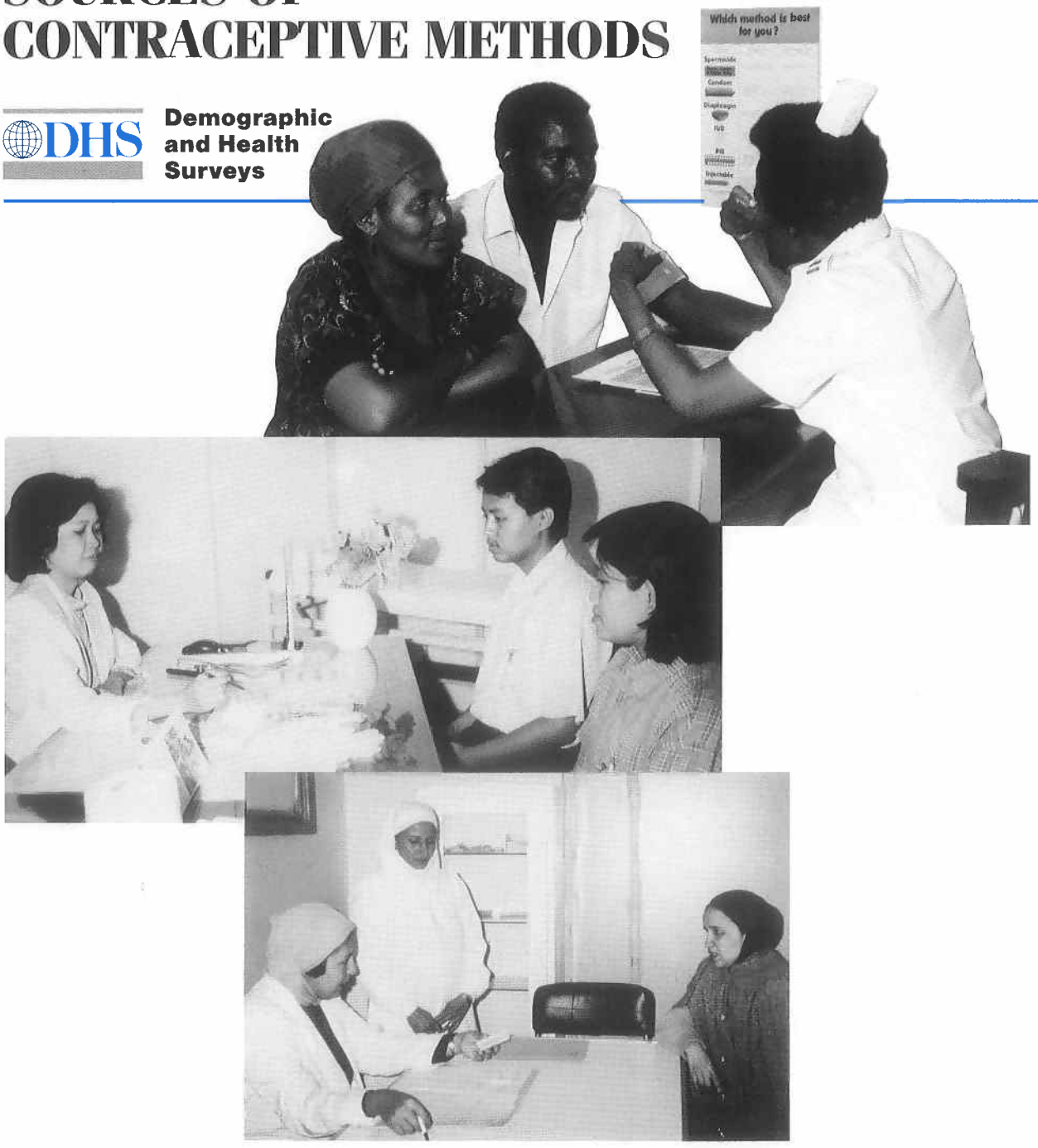
COMPARATIVE STUDIES 11

SOURCES OF CONTRACEPTIVE METHODS

DHS Demographic and Health Surveys



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The main objectives of the DHS program are (1) to promote widespread dissemination and utilization of DHS data among policymakers, (2) to expand the international population and health database, (3) to advance survey methodology, and (4) to develop in participating countries the skills and resources necessary to conduct high-quality demographic and health surveys.

For information about the Demographic and Health Surveys program, write to DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, U.S.A. (Telephone 301-572-0200; Telefax 301-572-0999).

Demographic and Health Surveys
Comparative Studies No. 11

Sources of Contraceptive Methods

MOHAMED AYAD
MARILYN WILKINSON
MELISSA McNIFF

Macro International Inc.
Calverton, Maryland USA

June 1994

Cover photos: Family Health Division, Ministry of Health [Botswana]
Central Bureau of Statistics [Indonesia]
Johns Hopkins Center for Communication Programs

Recommended citation:

Ayad, Mohamed, Marilyn Wilkinson, and Melissa McNiff. 1994. *Sources of Contraceptive Methods*. DHS Comparative Studies No. 11. Calverton, Maryland: Macro International Inc.

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Preface

One of the most significant contributions of the DHS program is the creation of an internationally comparable body of data on the demographic and health characteristics of populations in developing countries. The *DHS Comparative Studies* series examines these data across countries in a comparative framework, focusing on specific topics.

The objectives of the *DHS Comparative Studies* are: to describe similarities and differences between countries and regions, to highlight subgroups with specific needs, to provide information for policy formulation at the international level, and to examine individual country results in an international context. The comparative analysis of DHS data is carried out primarily by staff at the DHS headquarters in Calverton, Maryland. The topics covered in the series are selected by DHS staff in conjunction with the DHS Scientific Advisory Committee and USAID.

The reports in this series are based on a variable number of data sets that generally represent those countries for which data sets were available at the time the report was prepared. Each report provides detailed tables and graphs for countries in four regions: sub-Saharan Africa, Near East/North Africa, Asia, and Latin America/Caribbean. Survey-related issues such as questionnaire comparability, survey procedures, data quality, and methodological approaches are addressed in each report, as necessary. Where appropriate, data from previous survey programs, primarily the World Fertility Survey and the Contraceptive Prevalence Surveys, are used to evaluate trends over time.

As more surveys are conducted under the DHS program and additional data sets become available, some of the reports published early in the series will be updated.

It is hoped that the availability of comparable information for a large number of developing countries will have long-term usefulness for analysts and policymakers in the fields of international population and health.

Martin Vaessen
Project Director

Acknowledgments

The authors wish to thank Noureddine Abderrahim for program assistance and Ann Way for her valuable comments on the manuscript.

1 Introduction

Over the last two decades, most developing countries have been committed to reducing fertility by increasing access to and use of effective contraceptive methods. Since the 1950s, donor agencies have played a major role in initiating and sustaining family planning activities in the developing world. Now, however, they have difficulty providing sufficient funds to cover the increasing demand for contraception. In its Global Population Assistance Report of 1989, UNFPA estimated that total expenditures on family planning would reach $9 billion (US) by the year 2000 (UNFPA, 1989). To meet this demand, while conserving donor and government funds, family planning programs are looking to the private sector to supply an increasing share of contraceptive services (Cross et al., 1991). In recent years, policymakers have been using data on sources of modern methods to measure the performance of both public and private sectors in providing family planning.

Before the Demographic and Health Surveys (DHS) program, data on family planning outlets came mainly from the Contraceptive Prevalence Surveys (CPS) program and service statistics. Service statistics are of limited use, however, because they often cover only government facilities and rarely include the private sector. DHS is the most recent source of information on family planning outlets from nationally representative samples.

This report examines the sources of modern contraception using data from 25 surveys carried out during the first five-year phase of the DHS program (DHS-I). The following sections define the different sources of contraception and discuss the limitations of the data before presenting the results of the analysis and drawing some general conclusions. Appendix A briefly describes the government position on population and family planning. Appendix B presents detailed information on contraceptive sources for each country surveyed. Appendix C presents information on the proportion of women, both users and nonusers, who know of a source for modern contraceptive methods. Appendix D provides information on sources of information about periodic abstinence.

2 Data Sources and Definitions

The individual questionnaire used in DHS-I asked each woman who was currently using a modern method[1] of contraception other than female or male sterilization:

> "Where did you obtain (THE METHOD) the last time?"

Respondents who were sterilized for contraceptive reasons were asked instead:

> "Where did the sterilization take place?"

The coding categories for these two questions included all sources available in that country, many of which were specific to the country. For this analysis, contraceptive sources were reclassified into the following five groups:

(1) *Government stationary*—any government-run facility at a fixed location

(2) *Government mobile*—government outreach workers or mobile units

(3) *Pharmacy*—privately owned sources

(4) *Other private*—private organizations run by non-governmental organizations (NGOs) as well as private doctors, clinics, or other medical providers

(5) *Other sources*—family, friends, and inconsistent responses

Furthermore, modern contraceptive methods were divided into two main categories: supply and clinical methods. Supply methods include the pill, injection, condom, and vaginal methods (diaphragm, sponge, foam, jelly). Clinical methods include the IUD, Norplant, female sterilization, and male sterilization.

The base population for all tables consists of currently married women who were using modern contraception at the time of the survey. Currently married women include all women in a stable sexual relationship regardless of the legal status of their union.

The data are crosstabulated by the respondent's age (15-24, 25-34, 35-49), number of living children (0-2, 3-4, 5+), place of residence (urban or rural), and level of education (none, primary, secondary or higher).

[1]Modern methods include the pill, injection, condom, vaginal methods (diaphragm, sponge, foam, jelly), IUD, Norplant, female sterilization and male sterilization.

3 Limitations of the Data

DHS-I surveys systematically collected data on the sources of family planning methods from current contraceptive users as part of the Individual Questionnaire. These data measure the relative performance of the public and private sectors in providing family planning. While the data can provide a reasonable picture of patterns and trends in contraceptive sources, they do have the following limitations:

1. It is sometimes difficult to classify specific sources as public or private.

In some of the surveys, specific facilities have not been classified as public or private sector as accurately as might be desired. The main problem is a lack of detail in the source categories included in the survey questionnaires. To address this issue, the question on contraceptive sources has been modified for the second round of DHS surveys (DHS-II). The standard response categories are grouped under three major headings to distinguish between the public sector, medical private sector, and other private sector. These headings are included in each country-specific version of the DHS questionnaire, and all known facilities in a country are classified within these three major categories prior to fieldwork.

2. Only the final source of products is measured.

DHS results may understate the importance of some sources of contraception, because the surveys record only the final source of a product and do not identify its original source. In countries such as Egypt and Tunisia, for example, most users purchase pills from private pharmacies. What DHS results fail to indicate, however, is that these pills are supplied to the pharmacies by the public sector at fixed prices.

3. Data quality varies.

Coding errors may have taken place during fieldwork and/or data entry in some countries. In Bolivia, Brazil, and Peru, for example, pharmacies were cited as sources for *clinical* methods by small proportions of the users.

Also, data from Ecuador and Peru is not completely comparable with that from the other countries, because the question on contraceptive sources was phrased differently. In these surveys, the woman was asked where she last received *either* the service *or* advice about a specific method. This wording may affect the results since it is not clear what part of the question each woman was answering.

4. DHS data are not always comparable with data from earlier surveys.

Direct comparison of DHS-I data with data from earlier survey programs, particularly CPS surveys, is not always possible. CPS surveys asked women using modern methods where they usually obtained their methods, while DHS-I surveys asked where they had obtained their method the last time. The difference in the wording of the question may affect the trends in supply methods, particularly oral contraceptives. As more and more countries undertake repeat DHS surveys, however, analysis using only DHS data will allow more accurate assessment of trends.

4 Results

4.1 REGIONAL PATTERNS

Table 4.1 presents the distribution of contraceptive sources for all modern methods by country. In sub-Saharan Africa, the government is the major supplier of modern forms of contraception in all countries with the exception of Ghana, Liberia, Senegal, and Sudan, where private providers are relatively more important. Nongovernment providers also play an important role in Kenya, Togo, and Uganda. Only in Zimbabwe are mobile government providers an important source of modern contraceptives, serving 23 percent of current users.

Government providers are also the major source of contraception in the Near East/North Africa region, except in Egypt. There private providers dominate, especially pharmacies, which supply contraceptives to nearly half of all Egyptian women who use a modern method. In Morocco, one in three women rely on mobile government providers for contraception.

Government providers dominate even more completely in Asia, supplying more than 80 percent of users in each of the three

Table 4.1 Source of modern contraceptive methods

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, Demographic and Health Surveys, 1986-1990

Country	Government		Pharmacy	Other private	Other	Total	Number
	Station-ary	Mobile					
SUB-SAHARAN AFRICA							
Botswana	91.5	0.0	1.5	6.5	0.5	100.0	541
Burundi	(86.5)	(0.0)	(0.7)	(1.5)	(11.4)	(100.0)	33
Ghana	37.3	1.3	22.8	22.2	16.5	100.0	163
Kenya	71.6	1.8	0.7	25.1	0.8	100.0	851
Liberia	36.5	0.0	11.2	51.5	0.7	100.0	196
Mali	(75.9)	(0.0)	(1.5)	(7.6)	(15.0)	(100.0)	37
Senegal	45.8	0.0	2.8	45.8	5.6	100.0	72
Sudan (North)	46.5	0.3	22.6	24.6	6.1	100.0	296
Togo	51.3	0.0	14.5	15.8	18.4	100.0	76
Uganda	52.7	2.8	2.1	39.4	3.1	100.0	80
Zimbabwe	65.1[a]	23.0[a]	—6.7—		5.2	100.0	953
NEAR EAST/ NORTH AFRICA							
Egypt	25.9	0.0	45.7	26.4	2.0	100.0	2914
Morocco	40.9	33.8	9.5	11.9	4.0	100.0	1558
Tunisia	76.5	0.0	13.6	8.8	1.0	100.0	1620
ASIA							
Indonesia	73.8	6.7	2.5	9.8	7.2	100.0	4777
Sri Lanka	78.9	7.4	3.2	8.2	2.2	100.0	2175
Thailand	80.2	3.4	6.9	8.0	1.5	100.0	3957
LATIN AMERICA/ CARIBBEAN							
Bolivia	32.7	0.9	8.7	55.7	1.9	100.0	605
Brazil[b]	28.7	0.1	45.6	23.8	1.8	100.0	1961
Colombia	19.1	0.7	28.0	50.2	2.0	100.0	1487
Dominican Rep.	45.0	3.6	4.6	43.3	3.5	100.0	1921
Ecuador	41.2	0.0	6.4	51.8	0.6	100.0	1056
Guatemala[b]	31.7	3.4	7.3	55.1	2.5	100.0	641
Mexico	61.9	0.2	22.0	14.1	1.8	100.0	2517
Peru	54.2	0.3	20.4	24.6	0.5	100.0	666
Trinidad and Tobago	38.1	0.0	37.1	23.6	1.2	100.0	1161

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
[a]Government figures include local government clinics, the Ministry of Health and the Zimbabwe National Family Planning Council (ZNFPC). ZNFPC is a parastatal organization that receives contributions from the government and outside donors including IPPF.
[b]Women 15-44

countries surveyed. While government mobile services exist in each of these countries, they supply less than a tenth as many women as do stationary government providers. The private sector supplies at most 15 percent of modern users in these Asian countries.

The pattern is quite different in Latin America and the Caribbean, where government sources were cited by a majority of women only in Mexico and Peru, although they are also important in the Dominican Republic and Ecuador. Private providers are the leading sources of modern methods in the other countries, with pharmacies dominating in Brazil. Elsewhere, women most often cite other private providers, such as doctors and facilities operated by private voluntary organizations (including IPPF affiliates and other private family planning organizations).

4.2 SOURCE BY METHOD

Clinical versus Supply Methods

Table 4.2 shows how contraceptive sources differ for clinical and supply methods. Government sources are more important for clinical than supply methods (see Figure 4.1). Pharmacies and mobile government providers are virtually limited to supply methods.

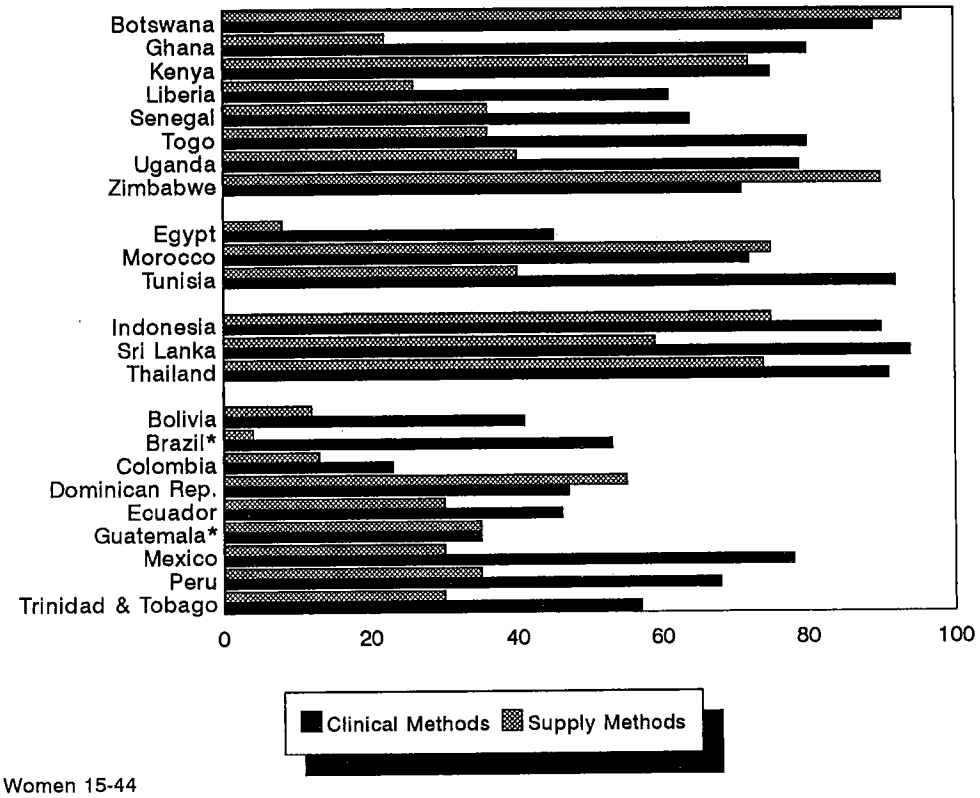
Table 4.2 Source of modern contraceptive methods by type of method (clinical or supply)

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, according to type of method (clinical or supply), Demographic and Health Surveys, 1986-1990

