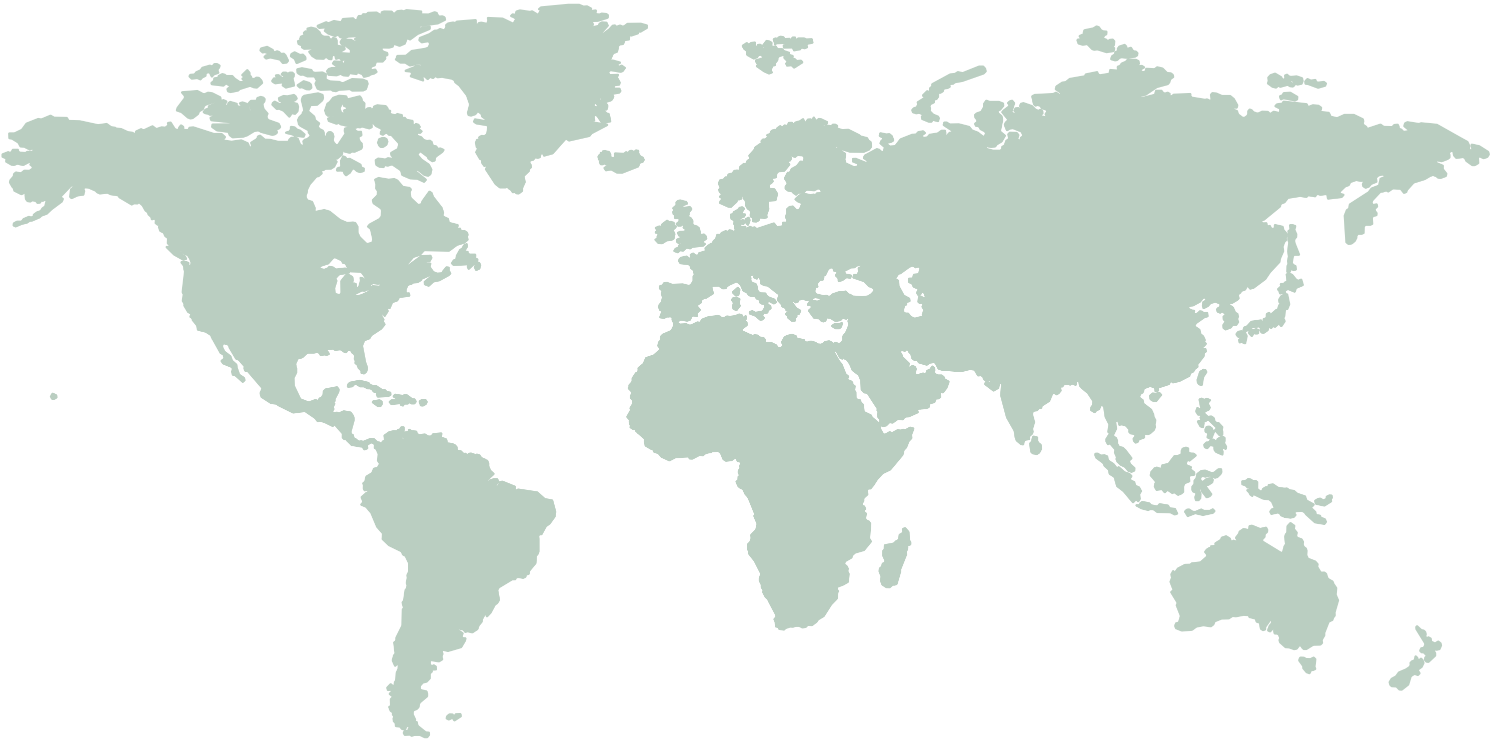
# Contraceptive Prevalence



# Contraceptive Prevalence

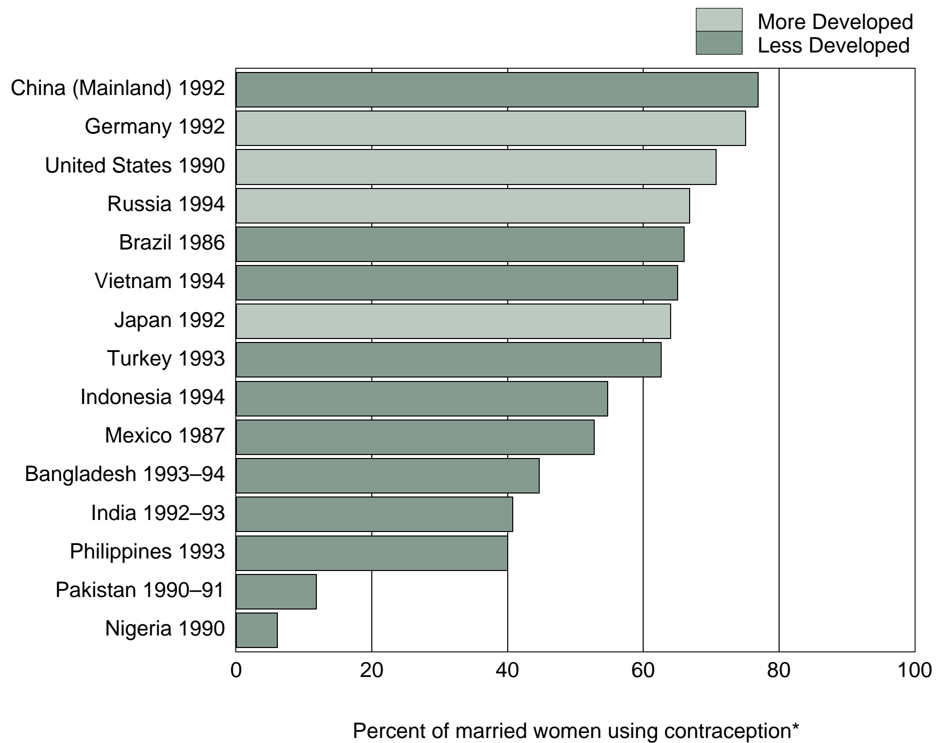
## Only About Half of Married Women Practice Contraception in World's Largest Countries

Women in more developed countries have historically used, and continue to use, family planning to control their fertility more often than women in less developed countries. For example, about 71 percent of married women of reproductive age (MWRA) in the United States used contraception in 1990, compared to an average of 47 percent of women in the largest less developed countries in the late 1980's or early 1990's (figure 34 and table A-11). While this kind of disparity underscores the continuing disadvantage of women in the developing world in terms of reproductive health, it is also true that contraceptive use is widespread in a number of less developed countries. Among the largest countries, over three-quarters of married women in China (Mainland) and two-thirds of married women in Brazil use some method of contraception.

***From the ICPD Program of Action:***

*"Reproductive health ... [implies that people] have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family-planning of their choice ..." (section 7.2)*

Figure 34.
**Contraceptive Prevalence Rate for Large Countries: Late 1980's or Later**




* Here and in all subsequent figures, contraceptive prevalence refers to percent of currently married women of reproductive age using contraception. In most cases, these women are ages 15-49.
Source: Table A-11.

## Contraceptive Prevalence Rates Are Highest in Asia and Latin America, Lowest in Sub-Saharan Africa, Among Developing Regions

Within the developing world, use of contraception by married women of reproductive age varies substantially from region to region, as well as from country to country (table A-11).

