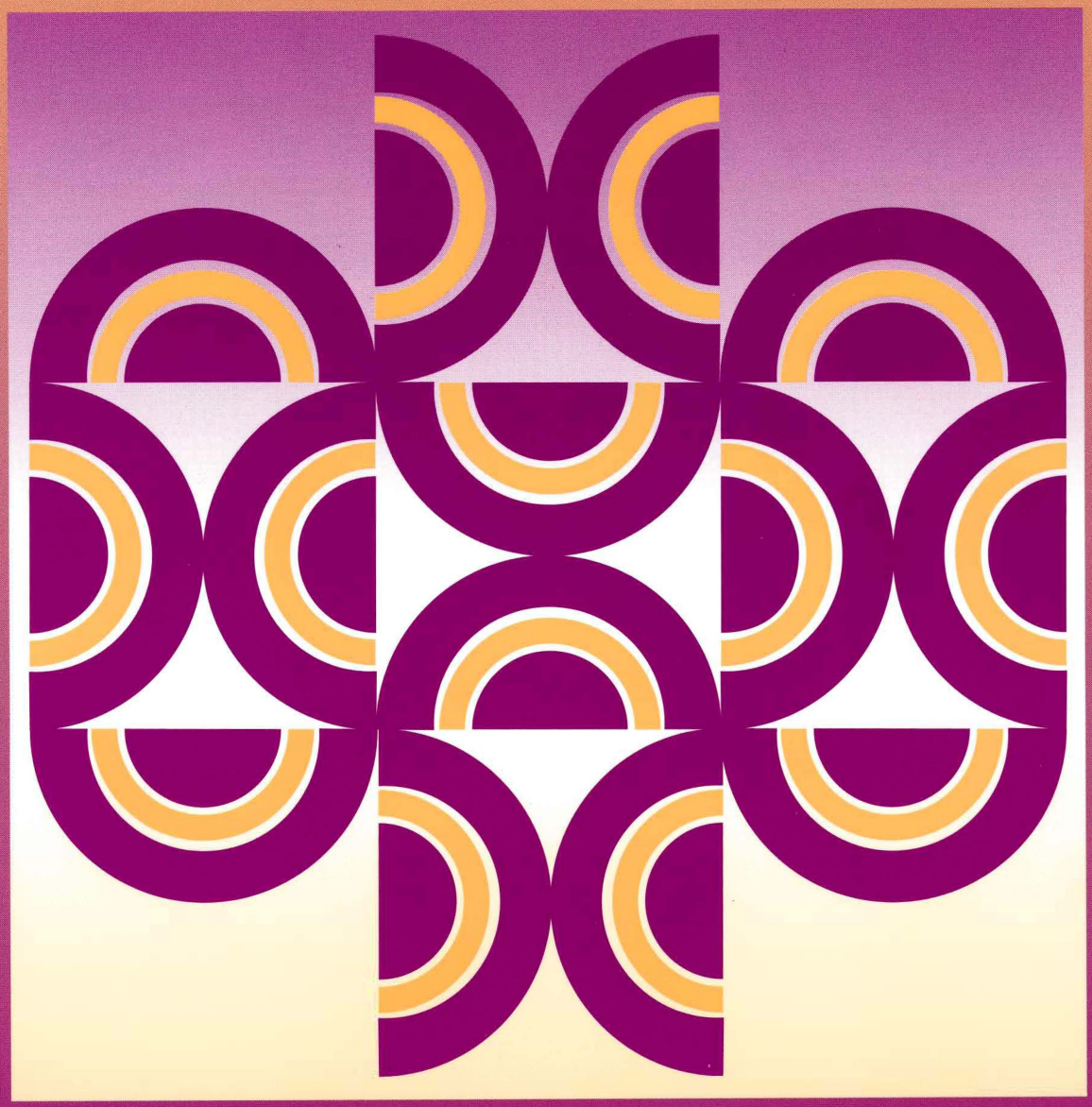
Economic & Social Affairs

Levels and Trends of Contraceptive Use as Assessed in 2002



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Department of Economic and Social Affairs
Population Division

LEVELS AND TRENDS OF CONTRACEPTIVE USE AS ASSESSED IN 2002

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DESA

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PREFACE

Studies of levels and trends of contraceptive use are carried out periodically by the Population Division of the Department of Social and Economic Affairs of the United Nations Secretariat as part of its effort to provide the international community with up-to-date and scientifically objective information on population and development. *Levels and Trends of Contraceptive Use as Assessed in 2002* is the fifth report in the series of assessments of current contraceptive use. The first four reports were prepared in 1983, 1988, 1994 and 1998[1].

The primary objective of the present report is to provide a comprehensive review of contraceptive use around the world. The review is based primarily on data obtained from nationally representative sample surveys. At the time this review was undertaken, contraceptive use data referring to 1980 or more recent years were available for 160 countries, including 125 developing countries and 35 developed countries. In 2002, those countries accounted for 96 per cent of the population of the world.

As in the previous assessment of contraceptive use conducted in 1998, this report reviews the extent to which contraception is used around the world, examines the specific methods of contraception that are used, and analyses trends in contraceptive use. Past trends of contraceptive use are estimates based on data collected between the early 1970s and 2000, whereas figures for later years are projections derived by estimating the growth in contraceptive practice that will be needed if fertility is to decline in accordance with United Nations population projections as presented in *World Population Prospects: the 2002 Revision*[2]. Two important chapters are new in this review: a chapter analysing contraceptive use dynamics and another one reviewing national policies regarding fertility, contraception and population growth.