	Clinical Methods							Supply Methods						
	Government							Government						
Country	Stationary	Mobile	Pharmacy	Other private	Other	Total	Number	Stationary	Mobile	Pharmacy	Other private	Other	Total	Number
SUB-SAHARAN AFRICA														
Botswana	88.8	0.0	0.0	10.8	0.3	100.0	174	92.8	0.0	2.2	4.4	0.6	100.0	367
Burundi	*	*	*	*	*	*	10	*	*	*	*	*	*	23
Ghana	(80.0)	(0.0)	(0.0)	(17.8)	(2.2)	(100.0)	48	20.4	1.8	31.9	23.9	22.1	100.0	115
Kenya	74.2	0.4	0.0	24.6	0.8	100.0	401	69.3	3.0	1.3	25.6	0.8	100.0	450
Liberia	61.0	0.0	0.0	36.7	2.3	100.0	59	26.1	0.0	16.0	57.9	0.0	100.0	138
Mali	*	*	*	*	*	*	7	(81.1)	(0.0)	(1.9)	(5.7)	(11.3)	(100.0)	30
Senegal	(64.0)	(0.0)	(0.0)	(28.0)	(8.0)	(100.0)	25	(36.2)	(0.0)	(4.3)	(55.3)	(4.3)	(100.0)	47
Sudan (North)	56.3	0.0	0.0	40.0	3.8	100.0	80	42.9	0.5	30.9	18.9	6.9	100.0	216
Togo	(80.0)	(0.0)	(0.0)	(20.0)	(0.0)	(100.0)	35	(26.8)	(0.0)	(26.8)	(12.2)	(34.1)	(100.0)	41
Uganda	(79.1)	(0.0)	(0.0)	(20.9)	(0.0)	(100.0)	32	(34.9)	(4.6)	(3.4)	(51.9)	(5.1)	(100.0)	48
Zimbabwe	71.3	0.0	—23.4—		5.3	100.0	95	64.5	25.5	—4.7—		5.2	100.0	858
NEAR EAST/ NORTH AFRICA														
Egypt	45.2	0.0	0.2	53.0	1.7	100.0	1419	7.6	0.0	88.9	1.2	2.3	100.0	1495
Morocco	70.9	1.5	0.0	26.9	0.7	100.0	275	34.5	40.8	11.5	8.7	4.5	100.0	1283
Tunisia	92.0	0.0	0.0	7.5	0.4	100.0	1141	39.5	0.0	46.1	11.9	2.5	100.0	479
ASIA														
Indonesia	85.1	4.6	0.0	8.9	1.4	100.0	1840	66.7	8.0	4.1	10.3	10.8	100.0	2937
Sri Lanka	93.3	0.7	0.0	5.6	0.4	100.0	1704	27.0	32.0	14.7	17.6	8.8	100.0	471
Thailand	88.1	2.9	0.0	8.7	0.2	100.0	2199	70.3	4.0	15.5	7.2	3.1	100.0	1758
LATIN AMERICA/ CARIBBEAN														
Bolivia	40.4	0.4	0.1	58.4	0.7	100.0	456	9.4	2.5	35.2	47.1	5.9	100.0	149
Brazil[1]	53.1	0.0	0.1	44.9	2.0	100.0	994	3.7	0.3	92.4	2.1	1.5	100.0	967
Colombia	22.0	0.0	0.0	77.8	0.2	100.0	839	10.8	1.6	64.2	19.1	4.3	100.0	648
Dominican	46.6	0.1	0.0	52.3	1.0	100.0	1490	39.4	15.7	20.3	12.5	12.1	100.0	431
Ecuador	46.2	0.0	0.0	53.7	0.1	100.0	732	29.9	0.0	21.0	47.5	1.5	100.0	324
Guatemala[1]	35.4	0.0	0.0	62.6	2.0	100.0	441	23.5	11.0	23.5	38.5	3.5	100.0	200
Mexico	78.3	0.0	0.0	19.9	1.8	100.0	1677	29.1	0.7	65.8	2.6	1.8	100.0	840
Peru	68.4	0.0	0.8	30.8	0.0	100.0	389	34.3	0.7	48.0	15.9	1.1	100.0	277
Trinidad and Tobago	57.3	0.0	0.0	40.9	1.8	100.0	335	30.3	0.0	52.2	16.6	1.0	100.0	826

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
* Less than 25 cases
[1]Women 15-44

Figure 4.1 Among currently married women 15-49 who are currently using any modern contraceptive method, the percentage using government sources to obtain clinical or supply methods, Demographic and Health Surveys, 1986-1989



* Women 15-44

In both sub-Saharan Africa and the Near East/North Africa region, stationary government facilities are cited by most women using clinical methods. Only in Egypt did more than half of women get a clinical method from a private provider. Private providers also played a substantial role in Kenya, Liberia, Morocco, Senegal, and Sudan, however, supplying at least 25 percent of users.

In the three Asian countries surveyed, government sources supply about nine of every ten women using a clinical method. Government stationary facilities dominate, but mobile providers were cited by nearly 5 percent women currently using a clinical method in Indonesia.

In Latin America and the Caribbean, roughly half of all users obtained their clinical method from a government source while the remainder used private providers, with the most notable exceptions being Bolivia, Colombia, Guatemala, Mexico, and Peru. In Bolivia, Colombia, and Guatemala, other private providers are the primary source of clinical methods. In contrast, government stationary facilities are the primary source of clinical methods in Mexico and Peru.

As expected, pharmacies are a major source of supply methods such as the pill for women around the world. Their role is least important, however, in sub-Saharan Africa. Only in Ghana, Sudan, and Togo do pharmacies supply more than a quarter of women using these types of contraceptives. Over half the women using supply methods in Liberia, Senegal, and Uganda cited other private providers. In Botswana, Kenya, Mali, and Zimbabwe, government stationary facilities are the major source of supply methods, while mobile government providers are also important in Zimbabwe.

In the Near East/North Africa region, pharmacies are the leading source of supply methods in Egypt and Tunisia, while government sources predominate in Morocco. Mobile government providers are more important than stationary government facilities in Morocco.

In the Asian countries surveyed, government providers are the leading source of supply methods, with mobile providers playing the most important role in Sri Lanka. Pharmacies and other private providers are also important sources for women using supply methods, although they serve no more than 35 percent of these women in any country.

In Latin America and the Caribbean, patterns vary widely from one country to another. Pharmacies are the leading source of supply methods in Brazil, Colombia, Mexico, Peru, and Trinidad and Tobago. Other private providers are the major source for women using supply methods in Bolivia, Ecuador, and Guatemala. In contrast, government providers, both stationary and mobile, are the most important sources in the Dominican Republic. Mobile government providers also serve a substantial number of women using supply methods in Guatemala.

Pill, IUD, and Sterilization

Table 4.3 examines sources of supply for three leading methods: the pill, IUD, and female sterilization. In most countries, as expected, these very different methods exhibit a different supply pattern.

In sub-Saharan Africa, stationary government facilities generally dominate, although private sources play a greater role in supplying the pill than the other two methods. In Ghana, Kenya, Liberia, Senegal, Sudan, Togo and Uganda, pharmacies and other private providers are the principal sources for the pill. In Zimbabwe, government mobile sources are important for pill users. The comparatively few IUD users in sub-Saharan Africa rely largely on stationary government facilities, with the exception of Sudan where most IUD users get their method from a private source. Likewise, women who are sterilized nearly always had the operation performed in a government facility.

In the Near East/North Africa region, there is great variation in source between countries for these methods. In Egypt, pharmacies supply most women with the pill and other private providers are the leading source of IUDs, while 70 percent of sterilized women had their operation at a government facility. In Morocco, government sources supply over 70 percent of the women, no matter which method they use; mobile government sources are important only for the pill. In Tunisia, pharmacies are the leading source for pill users, while most women with an IUD and virtually all those who are sterilized used a stationary government facility.

Government providers dominate in all three Asian countries surveyed, no matter what the method. In Sri Lanka, mobile government services are the most common source for pills, while pill users in Indonesia and Thailand largely depend on stationary government facilities. Pharmacies are a more important source for pill users in Thailand than in the other two countries. As for IUDs and female sterilization, from 89 to 97 percent of women using these methods were served by a government provider. In Sri Lanka, nearly one in ten IUD users was served by an outreach worker or mobile clinic.

For most countries in Latin America and the Caribbean, no one source completely dominates the supply of pills. Instead, women look to a mix of government providers, pharmacies, and other private sources. Brazil is notable because 92 percent of women obtain their supplies of the pill from pharmacies. Guatemala and the Dominican Republic are the only Latin American countries where mobile government providers are an important source for pill users. IUDs and sterilizations are largely limited to stationary government facilities and other private providers in this region, with government sources dominating both methods in Mexico and Peru, and private sources dominating both methods in Colombia and Guatemala. In three countries (Bolivia, Ecuador, and Trinidad and Tobago), women were more likely to go to a private source for an IUD but to a government facility for sterilization. The reverse was true in the Dominican Republic.

4.3 SOURCE BY URBAN-RURAL RESIDENCE

Table 4.4 presents the distribution of source by urban-rural residence. With some exceptions, urban users in every region are more likely to go to a private provider, including pharmacies, while rural users more frequently turn to government providers (see Figure 4.2). Mobile government suppliers also play a greater role in rural than urban areas.

In sub-Saharan Africa, one exception to this general pattern is Ghana, where there is little difference in the contraceptive sources used by urban and rural women. In both Mali and Senegal, the very small number of rural users makes any comparison meaningless. Zimbabwe is unique because of the heavy reliance of rural women on government mobile sources.

Private sources are more frequently mentioned by urban than rural users in the Near East/North Africa region, too, except in Egypt where private sources dominate in both rural and urban areas. In Morocco, rural users depend more on mobile than stationary government sources; the reverse is true for urban users.

In all three Asian countries surveyed, urban users are far more likely than their rural counterparts to use a private provider. The difference is especially striking in Thailand, where urban women are more than four times as likely as rural women to get their contraceptive supplies from a pharmacy and almost three times as likely to use another private provider.

Urban women in Latin America and the Caribbean are also more likely to rely on private sources than rural women, with the exception of Mexico and Brazil. Rural users in both these countries use pharmacies more often than do urban users, while rural women in Mexico are also more likely to use other private providers as well.

Table 4.3 Source of method for users of the pill, IUD, and female sterilization

Percent distribution of currently married women 15-49 who are currently using the pill, IUD, or female sterilization, by source of method, Demographic and Health Surveys, 1986-1990

	Pill							IUD							Female Sterilization						
	Government							Government							Government						
Country	Sta-tion-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Sta-tion-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Sta-tion-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber
SUB-SAHARAN AFRICA																					
Botswana	93.8	0.0	1.8	4.4	0.0	100.0	252	90.3	0.0	0.0	9.7	0.8	100.0	96	88.9	0.0	0.0	10.3	0.8	100.0	73
Burundi	*	*	*	*	*	*	6	*	*	*	*	*	*	7	*	*	*	*	*	*	3
Ghana	25.9	3.4	29.3	27.6	13.8	100.0	58	*	*	*	*	*	*	17	(89.3)	(0.0)	(0.0)	(7.1)	(3.6)	(100.0)	31
Kenya	69.3	3.4	1.0	25.4	0.9	100.0	248	72.4	0.2	0.0	26.3	1.2	100.0	177	75.6	0.6	0.0	23.3	0.6	100.0	224
Liberia	23.9	0.0	17.4	58.6	0.0	100.0	118	*	*	*	*	*	*	20	(66.7)	(0.0)	(0.0)	(29.7)	(3.6)	(100.0)	39
Mali	(84.4)	(0.0)	(2.2)	(6.7)	(6.7)	(100.0)	26	*	*	*	*	*	*	4	*	*	*	*	*	*	3
Senegal	(36.6)	(0.0)	(2.4)	(56.1)	(4.9)	(100.0)	41	(64.0)	(0.0)	(0.0)	(28.0)	(8.0)	(100.0)	25	U	U	U	U	U	U	8
Sudan (North)	44.6	0.5	29.4	19.0	6.5	100.0	207	(25.0)	(0.0)	(0.0)	(72.2)	(2.8)	(100.0)	36	(81.8)	(0.0)	(0.0)	(13.6)	(4.6)	(100.0)	44
Togo	*	*	*	*	*	*	11	*	*	*	*	*	*	20	*	*	*	*	*	*	15
Uganda	(31.3)	(1.7)	(4.8)	(55.0)	(7.2)	(100.0)	34	*	*	*	*	*	*	7	(93.6)	(0.0)	(0.0)	(6.4)	(0.0)	(100.0)	25
Zimbabwe	65.1	25.7	—4.0—		5.2	100.0	820	(50.0)	(0.0)	(0.0)	(35.7)	(14.3)	(100.0)	28	80.0	0.0	0.0	18.4	1.6	100.0	62
NEAR EAST/ NORTH AFRICA																					
Egypt	8.5	0.0	87.6	1.3	2.6	100.0	1258	42.6	0.0	0.0	55.6	1.8	100.0	1295	72.8	0.0	1.8	25.4	0.0	100.0	122
Morocco	34.8	41.3	11.1	8.3	4.5	100.0	1247	71.5	1.9	0.0	25.9	0.6	100.0	158	69.8	0.9	0.0	28.4	0.9	100.0	118
Tunisia	40.6	0.0	48.7	8.2	2.5	100.0	355	88.8	0.0	0.0	11.0	0.1	100.0	681	96.7	0.0	0.0	2.4	0.9	100.0	460
ASIA																					
Indonesia	66.3	11.8	1.6	3.3	16.9	100.0	1752	83.3	5.3	0.0	9.9	1.3	100.0	1442	93.5	0.0	0.0	5.9	0.6	100.0	340
Sri Lanka	17.5	49.2	14.0	12.6	6.7	100.0	223	85.3	9.6	0.0	5.0	0.0	100.0	115	96.4	0.0	0.0	3.4	0.2	100.0	1355
Thailand	65.1	5.1	20.5	5.1	4.2	100.0	1161	95.1	1.7	0.0	3.2	0.0	100.0	429	91.4	0.4	0.0	8.3	0.0	100.0	1424
LATIN AMERICA/ CARIBBEAN																					
Bolivia	4.1	0.0	38.9	50.6	6.4	100.0	93	20.1	0.8	0.3	78.1	0.8	100.0	238	62.9	0.0	0.0	36.6	0.5	100.0	217
Brazil[1]	3.9	0.3	92.1	2.3	1.4	100.0	874	(27.5)	(0.0)	(2.5)	(0.0)	(70.1)	(100.0)	33	55.1	0.0	0.0	42.8	2.1	100.0	931
Colombia	13.3	1.7	62.7	19.9	2.4	100.0	468	39.6	0.0	0.0	59.8	0.6	100.0	313	11.7	0.0	0.0	88.3	0.0	100.0	521
Dominican Rep.	40.8	17.3	17.1	12.9	11.9	100.0	363	69.5	1.7	0.0	24.1	4.7	100.0	123	44.5	0.0	0.0	55.1	0.4	100.0	1358
Ecuador	32.8	0.0	18.8	46.8	1.6	100.0	250	28.6	0.0	0.0	71.4	0.0	100.0	290	58.0	0.0	0.0	41.8	0.2	100.0	442
Guatemala[1]	29.3	15.8	11.3	40.6	3.0	100.0	133	11.5	0.0	0.0	88.5	0.0	100.0	61	41.5	0.0	0.0	56.4	2.0	100.0	349
Mexico	32.8	0.8	62.9	1.8	1.6	100.0	553	76.9	0.0	0.0	19.1	4.0	100.0	578	78.8	0.0	0.0	20.5	0.6	100.0	1058
Peru	38.6	1.1	45.0	14.8	0.5	100.0	189	63.4	0.0	1.4	34.6	0.0	100.0	213	74.0	0.0	0.0	26.0	0.0	100.0	177
Trinidad and Tobago	31.0	0.0	52.9	15.9	0.3	100.0	366	42.2	0.0	0.0	56.9	0.9	100.0	116	66.8	0.0	0.0	31.8	1.4	100.0	215

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
U=Unknown (question not asked)
* Less than 25 cases.
[1] Women 15-44

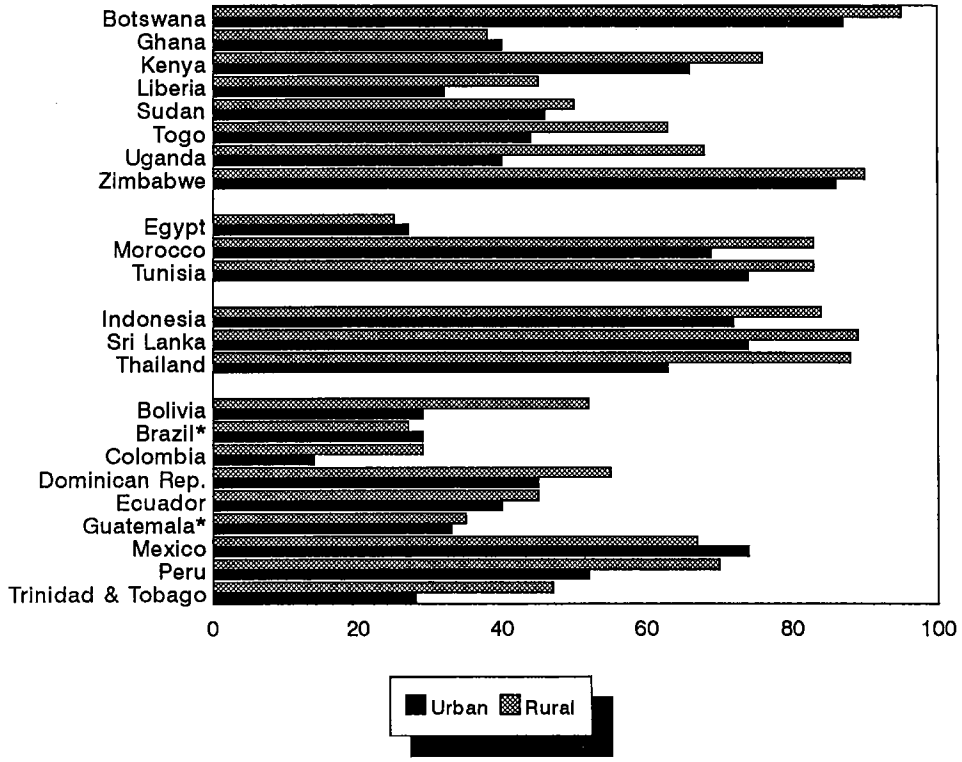
Table 4.4 Source of modern contraceptive method by urban-rural residence

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, according to urban-rural residence, Demographic and Health Surveys, 1986-1990

	Urban							Rural						
	Government							Government						
Country	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber
SUB-SAHARAN AFRICA														
Botswana	87.0	0.0	3.7	8.8	0.5	100.0	220	94.6	0.0	0.0	5.0	0.5	100.0	321
Burundi	*	*	*	*	*	*	12	*	*	*	*	*	*	21
Ghana	38.2	1.3	22.4	22.4	15.8	100.0	78	36.6	1.2	23.2	22.0	17.1	100.0	85
Kenya	65.1	1.0	1.7	31.2	1.0	100.0	190	73.5	2.0	0.4	23.4	0.7	100.0	661
Liberia	32.2	0.0	12.9	53.8	1.1	100.0	128	44.6	0.0	8.1	47.2	0.0	100.0	68
Mali	(79.3)	(0.0)	(1.6)	(8.0)	(11.1)	(100.0)	36	*	*	*	*	*	*	2
Senegal	46.3	0.0	1.5	46.3	6.0	100.0	67	*	*	*	*	*	*	5
Sudan (North)	45.3	0.4	22.9	25.1	6.3	100.0	223	50.0	0.0	21.6	23.0	5.4	100.0	74
Togo	(43.5)	(0.0)	(21.7)	(21.7)	(13.0)	(100.0)	46	(63.3)	(0.0)	(3.3)	(6.7)	(26.7)	(100.0)	30
Uganda	(38.1)	(1.6)	(0.0)	(60.3)	(0.0)	(100.0)	35	(64.3)	(3.7)	(3.7)	(22.8)	(5.5)	(100.0)	45
Zimbabwe	82.8	3.4	—10.4—		3.4	100.0	378	53.4	35.8	—4.4—		6.4	100.0	575
NEAR EAST/ NORTH AFRICA														
Egypt	26.5	0.0	44.5	27.3	1.7	100.0	1946	24.8	0.0	48.0	24.6	2.7	100.0	969
Morocco	41.9	27.5	10.6	17.1	2.9	100.0	934	39.4	43.3	7.9	4.2	5.3	100.0	624
Tunisia	73.5	0.0	15.5	10.0	1.0	100.0	1119	83.2	0.0	9.4	6.2	1.2	100.0	501
ASIA														
Indonesia	69.3	2.4	6.8	18.5	3.0	100.0	1430	75.8	8.5	0.7	6.1	8.9	100.0	3348
Sri Lanka	70.8	3.1	4.8	18.1	3.2	100.0	352	80.5	8.3	2.9	6.3	2.0	100.0	1823
Thailand	62.0	0.8	18.6	16.9	1.7	100.0	723	84.3	4.0	4.2	6.0	1.4	100.0	3234
LATIN AMERICA/ CARIBBEAN														
Bolivia	28.9	0.4	9.6	59.0	2.2	100.0	490	49.1	3.2	5.3	41.4	1.0	100.0	115
Brazil[1]	29.3	0.1	43.4	26.1	1.2	100.0	1527	26.8	0.2	53.4	15.6	3.9	100.0	436
Colombia	13.8	0.3	28.2	55.4	2.3	100.0	1110	26.7	1.9	27.5	42.8	1.1	100.0	377
Dominican Rep.	43.7	1.3	5.8	44.7	4.4	100.0	1230	47.3	7.7	2.3	40.8	1.9	100.0	690
Ecuador	39.5	0.0	6.8	53.0	0.7	100.0	709	44.7	0.0	5.8	49.3	0.3	100.0	347
Guatemala[1]	29.8	3.1	7.2	56.8	3.1	100.0	389	34.5	4.0	7.5	52.4	1.6	100.0	252
Mexico	73.4	0.6	16.1	7.0	2.9	100.0	474	66.7	0.3	20.7	10.2	2.2	100.0	363
Peru	52.2	0.0	21.1	26.2	0.5	100.0	577	67.4	2.2	15.7	14.6	0.0	100.0	89
Trinidad and Tobago	28.2	0.0	42.2	27.7	1.9	100.0	535	46.5	0.0	32.7	20.1	0.6	100.0	626

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
* Less than 25 cases
[1]Women 15-44

Figure 4.2 Among currently married women 15-49 who are currently using any modern contraceptive method, the percentage using government sources by urban-rural residence, Demographic and Health Surveys, 1986-1990



* Women 15-44

4.4 SOURCE BY PARITY

Table 4.5 examines the relationship between contraceptive sources and a woman's parity. Parity is categorized as 0 to 2 children, 3 to 4 children, or 5 or more children. While the trend is not always strong, the same pattern appears in every region: as parity increases, women are less likely to use pharmacies and other private providers and more likely to use a government source. This trend would make sense if users change methods as their parity increases, moving from short-term methods appropriate for spacing to long-term methods appropriate for limiting. Such a shift would imply less reliance on pharmacies, which can provide only short-term methods. In some countries it might also suggest less use of mobile government services and other private providers that do not provide a full range of methods. Instead women would seek out facilities that had the staff and equipment to provide more permanent methods. In practice, this may mean stationary government facilities.

