,960	21,920
Zimbabwe	6,680	53,640	21,120	70,240	73,160	66,760
Total	35,746	102,869	86,760	201,680	309,040	263,280
Oral Contraceptives						
Botswana	369	59,446	25,846	25,292	70,154	0
Burundi	0	115,385	0	0	0	0
Ghana	15,231	31,477	57,138	192,738	91,754	17,446
Kenya	3,231	5,908	5,538	0	0	0
Senegal	16,615	42,185	0	92	0	5,631
Togo	277	1,108	462	277	277	0
Uganda	143,538	120,923	104,400	277	15,415	84,185
Zimbabwe	107,815	566,769	511,200	290,031	569,092	831,323
Total	287,077	943,200	704,585	508,708	746,692	938,585
IUDs						
Botswana	8,000	181,500	0	8,500	37,000	37,500
Burundi	0	1,000	0	0	0	0

(con't)

Country	1984	1985	1986	1987	1988	1989
Ghana	3,250	1,250	3,250	70,500	81,500	25,000
Kenya	331,000	7,000	4,750	206,000	209,500	205,000
Senegal	82,000	12,500	0	0	0	12,500
Togo	1,000	10,050	500	0	7,500	0
Uganda	67,500	116,500	80,500	500	9,000	9,500
Zimbabwe	0	81,500	0	0	29,500	2,500
<b>Total</b>	<b>492,750</b>	<b>411,300</b>	<b>89,000</b>	<b>285,500</b>	<b>374,000</b>	<b>292,000</b>

## Foam Tablets

Botswana	0	0	0	0	0	32
Burundi	0	0	0	0	0	0
Ghana	0	288	40,864	128	10,944	7,072
Kenya	128	353	10,272	11,552	21,629	20,891
Senegal	0	256	1,184	0	96	0
Togo	0	576	32	32	16,384	0
Uganda	0	0	3,264	32	2,240	640
Zimbabwe	0	672	0	672	2,816	576
<b>Total</b>	<b>128</b>	<b>2,145</b>	<b>55,616</b>	<b>12,416</b>	<b>54,109</b>	<b>29,211</b>

## CYPs From Cumulative Shipments

## All Contraceptives

Botswana	17,769	263,235	296,882	344,514	481,628	527,200
Burundi	0	116,425	116,425	118,425	118,425	118,425
Ghana	24,001	86,496	201,148	475,595	720,472	790,111
Kenya	336,402	352,692	415,292	714,844	1,034,854	1,386,705
Senegal	103,382	165,643	166,987	172,119	176,255	211,386
Togo	1,437	15,771	16,884	19,673	57,194	60,674
Uganda	218,214	457,878	648,162	663,970	729,586	845,830
Zimbabwe	114,495	817,077	1,349,397	1,710,339	2,384,908	3,286,067
<b>Total</b>	<b>815,701</b>	<b>2,275,215</b>	<b>3,211,176</b>	<b>4,219,479</b>	<b>5,703,321</b>	<b>7,226,397</b>

## Condoms

Botswana	9,400	13,920	21,720	35,560	65,520	73,560
Burundi	0	40	40	2,040	2,040	2,040
Ghana	5,520	35,000	48,400	59,480	120,160	140,280
Kenya	2,043	5,072	47,112	129,112	217,992	343,952
Senegal	4,767	12,087	12,247	17,287	21,327	38,327
Togo	160	2,760	2,880	5,360	18,720	22,200

(con't)