In most of the larger countries of Sub-Saharan Africa, contraceptive prevalence is under 30 percent. The highest rates shown in figure 35 are 50 percent of MWRA in South Africa and 33 percent in Kenya. The median prevalence level for the region, based on the latest data for all countries in the region having data (table A-11), is 15 percent; that is, contraceptive prevalence levels are below 15 percent in half of the countries.

With the exception of Turkey, contraceptive use is also less common in the Near East and North Africa than in other parts of the developing world. The most recent estimates range from 7 percent for Yemen to 63 percent for Turkey.[4] The median value for the Near East and North Africa is 41 percent.

In Asia, a majority of countries now have prevalence rates for MWRA above 50 percent. In China (both Mainland and Taiwan), as well as in South Korea and Hong Kong, recent information indicates that over three-quarters of MWRA use some means of contraception to control their fertility, prevalence rates that are equal to those in many developed countries.

[4] Nearly half of Turkey's overall prevalence rate reflects use of less effective, traditional methods. Modern method prevalence in the region ranges from around 6 percent in Yemen to about 45 percent in Egypt. For purposes of international comparison, both total and modern method prevalence have advantages. Method-specific prevalence rates for currently-married women are shown in table A-11.

Figure 35.
**Contraceptive Prevalence and Total Fertility Rates for Largest Countries, by Region: 1985 or Later**

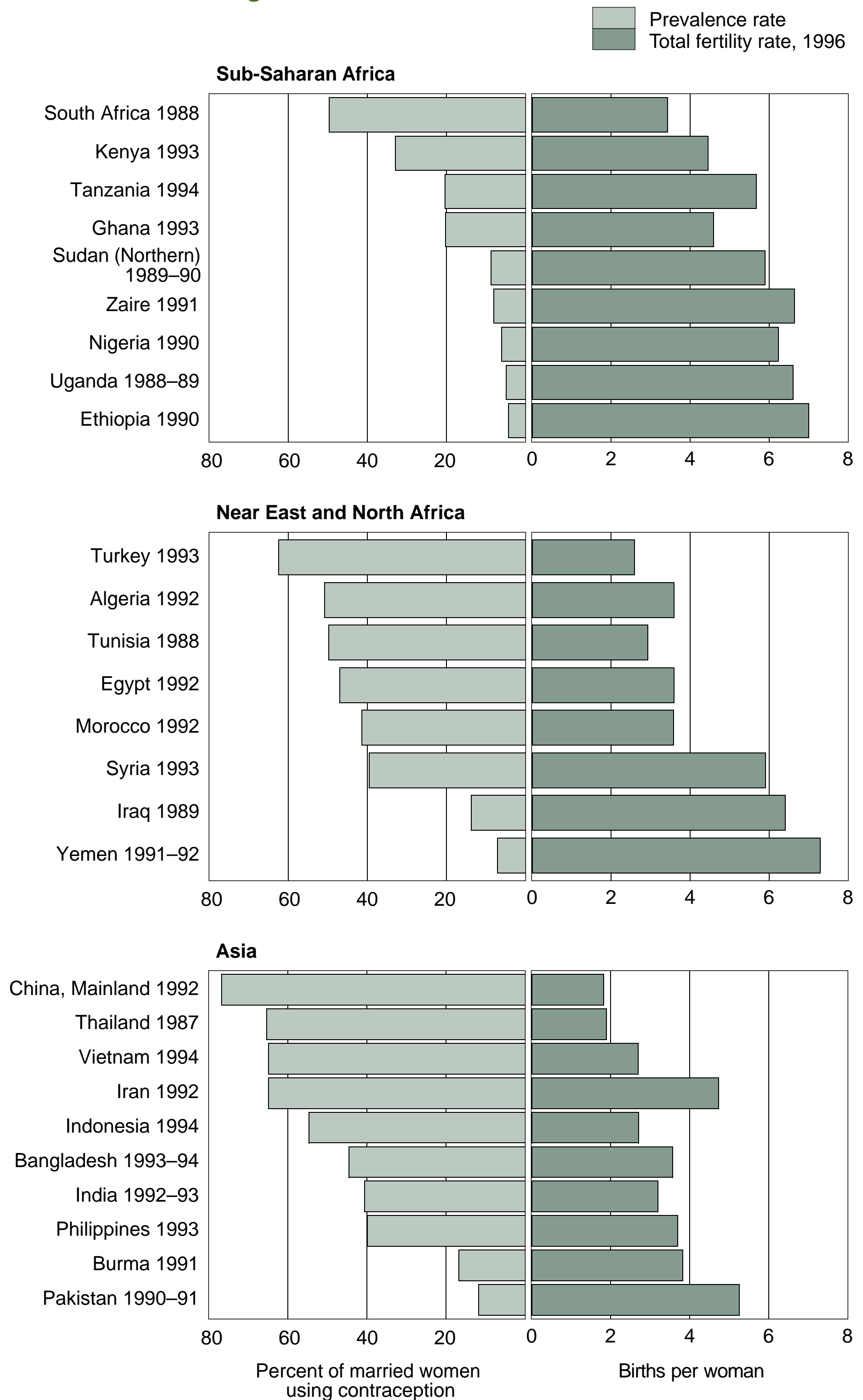
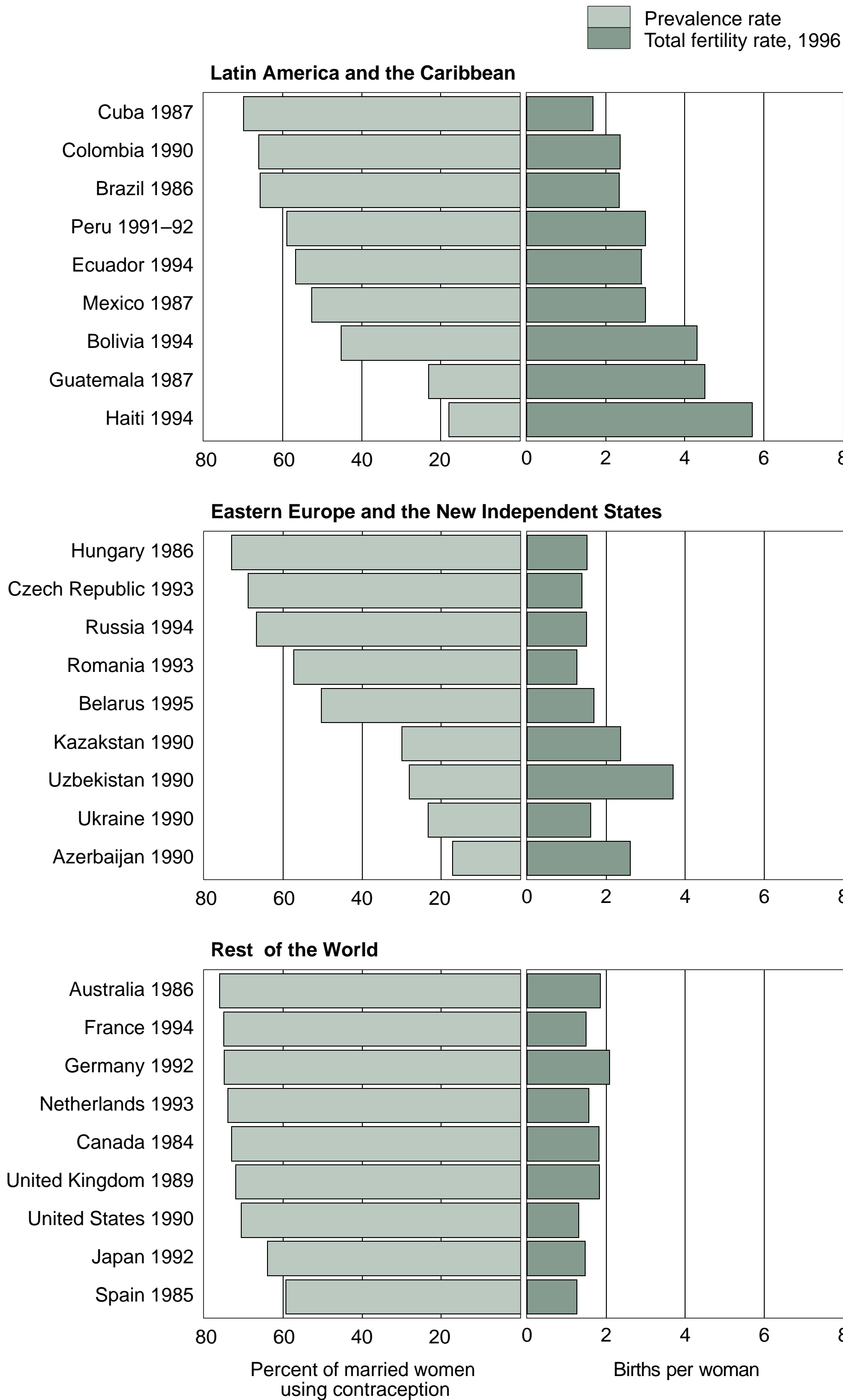