It is difficult to see any unequivocal trends in sub-Saharan Africa because of the small number of users in most countries, especially at low parities. Nevertheless, it does appear that as parity increases women are more likely to use government than private sources. There is little evidence from other sources, however, that a shift in method mix with increasing parity (as described above) is presently taking place in sub-Saharan Africa—with the exception of the use of female sterilization in Botswana, Kenya, and Zimbabwe (Rutenberg et al., 1991).

In the Near East/North Africa region, differences by parity are not strong, but there also seems to be a gradual shift toward greater use of government sources, at the expense of private sources, as parity increases.

Likewise, higher-parity women in Asia use government providers proportionately more (and pharmacies and other private sources proportionately less) than do lower-parity women. In Indonesia and Sri Lanka, women with more children are also less likely to use mobile government providers, although no strong trend is evident in Thailand.

In all the countries in Latin America and the Caribbean, the percentage of women relying on government stationary sources rises with parity. Mobile government sources, however, become

Table 4.5 Source of modern contraceptive methods by number of children

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, according to number of living children, Demographic and Health Surveys, 1986-1990

Country	0-2 Children							3-4 Children							5 Children or More						
	Government							Government							Government						
	Stationary	Mobile	Pharmacy	Other private	Other	Total	Number	Stationary	Mobile	Pharmacy	Other private	Other	Total	Number	Stationary	Mobile	Pharmacy	Other private	Other	Total	Number
SUB-SAHARAN AFRICA																					
Botswana	86.7	0.0	2.4	9.6	1.4	100.0	146	91.2	0.0	1.4	7.4	0.0	100.0	205	96.0	0.0	0.3	3.3	0.3	100.0	183
Burundi	*	*	*	*	*	*	7	*	*	*	*	*	*	12	*	*	*	*	*	*	14
Ghana	(25.0)	(0.0)	(25.0)	(16.7)	(33.3)	(100.0)	36	(1.3)	(4.3)	(19.6)	(23.9)	(10.9)	(100.0)	47	42.3	0.0	22.5	25.4	9.9	100.0	75
Kenya	72.2	1.6	0.8	24.2	1.2	100.0	141	64.4	3.1	1.0	31.5	0.0	100.0	263	75.8	1.1	0.3	21.7	1.2	100.0	445
Liberia	26.0	0.0	20.1	53.9	0.0	100.0	55	38.5	0.0	10.9	50.5	0.0	100.0	63	46.3	0.0	6.3	45.3	2.1	100.0	66
Mali	*	*	*	*	*	*	10	*	*	*	*	*	*	7	*	*	*	*	*	*	13
Senegal	*	*	*	*	*	*	21	*	*	*	*	*	*	22	(44.8)	(0.0	(3.4)	(41.4)	(10.3)	(100.0)	29
Sudan (North)	46.3	1.2	24.4	20.7	7.3	100.0	82	37.5	0.0	26.2	32.5	3.8	100.0	80	51.9	0.0	19.3	22.2	6.7	100.0	134
Togo	*	*	*	*	*	*	21	(40.0)	(0.0)	(20.0)	(12.0)	(28.0)	(100.0)	25	(74.1)	(0.0	(11.1)	(11.1)	(3.7)	(100.0)	27
Uganda	*	*	*	*	*	*	20	*	*	*	*	*	*	19	(56.0)	(4.1	(0.0)	(33.7)	(6.2)	(100.0)	4
Zimbabwe	67.6	19.3	—8.0—		5.1	100.0	333	65.9	21.1	—7.7—		5.3	100.0	323	61.2	29.3	—4.1—		5.4	100.0	294
NEAR EAST/ NORTH AFRICA																					
Egypt	22.2	0.0	44.1	31.2	2.6	100.0	790	26.1	0.0	46.4	26.1	1.5	100.0	1198	28.8	0.0	46.3	22.7	2.2	100.0	920
Morocco	39.9	32.7	10.0	12.5	4.2	100.0	409	37.0	36.6	11.0	12.0	3.4	100.0	465	45.0	32.6	7.8	11.1	3.5	100.0	656
Tunisia	71.4	0.0	15.5	11.7	1.4	100.0	427	75.6	0.0	14.7	9.2	0.5	100.0	598	81.2	0.0	11.2	6.3	1.4	100.0	591
ASIA																					
Indonesia	72.5	7.6	2.1	9.4	8.4	100.0	2022	73.5	6.2	3.4	10.9	6.2	100.0	1688	77.2	5.6	2.0	9.2	6.0	100.0	998
Sri Lanka	57.4	16.2	6.8	15.1	4.5	100.0	606	84.6	5.1	1.8	6.7	1.8	100.0	1014	93.0	2.0	1.4	3.4	0.2	100.0	545
Thailand	78.1	3.2	8.2	8.7	1.8	100.0	1955	84.4	2.8	4.2	8.1	0.5	100.0	1326	85.3	5.4	2.1	6.3	0.9	100.0	523
LATIN AMERICA/ CARIBBEAN																					
Bolivia	15.8	1.6	13.5	66.6	2.5	100.0	189	30.9	0.9	7.1	59.0	2.1	100.0	274	60.5	0.0	5.3	33.3	0.9	100.0	136
Brazil[1]	15.2	0.1	63.7	19.9	1.1	100.0	905	39.3	0.0	25.9	32.4	2.3	100.0	680	51.0	0.6	26.2	19.3	2.9	100.0	310
Colombia	16.3	1.2	36.1	43.9	2.6	100.0	617	16.6	0.5	24.3	56.7	1.9	100.0	524	20.1	0.3	15.5	64.1	0.0	100.0	316
Dominican Rep.	42.7	8.9	9.7	31.3	7.5	100.0	532	42.4	1.4	3.0	52.0	1.2	100.0	760	51.3	1.4	1.2	44.0	2.2	100.0	608
Ecuador	28.5	0.0	10.1	60.5	0.8	100.0	365	42.6	0.0	4.8	52.3	0.2	100.0	413	58.3	0.0	3.0	38.3	0.4	100.0	264
Guatemala[1]	22.2	4.6	14.4	54.2	4.6	100.0	153	32.6	3.0	5.6	57.2	1.6	100.0	304	38.9	3.3	3.9	51.7	2.2	100.0	180
Mexico	53.6	0.0	30.6	13.5	2.3	100.0	921	65.3	0.0	18.2	14.7	1.8	100.0	900	71.7	0.9	11.8	14.6	1.1	100.0	659
Peru	48.0	0.4	23.4	27.8	0.4	100.0	247	49.2	0.0	22.7	27.7	0.4	100.0	242	70.3	0.6	12.8	15.7	0.6	100.0	172
Trinidad and Tobago	33.2	0.0	43.0	23.0	0.8	100.0	491	42.8	0.0	30.0	26.2	1.0	100.0	390	55.3	0.0	21.8	21.8	1.1	100.0	188

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
* Less than 25 cases
[1]Women 15-44

less important in the Dominican Republic as parity increases and women turn increasingly to sterilization (Rutenberg et al., 1991). In every country, pharmacies become less important as women have more children. In contrast, the use of other private providers varies by country: it increases with parity in Colombia and Mexico, decreases with parity in Bolivia and Ecuador, while no straightforward pattern is evident in the other countries.

4.5 SOURCE BY WOMAN'S AGE

Table 4.6 examines the relationship between the sources of contraceptive methods and woman's age. The women are divided into three age groups: 15 to 24 years, 25 to 34 years, and 35 years and over. It is possible that, as they age, women might shift from temporary to more permanent methods as has been hypothesized to occur with increasing parity. Thus, with increasing age, women might shift away from those sources providing largely temporary methods like pharmacies to sources providing permanent methods like stationary government clinics. While this pattern does appear in some countries, the overall results are much less consistent than those for parity.

The small number of users in many sub-Saharan countries makes it difficult to discern any trends. Only Botswana, Kenya, and Zimbabwe have sufficient numbers of users in every age group to permit analysis. The use of government stationary facilities decreases with age in only one of these countries, Botswana. In both Kenya and Zimbabwe, there is no consistent trend.

In the Near East and North Africa region, the use of government stationary providers increases with age in Egypt and Morocco, but not Tunisia. Mobile government suppliers become less important with age in Morocco, and pharmacies decrease in importance with age in Egypt and Tunisia. Morocco is the only one of these countries to show a consistent trend in the use of other private sources: this increases with age.

In all three countries surveyed in Asia, government stationary providers become more important with age, most markedly in Sri Lanka. At the same time, mobile government sources become relatively less important in Indonesia and Sri Lanka as age increases, while they increase slightly in Thailand. The importance of pharmacies decreases as women age in Sri Lanka and Thailand, but the reverse is true in Indonesia. Use of other private sources does not vary by age in Indonesia, while it increases in importance as women age in Thailand and decreases in Sri Lanka.

In Latin America and the Caribbean, as women age they are more likely to use stationary government facilities in Bolivia, Brazil, Ecuador, Guatemala, and Mexico—but are *less* likely to do so in Colombia and the Dominican Republic. While government mobile sources are used more by older users in Bolivia, they appear to be used only by younger users in both the Dominican Republic and Guatemala. In every country in Latin America, the proportion of women relying on the pharmacy decreases with age. Other private sources are most important for older users in Brazil, Colombia, the Dominican Republic, Mexico, Peru, and Trinidad and Tobago; for younger users in Ecuador; and for the middle age group in Bolivia and Guatemala.

4.6 SOURCE BY EDUCATION

Educational level has been divided into three categories: no education, primary education, and secondary or higher education. Women with secondary or higher education in every country are more likely than women with no education to obtain contraceptives from a private source (see Figure 4.3). Education may serve as a proxy here for income level: more educated women may be better able to afford private providers, which presumably are more expensive than government sources.

Table 4.7 shows that, with some exceptions, government sources become less important and private sources more important as educational level increases in sub-Saharan Africa. This trend can be seen in Botswana, Ghana, Kenya, Sudan, and Zimbabwe (when stationary and mobile government sources are combined). The small number of users in Burundi, Mali, and Senegal made results there uninterpretable.

In the three Near East/North African countries surveyed, use of government providers falls with educational level, although only at the secondary level in Egypt. There is no consistent pattern for pharmacies, however: they are used most by the least educated women in Egypt, by the most educated women in Morocco, and by women with primary education in Tunisia. In every country in this region, the use of other private providers increases with educational level.

In every Asian country surveyed, reliance on pharmacies and other private providers rises with educational level. In Sri Lanka and Thailand, the proportion of women using some kind of government provider also falls with education. In Indonesia, reliance on stationary government facilities is higher among users with some education than those with no education. Offsetting this, however, may be the unusually high proportion of women with no education who cite "other" sources of contraception (family, friends, inconsistent responses).

Women in every country surveyed in Latin America and the Caribbean, with the exception of Colombia, are more likely to use stationary government facilities the less educated they are. Conversely, reliance on pharmacies rises with educational level in every country in this region. The use of other private sources also rises with educational level in all countries except Colombia, where they are most important for women with no education.

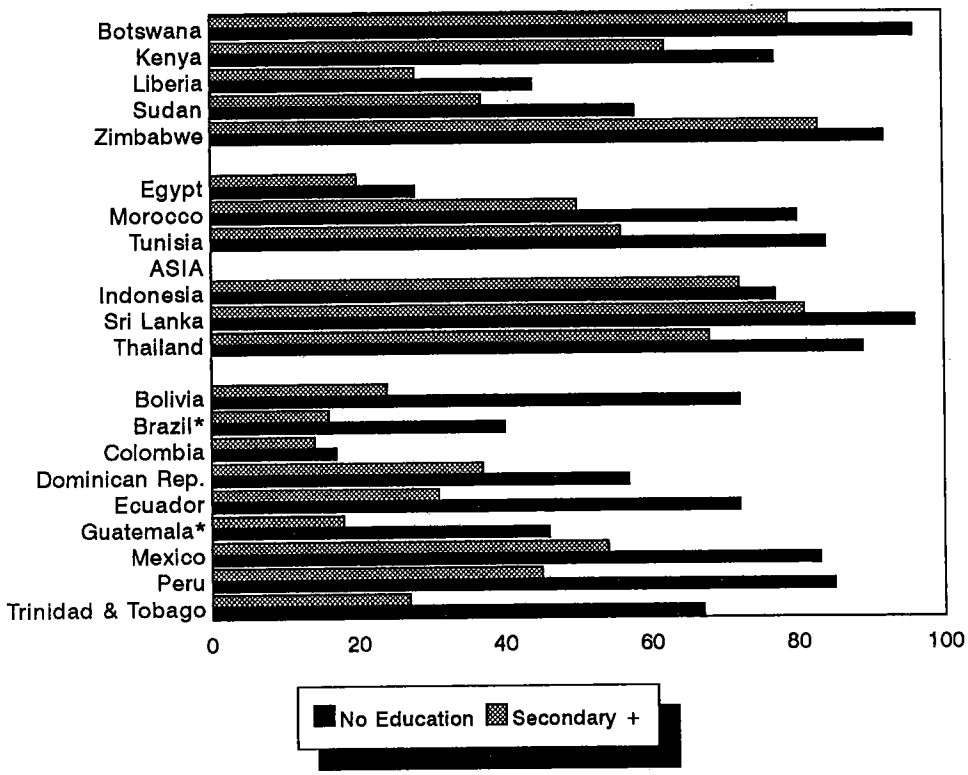
Table 4.6 Sources of modern contraceptive methods by age

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, according to current age, Demographic and Health Surveys, 1986-1990

Country	15-24 Years							25-34 Years							35-49 Years						
	Government							Government							Government						
	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber
SUB-SAHARAN AFRICA																					
Botswana	97.4	0.0	0.9	1.7	0.0	100.0	68	92.3	0.0	1.7	5.5	0.5	100.0	280	88.2	0.0	1.5	9.7	0.6	100.0	193
Burundi	*	*	*	*	*	*	4	*	*	*	*	*	*	18	*	*	*	*	*	*	11
Ghana	*	*	*	*	*	*	24	30.9	2.9	27.9	20.6	17.6	100.0	71	50.0	0.0	15.2	25.8	9.1	100.0	68
Kenya	73.1	2.6	1.0	23.0	0.3	100.0	116	69.1	2.6	1.2	26.7	0.4	100.0	371	73.7	0.7	0.1	24.2	1.3	100.0	364
Liberia	(32.2)	(0.0)	(13.6)	(54.2)	(0.0)	(100.0)	41	25.9	0.0	13.6	60.5	0.0	100.0	91	54.3	0.0	6.4	37.2	2.1	100.0	64
Mali	*	*	*	*	*	*	12	*	*	*	*	*	*	18	*	*	*	*	*	*	8
Senegal	*	*	*	*	*	*	6	(54.3)	(0.0)	(2.2)	(39.1)	(4.3)	(100.0)	46	*	*	*	*	*	*	20
Sudan (North)	(47.8)	(2.2)	(26.1)	(17.4)	(6.5)	(100.0)	46	45.6	0.0	26.5	23.5	4.4	100.0	136	47.0	0.0	16.5	28.7	7.8	100.0	114
Togo	*	*	*	*	*	*	13	(50.0)	(0.0)	(13.3)	(13.3)	(23.3)	(100.0)	30	(63.6)	(0.0)	(15.2)	(15.2)	(6.1)	(100.0)	33
Uganda	*	*	*	*	*	*	13	(37.3)	(0.0)	(0.0)	(62.7)	(0.0)	(100.0)	27	(68.5)	(4.1)	(0.0)	(21.3)	(6.1)	(100.0)	40
Zimbabwe	69.3	23.1	—3.0—		4.5	100.0	264	61.8	23.2	—8.0—		6.9	100.0	461	66.7	22.4	—8.4—		2.6	100.0	228
NEAR EAST/ NORTH AFRICA																					
Egypt	23.2	0.0	47.2	26.8	2.9	100.0	326	24.7	0.0	46.6	26.8	1.9	100.0	1216	27.6	0.0	44.5	26.0	1.9	100.0	1372
Morocco	37.9	39.7	9.6	5.5	7.3	100.0	219	39.7	34.9	10.5	12.1	2.8	100.0	713	43.3	30.5	8.3	14.1	3.8	100.0	626
Tunisia	76.1	0.0	17.4	5.2	1.3	100.0	155	73.9	0.0	14.5	10.5	1.1	100.0	697	78.9	0.0	12.1	8.1	0.9	100.0	768
ASIA																					
Indonesia	71.7	8.8	1.5	10.2	7.8	100.0	965	73.4	6.7	2.6	10.0	7.3	100.0	2271	75.8	5.4	3.0	9.2	6.5	100.0	1541
Sri Lanka	55.7	21.5	7.7	10.9	4.3	100.0	191	74.6	9.5	3.3	10.4	2.3	100.0	912	86.7	3.2	2.3	5.9	1.8	100.0	1072
Thailand	75.1	2.1	14.3	6.2	2.3	100.0	669	80.6	3.6	6.6	7.3	1.8	100.0	1737	82.0	3.7	3.9	9.6	0.8	100.0	1552
LATIN AMERICA/ CARIBBEAN																					
Bolivia	19.7	0.0	19.1	58.8	2.4	100.0	60	24.5	1.9	8.6	62.3	2.7	100.0	289	45.1	0.0	6.5	47.4	1.0	100.0	256
Brazil	10.1	0.2	82.0	6.2	1.5	100.0	350	27.2	0.1	47.8	23.6	1.3	100.0	945	40.6[a]	0.1[a]	23.4[a]	33.2[a]	2.7[a]	100.0	667
Colombia	23.5	2.3	39.5	32.3	2.3	100.0	266	14.8	0.5	33.1	48.6	2.9	100.0	681	16.7	0.2	15.9	66.5	0.7	100.0	540
Dominican Rep.	47.8	13.6	8.7	21.7	8.2	100.0	336	46.2	2.6	5.3	43.2	2.7	100.0	840	42.4	0.3	1.9	53.2	2.2	100.0	745
Ecuador	26.8	0.0	8.7	62.4	2.0	100.0	149	38.6	0.0	7.3	53.7	0.4	100.0	492	49.4	0.0	4.6	45.8	0.2	100.0	415
Guatemala	16.7	14.3	11.9	51.2	6.0	100.0	84	28.8	2.6	8.8	57.2	2.6	100.0	306	40.2[a]	0.8[a]	4.0[a]	53.8[a]	1.2[a]	100.0	251
Mexico	58.5	0.0	31.8	6.4	3.4	100.0	477	59.6	0.0	24.4	14.2	1.7	100.0	1088	66.1	0.6	14.3	17.9	1.1	100.0	955
Peru	56.8	0.0	25.3	17.9	0.0	100.0	95	50.2	0.6	24.6	24.6	0.0	100.0	309	58.0	0.0	13.7	27.1	1.1	100.0	262
Trinidad and Tobago	37.1	0.0	44.5	17.6	0.8	100.0	245	38.6	0.0	39.0	21.2	1.1	100.0	523	37.9	0.0	30.0	30.5	1.5	100.0	393