The latest data on contraceptive use shown in this report has been published in a wall chart entitled *World Contraceptive Use 2003*[3]. In addition, data are available in digital form. Interested users can purchase a CD-ROM[4] containing the available contraceptive prevalence data by country for years starting in the 1980s to the present. Selected output from this report as well as other population information may be accessed on the Population Division's web site at *http://www.unpopulation.org.*

The Population Division gratefully acknowledges the cooperation of the Council of Health Ministers of Gulf Co-operation Council States, the United Nations Children's Fund, the United Nations regional commissions, ORC Macro and the United States Centers for Disease Control and Prevention in providing the great majority of the data that are used in this report. The Population Division also wishes to accord recognition and appreciation to Messrs. John Cleland, Mohamed Ali and Iqbal Shah who prepared a draft of the chapter on contraceptive use dynamics. Responsibility for this publication rests with the Population Division.

Comments and suggestions on this report are welcome and may be addressed to the office of Ms. Hania Zlotnik, Director, Population Division/DESA, United Nations, New York, NY 10017, USA, at telephone (212) 963-3179 or fax (212) 963-2147. This report as well as related publications of the Population Division may be accessed at its website: www.unpopulation.org.

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[1] *Recent Levels and Trends of Contraceptive Use as Assessed in 1983* (United Nations publication, Sales No. E.84.XIII.5); *Levels and Trends of Contraceptive Use as Assessed in 1988* (United Nations publication, Sales No. E.89.XIII.4); *Levels and Trends of Contraceptive Use as Assessed in 1994* (United Nations publication, Sales No. E.96.XIII.13); and *Levels and Trends of Contraceptive Use as Assessed in 1998* (United Nations publication, Sales No. E.01.XIII.4).

[2] *World Population Prospects: The 2002 Revision*, vol. I: *Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6) and vol. II: *Sex and Age Distribution of Populations* (United Nations publication, Sales No. E.03.XIII.7).

[3] *World Contraceptive Use 2003, Wall Chart* (United Nations publication, Sales No. E.04.XIII.2).

[4] *World Contraceptive Use 2003, Datasets in Excel Format* (United Nations publication, POP/DB/CP/Rev.2003).

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Explanatory notes

The following symbols have been used in the tables throughout the report:

Two dots (..) indicate that data are not available.
An em dash (—) indicates that the amount is negligible.
A minus sign (-) before a number indicates a deficit or decrease, except as indicated.
A point (.) is used to indicate decimals.
A slash (/) indicates a crop year or financial year, e.g., 1994/95.
Use of a hyphen (-) between dates representing years signifies the full period involved including the beginning and end years.

Details and percentages in tables do not necessarily add to totals because of rounding.

The term "billion" signifies a thousand million.

The 50 least developed countries, classified as such by the United Nations General Assembly in December 2003 are: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Sudan, Timor-Leste, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen and Zambia.

The following abbreviations are used in the present report:

AIDS	Acquired immunodeficiency syndrome
CDC	United States Centers for Disease Control and Prevention
DHS	Demographic and Health Survey
FFS	Fertility and Family Survey
HIV	Human immunodeficiency virus
IEC	Information, education and counselling
IUD	Intra-uterine device
MICS	Multiple Indicator Cluster Survey
MWRA	Married women of reproductive age
TFR	Total fertility rate
UNICEF	United Nations Children's Fund
WFS	World Fertility Survey

EXECUTIVE SUMMARY

Contraception is one of the major determinants of fertility levels. Its use has been increasing steadily since 1970 and is currently widespread throughout the world. However, progress has been uneven across geographical areas, and great challenges remain in terms of both increasing the level of contraceptive use to satisfy existing needs in certain regions and in terms of making available an adequate variety of contraceptive methods to increase the ability of couples wishing to use contraception to do so in a consistent and efficient manner.

This report on *Levels and Trends of Contraceptive Use as Assessed in 2002*, prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, is part of the Population Division's on-going activities related to the monitoring of levels and trends of fertility, nuptiality and contraceptive use in all countries of the world. It shows that although the great majority of countries in the world have now endorsed policies in support of family planning, considerable disparities in their levels of contraceptive use still exist. Although contraceptive use has increased tremendously in the less developed regions, the overall level of use in those regions is still lower than that in the more developed regions. As this report documents, there are high proportions of couples in developing countries who discontinue the use of one method of contraception without promptly switching to another method, suggesting that mere increases in prevalence of contraceptive use need not necessarily mean success in avoiding unwanted or mistimed pregnancies.

Levels of contraceptive use

Worldwide, contraceptive prevalence—the percentage of women using contraception among women of reproductive age who are married or in a consensual union—is estimated to have reached 61 per cent in 1998, the average date for the most recent data available in 160 countries. However, this global average masks important disparities across and within developmental groups, major areas and regions.

Contraceptive prevalence in less developed regions, averaging 59 per cent, was below that in more developed regions, which stood at 69 per cent. Within the less developed regions, Asia and Latin America and the Caribbean, with 64 per cent and 71 per cent prevalence respectively, had reached contraceptive levels comparable to those of the more developed regions, while Africa still lagged far behind with 27 per cent prevalence. Average prevalence for sub-Saharan Africa as a whole, estimated at 20 per cent, was even lower. In the more developed regions, contraceptive prevalence was lower in Europe at 67 per cent than in Northern America, Australia and New Zealand with 76 per cent.

Contraceptive prevalence varied considerably among countries. In Africa, although half of all countries had prevalence levels below 20 per cent, a few had fairly high levels of contraceptive use, including Cape Verde, Egypt, Morocco, South Africa and Zimbabwe, whose contraceptive prevalence ranged from 50 per cent to 60 per cent; Algeria, Réunion and Tunisia with levels ranging from 60 per cent to 70 per cent; and Mauritius with 75 per cent.

In Asia, almost half of all countries had a contraceptive prevalence of 60 per cent or higher. Among them, China and Hong Kong (Special Administrative Region of China) had achieved the world's highest levels of contraceptive use with 84 per cent and 86 per cent respectively. The Islamic Republic of Iran, the Republic of Korea, Thailand and Viet Nam were also among the leading countries in terms of contraceptive prevalence, with levels higher than 70 per cent. In addition to China, four other populous countries of Asia—Bangladesh, India, Indonesia and Japan—had reached relatively high levels of contraceptive prevalence, at or above 50 per cent. Yet, prevalence was still below 30 per cent in eight countries: Afghanistan, Bhutan, Cambodia, Iraq, Oman, Pakistan, United Arab Emirates and Yemen.