Figure 35.
**Contraceptive Prevalence and Total Fertility Rates for Largest Countries, by Region: 1985 or Later**—Continued




Source: Tables A-8 and A-11.

The median level for Asian countries with data, including China but excluding Japan, is 58 percent.

In Latin America and the Caribbean, the most recent data from surveys indicate that use of family planning among MWRA in the most populous countries varies from 18 percent in Haiti to 70 percent in Cuba. Cuba, Colombia, and Brazil have the highest prevalence rates in the region (well over 60 percent); Guatemala and Haiti, the lowest (under 30 percent). The regional median prevalence rate for Latin America and the Caribbean is 53 percent.

Contraceptive prevalence rates among the largest countries of Eastern Europe and the former Soviet Union range from 17 percent to 73 percent. Eastern European rates are generally comparable to, or higher than, those for Western Europe. The corresponding values for the New Independent States tend to be lower, though in Russia, about two-thirds of MWRA report that they use contraception. Prevalence is much lower in Azerbaijan and Georgia, where the latest available data suggest the rate is on the order of 17 percent.

The regions of the developing world and the New Independent States contrast sharply with the remaining world (Western Europe, Japan, and Oceania) in terms of percentages of women using family planning. Contraceptive prevalence in the United States and the largest countries in the rest of the world ranges from 59 to 76 percent.

The contribution of family planning to reducing fertility (and national population growth) is underscored in figure 35. Fertility (as measured by TFR) and contraceptive prevalence are inversely related for the largest countries of each major world region except the Rest of the World. Though family planning is used to delay or

space wanted births as well as to limit childbearing once desired family size is reached, countries with higher proportions of MWRA making use of family planning tend also to be countries with lower fertility.

## Family Planning Use Is Typically Higher in Urban Areas...

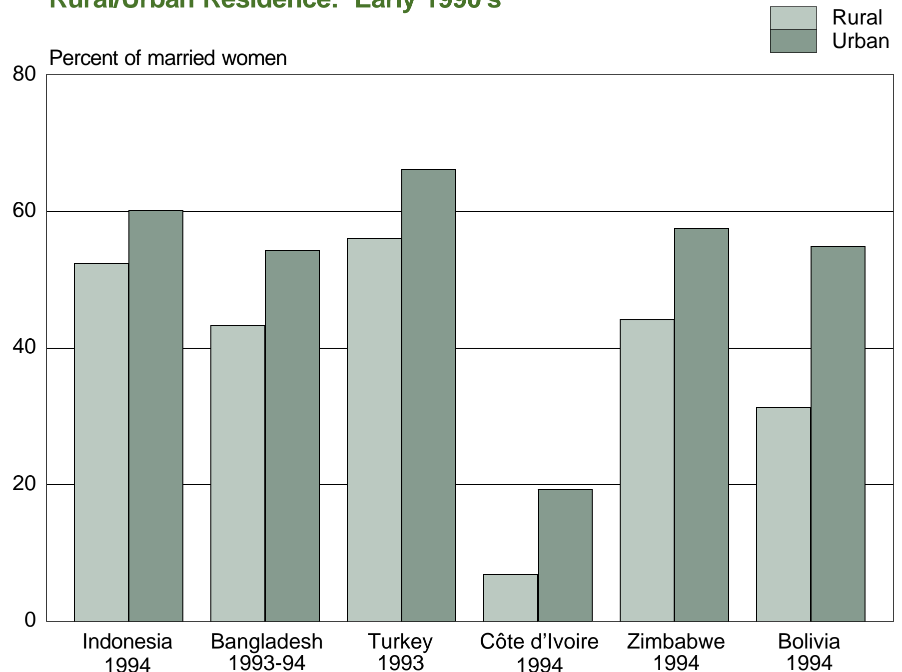
In developing countries, use of contraception is virtually always higher in urban areas than in the countryside, although the difference is sometimes minimal. In Indonesia, Bangladesh, and Turkey, for example, married women of reproductive age in rural areas are 80 to 90 percent as likely as their urban counterparts to plan their families (figure 36), but in other countries, as in Côte d'Ivoire, rural women are only about a third as likely as urban women to use contraception.

These kinds of differences are partially attributable to educational differentials between urban and rural populations, partially to higher costs of living and smaller family norms prevailing in urban areas, and partially to the greater availability of family planning services and products in urban settings.