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
* Less than 25 cases
[a]Women 35-44

Figure 4.3 Among currently married women 15-49 who are currently using any modern contraceptive method, the percentage using government sources by education, Demographic and Health Surveys, 1986-1990



* Women 15-44

Table 4.7 Source of modern contraceptive methods by education

Percent distribution of currently married women 15-49 who are currently using any modern contraceptive method by source of method, according to education, Demographic and Health Surveys, 1986-1990

Country	No Education							Primary							Secondary or Higher						
	Government							Government							Government						
	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber	Station-ary	Mo-bile	Phar-macy	Other private	Other	Total	Num-ber
SUB-SAHARAN AFRICA																					
Botswana	98.9	0.0	0.0	1.1	0.0	100.0	104	96.1	0.0	0.2	3.7	0.0	100.0	273	79.3	0.0	4.6	14.5	1.6	100.0	164
Burundi	*	*	*	*	*	*	14	*	*	*	*	*	*	9	*	*	*	*	*	*	10
Ghana	(54.3)	(2.2)	(19.6)	(15.2)	(8.7)	(100.0)	47	30.9	1.1	22.3	26.6	19.1	100.0	98	*	*	*	*	*	*	18
Kenya	76.8	0.5	0.2	21.6	0.9	100.0	146	74.8	2.5	0.4	21.4	1.0	100.0	470	62.1	1.2	1.7	34.7	0.4	100.0	235
Liberia	43.6	0.0	8.3	46.1	2.1	100.0	66	(48.3)	(0.0)	(18.0)	(33.6)	(0.0)	(100.0)	31	28.2	0.0	11.1	60.7	0.0	100.0	99
Mali	*	*	*	*	*	*	10	*	*	*	*	*	*	21	*	*	*	*	*	*	7
Senegal	*	*	*	*	*	*	21	*	*	*	*	*	*	18	(36.4)	(0.0)	(3.0)	(57.6)	(3.0)	(100.0)	33
Sudan (North)	55.9	1.7	16.9	23.7	1.7	100.0	58	51.8	0.0	16.7	25.4	6.1	100.0	114	37.1	0.0	30.6	24.2	8.1	100.0	124
Togo	(65.5)	(0.0)	(10.3)	(3.4)	(20.7)	(100.0)	2923	*	*	*	*	*	*	23	*	*	*	*	*	*	24
Uganda	*	*	*	*	*	*	13	(57.2)	(1.4)	(0.0)	(39.4)	(2.0)	(100.0)	42	(42.2)	(0.0)	(0.0)	(57.8)	(0.0)	(100.0)	25
Zimbabwe	60.7	31.1	—4.1—		4.1	100.0	122	63.4	26.5	—4.3—		5.9	100.0	543	70.1	12.8	—12.5—		4.5	100.0	288
NEAR EAST/ NORTH AFRICA																					
Egypt	27.7	0.0	49.8	20.6	1.9	100.0	1062	27.9	0.0	46.2	23.4	2.5	100.0	1128	20.1	0.0	39.0	39.6	1.3	100.0	725
Morocco	42.6	37.3	8.0	7.9	4.3	100.0	1105	42.3	29.7	12.2	12.6	3.3	100.0	246	30.2	20.0	14.1	33.2	2.5	100.0	205
Tunisia	83.8	0.0	10.2	4.9	1.1	100.0	850	73.2	0.0	18.5	7.2	1.1	100.0	552	56.4	0.0	14.7	28.0	0.9	100.0	218
ASIA																					
Indonesia	70.5	6.7	0.3	3.8	18.9	100.0	754	76.9	7.6	1.3	8.1	6.1	100.0	2985	67.4	4.2	7.6	19.1	1.7	100.0	1039
Sri Lanka	94.3	3.7	0.0	1.4	0.5	100.0	249	86.8	4.8	1.9	5.9	0.5	100.0	745	70.7	9.9	4.5	11.1	3.7	100.0	1179
Thailand	81.7	6.9	4.5	4.6	2.3	100.0	319	82.0	3.3	5.9	7.3	1.5	100.0	3200	66.3	1.3	15.9	15.9	0.6	100.0	439
LATIN AMERICA/ CARIBBEAN																					
Bolivia	63.1	9.2	0.8	26.8	0.0	100.0	27	45.7	0.6	8.7	43.2	1.8	100.0	205	23.4	0.5	9.4	64.9	2.1	100.0	373
Brazil[1]	39.4	0.6	34.8	18.3	6.8	100.0	136	31.3	0.1	46.5	20.5	1.6	100.0	1424	15.6	0.0	46.5	37.1	0.9	100.0	399
Colombia	17.4	0.0	21.6	61.0	0.0	100.0	91	20.0	0.5	25.8	51.2	2.5	100.0	819	12.9	1.1	32.1	52.3	1.5	100.0	578
Dominican Rep.	54.2	3.2	1.6	35.3	5.7	100.0	88	48.4	4.0	2.3	42.3	2.9	100.0	1319	34.6	2.8	10.8	47.2	4.5	100.0	513
Ecuador	71.7	0.0	4.3	23.9	0.0	100.0	46	46.8	0.0	4.5	47.8	0.9	100.0	556	31.3	0.0	9.0	59.5	0.2	100.0	454
Guatemala[1]	40.3	5.2	3.7	47.8	3.0	100.0	134	34.4	3.6	6.6	53.6	1.9	100.0	366	16.3	1.4	12.8	66.0	3.5	100.0	141
Mexico	81.9	1.3	11.3	4.7	0.8	100.0	154	64.4	0.3	20.0	12.9	2.4	100.0	1483	54.0	0.0	27.2	17.8	0.9	100.0	884
Peru	85.3	0.0	5.9	8.8	0.0	100.0	34	66.1	0.9	15.4	17.2	0.5	100.0	221	45.3	0.0	24.3	29.9	0.5	100.0	411
Trinidad and Tobago	66.7	0.0	0.0	33.3	0.0	100.0	6	48.7	0.0	29.9	20.1	1.2	100.0	591	26.6	0.0	45.0	27.1	1.2	100.0	564

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
* Less than 25 cases
[1]Women 15-44

5 Contraceptive Practice and Contraceptive Source Patterns

Contraceptive prevalence is often used as an indicator of a country's stage of family planning development. However, there is no conceptual framework to explain contraceptive source patterns across countries. Recently, Cross and colleagues (1991) presented a model linking the use of modern contraception with contraceptive source patterns. They contend that at the outset of fertility decline, when contraceptive prevalence is very low, most users of contraception are financially well-off urban residents. At this stage of family planning development, the private, for-profit sector meets the limited demand of high-income urban residents, while NGOs struggle to initiate interest among lower income individuals. During this phase, the government has limited interest in family planning.

Once family planning development reaches its middle stages, the role of NGOs becomes more established with the continued diffusion of family planning information and counseling services. This leads to a strong governmental role in the provision of contraceptive services. During the third and final stage, when the benefits of family planning are widely recognized and long-term methods are in demand, governments attempt to shift the responsibility for providing services to the private sector. Because the cost of high contraceptive prevalence with modern methods is rather exorbitant, demand begins to outstrip government capacity and/or interest in supplying contraceptives at a subsidized price. Consequently the private sector once again becomes the major provider of contraceptives. In this model, NGOs serve mainly as a motivational force in family planning development and do not play a significant role in providing contraception at any stage.

The DHS data presented in Table 5.1 can be used to test this model. In sub-Saharan Africa, the public sector is the major source of family planning methods in the three countries with moderate contraceptive prevalence rates (Botswana, Kenya, and Zimbabwe). Kenya is the only one of these three countries where NGOs supply a large number of modern contraceptive users (17 percent). In the Near East and North Africa region and in the Asian countries surveyed, the role of NGOs is almost nonexistent. However, NGOs provide between 14 and 39 percent of all modern services in four of the countries surveyed in Latin America and the Caribbean (see Figure 5.1).

DHS results indicate clearly that as long as governments have a strong population policy to reduce fertility (see Appendix A), the public sector remains the major provider of family planning services, even in countries where contraceptive prevalence rates are relatively high. Egypt is among the few countries with a comprehensive population policy where the role of the public sector in providing modern contraception is limited (to 26 percent). But, even in this case, the private sector is heavily subsidized by the government.

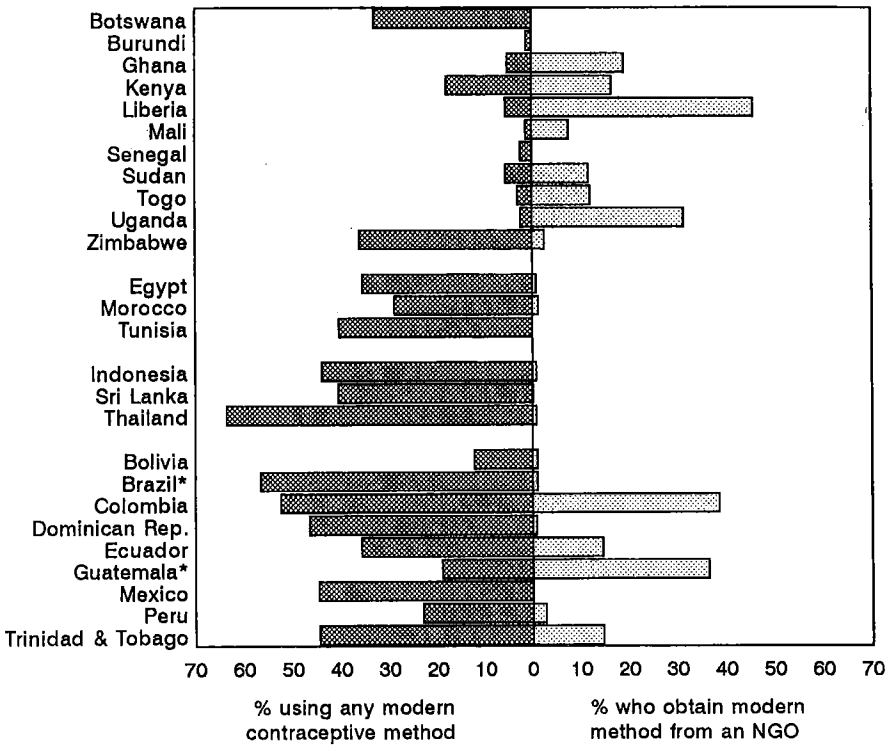
Table 5.1 Contraceptive prevalence and source of modern methods

Contraception prevalence among currently married women 15-49 and percent distribution by source of modern methods, Demographic and Health Surveys, 1986-1990

Country	Year of fieldwork	Contraceptive prevalence: All methods	Contraceptive prevalence: Modern methods	Number	Source of modern contraceptive methods: Private for-profit[1]	NGO[2]	Public[3]	Other[4]	Total	Number
SUB-SAHARAN AFRICA										
Botswana	1988	33.0	33.0	1708	8.0	0.0	91.5	0.5	100.0	541
Burundi	1987	8.7	1.2	2669	(2.1)	0.0	(86.5)	(11.4)	(100.0)	33
Ghana	1988	12.9	5.2	3156	25.3	19.2	38.6	16.5	100.0	163
Kenya	1988/89	26.9	17.9	4765	9.2	16.6	73.4	0.8	100.0	851
Liberia	1986	6.4	5.5	3538	17.1	45.7	36.5	0.7	100.0	196
Mali	1987	4.7	1.3	2948	(1.5)	(7.6)	(75.9)	(15.0)	(100.0)	37
Senegal	1986	11.3	2.4	3365	48.6	0.0	48.5	5.6	100.0	72
Sudan (North)	1989/90	8.7	5.5	5400	35.7	11.8	46.5	6.0	100.0	296
Togo	1988	33.9	3.1	2454	26.3	11.8	51.3	10.5	100.0	76
Uganda	1988/89	4.9	2.5	3180	10.1	31.4	55.4	3.1	100.0	80
Zimbabwe	1988/89	43.1	36.1	2643	4.2	2.5	88.1	5.2	100.0	953
NEAR EAST/ NORTH AFRICA										
Egypt	1988/89	37.8	35.5	8221	71.4	0.7	25.9	2.0	100.0	2914
Morocco	1987	35.8	28.9	5447	20.3	1.2	74.5	4.0	100.0	1558
Tunisia	1988	49.8	40.4	4012	22.5	-	76.5	1.0	100.0	1620
ASIA										
Indonesia	1987	47.7	43.9	10907	12.3	0.8	83.6	0.8	100.0	4777
Sri Lanka	1987	61.7	40.6	5442	10.2	1.1	86.5	2.2	100.0	2175
Thailand	1987	65.5	63.6	6236	14.8	0.8	83.6	1.5	100.0	3957
LATIN AMERICA/ CARIBBEAN										
Bolivia	1989	30.3	12.2	4941	63.5	1.0	33.6	1.9	100.0	605
Brazil[5]	1986	66.2	56.5	3471	68.4	1.0	28.8	1.8	100.0	1961
Colombia	1986	64.8	52.4	2580	39.6	38.6	19.8	2.0	100.0	1487
Dominican Republic	1986	49.8	46.5	4133	47.1	0.8	48.6	3.5	100.0	1921
Ecuador	1987	44.3	35.8	2957	43.7	14.5	41.2	0.6	100.0	1056
Guatemala[5]	1987	23.2	19.0	3377	25.9	36.5	35.1	2.5	100.0	641
Mexico	1987	52.7	44.6	5662	36.1	-	62.1	1.8	100.0	2517
Peru	1986	45.8	23.0	2900	42.6	2.4	54.5	0.5	100.0	666
Trinidad/Tobago	1987	52.7	44.4	2617	46.1	14.6	38.1	1.2	100.0	1161

Note: Figures in parentheses are based on 25-49 cases; "don't know" responses and missing cases are excluded.
[1]**Private for-profit** includes private doctor, private hospital or clinic, pharmacy, market or shop.
[2]**NGO** includes family planning associations affiliated with IPPF and church institutions.
[3]**Public** includes government and parastatal institutions.
[4]**Other** includes friends, parents and other responses.
[5]Women 15-44

Figure 5.1 Percentage of currently married women 15-49 currently using any modern contraceptive method and the percentage who obtain their method from an NGO



* Women 15-44

6 Summary and Conclusions

Some limitations have been identified in the DHS-I data on sources of modern contraceptive methods. There are two major concerns with these data: first, the difficulty in classifying specific facilities as public or private sector and, second, the failure to record the original source of supply methods which may be redistributed by other sources. Despite these shortcomings, the data provide reliable information on contraceptive sources from nationally representative samples.

The public sector remains the main source of family planning methods for half of the 26 countries under review. In all but four countries in sub-Saharan Africa, the government is the major supplier of all forms of modern contraception. In all the Latin American countries except Mexico, however, the majority of currently married users get their contraceptive methods from the private sector. Doctors and other private NGOs, including IPPF affiliates, are the major source of contraception in Bolivia, Colombia, Ecuador, and Guatemala.

The private sector is dominant in providing the pill in 14 countries, with the pharmacy, as expected, being the major source among private providers. For IUD users, the public sector is the major source in sub-Saharan Africa, North Africa (with the exception of Egypt), and Asia. For female sterilization, government providers are dominant in all countries but three (Colombia, Dominican Republic, and Guatemala).

Differentials in contraceptive sources by place of residence show that, overall, urban women rely more on private sources than rural women. As parity, and to a lesser extent age, increase, women in most countries are more likely to turn to stationary government facilities for contraception. Government providers become relatively less important, however, and private sources more important as women's educational level increases.

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Appendix A

Government Positions on Population and Family Planning

SUB-SAHARAN AFRICA

Botswana

The Maternal and Child Health/Family Planning (MCH/FP) Program is a major component of Primary Health Care (PHC) in Botswana. According to Chapter 14 of the 1976-81 National Development Plan (NDP), national health policy seeks to make "family planning advice and materials available to all potential parents and by so doing to achieve a reduction in the population growth rate. In addition the government will undertake research to discover parents' reasons for desiring large families: this is necessary if efforts to persuade people to have fewer children are to be effective."

Workshops and conferences on population and development have taken place to further sensitize policymakers on population matters. The results of the Botswana Family Health Survey of 1984 were disseminated during a seminar held for policymakers and implementers in October 1985. A conference on Population and Development for Parliamentarians and Chiefs was held in September 1986, followed in January 1987 by another conference on the same subject for permanent secretaries and senior public officers. A National Parliamentary Council on Population and Development has since been established to inform legislators and individual constituencies on population and development issues in the country. In January 1989, the government of Botswana created an Interministerial Programme Steering Committee on Population and Development to develop and implement a national population policy.

Sources: Lesetedi et al., 1989; Nortman, 1982.

Burundi

The government of Burundi believes the country's rates of population growth and fertility are too high and has adopted policies favoring family planning and improving women's status. It encourages the spacing of births and believes in full access to birth control, while always respecting individual rights and the cultural traditions of the population. There are no relevant laws concerning sterilization, and abortion is legal for medical reasons. Governmental organizations that deal with population activities include the Ministry of the Interior and the Ministry of Foreign Affairs and Cooperation. Nongovernmental organizations involved in population activities are the Association Burundaise pour le Bien-Etre Familial and the Centre d'Entraide de Développement/Caritas Burundi.

Sources: Segamba et al., 1988; United Nations, 1987.

Ghana

The government of Ghana was the first in sub-Saharan Africa to adopt a population policy. A major objective of this policy is to reduce population growth to a rate of 2 percent per annum by the year 2000. The Ghana National Family Planning Programme (GNFPP) uses existing facilities and personnel to offer family planning services to all, regardless of age, number of living children, or ability to pay. Since its inception in 1970, however, the GNFPP has focused on delivery of family planning services to target groups such as girls under age 18 who are pregnant, women with children under age two, families with histories of poor child survival and development, and women age 30-35 with four or more children. In 1986, a social marketing program was established allowing pharmacies and chemical sellers to sell contraceptives (pills, condoms, and vaginal foaming tablets) through some 3,600 retail outlets.