In Latin America and the Caribbean, variation at the country level was smaller than in Africa or Asia, with contraceptive prevalence ranging from around 30 per cent in Haiti, Guatemala and Guyana to around 75 per cent in Brazil, Colombia, Costa Rica, Cuba and Puerto Rico.

In Europe, contraceptive prevalence was in general below 50 per cent in the countries of Eastern Europe and in the successor States of the former Union of Soviet Socialist Republics (USSR), but in countries in the rest of Europe, contraceptive prevalence was usually above 70 per cent.

In the late 1990s, the level of use of modern methods of contraception among women of reproductive age who were married or in union was similar in the more developed regions (55 per cent) and in the less developed regions (54 per cent), but the prevalence of traditional methods of contraception was twice as high in the more developed regions (13 per cent) than in the less developed regions (6 per cent), accounting for much of the difference in overall prevalence between the more developed and the less developed regions.

Trends in contraceptive prevalence

Worldwide, contraceptive prevalence is estimated to have increased from 54 per cent in 1990 to 59 per cent in 1995 and to 63 per cent in 2000. This trend, based on comparable data for 120 countries, is the consequence of a much slower increase in the more developed regions than in the less developed regions. In the more developed regions, contraceptive prevalence rose from 66 per cent in 1990 to 68 per cent in 1995 and to 70 per cent in 2000, that is, it increased by 0.4 percentage points per year during the 1990s. In the less developed regions, contraceptive prevalence went from 52 per cent in 1990 to 57 per cent in 1995 and to 61 per cent in 2000, therefore rising by an annual average of 0.9 percentage points.

There are sizable variations in trends in contraceptive prevalence across major areas and regions. In the more developed regions, contraceptive prevalence did not change much in Europe and in Australia and New Zealand during the 1990s. However, it increased at a rapid pace in Northern America (by 1.0 percentage point per year). In the less developed regions, contraceptive prevalence increased rapidly in Africa and Latin America and the Caribbean (by more than 1.0 percentage point per year, on average) but more slowly in Asia (by 0.8 percentage points per year).

Over the past decade, the increase in contraceptive prevalence was related mainly to increased use of modern methods, whose prevalence rose from 47 per cent in 1990 to 52 per cent in 1995 and to 56 per cent in 2000. In the more developed regions, especially in Eastern and Southern Europe, the increase in the use of modern methods was accompanied by a decrease in the use of traditional methods.

In Africa, low levels of contraceptive use have persisted since the early 1970s in the countries of Eastern, Middle and Western Africa. Significant increases did not start in those regions until the late 1980s or early 1990s, a development that explains why 87 per cent of the countries in Africa with data on trends still had contraceptive prevalence levels below 30 per cent in 2000. In contrast, the countries of Northern and Southern Africa experienced rapid increases in contraceptive use starting in the 1970s.

In Asia, the countries of Eastern Asia reached high contraceptive prevalence levels, ranging from 60 per cent to 70 per cent, in the late 1970s and early 1980s but have experienced no significant increases since then. In the countries of South-central and South-eastern Asia, contraceptive prevalence levels were much lower in the 1970s but have been increasing steadily since then. In Western Asia, contraceptive use increased mainly in the 1990s.

The countries of Latin America and the Caribbean have also experienced sustained increases in contraceptive prevalence since 1970. During the 1990s, contraceptive prevalence increased by at least 1.0 percentage point per year in almost three-quarters of the countries in this major area.

In the countries of Northern Europe, Western Europe and Northern America, as well as in Australia and New Zealand, contraceptive prevalence levels of 70 per cent or higher have prevailed for a long time. In the

countries of Eastern and Southern Europe, prevalence levels have been lower, ranging between 50 per cent and 70 per cent, since the 1970s. An exception is Spain, which has currently one of the highest contraceptive prevalence levels in the world (above 80 per cent).

Specific contraceptive methods used

Only in a quarter of the countries with data available did a single method account for 50 per cent or more of the contraceptives used by women of reproductive age who were married or in union in 1998. In all major areas, only two contraceptive methods accounted for about 50 per cent or more of contraceptive use.

Current contraceptive use is dominated by the use of modern contraceptive methods. Modern methods are more commonly used in the less developed regions, where they account for 90 per cent of all contraceptive use, than in the more developed regions, where they account for 81 per cent. The three most used methods in the world are female sterilization, the intra-uterine device (IUD) and the pill, which are used by 21 per cent, 14 per cent and 7 per cent, respectively, of women of reproductive age who are married or in union. Taken together, these three methods are used by two out of every three women of reproductive age who are married or in union and using contraception. All traditional methods combined have a prevalence level of just 7 per cent.

The three most commonly used methods are particularly popular in the less developed regions, where 23 per cent of women of reproductive age who are married or in union rely on sterilization, an additional 15 per cent use the IUD, and 6 per cent use the pill. In the more developed regions, use of the pill is more common than in the less developed regions with 16 per cent prevalence. It is followed by condom use (13 per cent prevalence), female sterilization (10 per cent) and the IUD (8 per cent).

These prevalence levels mean that in the more developed regions, 42 per cent of couples using contraception rely either on the pill or condoms. In more developed regions, over six out of every ten women of reproductive age who use contraceptives and are married or in union rely on short-acting reversible methods (including traditional contraceptive methods), while only two out of every ten are sterilized and one in ten uses the IUD. In the less developed regions, by contrast, couples are more likely to rely on longer-acting, highly effective clinical contraceptive methods, with almost two-thirds of all female contraceptive users of reproductive age who are married or in union relying on sterilization or the IUD. High levels of female sterilization are common in a number of countries in Asia and Latin America, whereas high levels of IUD use are more common in countries of Asia, particularly in China.