## ...and Among More Educated Women

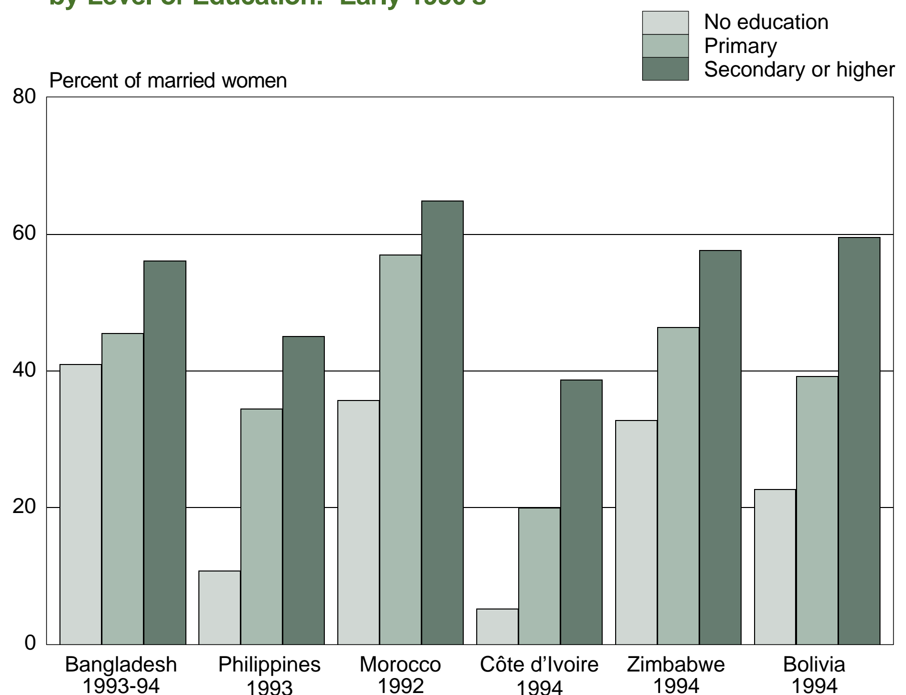
Female educational attainment has repeatedly been found to be closely linked to fertility regulation and to use of more effective methods of contraception. Women with some primary schooling are consistently more likely to be using contraception than women with no education, and women with more than a primary education have even higher prevalence rates in the countries shown in figure 37.

Figure 36.
**Contraceptive Prevalence Rate for Selected Countries by Rural/Urban Residence: Early 1990's**



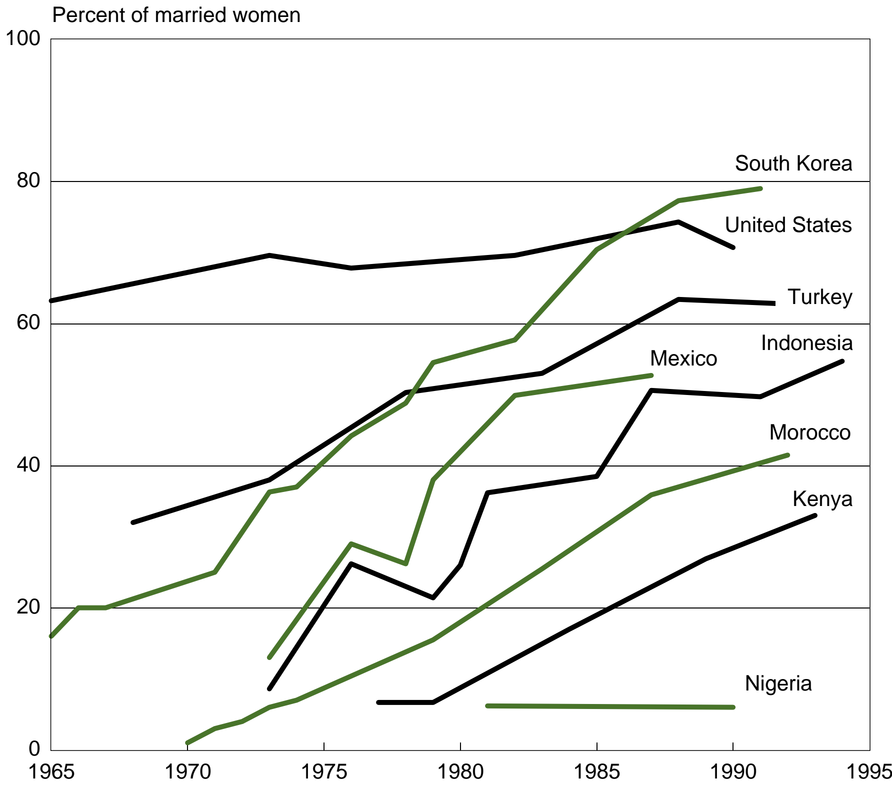

Source: Demographic and Health Surveys.

Figure 37.
**Contraceptive Prevalence Rate for Selected Countries by Level of Education: Early 1990's**




Source: Demographic and Health Surveys.

Figure 38.
**Trends in Contraceptive Prevalence for Selected Countries: 1965 to 1994**




Source: Table A-11.

## Women Are Adopting Family Planning in Increasing Numbers in Every World Region

In countries with multiple surveys the trend in contraceptive prevalence is upward virtually everywhere. As a result of the rapid growth in contraceptive prevalence in countries previously having lower levels of use, the gap between high- and low-prevalence countries (and between more- and less-developed regions) has continued to narrow.

Country-specific trends vary considerably within and between the world's regions, however. In Nigeria and Kenya, for example, only 6 to 7 percent of MWRA were using contraception when first measured in the late 1970's or early 1980's (figure 38). The latest surveys show the prevalence rate to have increased to 33 percent in Kenya (1993), while remaining unchanged in Nigeria (1991). In some other countries, where family planning was introduced much earlier, prevalence rates have grown more. For example, in South Korea, the rate increased from 16 percent of married women in 1965 to 79 percent in 1991; in Morocco, it increased from an estimated 1 percent in 1970 to 42 percent in 1992.

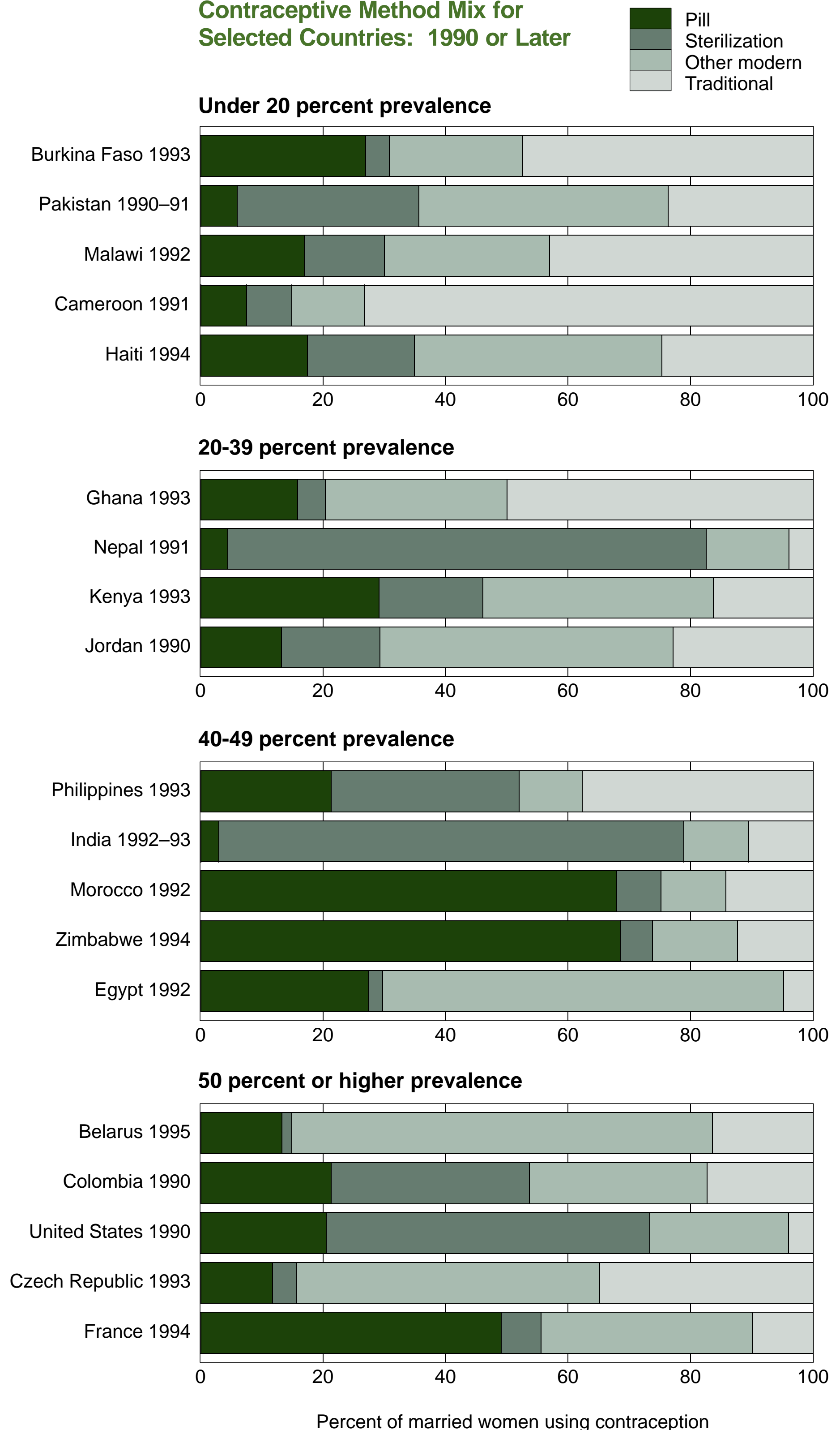
## Contraceptive Method Mix Varies Among Countries...