Country	1984	1985	1986	1987	1988	1989
Uganda	7,176	9,416	11,536	26,536	65,496	87,416
Zimbabwe	6,680	60,320	81,440	151,680	224,840	291,600
<b>Total</b>	<b>35,746</b>	<b>138,615</b>	<b>225,375</b>	<b>427,055</b>	<b>736,095</b>	<b>999,375</b>
<b>Oral Contraceptives</b>						
Botswana	369	59,815	85,662	110,954	181,108	181,108
Burundi	0	115,385	115,385	115,385	115,385	115,385
Ghana	15,231	46,708	103,846	296,585	388,338	405,785
Kenya	3,231	9,138	14,677	14,677	14,677	14,677
Senegal	16,615	58,800	58,800	58,892	58,892	64,523
Togo	277	1,385	1,846	2,123	2,400	2,400
Uganda	143,538	264,462	368,862	369,138	384,554	468,738
Zimbabwe	107,815	674,585	1,185,785	1,475,815	2,044,908	2,876,231
<b>Total</b>	<b>287,077</b>	<b>1,230,277</b>	<b>1,934,862</b>	<b>2,443,569</b>	<b>3,190,262</b>	<b>4,128,846</b>
<b>IUDs</b>						
Botswana	8,000	189,500	189,500	198,000	235,000	272,500
Burundi	0	1,000	1,000	1,000	1,000	1,000
Ghana	3,250	4,500	7,750	78,250	159,750	184,750
Kenya	331,000	338,000	342,750	548,750	758,250	963,250
Senegal	82,000	94,500	94,500	94,500	94,500	107,000
Togo	1,000	11,050	11,550	11,550	19,050	19,050
Uganda	67,500	184,000	264,500	265,000	274,000	283,500
Zimbabwe	0	81,500	81,500	81,500	111,000	113,500
<b>Total</b>	<b>492,750</b>	<b>904,050</b>	<b>993,050</b>	<b>1,278,550</b>	<b>1,652,550</b>	<b>1,944,550</b>
<b>Foam Tablets</b>						
Botswana	0	0	0	0	0	32
Burundi	0	0	0	0	0	0
Ghana	0	288	41,152	41,280	52,224	59,296
Kenya	128	481	10,753	22,305	43,935	64,826
Senegal	0	256	1,440	1,440	1,536	1,536
Togo	0	576	608	640	17,024	17,024
Uganda	0	0	3,264	3,296	5,536	6,176
Zimbabwe	0	672	672	1,344	4,160	4,736
<b>Total</b>	<b>128</b>	<b>2,273</b>	<b>57,889</b>	<b>70,305</b>	<b>124,415</b>	<b>153,626</b>

Source: Data on contraceptive shipments displayed in the companion table were converted to CYP as follows: Condoms and Foam Tablets were divided by 150, the assumed number of times African couples engaged in sexual relations in a year; Oral Contraceptives were divided by 13, the number of menses in a year; IUDs were multiplied by 2.5, the assumed average period in which IUDs remain in situ.

**TABLE A-3.-- POTENTIAL CONTRACEPTIVE PREVALENCE FROM CONTRACEPTIVES SUPPLIED BY USAID TO SELECTED AFRICAN NATIONS: 1984 TO 1989**

Country	1984	1985	1986	1987	1988	1989
<b>Potential Prevalence from All Contraceptives Shipped</b>						
Botswana	20.9%	275.8%	36.6%	55.4%	137.1%	43.8%
Burundi	0.0%	17.6%	0.0%	0.3%	0.0%	0.0%
Ghana	1.3%	3.3%	5.7%	13.1%	11.3%	3.1%
Kenya	12.7%	0.6%	2.2%	10.0%	10.2%	10.7%
Senegal	10.2%	6.0%	0.1%	0.5%	0.4%	3.0%
Togo	0.4%	3.4%	0.3%	0.6%	8.1%	0.7%
Uganda	10.4%	11.0%	8.4%	0.7%	2.7%	4.6%
Zimbabwe	10.1%	59.7%	43.6%	28.4%	51.0%	65.4%
Total	8.3%	14.2%	8.2%	9.0%	12.4%	12.5%
<b>Potential Prevalence from Condoms Shipped</b>						
Botswana	11.1%	5.1%	8.5%	16.1%	30.0%	7.7%
Burundi	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%
Ghana	0.3%	1.5%	0.7%	0.5%	2.8%	0.9%
Kenya	0.0%	0.1%	1.5%	2.7%	2.8%	3.8%
Senegal	0.5%	0.7%	0.0%	0.5%	0.4%	1.4%
Togo	0.0%	0.6%	0.0%	0.6%	2.9%	0.7%
Uganda	0.3%	0.1%	0.0%	0.6%	1.6%	0.9%
Zimbabwe	0.6%	4.6%	1.7%	5.5%	5.5%	4.8%
Total	0.4%	1.0%	0.8%	1.8%	2.7%	2.2%
<b>Potential Prevalence from Oral Contraceptives Shipped</b>						
Botswana	0.4%	66.8%	28.1%	29.4%	70.2%	0.0%
Burundi	0.0%	17.5%	0.0%	0.0%	0.0%	0.0%
Ghana	0.8%	1.6%	2.8%	9.2%	4.2%	0.8%
Kenya	0.1%	0.2%	0.2%	0.0%	0.0%	0.0%
Senegal	1.6%	4.1%	0.0%	0.0%	0.0%	0.5%
Togo	0.0%	0.3%	0.1%	0.0%	0.0%	0.0%
Uganda	6.8%	5.5%	4.6%	0.0%	0.6%	3.3%
Zimbabwe	9.5%	48.2%	41.8%	22.8%	43.0%	60.4%
Total	2.9%	9.2%	6.6%	4.6%	6.5%	7.9%
<b>Potential Prevalence from IUDs Shipped</b>						
Botswana	9.4%	203.9%	0.0%	9.9%	37.0%	36.1%
Burundi	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%
Ghana	0.2%	0.0%	0.2%	3.4%	3.8%	1.1%
Kenya	12.5%	0.3%	0.2%	6.8%	6.7%	6.3%