Worldwide, about one in every five couples using contraception relies on methods that require male participation (condom or male sterilization) or male cooperation (rhythm or withdrawal). Reliance on male-oriented methods is more common in the more developed regions, where two in every five couples use them, than in the less developed regions, where only one in seven couples relies on such methods.

Future trends in contraceptive use

Between 2000 and 2025, it is estimated that overall contraceptive prevalence at the world level needs to increase from 63 per cent to 67 per cent in order to make possible the reduction of total fertility from 2.8 children per woman to 2.3 children per woman as projected in the medium variant of the *2002 Revision* of the United Nations population projections[1]. Because the reduction of fertility is confined to the less developed regions, a marked increase in contraceptive prevalence is projected for those regions: from 61 per cent in 2000 to 68 per cent in 2025. In the more developed regions, fertility levels are projected to increase slightly, from 1.6 children per woman in 2000 to 1.7 children per woman in 2025, however, the expectation that the use of

[1] *World Population Prospects: The 2002 Revision*, vol. I: *Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6).

contraception will substitute some of the current recourse to abortion results in an expected rise in contraceptive prevalence, from 70 per cent in 2000 to 75 per cent in 2025.

In the less developed regions, the fastest and most significant increases in contraceptive prevalence need to occur in Africa, where prevalence must rise from 28 per cent to 49 per cent between 2000 and 2025 if fertility is to decline from 5.1 children per woman to 3.4 children per women as projected. In Asia, where fertility is projected to drop from 2.6 to 2.1 children per woman, contraceptive prevalence is expected to rise moderately: from 65 per cent to 71 per cent. In Latin America and the Caribbean, where fertility is projected to pass from 2.6 to 2.0 children per woman, contraceptive prevalence is expected to rise from 74 per cent to 78 per cent. Moderate increases in contraceptive prevalence are also expected in Oceania (from 62 per cent to 66 per cent), where total fertility is projected to decline from 2.4 children per woman in 2000 to 2.1 children per woman in 2025.

In Northern America, where fertility is projected to remain largely unchanged at 2 children per woman, contraceptive prevalence is also expected to remain constant at 82 per cent during 2000-2025. However, a moderate rise in contraceptive prevalence is expected in Europe (from 68 per cent to 75 per cent) even though its fertility is expected to rise between 2000 and 2025 (from 1.4 to 1.6 children per woman). The projected increase in contraceptive prevalence in Europe is based on the expectation that increases in the use of effective contraception will make less likely the recourse to abortion.

Between 2000 and 2025, the number of married women who use contraception is projected to increase from 654 million to 846 million at the world level, largely as a result of the growth projected for the less developed regions where that number is expected to rise from 535 million to 746 million. In contrast, the number of married contraceptive users in the more developed regions is expected to decrease from 119 million to 99 million because of both the projected decrease in the number of women of reproductive age—from 300 million in 2000 to 265 million in 2025—and a projected reduction in the proportion married.

The number of women of reproductive age who are married and using contraceptives is projected to triple in Africa, from 33 million to 100 million, and to increase significantly in both Asia and Latin America and the Caribbean, but at a lower pace: from 449 million to 559 million in Asia and from 61 million to 84 million in Latin America and the Caribbean. Smaller increases are projected for Northern America (from 34 million to 37 million) and Oceania (from 2.8 million to 3.2 million), whereas for Europe, a decrease is projected, from 74 million to 64 million, resulting from both a projected reduction in the number of women aged 15-49 and in the prevalence of marriage.

In addition, the number of unmarried women of reproductive age who use contraceptives is also projected to increase at the world level between 2000 and 2025, rising from 126 million to 178 million. Increases are projected for both the more developed regions (from 49 million to 54 million) and the less developed regions (from 77 million to 124 million).

Dynamics of contraceptive use

Evidence provided by the Demographic and Health Surveys indicates that in developing countries, high proportions of couples using reversible methods of contraception discontinue their use because of side effects, health concerns or other problems related to the methods involved. Yet, they do not switch immediately to alternative methods. The median probability of discontinuing use of a reversible contraceptive method within 12 months of beginning its use is nearly 50 per cent for injectables and condoms, and 34 per cent for the pill. The probability of discontinuing periodic abstinence or withdrawal is lower. Consequently, both of these methods can make a non-trivial contribution to the regulation of fertility. The high probabilities of discontinuation of condom use are of particular concern in contexts where HIV infection continues to spread.

The use of IUDs stands out because its probability of discontinuation is considerably lower, with the median value being just 12 per cent. Factors that probably contribute to the low discontinuation probability of

IUD use include its low failure rate and the fact that IUD removal typically requires a visit to a medical facility, thus involving a firmer resolve on the part of the user to discontinue use.

In general, couples who use contraception to limit childbearing were less likely than couples who use it to space births to abandon a method because of dissatisfaction. Urban and better educated couples had higher probabilities than their counterparts of switching quickly to an alternative method when one was abandoned. This feature probably accounts for the generally higher levels of current contraceptive use observed in urban areas and among better educated couples. Easier access to alternative methods among the better educated, better understanding of the methods available, and the social confidence to obtain them are all factors likely to shape the differentials observed.

Fertility, contraception and population policies

Government support for methods of contraception has been rising steadily since 1975. By 2001, 92 per cent of all countries supported family planning programmes and the distribution of contraceptives, either directly through government facilities (75 per cent), or indirectly through support of the activities of non-governmental organizations such as family planning associations (17 per cent). It is mainly in developing countries that the adoption of new policies supporting family planning has occurred. The proportion of developing countries supporting the use of contraceptive methods rose from 73 per cent in 1976 to 94 per cent in 2001. Among the least developed countries, the increase was more pronounced: from 57 per cent in 1976 to 96 per cent in 2001. Among developed countries, the percentage supporting family planning programmes has remained stable, at about 80 per cent, since 1976.