Methods of contraception used in both less developed and more developed world regions vary considerably from country to country. Specific method mixes depend on the availability and relative cost of public and private sector-supplied contraceptive services, community norms and personal preferences. Large proportions of couples in the developing world, as well as in more developed countries, are using more effective, modern methods of family planning (table A-11 and figure 39).

Where overall use of contraception is low, it is not unusual for a third or more of users to rely on traditional methods, which tend not to require the use of contraceptive devices. Such methods include periodic abstinence, withdrawal and douche, as well as various folk methods (herbs, amulets, etc.). In Sub-Saharan Africa, where contraceptive use is generally the lowest among world regions, married women who do plan their families have relied heavily on traditional methods, but this is changing.

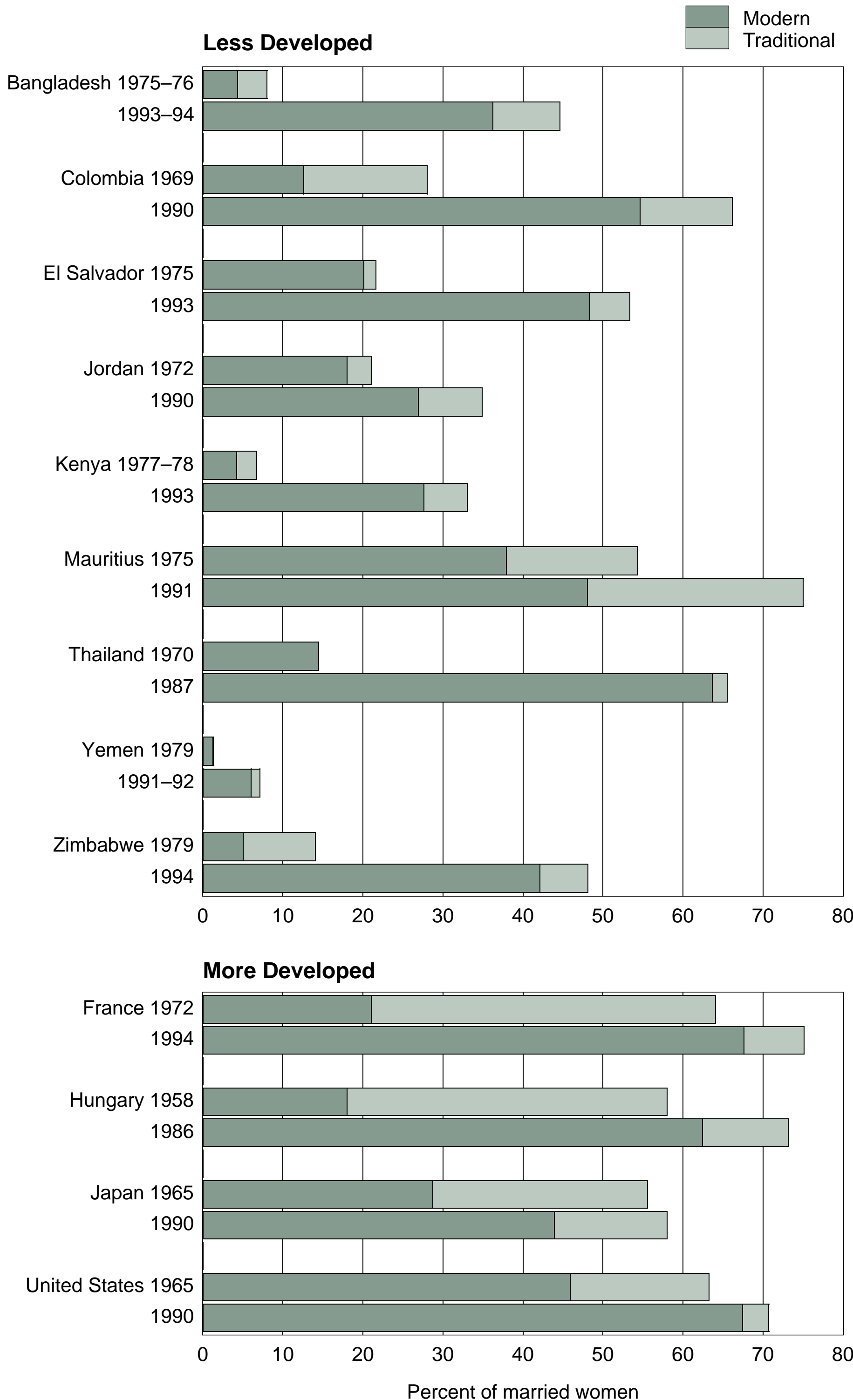
Where overall use of contraception is relatively high, modern methods dominate, though again, method mix varies from country to country. Among modern methods used worldwide, sterilization is becoming increasingly widespread. About half of users in the United States and Mainland China, and about three-quarters of users in India rely on sterilization to limit family size.

Figure 39.
**Contraceptive Method Mix for Selected Countries: 1990 or Later**




Note: Refers to method of contraception reported by currently married women ages 15 to 49. For Ghana, Morocco, Egypt, Japan, and the Czech Republic, male sterilization is not reported.
Source: Table A-11.

Figure 40.
**Trends in Use of Modern and Traditional Methods of Contraception: Selected Countries**




Source: Table A-11.

## ...and the Trend Is Towards Use of More Effective Modern Methods

Though not a universal pattern, increases in overall use over time are more often than not accompanied by increases in the percentage of users opting for more effective, modern methods of family planning (figure 40).

One of the best examples is Zimbabwe, where about two-thirds of users chose a traditional method, such as rhythm, in 1979. By 1984, however, only about 3 in 10 users relied on traditional methods, and in 1994 only 12 percent of married women using contraception chose traditional methods.