(con't)

Country	1984	1985	1986	1987	1988	1989
Senegal	8.1%	1.2%	0.0%	0.0%	0.0%	1.1%
Togo	0.2%	2.4%	0.1%	0.0%	1.6%	0.0%
Uganda	3.2%	5.3%	3.5%	0.0%	0.4%	0.4%
Zimbabwe	0.0%	6.9%	0.0%	0.0%	2.2%	0.2%
Total	5.0%	4.0%	0.8%	2.6%	3.3%	2.4%

**Potential Prevalence from Foam Tablets Shipped**

Botswana	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Burundi	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ghana	0.0%	0.0%	2.0%	0.0%	0.5%	0.3%
Kenya	0.0%	0.0%	0.4%	0.4%	0.7%	0.6%
Senegal	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Togo	0.0%	0.1%	0.0%	0.0%	3.5%	0.0%
Uganda	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Zimbabwe	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
Total	0.0%	0.0%	0.5%	0.1%	0.5%	0.2%

**Cumulative Potential Prevalence from All Contraceptives Shipped**

Botswana	21.9%	151.3%	111.6%	97.9%	106.6%	94.8%
Burundi	0.0%	8.9%	5.9%	4.4%	3.5%	2.8%
Ghana	1.3%	2.3%	3.5%	6.1%	7.2%	6.4%
Kenya	12.7%	6.5%	5.0%	6.3%	7.2%	7.8%
Senegal	10.2%	8.1%	5.3%	4.1%	3.3%	3.2%
Togo	0.4%	1.9%	1.3%	1.1%	2.6%	2.3%
Uganda	10.4%	10.7%	9.9%	7.4%	6.4%	6.1%
Zimbabwe	10.1%	35.4%	38.2%	35.6%	38.9%	43.8%
Total	8.3%	11.3%	10.4%	10.1%	10.7%	11.1%

**Cumulative Potential Prevalence from Condoms Shipped**

Botswana	11.1%	8.0%	8.2%	10.1%	14.5%	13.2%
Burundi	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ghana	0.3%	0.9%	0.8%	0.8%	1.2%	1.1%
Kenya	0.0%	0.0%	0.6%	1.1%	1.5%	1.9%
Senegal	0.5%	0.6%	0.4%	0.4%	0.4%	0.6%
Togo	0.0%	0.3%	0.2%	0.3%	0.9%	0.8%
Uganda	0.3%	0.2%	0.2%	0.3%	0.6%	0.6%
Zimbabwe	0.6%	2.6%	2.3%	3.2%	3.7%	3.9%
Total	0.4%	0.7%	0.7%	1.0%	1.4%	1.5%