KEY FINDINGS

1. Worldwide, contraceptive prevalence—the percentage of women using contraception among women of reproductive age who are married or in a consensual union—reached 61 per cent in 1998, the average date for the most recent data available for 160 countries. With an average level of 59 per cent, the less developed regions had a level of contraceptive prevalence ten points lower than that in the more developed regions (69 per cent).

2. In the late 1990s, Africa, with 27 per cent prevalence, had the lowest contraceptive prevalence in the world. Average prevalence for sub-Saharan Africa, estimated at 20 per cent, was even lower. In contrast, Asia and Latin America and the Caribbean, with 64 per cent and 71 per cent prevalence respectively, had reached levels of contraception comparable to those of the more developed regions, where Europe had 67 per cent prevalence and Northern America together with Australia/New Zealand had 76 per cent prevalence.

3. Worldwide, contraceptive prevalence increased from 54 per cent in 1990 to 59 per cent in 1995 and to 63 per cent in 2000. The increase was slower in the more developed regions than in the less developed regions because, having already attained relatively high levels in the 1980s, contraceptive prevalence did not change much in Europe and Australia/New Zealand during the 1990s. However, it increased at a rapid pace in Northern America (by 1.0 percentage point per year). In the less developed regions, contraceptive prevalence increased rapidly in Africa and Latin America and the Caribbean (by more than 1.0 percentage point per year, on average) but more slowly in Asia (by some 0.8 percentage points per year).

4. At the world level, 54 per cent of women of reproductive age who are married or in union rely on modern contraceptive methods, with 21 per cent having opted for female sterilization, 14 per cent using the intra-uterine device (IUD) and 7 per cent relying on the pill. Modern contraceptive methods account for a larger fraction of contraceptive use among women who are married or in union in the less developed regions than in the more developed regions: 90 per cent versus 81 per cent. The three most commonly used methods—female sterilization, the IUD and the pill—account for two-thirds of contraceptive use worldwide.

5. More than six out of every ten female contraceptive users in the more developed regions rely on short-acting reversible methods, while only two in ten are sterilized and one in ten uses the IUD. In the less developed regions, four in ten rely on sterilization and nearly three in ten on the IUD.

6. Worldwide, about 20 per cent of contraceptive users rely on a method that requires male participation or cooperation. However, reliance on male-oriented methods is greater in the more developed regions (about 40 per cent of overall contraceptive use) than in the less developed regions (about 14 per cent).

7. Between 2000 and 2025, world contraceptive prevalence is projected to increase slowly, from 63 per cent to 67 per cent, in order to reduce fertility from 2.8 to 2.3 children per woman as projected in the medium variant of the *2002 Revision* of the United Nations population projections[2]. Slightly faster increases are projected in the less developed regions than in the more developed regions, with prevalence rising from 61 per cent to 68 per cent in the less developed regions and from 70 per cent to 75 per cent in the more developed regions.

8. In the less developed regions, the fastest and most significant increases are expected in Africa, where prevalence needs to rise from 28 per cent to 49 per cent between 2000 and 2025 to achieve the reductions of fertility projected. In the other major areas, prevalence is expected to increase only slightly: from 65 per cent to 71 per cent in Asia, from 74 per cent to 78 per cent in Latin America and the Caribbean, and from 62 per cent to 66 per cent in Oceania. In Northern America, prevalence is projected to remain constant at 82 per cent

[2] *World Population Prospects: The 2002 Revision*, vol. I: *Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6).

during 2000-2025 because fertility is also projected to remain stable at 2 children per woman. In Europe, contraceptive prevalence is projected to rise from 68 per cent to 75 per cent although fertility is projected to increase slightly between 2000 and 2025. The increase in prevalence stems from an expectation that the more widespread use of contraceptive methods will reduce the recourse to abortion.

9. Between 2000 and 2025, the number of married women who are contraceptive users will need to increase from 654 million to 846 million at the world level, mainly as a result of the growth projected in the less developed regions, where the number of female married contraceptive users will need to increase from 535 million to 746 million in order to achieve the fertility reductions projected. In the more developed regions, the number of married women using contraception is projected to decrease slightly, from 119 million to 99 million due to the low fertility levels projected and the expected decrease in both the proportions married and the population of reproductive age.

10. Between 2000 and 2025, the number of unmarried women using contraception is projected to increase from 126 million to 178 million at the world level. Increases are projected both in the less developed regions (from 77 million to 124 million) and in the more developed regions (from 49 million to 54 million).

11. Large proportions of couples living in developing countries discontinue the use of reversible methods of contraception because of their side effects, health concerns about the use of the methods involved or other problems related to the use of such methods. Yet, couples often do not switch quickly to another method after one is abandoned. Data from the Demographic and Health Surveys indicate that the median probability of stopping use within 12 months of adoption of a method was nearly 50 per cent for injectables and condoms, and 34 per cent in the case of the pill. Discontinuation of periodic abstinence and withdrawal was lower. IUDs are the notable exception to the rule that reversible methods are often abandoned by many of the couples trying them. The median proportion of couples discontinuing IUD use within 12 months was 12 per cent, lower than that for any other reversible method.

12. By 2001, 92 per cent of all countries supported family planning programmes and the distribution of contraceptives, either directly through government facilities (75 per cent), or indirectly through support of the activities of non-governmental organizations, such as family planning associations (17 per cent).

أهم النتائج

1 - بالنسبة للعالم ككل، وصل معدل انتشار وسائل منع الحمل - أي النسبة المئوية للنساء اللواتي يستخدمن هذه الوسائل بين النساء اللاتي في سن الإنجاب المتزوجات أو المعاشرات - إلى 61 في المائة في عام 1998، وهو التاريخ المتوسط لأغلب البيانات الأخيرة التي توافرت عن 160 بلدا. ومع انتشار وسائل منع الحمل في المناطق الأقل تقدما بمتوسط نسبته 59 في المائة، تكون هذه الوسائل أقل بعشر نقاط عن مثيلتها في المناطق الأكثر تقدما (69 في المائة).