In Kenya the contraceptive prevalence rate increased from 7 percent to 33 percent of married women ages 15 to 49 between 1978 and 1993. During the same period, the proportion of these users selecting modern methods increased from 63 percent to 84 percent. In Hungary, as overall prevalence increased from 58 percent of MWRA in 1958 to 73 percent in 1986, the proportion of users relying on modern methods rose from 31 to 85 percent. Recent surveys show similar trends in Colombia, Thailand, and other countries.

There are also exceptions to the rule: In Mauritius, Jordan, Yemen, and El Salvador, for example, the proportion of traditional methods has actually risen slightly since the 1970's, while the overall prevalence rate has increased substantially.

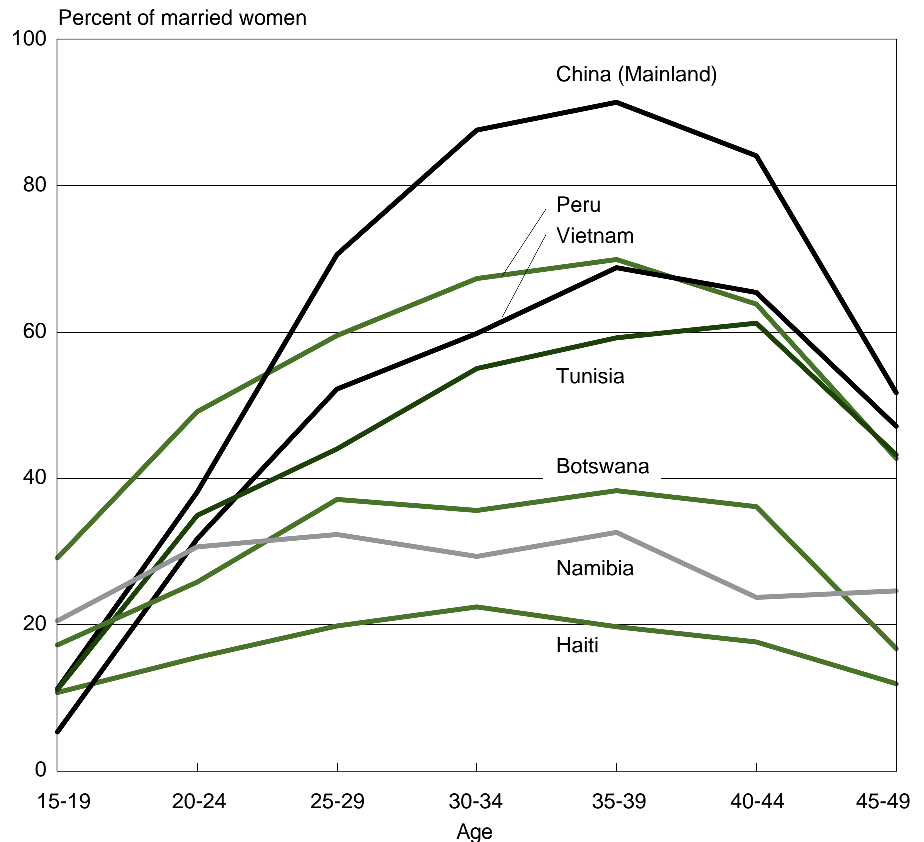
In two-thirds of the less developed countries with multiple data points included in table A-11, the proportion of users relying on modern methods has risen between the earliest and latest surveys.

## Contraceptive Use Is Typically Highest Among Women in Their Late Thirties...

Married women in their thirties, usually their late thirties, are the most likely to use contraception to plan their families (table A-12). As illustrated by a sample of countries from all developing regions, this is true regardless of the level of overall use, although differences among age groups are largest when overall use is high (figure 41). In Mainland China and Peru, for example, where overall rates are relatively high, contraceptive use follows a pattern of low rates at ages 15 to 19 years, climbing to a high at ages 35 to 39 years, and declining again for the older reproductive ages. In Namibia, which has one of the lowest overall rates among the countries shown (29 percent), prevalence is roughly constant for age groups 20 to 24 through 35 to 39.

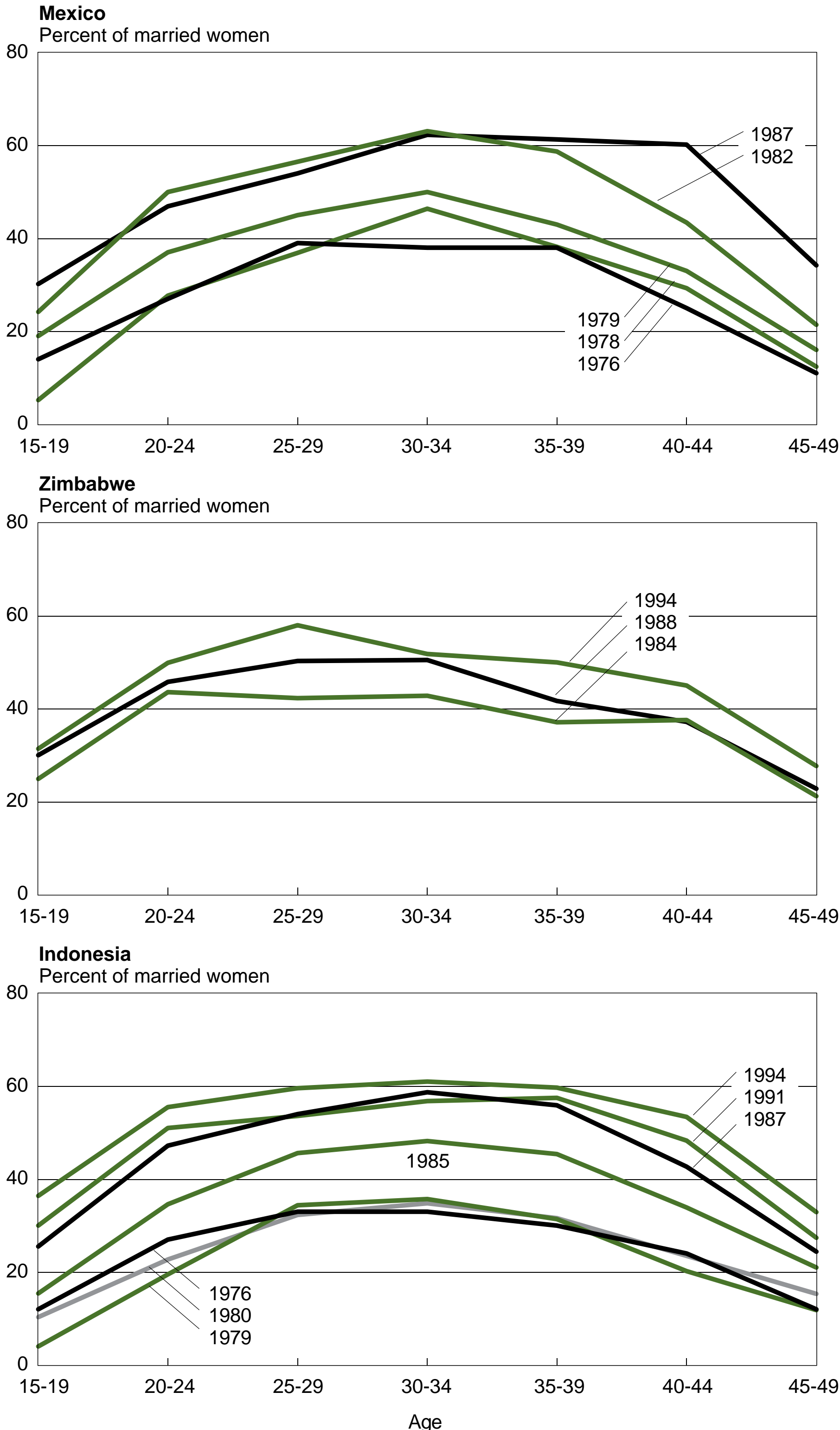
In Haiti, which has the lowest overall prevalence of the countries shown, the spread in age-specific prevalence rates is only 11 percentage points. In Mainland China, in contrast, age group 35 to 39 has a prevalence rate 80 percentage points higher than age group 15 to 19.