Nongovernmental agencies like the Planned Parenthood Association of Ghana (PPAG) and the Christian Council of Ghana (CCG) operate family planning clinics as a supplement to the efforts of the Ministry of Health. In addition, the Catholic Secretarial encourages use of the rhythm or ovulation method, and private medical practitioners offer family planning services.

Source: GSS and IRD, 1989.

Kenya

Private family planning activities began in Kenya as early as 1952, and these efforts led to the creation in 1962 of the Family Planning Association of Kenya (FPAK). In its first development plan the government of Kenya recognized the serious impact of population growth, and an official national family planning program was launched in 1967 as an integrated activity within the Maternal and Child Health Division of the Ministry of Health. The 1974-1978 development plan proposed a comprehensive program for achieving specific demographic targets. The goals of the 1975-1979 family planning program were to reduce the annual rate of population growth from 3.3 percent to 3.0 percent over the five-year period and to improve the MCH program.

The 1979 census found a population growth rate of 3.8 percent per annum, far higher than the targeted rate of 3.0 percent. The failure to achieve the targeted rate was the result, in part, of faulty assumptions used in setting the target. The government of Kenya, realizing that the family planning program needed improvement, in 1982 established the National Council for Population and Development (NCPD). The Council's mandate is to formulate population policies and strategies as well as to coordinate the activities of government ministries, nongovernmental organizations, and donors involved in population, integrated rural health, and family planning activities. The government target is to reduce the total fertility rate to 5.2 by the year 2000.

Sources: NCPD and IRD, 1989; Stamper, 1977.

Liberia

It has been argued that until the early 1980s, Liberia successfully balanced economic and population growth. More recently, however, Liberia's declining economic status and relatively high morbidity rates have prompted the government to modify its population policy. As a result, the government now promotes family planning for health reasons and has integrated family planning into the MCH program. The Liberian government directly provides family planning services with the objective of improving maternal and child health and family well-being. It also supports training of paramedical personnel in family planning methods, promotion of natural family planning methods, reduction of infertility, and community-based distribution of contraceptives. Moreover, in April 1986 the Liberian National Population Commission conducted a seminar on the role of fertility regulation in national development.

Family planning services are also available through the private Family Planning Association of Liberia. Abortion is permitted in Liberia if the woman's life is in danger and also on eugenic and juridical grounds. There are no legal provisions concerning sterilization.

Sources: Chieh-Johnson et al., 1988; United Nations, 1989.

Mali

The population issues that most concern the government of Mali are the nation's high rates of morbidity, mortality, and emigration. It supports family planning as a component of its MCH program to reduce maternal and child morbidity and mortality via birth spacing. Mali was one of the first countries in West Africa to repeal the 1920 French colonial law prohibiting the advertising, sale, or distribution of contraceptives. Abortion is illegal but may be authorized to save a woman's life, and sterilization is available for medical reasons. The Population Planning Unit of the Human Resources Division of the Ministry of Planning is charged with integrating population policies into development plans. Nongovernmental organizations involved with population include the Malian Association for the Promotion and Protection of the Family and the Gabriel Touré Hospital. As of 1991, Mali adopted a Declaration of Population Policy (DPP) which gives top priority to the protection and preservation of renewable resources.

Sources: Traoré et al., 1989.

Senegal

Senegal was the first Francophone African country to repeal the 1920 colonial law banning contraceptives. Currently, the government of Senegal is concerned with high population growth and its impact on the country's economic and social structures. In 1988 it adopted a population policy that attempts to balance population growth and development. The government now directly supports efforts aimed at reducing fertility, infant and child mortality, and maternal mortality. Government policy aimed at reducing fertility includes the development of information and training programs to promote child spacing, the encouragement of breastfeeding, and the distribution of contraceptives. The government also intends to expand the country's network of family planning centers. The main organizations involved with family planning in the country are the Association Senegalaise pour le Bien-Etre Familial, the Ministry of Social Development and the Ministry of Health. Sterilization is illegal in Senegal, and abortion is allowed only to protect the health of the mother.

Sources: Ndiaye et al., 1988.

Sudan

Although the government of Sudan has no explicit population policy, it supports family planning activities through the Sudan Family Planning Association and the Ministry of Health. The government has integrated family planning into the overall maternal and child health program as a means of reducing maternal morbidity and mortality. Other objectives of the family planning program are to reduce the high rate of natural population increase and to improve the health of mothers and their children under age five.

Since the Third National Population Conference in 1987, action has been taken to strengthen the maternal and child health and family planning clinical network, to promote population education both in and out of school, and to improve the status of women, especially in rural areas.

Sources: DOS and IRD, 1991; United Nations, 1990.

Togo

Togo does not yet have an official population policy, but the government supports family planning services through the activities of:

- The National Family Welfare Program (Programme National du Bien-Etre Familial or PNBEF)—This is integrated with the Ministry of Public Health program that provides MCH and family planning services.

- The Togolese Association for Family Welfare (Association Togolaise pour le Bien-Etre Familial or ASTBEF)—Established in 1976 to promote family health and birth control, ASTBEF sponsors a network of volunteers throughout Togo as well as a pilot clinic in Lomé to provide family planning information and motivation. It also supplies contraceptives to hospitals and clinics in the major towns of the Health Subdivisions and to the MCH services in order to combat sexually transmissible diseases (STDs).

Abortion is legal under certain medical circumstances, while sterilization is illegal.

Sources: Agounké et al., 1989; United Nations, 1990.

Uganda

Although Uganda lacks an explicit population policy, government interest in population matters dates back to the Third Five-Year Plan (1971/72-1975/76) which devoted an entire chapter to demographic analysis. In 1988, a population secretariat was established in the Ministry of Planning and Economic Development to coordinate population activities conducted by different ministries and to develop population guidelines for the country.

Family planning services currently are provided through clinics administrated by the Family Planning Association of Uganda (FPAU). Since 1980, family planning has been increasingly viewed as an important component of maternal and child health. As a consequence, most government hospitals and health centers also provide family planning services. In spite of this support, coverage remains very low and is largely limited to urban centers; there has been minimal infiltration in the rural areas where 90 percent of Uganda's total population lives. All contraceptive methods are available, although abortion is illegal. Natural family planning is gradually gaining support in Uganda.

Sources: Kaijuka et al., 1989; Stamper, 1977.

Zimbabwe

The Family Planning Association (FPA) established in 1965 initially provided services only to the white community. In 1966, however, the Minister of Health made contraceptive methods available to both African and European populations through government hospitals. The FPA began recruiting field educators to inform and motivate the population; over time their role expanded to include the distribution of contraceptives. They formed the basis for the current community-based distribution system. In 1968, government support for family planning was strengthened by the decision to provide an annual subsidy to the FPA.

In September 1981, in response to harsh criticism, the Family Planning Association was placed under control of the Ministry of Health and renamed the Zimbabwe Child Spacing and Fertility Association (CFSA). In January 1984, the Association legally became the Zimbabwe National Family Planning Council (ZNFPC). The ZNFPC has become the primary provider of family planning through its network of clinics and community-based distributors. The ZNFPC also provides contraceptives to 200 non-ZNFPC hospitals and clinics, operated for the most part by the Ministry of Health or local governments. Abortion is legal only when the mother's life is in danger, in the case of rape or incest, or when the fetus suffers from serious physical or mental impairment. Sterilization is permitted only when age, marital status, and parity are considered.

Sources: CSO and IRD, 1989; United Nations, 1990.

NEAR EAST/NORTH AFRICA

Egypt

Egypt has the largest family planning program in the Middle East and North Africa. Private sector activities were first established in the 1950s, and a large-scale national program stated that population growth was the main obstacle to raising living standards in Egypt.

National population policy has passed through many phases, the latest of which was approved by the National Population Council (NPC) in 1986. Current policy aims are to reduce fertility, to achieve better geographic distribution, and to improve population characteristics with respect to literacy, women's status, child health, and education. The NPC's goal is to reduce the population growth rate to 2.1 percent by 2001. In order to reach this target, the number of couples using contraception must rise from the current level of 3 million to 5.8 million.

Both abortion and sterilization are carried out on medical grounds.

Sources: Gillespie et al., 1989; Khalifa et al., 1982; United Nations, 1987.

Morocco

Morocco has had a national family planning program since 1966. During this same year, a High Population Commission (Commission Supérieure de Population) and Local Population Commis-

sions (Commissions Locales de Population) were established. In 1967, the French law of 1920 prohibiting the advertising, sale, and distribution of contraceptives was repealed. Abortion is authorized only for medical reasons, and sterilization is available.

In Morocco, most family planning activities have been integrated with other preventive health services delivered by the Ministry of Public Health (MPOH). Rural areas are served through the mobile outreach program (Visite à Domicile de Motivation Systématique: VDMS). This approach increases overall contraceptive prevalence, but the heavy reliance on oral contraceptives (the pill comprises 80% of modern contraceptive use) may be a major problem for the Moroccan program.

Source: Azelmat et al., 1989.

Tunisia

Tunisia first established an official population program in favor of family planning in 1964. Over time a series of legislative measures were passed that responded to and reinforced social changes; some also were designed for demographic action. Some of the laws had a direct effect on fertility:

- the 1961 repeal of the French law of 1920 banning the sale and promotion of contraceptives;
- the 1964 increase in the legal age of marriage to 17 for women and 20 for men; and
- the 1973 measure making abortion during the first trimester of pregnancy available to women who do not wish to give birth (prior law allowed abortion only if a woman's health was in danger or if she had at least five living children).

Other laws, numerous and diverse, had an indirect effect on fertility levels:

- the 1956 abolition of polygamy and the husband's sole right of divorce;
- the 1960 and 1988 limitations placed on child allowances, initially restricting them to the first four children, later to the first three children; and
- the 1966 labor legislation establishing equal rights for men and women to work and banning the employment of children under age 15 in industry.

The Office National de la Famille et de la Population (ONFP) was created in 1973 with the responsibility for planning, coordinating, implementing, and evaluating family planning activities. Today, the Tunisian family planning program is one of the most advanced programs in Africa and the Middle East.

Source: Aloui et al., 1989.

ASIA

Indonesia

The Family Planning Association, a private organization affiliated with IPPF, began family planning activities in Indonesia in 1956. In 1968, family planning became a national program with the full assistance, support, and protection of the government, administered through the National Family Planning Institute of Indonesia. Two years later, the Institute was reorganized as the National Family Planning Coordinating Board (NFPCB). Since the NFPCB is a non-departmental body, its Chairman reports directly to the President. The main purposes of the family planning program in Indonesia are:

- to improve the health and welfare of mothers and children as well as their families and the nation in general,

- to improve living conditions by decreasing the birth rate so that population growth will not outstrip productive capacity.

The practice of family planning is entirely voluntary and is supported by religious and community leaders in the country.

The program began in the provinces of Java and Bali, then expanded to the provinces classified as the "Outer Javi-Bali I Region" and "Outer Java-Bali II Region." More recently, there has been a shift towards establishing a wider family planning movement, with the program carrying out activities in cooperation with other government agencies, forming an integrated effort.

Sources: CBS and IRD, 1989: Stamper, 1977.

Sri Lanka

The government of Sri Lanka has long supported family planning for demographic reasons. The national Family Planning Programme was inaugurated in 1965 and operates in close cooperation with the Family Planning Association of Sri Lanka (FPASL), established in 1953. Programme activities are provided through the Ministry of Public Health network within the maternal and child care survey.

Besides the FPASL, there are several other nongovernmental organizations involved with the provision of family planning services. Among these are the Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC) established in 1974 and the Community Development Services (CDS) established in 1978.

Government policy is to provide a variety of family planning services, including information, education, and communication services, as well as the provision of contraceptives. Sterilization is the most widely used method in Sri Lanka. The government supports sterilization through an incentive scheme that provides acceptors with reimbursement of incidental expenses, travel costs, and lost income. It is now also focusing on developing a system to increase the use of effective temporary methods acceptable to the population.

Sources: DCS and IRD, 1988; Nortman, 1982.

Thailand

The official policy to reduce population growth in Thailand was declared in 1970. At the same time, the national Family Planning Program was formally established under the auspices of the Ministry of Public Health. The constitution drafted in 1974 explicitly recognizes the importance of population developments for the nation's welfare, and a special committee was established to advise the cabinet on population policy.

Current national health development programs focus on basic needs: reducing mortality, morbidity, and the incidence of diseases identified as major health problems; expanding and promoting health personnel and infrastructure; and reducing the population growth rate to 1.3 percent by 1991. All modern methods are available, including sterilization and trained paramedical personnel to dispense oral contraceptives.

Sources: Chayovan et al., 1988; Nortman, 1982.

LATIN AMERICA/CARIBBEAN

Bolivia

Until recently, population policy in Bolivia favored increasing the population by encouraging immigration, maintaining fertility, decreasing mortality, and discouraging emigration. However, the Bolivian government has acknowledged the need to improve maternal and child health by modifying fertility levels. Consequently, there is indirect government support for access to contraception. In 1988, the Consejo Nacional de Población (CONAPO) presented these guidelines for population policy in Bolivia:

- Because of the low population density, family planning should not be the objective of population policy in Bolivia; couples should have the right to decide freely on the number of children they want to have. However, family planning (for health rather than demographic reasons) can decrease the number of high risk pregnancies. A number of measures have been implemented to protect mothers and children that may stimulate fertility.
- The Bolivian population is heterogeneous in terms of geographic region, socioeconomic situation, educational level, and cultural background. Population policy should take these differences into account. For instance, in rural areas, sexual education and the provision of family planning services should be emphasized. In urban areas, an informational media campaign is needed to discourage the use of abortion as the dominant method of avoiding unwanted births.

Sources: INE and IRD, 1990; United Nations, 1987.

Brazil

Historically, the Brazilian government has operated from a pronatalist perspective and has felt it inappropriate that policy should influence the rate of growth or fertility level. However, there is heightened concern within the Brazilian government regarding the country's growth rate and its impact on future development. In 1984, the first government-sponsored family planning program was formulated. The government believes individuals should have the right to freely access family planning information and services, and so it has incorporated family planning services into its MCH program.

The major source of family planning in the country is the private organization BEMFAM (Sociedad Civil Bem-Estar Familiar no Brasil), while population issues are addressed through the Ministry of Health and the Ministry of Planning. Currently all forms of contraception are legal, including sterilization. Abortion is legal only on medical or juridical grounds.

Sources: Arruda et al., 1987; United Nations, 1987.

Colombia

Currently, there is no official government policy regarding family planning or fertility in Colombia. Modernization and the success of past policies have brought population growth and fertility to acceptable levels. Moreover, many population issues are addressed by Colombia's social policies, which include measures that improve the status of women (more schooling and labor force participation); expanded family planning programs; and subsidies to promote infant welfare.

The major force behind Colombia's family planning program has been PROFAMILIA (Asociación Pro-Bienestar de la Familia Colombiana), while ASCOFAME (Asociación Colombiana de Facultades de Medicina), an association of medical faculties of major universities, and the Ministry of Health have also participated in the family planning effort. PROFAMILIA, a private organization, has been extremely innovative, being among the first to offer vasectomies, use community-based and commercial-based outreach, emphasize communication and public education as ways

of recruiting clients, and involve professional medical and health organizations in family planning activities. Sterilization is available on demand in Colombia, while abortion is illegal.

Sources: CCRP et al., 1988; United Nations, 1987.

Dominican Republic

In 1968, the government created the Consejo Nacional de Población y Familia (CONAPOFA) and gave it responsibility for training, research, and evaluation. At that time it also adopted the goal of reducing the birth rate to 28 per thousand within a decade. This goal was not achieved, but the program has been strengthened and expanded to include a community-based contraceptive distribution system. Family planning services are also provided by the government's MCH program and by the Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA), which was created in 1966 and became an International Planned Parenthood Federation affiliate in 1969.

- Information and medical referral regarding contraceptive methods;
- Free supply of contraceptive methods;
- Maternal and child health care;
- Gynecology exams; and
- Voluntary sterilization.

Sources: CONAPOFA and IRD, 1987; United Nations, 1987.

Ecuador

The government of Ecuador has not formulated a specific policy concerning the country's level of fertility and rate of demographic growth. However, the government directly supports family planning in order to improve maternal and child health and has established quantitative new acceptor targets. The country's Constitution supports responsible parenthood and appropriate education for the advancement of the family, including the right of parents to have the number of children they can support and educate.

The major government entities involved in family planning are the Consejo Nacional de Desarrollo (CONADE) and the Ministry of Public Health. Private organizations with family planning activities include the Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE) and the Centro Médico de Orientación de Planificación Familiar (CEMOPLAF). Sterilization is allowed for women who are at least age 25 and have 3 children, while abortion is legal in some instances.

Sources: CEPAR et al., 1988; United Nations, 1987.

Guatemala

Guatemala does not have a specific policy on either population growth or the level of fertility. There is increasing concern, however, that the current rate of population growth will result in rising unemployment and underutilize Guatemala's human resource potential. The government is concerned that high population growth will place limitations on the educational and social systems and will hinder the productivity of the work force. Therefore, it is likely that the government will develop an official family planning policy in the future.

The 1985 Constitution guarantees Guatemalan citizens the right to family planning, and the Department of Maternal, Child, and Family Health provides direct and indirect support for family planning programs. The Ministry of Education formed a partnership with APROFAM (Asociación Pro-Bienestar de la Familia), the Guatemalan affiliate of the International Planned Parenthood Federation, to develop population education projects and communication programs. Abortion is illegal except to save the life of the mother. Voluntary sterilization is performed in both government and private institutions.

Sources: INCAP and IRD, 1989; United Nations, 1989.

Mexico

Mexican law treats family planning not as an end in itself, but rather as a means to help the socioeconomic development of the country. A 1974 population policy law established El Consejo Nacional de Población (CONAPO) to implement demographic policy by defining short-, medium-, and long-term goals. The official targets were to reduce the growth rate from 3.2 percent in 1974 to 1.8 percent by 1988 and 1 percent by 2000. To accomplish this, CONAPO aims to expand and improve family planning coverage, to raise the age at which couples marry, and to widen the spacing of births. In 1977, the Plan Nacional de Planificación Familiar (PNPF) was approved, and responsibility for executing the plan was given to the Directorate-General of Family Planning in the Ministry of Health. Its role is to set objectives, goals, and strategies and to establish population policy guidelines.

Public agencies providing health and family planning services are the Maternal and Child Health Care program of the Health Ministry, the National Institute for Infant Protection, the Social Security Institute (Instituto Mexicano del Seguro Social), the Social Security Institute for State Workers (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado), and the Sistema Nacional para el Desarrollo Integral de la Familia.

Sources: DGPF et al., 1989; Nortman, 1982.

Peru

The Population Law enacted in July 1985 forms the basis of Peru's population policy. While this law prohibits abortion and sterilization as methods of family planning, it guarantees couples the right to freely determine the number and spacing of children. Sources indicate that both sterilization and abortion may be performed for medical reasons. The national government is actively involved in disseminating information about the health advantages of family planning, and it has set a target fertility rate of 3.0 to be reached by the year 2000. The Directorate-General of Family Planning was created within the Ministry of Health to coordinate all family planning activities in both the public and private sectors. The urban poor and the poor living in the suburbs of Lima have been selected as the main targets of family planning services. While the government is also concerned with adolescent fertility, access to contraception by unmarried adolescents is officially prohibited.