2 - وفي أواخر التسعينات، كانت أفريقيا أقل قارة في العالم تنتشر فيها وسائل منع الحمل، حيث لم تتعد هذه النسبة 27 في المائة. بل إن متوسط انتشار هذه الوسائل في أفريقيا جنوب الصحراء كان أقل، حيث تقدّر النسبة بنحو 20 في المائة فقط. وعلى النقيض من ذلك ففي آسيا، وأمريكا اللاتينية والكاريبي، حيث كانت نسبة الانتشار 64 في المائة و 71 في المائة على التوالي، كانت مستويات انتشار وسائل منع الحمل قد اقتربت من مستويات تقارن بالمناطق الأكثر تقدما، حيث كانت هذه النسبة في أوروبا 67 في المائة، وفي أمريكا الشمالية، ومعها أستراليا/نيوزيلندا، 76 في المائة.

3 - وعلى مستوى العالم، زاد انتشار وسائل منع الحمل من 54 في المائة عام 1990 إلى 59 في المائة عام 1995، ثم إلى 63 في المائة عام 2000. وكانت الزيادة أبطأ في المناطق الأكثر تقدما عنها في المناطق الأقل تقدما، لأنه مع وصول هذه النسب إلى مستويات مرتفعة نسبيا في الثمانينات، لم يطرأ عليها تغيير كبير في أوروبا وأستراليا/نيوزيلندا في التسعينات. ولكنها زادت بخطى سريعة في أمريكا الشمالية (بنسبة 1 في المائة سنويا). وفي المناطق الأقل تقدما، زاد انتشار وسائل منع الحمل بسرعة في أفريقيا، وفي أمريكا اللاتينية والكاريبي (بأكثر من 1 في المائة سنويا في المتوسط) ولكن السرعة كانت أبطأ قليلا في آسيا (بنسبة 0.8 في المائة تقريبا سنويا).

4 - وعلى مستوى العالم، يعتمد 54 في المائة من النساء اللاتي في سن الإنجاب من المتزوجات أو المعاشرات على وسائل منع الحمل الحديثة، حيث اختار 21 في المائة منهن تعقيم أنفسهن، واستخدم 14 في المائة وسائل توضع داخل الرحم، واعتمد 7 في المائة على الحبوب. وتمثل وسائل منع

الحمل الحديثة أكبر شريحة من الوسائل التي تستخدمها النساء المتزوجات أو المعاشرات في البلدان الأقل نموا عن تلك المستخدمة في المناطق الأكثر تقدما: حيث تصل النسبة إلى 90 في المائة مقابل 81 في المائة. وتمثل الوسائل الثلاث الأكثر شيوعا - وهي تعقيم النساء، والوسائل التي توضع داخل الرحم، والحبوب - ثلثي وسائل منع الحمل المستخدمة في مختلف أنحاء العالم.

5 - من بين كل 10 نساء يستخدمن وسائل منع الحمل في المناطق الأكثر تقدما، هناك أكثر من 6 نساء يعتمدن على الوسائل القصيرة المفعول التي يمكن التخلي عنها، بينما تلجأ اثنتان من كل 10 إلى التعقيم، وواحدة من كل 10 تستخدم الوسائل التي توضع داخل الرحم. أما في المناطق الأقل تقدما، فإن 4 نساء من بين كل 10 يلجأن إلى التعقيم، وما يقرب من 3 من كل 10 يلجأن إلى الوسائل التي توضع داخل الرحم.

6 - وبالنسبة للعالم ككل، يعتمد نحو 20 في المائة من الذين يستخدمون وسائل منع الحمل على وسائل تتطلب مشاركة الذكور أو تعاونهم. ومع ذلك فإن الاعتماد على الوسائل الخاصة بالذكور أكبر في المناطق الأكثر تقدما (40 في المائة تقريبا من جميع مستخدمي وسائل منع الحمل) منه في المناطق الأقل تقدما (14 في المائة تقريبا).

7 - فيما بين عامي 2000 و 2025، من المتوقع أن يزيد انتشار وسائل منع الحمل في العالم ببطء، من 63 في المائة إلى 67 في المائة، لكي تنخفض الخصوبة من 2.8 إلى 2.3 طفل لكل امرأة، كما هو متوقع في المتغير المتوسط لطبعة عام 2002 المنقحة من توقعات الأمم المتحدة للسكان[1]. وتشير التوقعات إلى حدوث زيادة أسرع قليلا في المناطق الأقل تقدما منها في المناطق الأكثر تقدما، حيث ينتظر أن يزيد انتشار هذه الوسائل من 61 في المائة إلى 68 في المائة في البلدان النامية ككل، ومن 70 في المائة إلى 75 في المائة في البلدان المتقدمة.

8 - في المناطق الأقل تقدما، ينتظر أن تحدث أسرع وأكبر زيادة في انتشار وسائل منع الحمل في أفريقيا، حيث يحتاج الأمر إلى زيادة نسبة

(منشورات الأمم المتحدة، رقم المبيع A.03.XIII.6).

انتشار هذه الوسائل من 28 في المائة إلى 49 في المائة فيما بين عامي 2000 و 2025، لتحقيق الانخفاض المتوقع في الخصوبة. أما في المناطق الرئيسية الأخرى، فمن المتوقع ألا يزيد الانتشار إلا بنسب بسيطة: من 65 في المائة إلى 71 في المائة في آسيا، ومن 74 في المائة إلى 78 في المائة في أمريكا اللاتينية ومنطقة البحر الكاريبي، ومن 62 إلى 66 في المائة في أوقيانوسيا. أما في أمريكا الشمالية، فمن المتوقع أن تظل نسبة الانتشار ثابتة عند 82 في المائة في الفترة 2000-2025، لأن من المتوقع أيضا أن تظل الخصوبة ثابتة عند طفلين لكل امرأة. وفي أوروبا، من المتوقع أن تزيد نسبة انتشار وسائل منع الحمل من 68 في المائة إلى 75 في المائة، وإن كان من المتوقع أن تزيد معدلات الخصوبة قليلا فيما بين عامي 2000 و 2025. وتأتي الزيادة المتوقعة في انتشار وسائل منع الحمل نتيجة ما يتوقع من أن الإقبال على استعمالها سيقلل من اللجوء إلى عمليات الإجهاض.