Figure 41.
**Contraceptive Prevalence Rate by Age for Selected Countries: 1988 or Later**




Source: Table A-12.

Figure 42.
**Trends in Contraceptive Prevalence Rate by Age for Selected Countries: 1976 to 1994**




Source: Table A-12.

## ...but Patterns of Increase in Age-Specific Prevalence Depend on Reasons for Use

Over time, increases in contraceptive use within populations that use family planning to limit, rather than space, childbearing tend to be smallest among younger women, who have yet to attain their desired family size; largest, among women in their thirties and early forties, who ***have*** attained desired family size but are not yet subject to the decreased fecundity characteristic of the 45 to 49 age group (figure 42). In Mexico, for example, while the overall contraceptive prevalence rate was increasing from 29 percent to 53 percent between 1976 and 1987, the rate for women ages 25 to 29 years increased by 15 percentage points; and that for women ages 40 to 44 years, by 35 percentage points, the largest increase in any age group.

Where contraception is used more to space births or where family planning and educational attainment are highly correlated, increases in age-specific prevalence may be concentrated in the 20's and 30's, as in Zimbabwe (Zimbabwe, Central Statistical Office and Macro International 1989:50).

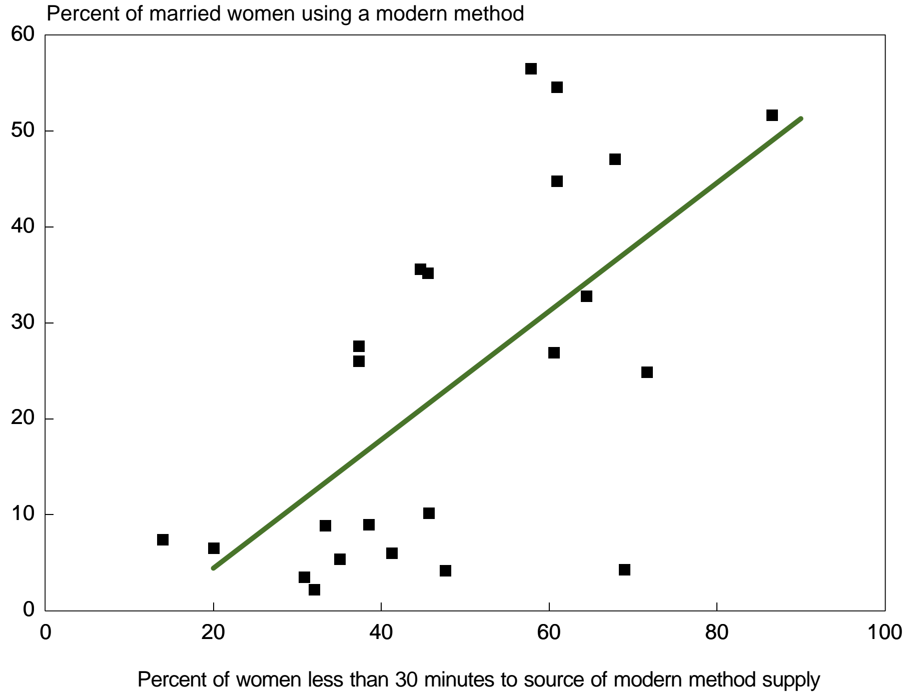
In Indonesia, where some 55 percent of married women of reproductive age were using family planning in 1994, increases in prevalence rates since 1976 have been about equal for every age group other than the very youngest (15 to 19) and oldest (45 to 49). These increases, averaging 27 percentage points, reflect widespread use of contraception for both child spacing and family size limitation (Indonesia, Central Bureau of Statistics, et al. 1995:70).

## Continued Expansion in Contraceptive Prevalence Is Partially a Matter of Access

If family planning is to continue to play an important role in improving reproductive health around the world, and in the developing world in particular, couples must know about contraceptive methods, including the demonstrated benefits of lower-risk pregnancies to maternal and child health; couples must be motivated to use family planning; and family planning services must be readily available to them. Evidence from surveys conducted in the late 1980's and early 1990's shows that modern method prevalence is associated with proximity of a source of supply (figure 43).

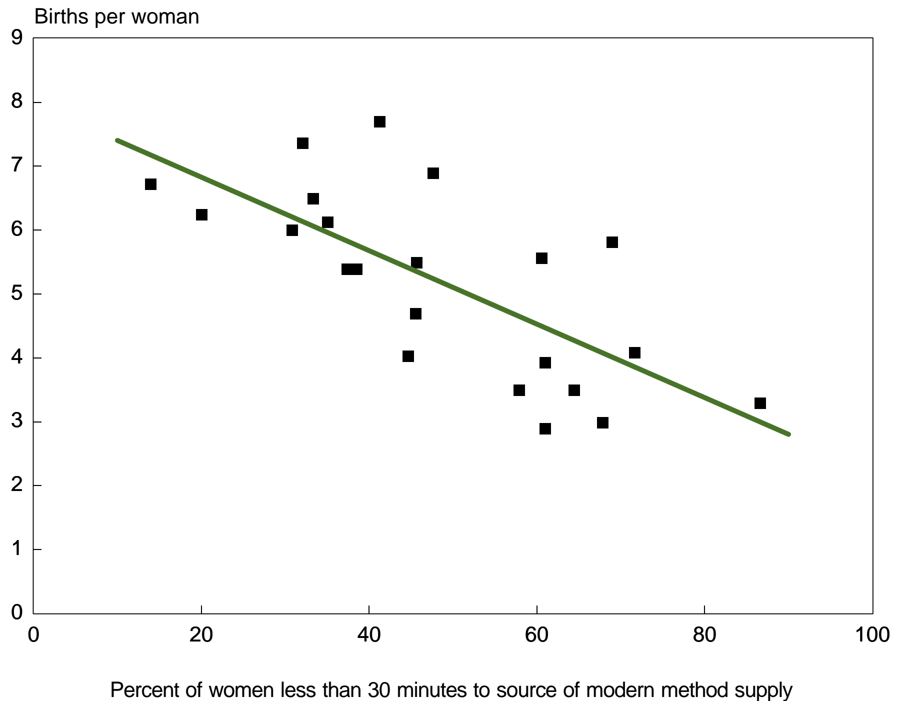
Moreover, the general pattern is that women have fewer children (TFR) where modern methods are more readily available, again as measured by proximity (figure 44).