INPPARES (Instituto Peruano de Paternidad Responsable), an IPPF affiliate, is the main organization involved in family planning in Peru, and the National Population Commission is the main government entity involved with population matters.

Sources: INE et al., 1988; United Nations, 1990.

Trinidad and Tobago

The government has supported family planning since 1967 as part of its policy to reduce the rate of population growth. In June 1967, a population council was appointed to give overall direction to the National Family Planning Programme in collaboration with the Family Planning Association of Trinidad and Tobago (FPATT) and the Catholic Marriage Advisory Council (since renamed the Archdiocesan Family Life Commission, or AFLC).

Currently, the government offers family planning at 95 health centers; the FPATT operates two facilities; and the AFLC provides instructions on natural family planning at 10 facilities. Contraceptive information and supplies thus are easily available on both islands.

Source: Heath et al., 1988.

Appendix B

Sources of Modern Contraceptive Methods

Table B.1 Source of supply for modern contraceptive methods: Botswana

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Botswana DHS, 1988

	Supply Methods			Clinical Methods			
Source of supply	Pill	Injection	Total	IUD	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY							
Government Health Post	1.7	3.1	2.0	0.0	0.0	0.0	1.3
Government Clinic	84.3	73.8	80.4	66.8	0.0	37.0	66.4
Government Hospital/HC	7.7	18.1	10.3	23.5	88.9	51.8	23.6
PHARMACY	1.8	0.0	2.2	0.0	0.0	0.0	1.5
OTHER PRIVATE							
Private Doctor/Clinic	4.4	4.4	4.4	9.7	10.3	10.8	6.5
OTHER/DON'T KNOW	0.0	0.0	0.6	0.0	0.8	0.3	0.5
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	252	93	367[a]	96	73	174[b]	541

HC = Health Center
[a]Includes current users of condom (N=22) and diaphragm (N=1)
[b]Includes current users of male sterilization (N=4)

Table B.2 Source of supply for modern contraceptive methods: Burundi

Percent distribution of currently married women 15-49 who are using a modern contraceptive method by most recent source of supply, Burundi DHS, 1987

Source of supply	All Modern Methods
GOVERNMENT STATIONARY	
Govt. Hospital/Maternity	(45.4)
Govt. Health Center	(18.6)
Govt. Dispensary	(22.4)
PHARMACY	(0.7)
OTHER PRIVATE	
Private Doctor	(1.5)
OTHER/DON'T KNOW	(11.4)
Total percent	(100.0)
Number of users	33[a]

Note: Figures in parentheses are based on 25-49 cases.
[a]Includes current users of the pill (N=6), injection (N=15), condom (N=2), IUD (N=7), and female sterilization (N=3)

Table B.3 Source of supply for modern contraceptive methods: Ghana

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Ghana DHS, 1988

Source of supply	Supply Methods			Clinical Methods		All Modern Methods
	Pill	Vaginals	Total	Female Sterilization	Total	
GOVERNMENT STATIONARY						
Government Hospital	20.7	(2.5)	12.2	(80.6)	(72.9)	30.1
Government Health Center	5.2	(10.0)	7.8	(0.0)	(2.1)	6.1
GOVERNMENT MOBILE						
Field Worker	3.4	(0.0)	1.7	(0.0)	(0.0)	1.2
PHARMACY	29.3	(40.0)	31.3	(0.0)	(0.0)	22.1
OTHER PRIVATE						
PPAG Clinic	24.1	(12.5)	21.7	(3.2)	(12.5)	19.0
Private Doctor/Clinic	3.4	(0.0)	1.7	(3.2)	(4.2)	2.5
Christian Council	1.7	(0.0)	0.9	(0.0)	(0.0)	0.6
OTHER/DON'T KNOW	12.1	(35.0)	22.6	(5.2)	(4.1)	18.4
Total percent	100.0	(100.0)	100.0	(100.0)	(100.0)	100.0
Number of users	58	40	115[a]	31	48[b]	163

Note: Figures in parentheses are based on 25-49 cases.
PPAG = Planned Parenthood Association of Ghana/IPPF affiliate
[a]Includes current users of injection (N=8) and condom (N=9)
[b]Includes current users of IUD (N=17)

Table B.4 Source of supply for modern contraceptive methods: Kenya

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Kenya DHS, 1989

Source of supply	Supply Methods			Clinical Methods			All Modern Methods
	Pill	Injection	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY							
Government Hospital	43.4	55.0	47.7	55.1	75.3	66.4	56.5
Government Clinic/ Health Center	25.9	14.4	21.5	17.2	0.3	7.8	15.0
GOVERNMENT MOBILE							
Mobile Clinic	1.3	3.2	1.8	0.2	0.6	0.4	1.2
Field Educator	2.1	0.0	1.1	0.0	0.0	0.0	0.6
PHARMACY	1.0	0.0	1.3	0.0	0.0	0.0	0.7
OTHER PRIVATE							
FPAK Clinic	14.2	14.0	13.5	12.1	2.9	7.0	10.4
Other Hospital/Clinic	5.8	6.2	6.1	1.9	9.8	6.3	6.2
Private Doctor	5.4	6.4	6.0	12.3	10.6	11.3	8.5
OTHER/DON'T KNOW	0.9	0.9	0.8	1.2	0.6	0.9	0.9
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	248	159	451[a]	177	224	401	852

FPAK = Family Planning Association of Kenya/IPPF affiliate
[a]Includes current users of condom (N=23) and vaginal methods (N=21)

Table B.5 Source of supply for modern contraceptive methods: Liberia

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Liberia DHS, 1986

	Supply Methods		Clinical Methods		
Source of supply	Pill	Total	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY					
Government Hospital/Clinic	23.9	26.1	(66.7)	61.0	36.5
PHARMACY					
Pharmacy/Shop	17.4	16.0	(0.0)	0.0	11.2
OTHER PRIVATE					
FPAL Clinic	52.5	49.5	(3.6)	14.7	39.1
Church Hospital/Clinic	2.5	3.3	(18.3)	14.4	6.6
Private Doctor/Clinic	3.6	5.1	(7.9)	7.6	5.9
OTHER	0.0	0.0	(3.6)	2.3	0.7
Total percent	100.0	100.0	(100.0)	100.0	100.0
Number of users	118	138[a]	39	59[b]	196

Note: Figures in parentheses are based on 25-49 cases.
FPAL = Family Planning Association of Liberia/IPPF affiliate
[a]Includes current users of injection (=12), condom (=2) and vaginal methods (N=6)
[b]Includes current users of IUD (N=20)

Table B.6 Source of supply for modern contraceptive methods: Mali

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Mali DHS, 1987

	Supply Methods		
Source of supply	Pill	Total	All Modern Methods
GOVERNMENT STATIONARY			
Govt. MCH Center	(53.3)	(49.1)	(44.0)
Govt. Dispensary	(13.4)	(16.9)	(13.6)
Govt. Health Center	(17.8)	(15.1)	(18.3)
PHARMACY	(2.2)	(1.9)	(1.5)
OTHER PRIVATE			
AMPPF Clinic	(6.7)	(5.7)	(7.6)
OTHER	(6.7)	(11.3)	(15.0)
Total percent	(100.0)	(100.0)	(100.0)
Number of users	26	31[a]	38[b]

Note: Figures in parentheses are based on 25-49 cases.
AMPPF = Association Malienne pour la Protection et la Promotion de la Famille/IPPF affiliate
[a]Includes current users of injection (N=2), condom (N=1) and vaginal methods (N=2)
[b]Includes current users of IUD (N=7) and female sterilization (N=3)

Table B.7 Source of supply for modern contraceptive methods: Senegal

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Senegal DHS, 1986

Source of supply	Supply Methods		Clinical Methods		All Modern Methods
	Pill	Total	IUD	Total	
GOVERNMENT STATIONARY					
Government Hospital	(12.2)	(14.9)	(16.0)	(16.0)	15.3
Government Dispensary	(14.6)	(12.8)	(28.0)	(28.0)	18.1
Government MCH Center	(9.8)	(8.5)	(20.0)	(20.0)	12.5
PHARMACY	(2.4)	(4.3)	(0.0)	(0.0)	2.8
OTHER PRIVATE					
Private Doctor/Hospital	(56.1)	(55.3)	(28.0)	(28.0)	45.8
OTHER	(4.9)	(4.3)	(8.0)	(8.0)	5.6
Total percent	(100.0)	(100.0)	(100.0)	(100.0)	100.0
Number of users	41	47[a]	25	25[b]	72

Note: Figures in parentheses are based on 25-49 cases.
[a]Includes current users of injection (N=2), condom (N=2) and vaginal methods (N=2)
[b]Eight sterilized women were not asked about source and are therefore excluded from this table.

Table B.8 Source of supply for modern contraceptive methods: Sudan (North)

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Sudan DHS, 1989/90

Source of supply	Supply Methods		Clinical Methods			All Modern Methods
	Pill	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY						
Government Hospital	10.6	10.6	(13.9)	(81.8)	51.3	64.0
Government Health Center	31.2	30.0	(8.3)	(0.0)	3.8	22.9
Dispensary	1.9	1.8	(0.0)		0.0	1.4
Other Health Center	0.5	0.5	(2.8)		1.3	0.7
GOVERNMENT MOBILE						
Mobile Clinic	0.5	0.5	(0.0)	(0.0)	0.0	0.3
PHARMACY	29.3	30.9	(0.0)	(0.0)	0.0	22.6
OTHER PRIVATE						
FP Clinic	14.4	14.3	(11.1)	(3.2)	5.0	11.8
Private Doctor	3.9	3.7	(52.8)	(11.4)	30.0	10.8
Private Hospital	0.5	0.9	(8.3)	(2.3)	5.0	2.0
OTHER/DON'T KNOW	7.2	6.9	(2.8)	(4.6)	3.8	6.1
Total percent	100.0	100.0	(100.0)	(100.0)	100.0	100.0
Number of users	208	217[a]	36	44	80	297

Note: Figures in parentheses are based on 25-49 cases.
[a]Includes current users of injection (N=3) and condom (N=6)

Table B.9 Source of supply for modern contraceptive methods: Togo

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to type of method, Togo DHS, 1988

Source of supply	Supply Methods	Clinical Methods	All Modern Methods
	Total	Total	
GOVERNMENT STATIONARY			
Govt. Hospital	(19.5)	(74.3)	44.7
Govt. Dispensary	(2.4)	(0.0)	1.3
Govt. Health Center	(4.9)	(5.7)	5.3
PHARMACY	(26.8)	(0.0)	14.5
OTHER PRIVATE			
Private Clinic	(4.9)	(2.9)	3.9
ATBEF Clinic	(7.3)	(17.1)	11.8
OTHER/DON'T KNOW	(19.5)	(0.0)	10.5
Market	(14.6)	(0.0)	7.9
Total percent	(100.0)	(100.0)	100.0
Number of users	41[a]	35[b]	76

Note: Figures in parentheses are based on 25-49 cases.
ATBEF = Association Togolaise pour le Bien-Etre Familal/IPPF affiliate
[a]Includes current users of pill (N=11), injection (N=5), condom (N=10) and vaginals methods (N=15)
[b]Includes current users of IUD (N=20) and female sterilization (N=15)

Table B.10 Source of supply for modern contraceptive methods: Uganda

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Uganda DHS, 1988-89

Source of supply	Supply Methods		Clinical Methods		All Modern Methods
	Pill	Total	Female Sterilization	Total	
GOVERNMENT STATIONARY					
Government Hospital	(23.0)	(22.2)	(93.6)	(79.1)	45.1
Government Health Center	(8.3)	(12.7)	(0.0)	(0.0)	7.6
GOVERNMENT MOBILE					
Field Worker	(1.7)	(4.6)	(0.0)	(0.0)	2.8
PHARMACY	(4.8)	(3.4)	(0.0)	(0.0)	2.1
OTHER PRIVATE					
FPAU Clinic	(42.6)	(43.1)	(0.0)	(14.0)	31.4
Private Doctor	(5.7)	(4.1)	(0.0)	(0.0)	2.4
Private Hospital/Clinic	(6.6)	(4.7)	(6.4)	(6.9)	5.6
OTHER/DON'T KNOW	(7.2)	(5.1)	(0.0)	(0.0)	3.1
Total percent	(100.0)	(100.0)	(100.0)	(100.0)	100.0
Number of users	34	48[a]	25	32[b]	80

Note: Figures in parentheses are based on 25-49 cases.
FPAU = Family Planning Association of Uganda/IPPF affiliate
[a]Includes current users of injection (N=13) and condom (N=1)
[b]Includes current users of IUD (N=7)

Table B.11 Source of supply for modern contraceptive methods: Zimbabwe

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Zimbabwe DHS, 1988

Source of supply	Supply Methods			Clinical Methods			All Modern Methods
	Pill	Condom	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY							
Govt. Hospital/Clinic	14.6	(6.5)	14.6	14.3	72.6	55.2	18.7
Municipal/Local Clinic	17.7	(16.1)	17.5	10.7	3.2	6.3	16.4
Rural Council Clinic	18.5	(16.1)	18.3	0.0	0.0	0.0	16.5
ZNFPC Clinic	14.3	(9.7)	14.1	25.0	1.6	8.3	18.7
GOVERNMENT MOBILE							
Community Based Distribution Worker	25.8	(25.8)	25.5	0.0	0.0	0.0	22.9
OTHER PRIVATE							
Private Doctor[a]	1.5	(19.4)	2.4	32.1	12.9	18.8	4.1
Commerce/Industry	0.6	(0.0)	0.6	0.0	0.0	0.0	0.5
Mission/Church	1.8	(0.0)	1.7	3.6	4.8	4.2	2.0
OTHER/DON'T KNOW	5.2	(6.4)	5.3	14.3	1.6	5.2	5.3
Total percent	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	820	31	858[b]	28	62	96[c]	954

Note: Figures in parentheses are based on 25-49 cases.
ZNFPC = Zimbabwe National Family Planning Council
[a]Includes pharmacy
[b]Includes current users of injection (N=7)
[c]Includes current users of male sterilization (N=6)

Table B.12 Source of supply for modern contraceptive methods: Egypt

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Egypt DHS, 1988

Source of supply	Supply Methods				Clinical Methods			All Modern Methods
	Pill	Condom	Vaginals	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY								
Government FP Clinic	3.0	0.7	(0.0)	2.7	13.7	0.0	12.5	7.5
Government MCH Center	2.2	0.0	(3.3)	1.9	7.9	0.0	7.2	4.5
Government Hospital	3.3	0.6	(0.0)	3.1	21.0	72.8	25.5	14.0
PHARMACY	87.5	97.8	(96.7)	88.8	0.0	1.8	0.2	45.7
OTHER PRIVATE								
Private FP Clinic	0.3	0.0	(0.0)	0.2	1.3	0.0	1.2	0.7
Private Doctor/Clinic	0.9	0.3	(0.0)	0.8	54.3	25.4	51.8	25.6
OTHER/DON'T KNOW	2.8	0.6	(0.0)	2.4	1.8	0.0	1.7	2.1
Total percent	100.0	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	1258	198	34	1497	1295	122	1419	2916

Note: Figures in parentheses are based on 25-49 cases.

Table B.13 Source of supply for modern contraceptive methods: Morocco

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Morocco DHS, 1987

	Supply Methods			Clinical Methods			
Source of supply	Pill	Condom	Total	IUD	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY							
Public Hospital	1.4	(0.0)	1.3	13.3	55.1	31.3	6.6
Govt. Maternity Center	0.5	(0.0)	0.5	5.1	10.2	7.2	1.6
Govt. Health Center	4.6	(0.0)	4.5	26.6	3.4	16.5	6.6
Govt. Dispensary	28.0	(34.5)	27.8	26.6	0.0	15.1	25.6
GOVERNMENT MOBILE							
Home Visit	36.3	(37.9)	35.9	0.0	0.8	0.8	29.6
Mobile Clinic	4.6	(0.0)	4.4	1.9	0.0	1.1	3.8
PHARMACY	11.0	(13.8)	11.4	0.0	0.0	0.0	9.4
OTHER PRIVATE							
AMPF Clinic	1.0	(0.0)	1.0	3.2	0.0	1.8	1.1
Private Clinic	2.7	(3.4)	2.8	8.2	27.1	16.2	5.1
Private doctor/Midwife	4.4	(6.9)	4.9	14.6	0.8	8.6	5.5
OTHER/DON'T KNOW	4.4	(3.4)	4.4	0.6	0.8	0.8	3.8
Total percent	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	1247	29	1298[a]	158	118	278[b]	1576

Note: Figures in parentheses are based on 25-49 cases.
AMPF = Association Marocaine de Planification Familiale/IPPF affiliate
[a]Includes current users of injection (N=15) and vaginal methods (N=7)
[b]Includes current users of male sterlization (N=2)

Table B.14 Source of supply for modern contraceptive methods: Tunisia

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Tunisia DHS, 1988

	Supply Methods					Clinical Methods			
Source of supply	Pill	Injection	Condom	Vaginals	Total	IUD	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY									
Govt. Hospital/MCH Center	14.1	(18.8)	11.8	(7.3)	13.6	26.0	55.7	37.9	30.7
Govt. FP Clinic (CREPF)	9.6	(0.0)	21.6	(9.8)	10.2	31.0	38.5	34.0	27.0
Govt. Maternity Center/Dispensary	16.6	(12.5)	5.9	(14.6)	15.0	31.3	2.4	19.6	18.3
GOVERNMENT MOBILE									
Outreach Clinic/Service Points[1]	0.3	(0.0)	2.0	(2.4)	0.6	0.6	0.2	0.4	0.5
PHARMACY	48.7	(0.0)	47.1	(58.5)	46.1	0.0	0.0	0.0	13.6
OTHER PRIVATE									
Private Doctor/Clinic	8.2	(68.8)	7.8	(4.9)	11.9	11.0	2.4	7.5	8.8
OTHER/DON'T KNOW	2.5	(0.0)	3.9	(2.4)	2.5	0.1	0.9	0.5	1.0
Total percent	100.0	(100.0)	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	355	32	51	41	479	681	460	141	1620

Note: Figures in parentheses are based on 25-49 cases.
CREPF = Centre Régional de l'Education et du Planning Familal de l'Office National de la Famille et de la Population
[1]Called "Salle de Soins/Points de Rassemblement" and are served by a mobile clinic

Table B.15 Source of supply for modern contraceptive methods: Indonesia

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Indonesia DHS, 1987

	Supply Methods					Clinical Methods			All Modern Methods
Source of supply	Pill	Injection	Condom	Vaginals	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY									
FP Clinic/Hospital/HC	30.9	65.0	23.1	42.3	75.9	93.3	(63.1)	78.9	56.4
Integrated Service Post (Volunteers)	6.0	4.3	1.3	5.1	2.5	0.0	(3.5)	2.1	4.0
FP Post	29.4	3.3	9.6	19.2	4.9	0.0	(3.1)	3.9	13.3
GOVERNMENT MOBILE									
Govt. FP Field Worker	11.6	1.4	4.3	7.6	2.3	0.0	(3.4)	1.9	5.4
Govt. Mobile Clinic	0.3	0.6	0.1	0.4	1.4	0.0	(10.2)	1.3	0.7
Govt. Safari Campaign Drive	0.0	0.0	0.0	0,0	1.6	0.0	(3.2)	1.3	0.5
PHARMACY	1.6	0.0	53.6	4.1	0.0	0.0	(0.0)	0.0	2.5
OTHER PRIVATE									
Private Doctor	1.0	11.7	0.9	4.7	7.1	5.6	(2.5)	6.6	5.4
Private Midwife	2.4	11.5	3.7	5.6	2.8	0.2	(0.0)	2.3	4.3
OTHER/DON'T KNOW	16.9	7.3	3.4	16.5	4.4	0.6	(10.5)	4.7	16.3
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	(100.0)	100.0	100.0
Number of users	1752	1021	172	2945	1442	340[a]	45	1845	4790