(con't)

Country	1984	1985	1986	1987	1988	1989
<b>Cumulative Potential Prevalence from Oral Contraceptives Shipped</b>						
Botswana	0.4%	34.4%	32.2%	31.5%	40.1%	32.6%
Burundi	0.0%	8.9%	5.8%	4.3%	3.4%	2.8%
Ghana	0.8%	1.2%	1.8%	3.8%	3.9%	3.3%
Kenya	0.1%	0.2%	0.2%	0.1%	0.1%	0.0%
Senegal	1.6%	2.9%	1.9%	1.4%	1.1%	1.0%
Togo	0.0%	0.2%	0.1%	0.1%	0.1%	0.0%
Uganda	6.8%	6.2%	5.6%	4.1%	3.4%	3.4%
Zimbabwe	9.5%	29.2%	33.6%	30.7%	33.4%	38.3%
Total	2.9%	6.1%	6.3%	5.8%	6.0%	6.3%
<b>Cumulative Potential Prevalence from IUDs Shipped</b>						
Botswana	9.4%	108.9%	71.2%	56.3%	52.0%	49.0%
Burundi	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ghana	0.2%	0.1%	0.1%	1.0%	1.6%	1.5%
Kenya	12.5%	6.2%	4.1%	4.9%	5.2%	5.4%
Senegal	8.1%	4.6%	3.0%	2.2%	1.8%	1.6%
Togo	0.2%	1.3%	0.9%	0.7%	0.9%	0.7%
Uganda	3.2%	4.3%	4.0%	3.0%	2.4%	2.0%
Zimbabwe	0.0%	3.5%	2.3%	1.7%	1.8%	1.5%
Total	5.0%	4.5%	3.2%	3.1%	3.1%	3.0%
<b>Cumulative Potential Prevalence from Foam Tablets Shipped</b>						
Botswana	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Burundi	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ghana	0.0%	0.0%	0.7%	0.5%	0.5%	0.5%
Kenya	0.0%	0.0%	0.1%	0.2%	0.3%	0.4%
Senegal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Togo	0.0%	0.0%	0.0%	0.0%	0.8%	0.6%
Uganda	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Zimbabwe	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	0.0%	0.0%	0.2%	0.2%	0.2%	0.2%

Source: Estimates of Couple Years of Protection from USAID supplied contraceptives were divided by estimates of married women of reproductive age. Cumulative potential prevalence was derived by dividing cumulative CYPs by cumulative married women of reproductive age.

**TABLE A-4.— HUSBAND AND WIFE PREFERENCES FOR FUTURE CHILDREN:  
GHANA 1988**

Wife's Preference	Husband's Preference					TOTAL
	Does Not Future Baby	Wants Baby After 2 Years or More	Wants, Baby Unsure When	Undecided If Want Baby	Wants Baby Within 2 years	
Does Not Want Future Baby	12.2%	6.4%	1.3%	2.3%	2.6%	24.8%
Wants Baby After 2 Years or More	3.4%	28.4%	3.6%	2.2%	6.9%	44.5%
Wants Baby, Not Sure When	0.4%	1.0%	2.0%	0.3%	0.8%	4.5%
Undecided	0.8%	1.9%	0.8%	0.7%	0.7%	5.0%
Wants Baby Within 2 Years	1.3%	4.4%	3.1%	0.7%	11.6%	21.2%
Total	18.2%	42.1%	10.8%	6.2%	22.6%	100.0%

Note: Data relate to cases where both husband and wife were interviewed, approximately one third of the sample of women. Since the tabulation unit was women whose husbands were interviewed, husbands with more than one wife were counted for each wife. Thus, the data displayed in this table may differ slightly from previously published data.

Source: Based on special tabulation of the 1988 Ghana Demographic and Health Survey prepared by the Institute for Development Resources in September 1989.

TABLE A-5.-- TRAVEL TIME TO FAMILY PLANNING OUTLETS

(Note: Calculations in this table were performed on unrounded numbers. Thus, the reader may not be able to reproduce the numbers in the lower panel by using those in the upper panel.)