9 - في الفترة بين عامي 2000 و 2025، يُنتظر أن يزيد عدد النساء المتزوجات اللواتي يستخدمن وسائل منع الحمل من 654 مليون إلى 846 مليون امرأة على مستوى العالم، ويرجع ذلك في المقام الأول إلى الزيادة المتوقعة في المناطق الأقل نموا، حيث ينتظر أن يزيد عدد الإناث المتزوجات اللواتي يستخدمن وسائل منع الحمل من 535 مليون إلى 746 مليون امرأة. أما في المناطق الأكثر تقدما، فيُنتظر أن ينخفض عدد النساء المتزوجات اللواتي يستخدمن وسائل منع الحمل انخفاضا بسيطا، من 119 مليون إلى 99 مليون امرأة، نتيجة لانخفاض نسب المتزوجات بالإضافة إلى انخفاض عدد السكان في سن الإنجاب.

10 - وفيما بين عامي 2000 و 2025، ينتظر أن يزيد عدد النساء غير المتزوجات اللواتي يستخدمن وسائل منع الحمل من 126 مليون إلى 178 مليون امرأة على مستوى العالم. والزيادة المتوقعة ينتظر أن تحدث في المناطق الأقل تقدما (من 77 مليون إلى 124 مليون) وفي المناطق الأكثر تقدما (من 49 مليون إلى 54 مليون).

11 - وتوقفت شرائح كبيرة من المتعاشرين الذين يعيشون في البلدان النامية عن استخدام وسائل منع الحمل التي يمكن العدول عنها بسبب آثارها الجانبية، والشواغل الشخصية المتعلقة باستخدام مثل هذه الطرق أو

المشكلات المتعلقة باستخدام الوسيلة نفسها. ومع ذلك، فإن المتعاشرين لا يتحولون في الغالب بسرعة إلى وسيلة أخرى بعد ترك إحدى الوسائل. فالبيانات المتوافرة من الدراسات الاستقصائية الديموغرافية والصحية تشير إلى أن متوسط احتمال التوقف عن استخدام الحقن والرفال بعد 12 شهرا من استخدامهما كان يقترب من 50 في المائة، بينما كانت النسبة 34 في المائة في حالة الحبوب. وانخفض معدل التوقف عن ممارسة الامتناع الدوري والعزل. أما الوسائل التي توضع داخل الرحم فكانت استثناء ملحوظا من القاعدة القائلة بأن الطرق التي يمكن العدول عنها غالبا ما يهجرها الكثيرون من المتعاشرين الذين يجربونها. فمتوسط احتمال توقف المتعاشرين عن استخدام الوسائل التي توضع داخل الرحم خلال 12 شهرا، كان 12 في المائة، وهي أقل نسبة بين جميع نسب الوسائل الأخرى التي يمكن العدول عنها.

12 - وفي عام 2001، كان هناك 92 في المائة من جميع البلدان تساند برامج تنظيم الأسرة وتوزيع وسائل منع الحمل، سواء بصورة مباشرة عن طريق مرافق حكومية، (75 في المائة)، أو بطرق غير مباشرة من خلال دعم أنشطة المنظمات غير الحكومية مثل رابطات تنظيم الأسرة (17 في المائة).

موجز تنفيذي

وسائل منع الحمل هي إحدى أهم العوامل التي تحدد مستويات الخصوبة. وقد ظل استعمالها يتزايد باستمرار منذ عام 1970، حتى انتشرت الآن في جميع أنحاء العالم. ومع ذلك ، فإن هذا الانتشار لم يكن متساويا في جميع المناطق الجغرافية، وما زالت هناك تحديات كبيرة قائمة سواء بالنسبة لزيادة مستوى استخدام هذه الوسائل لتلبية الطلب القائم في مناطق معينة، أو من حيث توفير تنويعات كافية من وسائل منع الحمل لزيادة قدرة المتعاشرين الراغبين في استعمالها لكي يفعلوا ذلك بطريقة متسقة وكفؤة.

وهذا التقرير عن مستويات واتجاهات وسائل منع الحمل حسب تقديرات عام 2002، الذي أعدته شعبة السكان في إدارة الشؤون الاقتصادية والاجتماعية بالأمانة العامة للأمم المتحدة، هو جزء من الأنشطة التي تقوم بها شعبة السكان في الوقت الحاضر فيما يتعلق برصد مستويات واتجاهات

الخصوبة والزواج واستخدام وسائل منع الحمل في جميع بلدان العالم. ويبين هذا التقرير أنه رغم أن الغالبية العظمى من بلدان العالم أصبحت الآن تساند سياسات تدعم تنظيم الأسرة، فما زالت هناك فوارق هائلة في مستويات استخدامها لوسائل منع الحمل. ورغم الزيادة الهائلة في استعمال هذه الوسائل في المناطق الأقل نموا، فإن المستوى العام لاستخدامها في تلك المناطق ما زال أقل من مثيله في المناطق الأكثر تقدما. وكما يوثق هذا التقرير، فإن هناك أعدادا كبيرة من المتعاشرين في البلدان النامية توقفوا عن استخدام إحدى وسائل منع الحمل دون أن يتحولوا بسرعة إلى وسيلة أخرى، الأمر الذي يوحي بأن مجرد زيادة انتشار استعمال وسائل منع الحمل، لا ينبغي أن يعني بالضرورة النجاح في تلافي حالات الحمل غير المرغوب فيها أو التي تأتي في غير وقتها.