Note: Figures in parentheses are based on 25-49 cases.
[a]Includes current users of male sterilization (N=18)

Table B.16 Source of supply for modern contraceptive methods: Sri Lanka

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Sri Lanka DHS, 1987

	Supply Methods				Clinical Methods				All Modern Methods
Source of supply	Pill	Injection	Condom	Total	IUD	Female Sterili-zation	Male Sterili-zation	Total	
GOVERNMENT STATIONARY									
Government Hospital/ MCH Center	17.4	54.4	8.9	26.9	85.3	94.6	78.4	91.5	77.7
GOVERNMENT MOBILE									
Govt. Midwife/Nurse	49.0	12.4	23.0	31.9	9.6	0.0	0.0	0.6	7.3
PHARMACY	13.9	0.0	37.1	14.7	0.0	0.0	0.0	0.0	3.1
OTHERPRIVATE									
Mobile Clinic	0.4	0.6	1.3	0.7	0.0	0.4	5.7	1.2	1.1
Private Doctor	11.2	28.5	3.8	15.2	4.3	2.1	1.0	2.1	4.9
Non-Government Clinic	0.6	3.2	0.0	1.3	0.7	0.8	10.0	2.2	2.0
Other Field Source	0.3	0.0	1.3	0.4	0.0	0.0	0.0	0.0	0.1
OTHER/DON'T KNOW	6.7	1.4	24.6	9.9	0.0	1.5	1.5	1.7	4.7
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	223	145	103	472[a]	115	1355	268	1738	2210

[a]Includes one current user of vaginal methods

Table B.17 Source of supply for modern contraceptive methods: Thailand

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Thailand DHS, 1987

	Supply Methods				Clinical Methods				
Source of supply	Pill	Injection	Condom	Total	IUD	Female Sterilization	Male Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY									
Government Hospital	9.2	21.3	12.4	12.9	65.5	85.3	54.8	76.5	48.3
Govt. Health Center	53.8	60.6	30.8	54.9	25.5	1.7	9.7	7.6	28.6
Govt. MCH or Bangkok H.C.	2.2	3.2	2.8	2.5	4.1	4.0	1.0	3.6	3.1
GOVERNMENT MOBILE									
Mobile Clinic	0.1	1.5	1.1	0.6	1.7	0.4	14.6	2.9	1.9
Govt. Health Volunteer	5.0	0.0	3.7	3.4	0.0	0.0	0.0	0.0	1.5
PHARMACY	20.5	1.1	39.9	15.5	0.0	0.0	0.0	0.0	6.8
OTHER PRIVATE									
Private Hospital/Clinic	4.6	11.5	3.6	6.7	3.1	8.2	10.8	7.6	7.2
Family Planning Clinic	0.5	0.2	2.1	0.5	0.1	0.0	6.3	1.1	0.8
OTHER/DON'T KNOW	4.3	0.6	3.7	3.1	0.0	0.0	1.3	0.2	1.5
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	1161	529	67	1758[a]	429	1424	356	2209	3967

[a]Includes current users of vaginal methods (N=2)

Table B.18 Source of supply for modern contraceptive methods: Bolivia

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Bolivia DHS, 1989

	Supply Methods			Clinical Methods			
Source of supply	Pill	Injection	Total	IUD	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY							
Public Hospital	1.0	(20.9)	6.2	10.5	53.9	31.1	25.0
Government Health Center	1.5	(0.0)	0.9	5.0	0.4	2.8	2.3
Government Health Post	1.3	(4.1)	1.7	1.7	0.2	1.0	1.2
CNS/Other Systems	0.3	(1.2)	0.5	2.9	8.4	5.5	4.3
GOVERNMENT MOBILE							
Health Promoter	0.0	(10.6)	2.5	0.8	0.0	0.4	0.9
PHARMACY	38.8	(15.6)	35.1	0.3	0.0	0.1	8.7
OTHER PRIVATE							
Private Doctor	44.4	(34.8)	38.7	67.6	8.4	39.3	39.1
Private Hospital	0.5	(5.3)	3.1	8.7	28.1	118.2	14.5
Family Planning Clinic	2.1	(0.0)	1.3	1.8	0.0	0.9	1.0
Private Medical Post	3.6	(7.4)	4.0	0.0	0.1	0.1	1.0
OTHER/DON'T KNOW	6.4	(0.0)	5.9	0.8	0.5	0.7	2.0
Total percent	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	93	34	149[a]	238	217	456[b]	605

Note: Figures in parentheses are based on 25-49 cases
CNS = Caja Nacional de Seguros/Social Security
[a]Includes current users of condom (N=17) and vaginal methods (N=6)
[b]Includes one current user of male sterilization

Table B.19 Source of supply for modern contraceptive methods: Brazil

Percent distribution of currently married women 15-44 using a modern contraceptive method by most recent source of supply, according to specific methods, Brazil DHS, 1986

	Supply Methods			Clinical Methods				
Source of supply	Pill	Condom	Total	IUD	Female Sterilization	Male Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY								
Government Hospital	0.5	0.0	0.5	(22.1)	9.9	(4.6)	10.1	5.3
MOH Facilities[a]	3.0	0.0	2.9	(2.7)	0.1	(0.0)	0.2	1.5
Social Security	0.4	0.0	0.4	(2.7)	45.8	(13.5)	43.4	22.2
PHARMACY	92.1	98.5	92.4	(2.5)	0.0	(0.0)	0.1	45.6
OTHER PRIVATE								
Private Hospital/Doctor	1.3	0.0	1.2	(59.5)	42.2	(79.1)	43.8	22.8
Private Institution	1.3	0.0	1.2	(10.6)	0.6	(2.8)	1.0	1.0
OTHER/DON'T KNOW	1.4	1.5	1.5	(0.0)	1.5	(0.0)	1.3	1.4
Total percent	100.0	100.0	100.0	100.0	100.0	(100.0)	100.0	100.0
Number of users	874	58	967[b]	33	931	29	994	1961

Note: Figures in parentheses are based on 25-49 cases.
[a]At the state level
[b]Includes current users of injection (N=19) and vaginal methods (N=16)

Table B.20 Source of supply for modern contraceptive methods: Colombia

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Colombia DHS, 1986

	Supply Methods				Clinical Methods				
Source of supply	Pill	Injection	Condom	Total	IUD	Female Sterilization	Male Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY									
Government Hospital/Health Center	12.0	6.3	(4.7)	0.0	9.6	35.2	11.6	20.2	15.6
Caja Compensación[a]	2.5	1.3	(0.0)	1.5	2.1	0.3	4.2	2.7	2.4
Social Security	0.9	0.0	(0.0)	1.2	0.8	3.6	0.0	1.3	1.1
GOVERNMENT MOBILE									
Health Promoter	1.7	2.8	(0.0)	1.2	1.6	0.0	0.0	0.0	0.7
PHARMACY	62.7	72.9	(47.9)	76.0	64.0	0.0	0.0	0.0	27.9
OTHER PRIVATE									
Profamilia Clinic[b]	2.7	2.1	(7.0)	2.7	3.0	44.8	71.9	62.2	36.4
Profamilia Distribution Post[b]	5.7	1.4	(7.8)	3.0	5.1	0.0	0.0	0.0	2.2
Private Hospital/Clinic	0.9	4.2	(0.0)	1.5	1.2	5.2	11.0	8.7	5.4
Private Doctor	8.1	7.6	(9.3)	2.7	7.6	9.4	0.3	3.7	5.4
Caja de Previsión[c]	0.4	0.0	(0.0)	0.0	0.3	0.8	0.0	0.3	0.3
OTHER/DON'T KNOW	2.4	1.4	(18.4)	10.3	4.3	0.6	0.0	0.2	2.0
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	468	69	49	65	651	313	521	844[d]	1495

Note: Figures in parentheses are based on 25-49 cases.
[a]Government Employee System
[b]IPPF affiliate
[c]Private Employee System
[d]Includes current users of male sterilization (N=11)

Table B.21 Source of supply for modern contraceptive methods: Dominican Republic

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Dominican Republic DHS, 1986

	Supply Methods			Clinical Methods			
Source of supply	Pill	Condom	Total	IUD	Female Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY							
Public Hospital	39.6	32.7	38.5	65.5	40.8	43.0	42.0
IDSS/FFAA Hospital	1.2	0.0	1.0	4.0	3.6	3.6	3.0
GOVERNMENT MOBILE							
Health Promoter	17.3	4.0	15.7	1.7	0.0	0.1	3.6
PHARMACY	17.1	42.5	20.3	0.0	0.0	0.0	4.6
OTHER PRIVATE							
Profamilia Clinic/Worker[a]	2.3	6.1	2.7	2.3	0.1	0.2	0.8
Private Doctor	1.3	1.0	1.2	0.0	1.3	1.2	1.2
Private Hospital	9.3	1.2	8.5	21.9	53.8	50.8	41.3
OTHER/DON'T KNOW	11.9	12.5	12.1	4.7	0.4	1.0	3.4
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	363	57	431[b]	123	1358	1489[c]	1921

FFAA = Fuerzas Armadas
IDSS = Instituto Dominicano de Seguros Sociales
[a]Asociación Dominicana Pro Bienestar de la Familia/IPPF affiliate
[b]Includes current users of injection (N=3) and vaginal methods (N=9)
[c]Includes current users of male sterilization (N=2) and Norplant (N=6)

Table B.22 Source of supply for modern contraceptive methods: Ecuador

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Ecuador DHS, 1986

	Supply Methods			Clinical Methods			
Source of supply	Pill	Modern Vaginals	Total	IUD	Female Sterilization	Total	All Methods
GOVERNMENT STATIONARY							
Govt. Hospital/Health Center	31.2	(30.6)	28.3	25.2	54.1	42.5	38.1
FFAA/Armed Forces	0.8	(0.0)	0.6	2.4	1.1	1.6	1.3
IESS/Social Security	0.8	(0.0)	0.9	1.0	2.5	1.9	1.6
PHARMACY	18.8	(19.4)	20.9	0.0	0.0	0.0	6.4
OTHER PRIVATE							
Private Doctor/Clinic	32.0	(30.6)	32.1	33.8	36.2	35.3	34.6
APROFE	13.2	(11.1)	12.3	31.0	5.2	15.5	14.5
CEMOPLAF/Private	1.6	(5.6)	2.2	6.6	0.2	2.7	2.5
OTHER/DON'T KNOW	1.6	(2.8)	1.9	0.0	0.7	0.4	0.9
Total percent	100.0	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	250	36	325[a]	734	290	442	1059

Note: Figures in parentheses are based on 25-49 cases.
APROFE = Asociación Pro-Bienestar de la Familia Ecuatoriana/IPPF affiliate
CEMOPLAF = Centro Médico de Orientación de Planificación Familiar/Private
FFAA = Fuerzas Armadas
IESS = Instituto Ecuatoriano de la Seguridad Social
[a]Includes current users of injection (N=20) and condom (N=19)

Table B.23 Source of supply for modern contraceptive methods: Guatemala

Percent distribution of currently married women 15-44 using a modern contraceptive method by most recent source of supply, according to specific methods, Guatemala DHS, 1987

	Supply Methods			Clinical Methods				
Source of supply	Pill	Condom	Total	IUD	Female Sterilization	Male Sterilization	Total	All Modern Methods
GOVERNMENT STATIONARY								
Public Hospital	1.5	(0.0)	1.0	1.6	24.4	(3.2)	19.7	13.9
Hospital Roosevelt	0.8	(0.0)	0.5	4.9	0.0	(0.0)	0.7	0.6
Health Center	20.3	(10.3)	16.5	3.3	0.6	(0.0)	0.9	5.8
Health Post	6.0	(2.6)	5.0	1.6	0.0	(0.0)	0.2	1.7
Social Security Clinics	0.8	(0.0)	0.5	0.0	16.6	(9.7)	13.8	9.7
GOVERNMENT MOBILE								
Health Promoter/CBD Worker	15.8	(0.0)	11.0	0.0	0.0	(0.0)	0.0	3.4
PHARMACY	11.3	(69.2)	23.5	0.0	0.0	(0.0)	0.0	7.3
OTHER PRIVATE								
APROFAM Clinics	27.8	(7.7)	25.0	47.5	38.7	(64.5)	41.7	36.5
Private Hospital	0.8	(0.0)	0.5	1.6	17.8	(16.1)	15.4	10.8
Private Clinic	12.0	(5.1)	13.0	39.3	0.0	(0.0)	5.4	7.8
OTHER/DON'T KNOW	3.0	(5.1)	3.5	0.0	2.0	(6.5)	2.0	2.5
Total percent	100.0	(100.0)	100.0	100.0	100.0	(100.0)	100.0	100.0
Number of users	133	39	200[a]	61	349	31	441	641

Note: Figures in parentheses are based on 25-49 cases
APROFAM = Asociación Pro-Bienestar de la Familia/IPPF affiliate
[a]Includes current users of injection (N=16) and vaginal methods (N=12)

Table B.24 Source of supply for modern contraceptive methods: Mexico

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Mexico DHS, 1987

	Supply Methods					Clinical Methods				
Source of supply	Total	Pill	Injection	Condom	Vaginals	Total	IUD	Female Sterilization	Male Sterilization	All Modern Methods
GOVERNMENT STATIONARY										
Govt. Health Center	14.6	16.0	11.1	17.1	(0.0)	14.3	24.3	9.3	(2.4)	14.4
Govt. Health Worker	2.6	3.3	0.0	3.8	(0.0)	0.0	0.0	0.0	(0.0)	0.9
Other Govt. Institution	0.8	0.7	0.7	1.9	(0.0)	2.9	1.6	3.7	(2.4)	2.2
IMSS Clinic	7.1	8.2	0.7	12.4	(3.0)	51.4	43.7	55.5	(54.8)	36.6
Conasupo Clinic	1.0	1.5	0.0	0.0	(0.0)	0.8	1.2	0.7	(0.0)	0.9
ISSSTE Clinic	1.7	1.6	0.7	3.8	(0.0)	7.7	7.7	8.4	(19.1)	5.7
PEMEX/DIF Clinic	1.2	1.5	0.0	2.0	(0.0)	0.8	0.7	0.9	(0.0)	0.9
GOVERNMENT MOBILE										
Health Promoter	0.6	0.7	0.7	0.0	(0.0)	0.0	0.0	0.0	(0.0)	0.2
PHARMACY	66.1	63.0	80.4	56.2	(81.8)	0.0	0.0	0.0	(0.0)	22.1
OTHER PRIVATE										
Defense Clinic	0.0	0.0	0.0	0.0	(0.0)	0.4	0.0	0.5	(4.8)	0.3
Private Doctor	2.6	1.8	5.2	0.0	(12.1)	19.9	19.1	20.5	(16.7)	14.1
Midwife	1.0	1.3	0.7	0.0	(0.0)	0.0	0.0	0.0	(0.0)	0.3
OTHER/DON'T KNOW	0.7	0.4	0.0	2.9	(3.0)	1.8	4.0	0.7	(0.0)	1.4
Total percent	100.0	100.0	100.0	100.0	(100.0)	100.0	100.0	100.0	(100.0)	100.0
Number of users	840	549	15	105	33	1677	577	1058	42	2517

Note: Figures in parentheses are based on 25-49 cases.
CONASUPO = Consejo Nacional Superior de Población
DIF = Sistema Nacional para el Desarrollo Integral de la Familia
IMSS = Instituto Mexicano del Seguro Social (Social Security clinics)
ISSSTE = Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (government clinics)
PEMEX = Petroleos de México

Table B.25 Source of supply for modern contraceptive methods: Peru

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Peru DHS, 1986

Source of supply	Supply Methods					Clinical Methods			All Modern Methods
	Pill	Injection	Condom	Vaginals	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY									
MOH Hospital, Health Center	34.9	(33.3)	(23.8)	(7.1)	31.1	53.5	66.1	59.1	47.5
Other Public Hospital	3.7	(2.6)	(4.8)	(0.0)	3.3	9.9	7.9	9.0	6.6
GOVERNMENT MOBILE									
Health Promoter	1.1	(0.0)	(0.0)	(0.0)	0.7	0.0	0.0	0.0	0.3
PHARMACY	45.0	(48.7)	(57.1)	(60.7)	48.0	1.4	0.0	0.7	20.4
OTHER PRIVATE									
Private Voluntary Organ.	3.2	(2.6)	(4.8)	(0.0)	2.9	3.8	0.0	2.1	2.4
Private Doctor	11.1	(12.8)	(9.5)	(21.4)	12.3	25.4	2.3	15.1	13.8
Private Clinic	0.5	(0.0)	(0.0)	(3.6)	0.7	5.2	23.7	13.8	8.4
OTHER/DON'T KNOW	0.5	(0.0)	(0.0)	(7.1)	1.1	0.5	0.0	0.2	0.5
Total percent	100.0	(100.0)	(100.0)	(100.0)	100.0	100.0	100.0	100.0	100.0
Number of users	189	39	21	28	277	213	177	391[a]	668

Note: Figures in parentheses are based on 25-49 cases.
[a]Includes one current user of male sterilization

Table B.26 Source of supply for modern contraceptive methods: Trinidad and Tobago

Percent distribution of currently married women 15-49 using a modern contraceptive method by most recent source of supply, according to specific methods, Trinidad and Tobago DHS, 1986

Source of supply	Supply Methods				Clinical Methods			All Modern Methods
	Pill	Condom	Vaginals	Total	IUD	Female Sterilization	Total	
GOVERNMENT STATIONARY								
Government Hospital	30.9	29.0	33.8	30.2	42.2	66.5	57.1	38.0
PHARMACY	52.7	56.5	48.5	52.1	0.0	0.0	0.0	37.1
OTHER PRIVATE								
FPATT	7.1	11.6	16.2	10.6	32.8	19.1	24.4	14.6
Private Doctor/Hospital	8.7	1.0	0.8	5.9	24.1	12.6	16.3	8.9
OTHER/DON'T KNOW	0.3	1.9	0.8	1.0	0.9	1.4	1.8	1.2
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	366	310	130	827[a]	116	215	336[b]	1163

FPATT = Family Planning Association of Trinidad and Tobago/IPPF affiliate
[a]Includes current users of injection (N=21)
[b]Includes current users of male sterilization (N=5)

Appendix C

Knowledge of Source for Modern Contraceptive Methods

In addition to information about where current users obtain their methods, DHS-I also collected information about whether women knew where they could get a modern method of which they had heard (see Table C.1). Figure C.1 shows the percentage of married women who know of a modern method of contraception and the percentage who know a source for any modern method. The difference between these two percentages as well as the overall proportion of women who know a source are of interest. Mexico is excluded from both Table C.1 and Figure C.1 because nonusers there were not asked if they knew of a source for modern methods. Data on knowledge of source by method is not available for Liberia.