	Botswana 1984 Any	Kenya 1977/78 Any	Ghana 1979/80 Pill	Zimbabwe 1984 Any
Percent of all women				
Total Women	100%	100%	100%	100%
Don't Know source	25%	57%	64%	29%
Know Source	75%	43%	36%	71%
Travel Time				
No Travel	--	--	9%	17%
Under 15 Minutes	31%	4%	6%	22%
15 to 29 Minutes	20%	5%	7%	14%
30 to 59 Minutes	11%	13%	6%	10%
One Hour or More	13%	21%	8%	7%
Other, na	--	--	0%	1%
Percent of those who know a source				
Know Source	100%	100%	100%	100%
Travel Time				
No Travel	0%	0%	25%	24%
Under 15 Minutes	42%	9%	16%	30%
15 to 29 Minutes	27%	12%	19%	20%
30 to 59 Minutes	15%	30%	17%	14%
One Hour or More	17%	48%	22%	10%
Other	--	--	1%	1%

Source: Data from individual and community surveys for the respective countries.

**TABLE A-6.— TRAVEL TIME AND MODE OF TRANSPORTATION TO FAMILY PLANNING OUTLET BY KNOWLEDGE OF OUTLET: UGANDA 1989**

(Note: Data on existence of a source, mode of transportation, and travel time are from the community survey. Data on knowledge of a family planning source are from the individual survey. At the time these tabulations were done data for some sampling clusters were not available. In addition, security problems precluded survey activities in some parts of Uganda.)

Existence of family planning source; mode of transportation and travel time to source	Women's knowledge of source from individual survey		
	Know Source	Don't know Source	Total
Total	72%	28%	100%
Source Exists	26%	10%	36%
No Source Exists	46%	18%	64%
Source Exist	100%	100%	100%
All Modes	37%	35%	36%
30 Minutes or Less	12%	6%	10%
31 to 60 Minutes	7%	6%	7%
More Than One Hour	18%	23%	19%
Walk	21%	19%	20%
30 Minutes or Less	4%	2%	3%
31 to 60 Minutes	3%	3%	3%
More Than One Hour	14%	15%	14%
Bicycle	8%	11%	9%
30 Minutes or Less	1%	1%	1%
31 to 60 Minutes	2%	3%	3%
More Than One Hour	4%	7%	5%
Motorized	8%	5%	7%
30 Minutes or Less	7%	3%	6%
31 to 60 Minutes	1%	1%	1%
More Than One Hour	0%	0%	0%

Source: Special tabulations of the community and individual surveys.

**TABLE A-7.— PERCENT OF WOMEN LIVING IN AREAS WITH FAMILY PLANNING OUTLETS BY TYPE OF OUTLET, AND YEAR SERVICES WERE FIRST INTRODUCED UGANDA, 1989**

Method Year	Added to Service Area During Year			Living in Service At Yearend		
	Hospital	Health Center	Private Clinic	Hospital	Health Center	Private Clinic
<b>Pill</b>						
1966	1%	--	--	1%	0%	0%
1974	1%	--	--	1%	0%	0%
1975	1%	--	--	2%	0%	0%
1977	5%	--	--	7%	0%	0%
1978	4%	--	--	10%	1%	0%
1980	2%	--	--	12%	1%	1%
1983	1%	1%	--	13%	2%	1%
1984	9%	4%	3%	22%	5%	4%
1985	1%	3%	2%	23%	9%	6%
1986	3%	3%	1%	27%	12%	7%
1987	--	2%	--	27%	14%	7%
1988	2%	2%	3%	29%	16%	11%
Don't Know	6%	1%	2%	35%	18%	12%
Not Stated	1%	4%	1%	36%	22%	13%
No Facility	64%	78%	87%	100%	100%	100%
<b>IUD</b>						
1966	1%	--	--	1%	0%	0%
1974	1%	--	--	1%	0%	1%
1977	4%	--	--	6%	0%	1%
1978	1%	--	--	7%	1%	1%
1980	2%	--	--	8%	1%	1%
1982	--	1%	--	8%	2%	1%
1984	9%	--	--	18%	2%	1%
1985	1%	1%	--	18%	3%	1%
1986	4%	--	--	22%	3%	1%
1987	2%	--	--	24%	3%	1%
1988	1%	1%	--	26%	4%	1%
Don't Know	5%	1%	1%	31%	6%	2%
Not Stated	1%	--	--	31%	6%	2%
No Facility	69%	94%	98%	100%	100%	100%