Figure 43.
**Modern Method Contraceptive Use by Proximity to Supply Source**
(23 countries)




Source: Demographic and Health Surveys.

Figure 44.
**Total Fertility Rate by Proximity to Supply Source**
(23 countries)




Source: Demographic and Health Surveys.

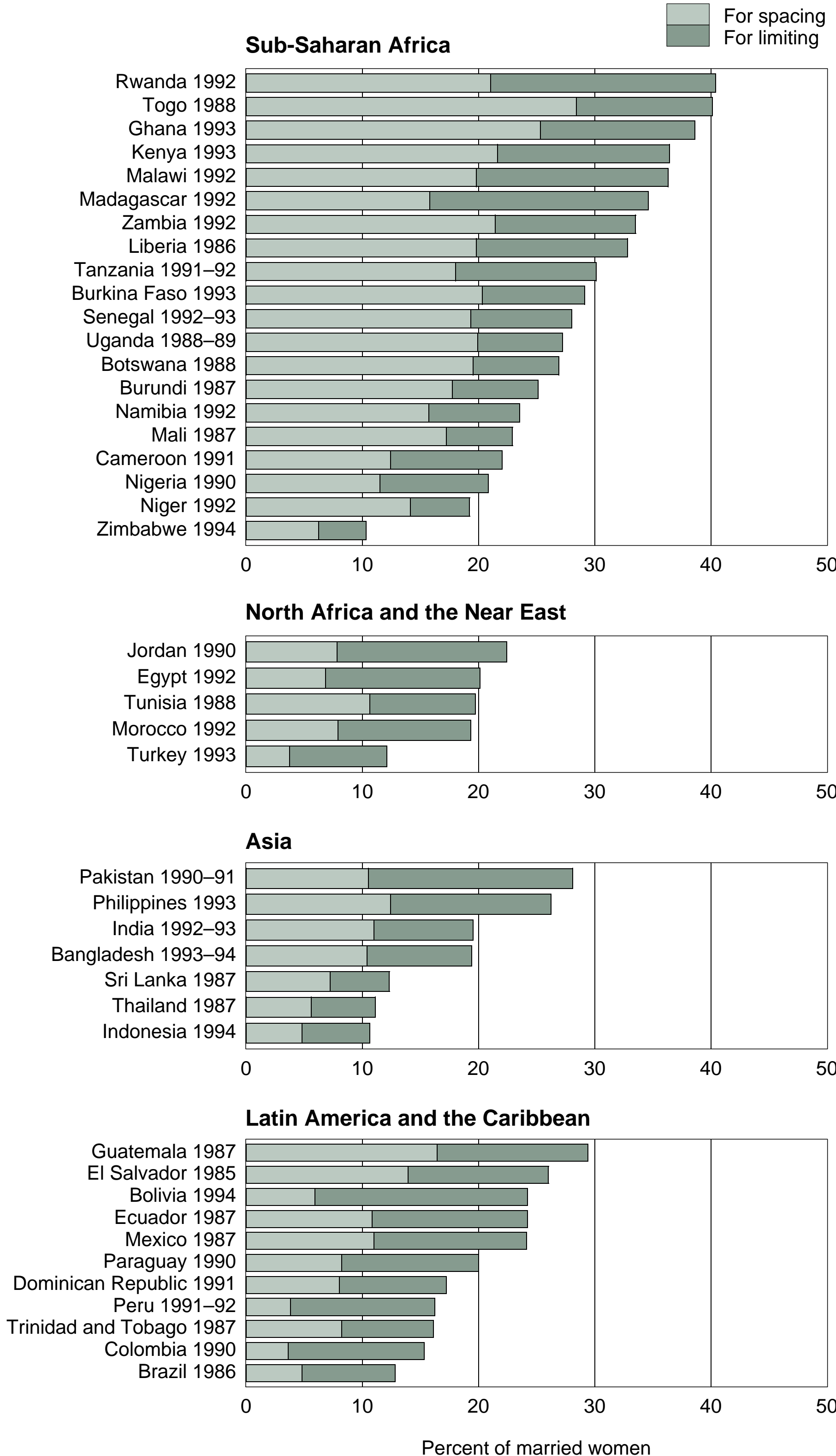



Figure 45.
**Unmet Need for Family Planning Among Currently Married Women for Selected Countries by Region: 1985 or Later**

Source: Most recent Demographic and Health Surveys.

## Growing Body of Evidence Indicates Unmet Need for Family Planning Is Widespread

Many women at risk of childbearing say they would like to delay the onset of childbearing, postpone their next pregnancy, or have no additional births, but are not using contraception. Since the publication of data about this unmet need for 25 countries in 1991 (Westoff and Ochoa 1991, reproduced in *World Population Profile: 1994*), information on unmet need has become available for an additional 18 countries. These data and the earlier data together portray each major region of the developing world as having substantial unmet need for family planning (figure 45).

Unmet need is generally highest in Sub-Saharan Africa, where the primary component is the need for methods for spacing births. Unmet need is particularly high in Rwanda, Togo, Kenya, and Ghana where roughly 2 in every 5 currently married women of reproductive age are not using contraception but desire to control their fertility.

Unmet need is high in some Latin American, Near East and North Africa, and Asian countries as well. Pakistan (28 percent), the Philippines (26 percent), El Salvador (26 percent), and Guatemala (29 percent) have particularly high levels of unmet need. In Latin America and the Caribbean, and in the Near East and North Africa, the primary component of unmet need is often a need to limit rather than a need to space births.

In the seven Asian countries with information on unmet need, evidence suggests overall unmet need is moderate, with a balance between unsatisfied demand for family planning for spacing and limitation.

The ICPD Program of Action (United Nations 1995a: section 7.13) notes that, while five times as many couples are using some method of family planning today in developing countries, compared with the situation prevailing in the 1960's, the full range of modern methods is unavailable to as many as 350 million couples worldwide. In recognition of this unmet need, much of it in the developing countries of Africa, Asia and Latin America, the International Conference on Population and Development adopted universal access to family planning methods and related reproductive health services as a key goal to be pursued over the course of the next two decades.

Improved availability of family planning services, leading to more widespread use of family planning, would carry widely recognized maternal and child health benefits, particularly in less developed countries (United Nations 1995d, Maine 1981, Omran 1984). The ICPD Program of Action draws attention to survey evidence indicating that some 120 million additional women worldwide would use a modern method of contraception if services were more accessible and if their partners, families, and communities were more supportive of family planning.

Giving couples more control over the number and spacing of their children could have substantial demographic effects apart from expected impacts on infant, child, and maternal mortality. Specifically, greater use of family planning could reduce unwanted fertility, which may be as high as 15 to 20 percent of all fertility in Asia and Sub-Saharan Africa, and as high as 30 percent in Latin America and North Africa.[5]

[5] Unweighted region-specific means of percentage differences between total fertility rates and desired total fertility rates taken from Westoff (1991: table 5.1). Westoff's data are from 26 DHS surveys conducted in the late 1980's.

### *From the ICPD Program of Action:*

*"All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services ..." (section 7.16).*

*"... approximately 120 million additional women worldwide would be currently using a modern family-planning method if more accurate information and affordable services were easily available, and if partners, extended families and the community were more supportive. These numbers do not include the substantial and growing numbers of sexually active unmarried individuals wanting and in need of information and services." (section 7.13)*