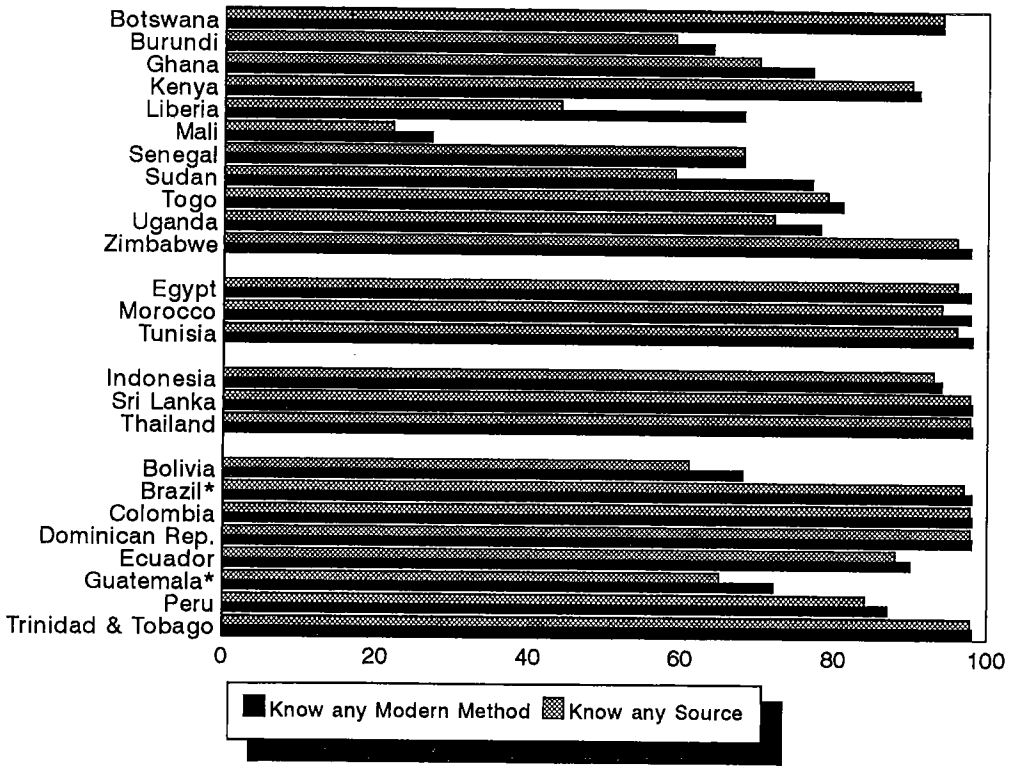
In sub-Saharan Africa, knowledge of a source of contraceptive methods ranges from almost universal in Botswana, Kenya, and Zimbabwe to less than half of all married women in Mali. Mali and Liberia are the countries in which there is the largest discrepancy between knowledge of a method and knowledge of a source, with nearly a 20 percentage point difference in Liberia and an 8 percentage point difference in Mali. Generally, women are more likely to know of a source for the pill than for any other method. Sources for vaginal methods and male sterilization are least well known. Levels of knowledge vary greatly for other methods.

In North Africa, there is nearly universal knowledge of modern methods and where they can be obtained. In general, sources of the pill and IUD are the most widely known, while a source for male sterilization is the least well known.

Knowledge of a source for modern methods is almost universal in Asia, too. Sources for the pill, IUD and injection are widely known in all three countries surveyed. Knowledge of sources for other methods varies by country, however, presumably depending upon which methods service providers emphasize in each country.

The countries of Latin America and the Caribbean show great variation in knowledge levels. Women in Bolivia and Guatemala are least likely to know a method or a source; these two countries also display the widest gap between the two types of knowledge. Sources for the pill and female sterilization seem to be the most widely known in this region, although there is a great deal of variation between countries.

Figure C.1 Percentage of currently married women 15-49 who know any modern contraceptive method, and percentage who know any source for clinical and supply methods, Demographic and Health Surveys, 1986-1990



* Women 15-44

Table C.1 Percentage of currently married women 15-49 who know any source for specific modern methods, Demographic and Health Surveys, 1986-1990

Country	Any Modern Method	Pill	IUD	Injection	Vaginals	Condom	Female Sterilization	Male Sterilization
SUB-SAHARAN AFRICA								
Botswana	94.2	93.3	89.2	89.2	51.1	86.1	65.7	24.2
Burundi	58.6	37.8	22.3	51.9	6.3	11.9	13.5	3.3
Ghana	69.6	53.1	32.2	39.6	33.0	38.9	51.8	9.1
Kenya	89.9	86.3	65.1	79.9	25.5	51.7	70.6	21.2
Mali	22.3	16.3	10.7	13.2	3.9	6.2	11.7	3.3
Senegal	67.5	50.5	28.6	26.9	8.6	26.4	55.9	3.1
Sudan (North)	59.2	54.5	33.0	36.0	5.9	13.4	40.1	4.2
Togo	78.6	38.6	40.8	55.3	23.7	29.9	68.0	13.1
Uganda	72.2	54.0	16.4	35.2	8.7	20.7	59.7	8.2
Zimbabwe	96.0	94.6	52.4	65.5	12.4	72.5	51.2	15.5
NEAR EAST/NORTH AFRICA								
Egypt	95.9	94.7	88.2	49.2	37.9	41.5	51.1	8.7
Morocco	94.3	92.6	70.1	35.0	20.5	52.3	70.8	2.7
Tunisia	96.3	86.9	87.2	43.9	55.4	57.8	89.1	10.7
ASIA								
Indonesia	92.7	88.4	76.2	81.4	3.1	52.3	48.7	24.2
Sri Lanka	98.0	82.4	73.3	74.9	10.4	62.2	96.0	86.9
Thailand	99.3	97.6	91.0	95.7	14.0	79.3	96.3	92.5
LATIN AMERICA/CARIBBEAN								
Bolivia	61.1	45.7	48.3	38.8	21.0	24.6	46.4	13.1
Brazil[1]	97.3	94.7	42.3	47.2	29.6	74.0	85.1	40.4
Colombia	99.0	95.2	89.4	85.1	82.0	65.0	93.2	46.1
Dominican Republic	98.5	93.9	83.8	63.8	63.5	79.3	96.0	38.7
Ecuador	87.6	79.1	74.4	59.4	52.2	44.5	73.0	15.6
Guatemala[1]	64.9	56.2	39.6	41.6	20.2	33.3	55.5	34.3
Peru	83.9	71.4	68.2	64.4	43.7	45.4	72.5	24.8
Trinidad and Tobago	98.5	95.0	84.7	75.0	78.0	94.3	90.5	54.9

Notes: Knowledge of source by method was not asked in Liberia; no knowledge questions were asked in Mexico.
[1]Women 15-44

Appendix D

Use of Periodic Abstinence and Source of Information on Periodic Abstinence

The DHS-I survey asked women who were currently using periodic abstinence, "Where did you obtain instruction for this method?" Table D.1 presents this information together with the percentage of married women currently using periodic abstinence in each country surveyed. While the prevalence of this method ranges from 0.2 percent in Botswana to a high of 17 percent in Peru, in most countries it is little used. Less than 3 percent of married women reported currently using periodic abstinence in 14 of the 25 surveys. The prevalence of periodic abstinence is more than 10 percent in only three countries: Bolivia, Peru, and Sri Lanka.

In sub-Saharan Africa, the church (and its affiliated institutions) is an important source of instruction. The church is the leading source of information for women in Ghana, Kenya, and Uganda and also provides instruction to more than 20 percent of women using periodic abstinence in Togo and Burundi. However, in Mali and Senegal, where Islam predominates, the church plays no role in promoting the use of periodic abstinence. Only in Burundi is the public sector the leading source of information.

In the countries surveyed in the Near East/North Africa region and Asia, most of the women using the method never visited any source to get instructions on periodic abstinence. Only in Indonesia did more than 20 percent of women get their information from government sources.

The countries of Latin America and the Caribbean show great variation in where women get instruction on periodic abstinence. Most users in Colombia, Ecuador, Guatemala, and Trinidad and Tobago did not visit any source. In Bolivia, Brazil, the Dominican Republic, and Peru, however, most users reported getting their information from the church and "other" sources, such as friends and parents. Only in Peru is the public sector an important source of information on periodic abstinence. In Bolivia, Brazil, and Dominican Republic, the private sector plays a greater role.

Table D.1 Use of periodic abstinence and source of information on periodic abstinence

Percentage of currently married women 15-49 reporting current use of periodic abstinence and percent distribution by source of information on periodic abstinence, Demographic and Health Surveys, 1986-1990

Country	Year of Fieldwork	Percent Reporting Current Use of Periodic Abstinence	Source of information on periodic abstinence					Total Percent	Number
			Public Sector[1]	Private Sector[2]	Church[3]	Other[4]	No Visit		
SUB-SAHARAN AFRICA									
Botswana	1988	0.2	*	*	*	*	*	*	3
Burundi	1987	4.8	59.6	2.0	24.2	13.2	0.9	100.0	127
Ghana	1988	6.2	10.2	9.2	58.2	6.6	15.8	100.0	196
Kenya	1988/89	7.5	6.0	9.4	59.5	23.7	0.0	100.0	357
Liberia	1986	0.6						100.0	20
Mali	1987	1.3	(15.4)	(80.1)	0.0	(1.5)	0.0	(100.0)	38
Senegal	1986	0.9	(6.7)	(13.3)	0.0	(80.0)	0.0	(100.0)	30
Sudan (North)	1989/90	2.2	5.0	19.3	0.0	75.6	0.0	100.0	88
Togo	1988	6.4	16.7	6.4	19.9	56.4	0.6	100.0	156
Uganda	1988/89	1.6	12.5	3.8	60.2	14.7	7.7	100.0	51
Zimbabwe	1988/89	0.3	*	*	*	*	*	*	8
NEAR EAST/ NORTH AFRICA									
Egypt	1988/89	0.6	U	U	U	U	U	100.0	50
Morocco	1987	2.3	10.6	4.9	*	3.3	81.3	100.0	123
Tunisia	1988	6.3	2.8	3.6	*	*	93.6	100.0	251
ASIA									
Indonesia	1987	1.2	20.2	13.0	*	11.0	55.7	100.0	127
Sri Lanka	1987	14.9	7.7	0.8	0.4	1.2	89.9	100.0	810
Thailand	1987	0.9	13.3	3.4	*	*	83.3	100.0	56
LATIN AMERICA/ CARIBBEAN									
Bolivia	1989	16.1	15.0	25.2	25.8	33.8	*	100.0	797
Brazil[5]	1986	4.0	12.4	22.3	53.0	12.2	*	100.0	138
Colombia	1986	5.7	4.4	7.8	*	*	87.8	100.0	162
Dominican Republic	1986	1.4	8.7	32.2	34.0	24.1	1.0	100.0	57
Ecuador	1987	6.1	11.1	17.2	*	8.3	63.3	100.0	180
Guatemala[5]	1987	2.8	10.4	9.4	*	4.2	76.0	100.0	96
Mexico	1987	4.4	U	U	U	U	U	100.0	248
Peru	1986	17.7	32.1	13.4	32.7	16.7	5.1	100.0	514
Trinidad and Tobago	1987	2.6	6.0	14.9	6.0	10.4	62.7	100.0	67

Note: Figures in parentheses are based on 25-49 cases.
U = Unknown (question not asked)
* Less than 25 cases
[1]**Public sector** includes government and parastatel institutions.
[2]**Private sector** includes private doctor, private hospital or clinic, pharmacy and NGOs.
[3]**Church** includes all institutions run by Protestant missions and Catholic churches.
[4]**Other** includes friends, parents and other responses.

Appendix E

Summary of DHS-I and DHS-II Surveys, 1985-1993

Region and Country	Date of Fieldwork	Implementing Organization	Respondents	Sample Size	Male/Husband Survey	Supplemental Studies, Modules, and Additional Questions
SUB-SAHARAN AFRICA						
DHS-I						
Botswana	Aug-Dec 1988	Central Statistics Office	AW 15-49	4,368		AIDS, PC, adolescent fertility
Burundi	Apr-Jul 1987	Département de la Population, Ministère de l'Intérieur	AW 15-49	3,970	542 Husbands	CA, SAI, adult mortality
Ghana	Feb-May 1988	Ghana Statistical Service	AW 15-49	4,488	943 Husbands	CA, SM, WE
Kenya	Dec-May 1988/89	National Council for Population and Development	AW 15-49	7,150	1,133 Husbands	
Liberia	Feb-Jul 1986	Bureau of Statistics, Ministry of Planning and Economic Affairs	AW 15-49	5,239		TBH, employment status
Mali	Mar-Aug 1987	Institut du Sahel, USED/CERPOD	AW 15-49	3,200	970 Men 20-55	CA, VC, childhood physical handicaps
Ondo State, Nigeria	Sep-Jan 1986/87	Ministry of Health, Ondo State	AW 15-49	4,213		CA, TBH
Senegal	Apr-Jul 1986	Direction de la Statistique, Ministère de l'Economie et des Finances	AW 15-49	4,415		CA, CD
Sudan	Nov-May 1989/90	Department of Statistics, Ministry of Economic and National Planning	EMW 15-49	5,860		M, MM, female circumcision, family planning services
Togo	Jun-Nov 1988	Unité de Recherche Démographique, Université du Benin	AW 15-49	3,360		CA, SAI, marriage history
Uganda	Sep-Feb 1988/89	Ministry of Health	AW 15-49	4,730		CA, SAI
Zimbabwe	Sep-Jan 1988/89	Central Statistical Office	AW 15-49	4,201		AIDS, CA, PC, SAI, WE
DHS-II						
Burkina Faso	Dec-Mar 1992/93	Institut National de la Statistique et de la Démographie	AW 15-49	6,000	1,845 Men 18+	AIDS, CA, MA, SAI
Cameroon	Apr-Sep 1991	Direction Nationale du Deuxième Recensement Général de la Population et de l'Habitat	AW 15-49	3,871	814 Husbands	CA, CD, SAI
Madagascar	May-Nov 1992	Centre National de Recherches sur l'Environnement	AW 15-49	6,260		CA, MM, SAI
Malawi	Sep-Nov 1992	National Statistical Office	AW 15-49	4,850	1,151 Men 20-54	AIDS, CA, MA, MM, SAI
Namibia	Jul-Nov 1992	Ministry of Health and Social Services, Central Statistical Office	AW 15-49	5,421		CA, CD, MA, MM
Niger	Mar-Jun 1992	Direction de la Statistique et des Comtes Nationaux	AW 15-49	6,503	1,570 Husbands	CA, MA, MM, SAI
Nigeria	Apr-Oct 1990	Federal Office of Statistics	AW 15-49	8,781		CA, SAI
Rwanda	Jun-Oct 1992	Office National de la Population	AW 15-49	6,551	598 Husbands	CA, SAI
Senegal	Nov-Aug 1992/93	Direction de la Prévision et de la Statistique	AW 15-49	6,310	1,436 Men 20+	AIDS, CA, MA, MM, SAI
Tanzania	Oct-Mar 1991/92	Bureau of Statistics, Planning Commission	AW 15-49	9,238	2,114 Men 15-60	AIDS, CA, MA, SAI
Zambia	Jan-May 1992	University of Zambia	AW 15-49	7,060		AIDS, CA, MA
NEAR EAST/NORTH AFRICA						
DHS-I						
Egypt	Oct-Jan 1988/89	National Population Council	EMW 15-49	8,911		CA, CD, MM, PC, SAI, WE, women's status
Morocco	May-Jul 1987	Ministère de la Santé Publique	EMW 15-49	5,982		CA, CD, S
Tunisia	Jun-Oct 1988	Office National de la Famille et de la Population	EMW 15-49	4,184		CA, CD, S, SAI
DHS-II						
Egypt	Nov-Dec 1992	National Population Council	EMW 15-49	9,864	2,406 Husbands	CA, MA, PC, SM
Jordan	Oct-Dec 1990	Department of Statistics, Ministry of Health	EMW 15-49	6,462		CA, SAI
Morocco	Jan-Apr 1992	Ministère de la Santé Publique	AW 15-49	9,256	1,336 Men 20-70	CA, MA, MM, SAI
Yemen	Nov-Jan 1991/92	Central Statistical Organization	EMW 15-49	5,687		CA, CD, SAI

Region and Country	Date of Fieldwork	Implementing Organization	Respondents	Sample Size	Male/Husband Survey	Supplemental Studies, Modules, and Additional Questions
ASIA						
DHS-I						
Indonesia	Sep-Dec 1987	Central Bureau of Statistics, National Family Planning Coordinating Board	EMW 15-49	11,844		PC, SM
Nepal (In-depth)	Feb-Apr 1987	New Era	CMW 15-49	1,623		KAP–gap survey
Sri Lanka	Jan-Mar 1987	Department. of Census and Statistics, Ministry of Plan Implementation	EMW 15-49	5,865		CA, NFP
Thailand	Mar-Jun 1987	Institute of Population Studies, Chulalongkorn University	EMW 15-49	6,775		CA, S, SAI
DHS-II						
Indonesia	May-Jul 1991	Central Bureau of Statistics, National Family Planning Coordinating Board, Ministry of Health	EMW 15-49	22,909		PC, SM
Pakistan	Dec-May 1990/91	National Institute of Population Studies	EMW 15-49	6,611	1,354 Husbands	CA
LATIN AMERICA & CARIBBEAN						
DHS-I						
Bolivia	Mar-Jun 1989	Instituto Nacional de Estadística	AW 15-49	7,923		CA, CD, MM, PC, S, WE
Bolivia (In-depth)	Mar-Jun 1989	Instituto Nacional de Estadística	AW 15-49	7,923		Health
Brazil	May-Aug 1986	Sociedade Civil Bem-Estar Familiar no Brasil	AW 15-44	5,892		CA, PC, SM, abortion, young adult use of contraception
Colombia	Oct-Dec 1986	Corporación Centro Regional de Población, Ministerio de Salud	AW 15-49	5,329		CA, PC, SAI, SM
Dominican Republic	Sep-Dec 1986	Consejo Nacional de Población y Familia	AW 15-49	7,649		NFP, S, SAI, SM family planning communication
Dominican Rep. (Experimental)	Sep-Dec 1986	Consejo Nacional de Población y Familia	AW 15-49	3,885		
Ecuador	Jan-Mar 1987	Centro de Estudios de Población y Paternidad Responsable	AW 15-49	4,713		CD, SAI, employment
El Salvador	May-Jun 1985	Asociación Demográfica Salvadoreña	AW 15-49	5,207		S, TBH
Guatemala	Oct-Dec 1987	Instituto de Nutrición de Centro América y Panamá	AW 15-44	5,160		S, SAI
Mexico	Feb-May 1987	Dirección General de Planificación Familiar Secretaría de Salud	AW 15-49	9,310		NFP, S, employment
Peru	Sep-Dec 1986	Instituto Nacional de Estadística	AW 15-49	4,999		NFP, employment, cost of family planning
Peru (Experimental)	Sep-Dec 1986	Instituto Nacional de Estadística	AW 15-49	2,534		
Trinidad and Tobago	May-Aug 1987	Family Planning Association of Trinidad and Tobago	AW 15-49	3,806		CA, NFP, breastfeeding
DHS-II						
Brazil (NE)	Sep-Dec 1991	Sociedade Civil Bem-Estar Familiar no Brasil	AW 15-49	6,222	1,266 Husbands	AIDS, PC
Colombia	May-Aug 1990	PROFAMILIA	AW 15-49	8,644		AIDS
Dominican Republic	Jul-Nov 1991	Instituto de Estudios de Población y Desarrollo (PROFAMILIA), Oficina Nacional de Planificación	AW 15-49	7,320		CA, MA, S, SAI
Paraguay	May-Aug 1990	Centro Paraguayo de Estudios de Población	AW 15-49	5,827		CA, SAI
Peru	Oct-Mar 1991/92	Instituto Nacional de Estadística e Informática	AW 15-49	15,882		CA, MA, MM, SAI

AW all women
CMW currently married women
EMW ever-married women

AIDS acquired immune deficiency syndrome
CA child anthropometry
CD causes of death (verbal reports of symptoms)
M migration
MA maternal anthropometry
MM maternal mortality

NFP natural family planning
PC pill compliance
S sterilization
SAI service availability information
SM social marketing
TBH truncated birth history
VC value of children