(Con't)

Method Year	Added to Service Area During Year			Living in Service At Yearend		
	Hospital	Health Center	Private Clinic	Hospital	Health Center	Private Clinic
<b>Injection</b>						
1966	1%	--	--	1%	0%	0%
1974	1%	--	--	1%	0%	1%
1977	4%	--	--	6%	0%	1%
1978	3%	--	--	9%	1%	1%
1980	2%	--	--	11%	1%	1%
1983	--	1%	--	11%	2%	1%
1984	9%	1%	--	20%	3%	1%
1985	1%	1%	1%	21%	4%	1%
1986	2%	4%	1%	24%	7%	2%
1988	2%	2%	1%	26%	9%	3%
Don't Know	6%	1%	2%	32%	10%	5%
Not Stated	--	2%	--	32%	12%	5%
No Facility	68%	88%	95%	100%	100%	100%
<b>Vaginal Methods</b>						
1966	1%	--	--	1%	0%	0%
1974	1%	--	--	1%	0%	1%
1977	5%	--	--	6%	0%	1%
1978	1%	--	--	7%	1%	1%
1980	2%	--	--	9%	1%	1%
1983	--	1%	--	9%	2%	1%
1984	9%	1%	--	18%	3%	1%
1985	--	--	1%	19%	3%	2%
1986	4%	--	--	23%	3%	2%
1988	2%	2%	2%	25%	4%	3%
Don't Know	3%	1%	1%	28%	6%	5%
Not Stated	1%	2%	--	29%	7%	5%
No Facility	71%	93%	95%	100%	100%	100%
<b>Condom</b>						
1966	1%	--	--	1%	0%	0%
1974	1%	--	--	1%	0%	1%
1975	1%	--	--	2%	0%	1%
1977	4%	--	--	6%	0%	1%
1978	3%	--	--	9%	1%	1%
1980	3%	--	--	12%	1%	1%
1983	--	1%	--	12%	2%	1%

(Con't)

Method Year	Added to Service Area During Year			Living in Service At Yearend		
	Hospital	Health Center	Private Clinic	Hospital	Health Center	Private Clinic
1984	9%	4%	—	21%	6%	1%
1985	—	2%	2%	21%	8%	2%
1986	3%	2%	1%	24%	9%	3%
1987	—	1%	—	24%	10%	4%
1988	2%	2%	1%	26%	13%	5%
Don't Know	5%	1%	2%	32%	14%	6%
Not Stated	1%	4%	1%	32%	18%	7%
No Facility	68%	82%	93%	100%	100%	100%
<b>Tubectomy</b>						
1960	1%	—	—	1%	0%	0%
1968	2%	—	—	3%	0%	0%
1969	1%	—	—	4%	0%	0%
1974	1%	—	—	5%	0%	0%
1975	1%	—	—	5%	0%	0%
1977	4%	—	—	9%	0%	0%
1980	1%	—	—	11%	0%	0%
1984	7%	—	—	18%	0%	0%
1985	2%	—	—	20%	0%	0%
1986	2%	—	—	21%	0%	0%
1988	—	—	1%	21%	0%	1%
Don't Know	3%	1%	1%	24%	1%	2%
No Facility	76%	99%	98%	100%	100%	100%
<b>Vasectomy</b>						
1974	1%	—	—	1%	0%	0%
1977	1%	—	—	2%	0%	0%
1980	1%	—	—	3%	0%	0%
1984	3%	—	—	6%	0%	0%
1985	1%	—	—	7%	0%	0%
1986	1%	—	—	8%	0%	0%
Don't Know	2%	1%	1%	10%	1%	1%
No Facility	90%	99%	99%	100%	100%	100%

Source: Based on special tabulations of data from the community survey.