مستويات استعمال وسائل منع الحمل

بالنسبة للعالم ككل، تشير التقديرات إلى أن انتشار وسائل منع الحمل - أي النسبة المئوية للنساء اللواتي يستخدمن وسائل منع الحمل من بين النساء اللواتي في سن الإنجاب المتزوجات أو المتعاشرات - قد وصل إلى 61 في المائة في عام 1998، وهو التاريخ المتوسط لأغلب البيانات الحديثة المتوافرة عن 160 بلدا. ومع ذلك، فإن هذا المتوسط العالمي يخفي وراءه تفاوتات كبيرة داخل المجموعة النامية الواحدة وفيما بين هذه المجموعات، وبين أهم المناطق والأقاليم.

كان انتشار وسائل منع الحمل في المناطق الأقل نموا، الذي تراوح حول 59 في المائة في المتوسط، أقل من مثيله في المناطق الأكثر تقدما، حيث كانت النسبة في هذه الأخيرة 69 في المائة. وفي داخل المناطق الأقل نموا كانت نسبة انتشار وسائل منع الحمل في آسيا وفي أمريكا اللاتينية والكاريبي، وهي 64 في المائة و 71 في المائة على التوالي، قد وصلت إلى مستويات تقارن بالمناطق الأكثر تقدما، بينما ظلت أفريقيا بعيدا وراءهما، بنسبة انتشار قدرها 27 في المائة. بل إن انتشار هذه الوسائل في أفريقيا جنوب الصحراء ككل كان أقل من ذلك، إذ تشير التقديرات إلى أنها بلغت 20 في المائة فقط. وفي المناطق الأكثر تقدما، كان انتشار وسائل منع الحمل

أقل في أوروبا حيث كانت النسبة 67 في المائة، منه في أمريكا الشمالية وأستراليا ونيوزيلندا حيث كانت النسبة 76 في المائة.

وتفاوتت نسبة انتشار وسائل منع الحمل تفاوتا كبيرا من بلد إلى آخر. ففي أفريقيا، ورغم أن نسبة الانتشار في نصف مجموع البلدان تقل عن 20 في المائة، فإن هناك عددا قليلا تحققت فيه مستويات مرتفعة إلى حد ما مثل الرأس الأخضر، ومصر، والمغرب، وجنوب أفريقيا، وزمبابوي، حيث تتراوح نسبة انتشار وسائل منع الحمل بين 50 في المائة و 60 في المائة، وفي الجزائر وجزر ريونيون وتونس تتراوح النسبة بين 60 في المائة و 70 في المائة، أما في موريشيوس فهي 75 في المائة.

وفي آسيا تصل نسبة انتشار وسائل منع الحمل في نصف مجموع البلدان تقريبا إلى 60 في المائة أو أكثر. فقد حققت الصين وهونغ كونج (المنطقة الإدارية الخاصة في الصين) أعلى معدلات استعمال وسائل منع الحمل في العالم، حيث وصلت هذه النسبة إلى 84 في المائة و 86 في المائة على التوالي. وكانت جمهورية إيران الإسلامية وجمهورية كوريا وتايلند وفييت نام أيضا من بين أكثر البلدان استعمالا لوسائل منع الحمل، حيث وصلت النسب فيها إلى أكثر من 70 في المائة. وبالإضافة إلى ذلك فإن الصين - ومعها أربعة بلدان كثيفة السكان في آسيا، هي بنغلاديش والهند وإندونيسيا واليابان - وصلت إلى مستويات مرتفعة نسبيا في استعمال وسائل منع الحمل، حيث تخطت هذه النسبة 50 في المائة. ولكن هذه النسبة ما زالت أقل من 30 في المائة في ثمانية بلدان، هي: أفغانستان، وبوتان، وكمبوديا، والعراق، وعمان، وباكستان، والإمارات العربية المتحدة، واليمن.

وفي أمريكا اللاتينية والكاريبي، كان التفاوت من بلد إلى آخر أقل من مثيله في أفريقيا أو آسيا، حيث تتراوح نسبة انتشار وسائل منع الحمل بين 30 في المائة في هايتي وغواتيمالا وغيانا و 75 في المائة تقريبا في البرازيل، وكمبوديا، وكوستاريكا، وكوبا، وبورتوريكو.

وفي أوروبا كانت نسبة انتشار وسائل منع الحمل عموما تحت 50 في المائة في بلدان أوروبا الشرقية وفي الدول التي خلفت اتحاد الجمهوريات الاشتراكية السوفياتية السابق، أما في باقي بلدان أوروبا، فإن نسبة الانتشار تفوق عادة 70 في المائة.

في أواخر التسعينات، كان مستوى استعمال الوسائل الحديثة لمنع الحمل بين النساء اللاتي في سن الإنجاب المتزوجات أو المعاشرات متقاربة بين المناطق الأكثر تقدما (55 في المائة) والمناطق الأقل تقدما (54 في المائة)، أما وسائل منع الحمل التقليدية فكانت في المناطق الأكثر تقدما (13 في المائة) ضعف مثيلتها في المناطق الأقل تقدما (6 في المائة) وهو ما يفسر الكثير من الاختلاف في انتشار هذه الوسائل بشكل عام بين المناطق الأكثر تقدما والمناطق الأقل تقدما.

اتجاهات انتشار وسائل منع الحمل

بالنسبة للعالم ككل، تشير التقديرات إلى أن انتشار وسائل منع الحمل قد زاد من 54 في المائة في عام 1990 إلى 59 في المائة عام 1995 ثم إلى 63 في المائة عام 2000. وهذا الاتجاه، الذي يقوم على بيانات مقارنة وردت من 120 بلدا، يأتي نتيجة بطء الزيادة في المناطق الأكثر تقدما عنها في المناطق الأقل تقدما. فقد زاد انتشار وسائل منع الحمل في المناطق الأكثر تقدما من 66 في المائة عام 1990 إلى 68 في المائة عام 1995 ثم إلى 70 في المائة عام 2000، أي أنه زاد بنسبة 0.4 في المائة سنويا طوال التسعينات. أما في المناطق الأقل تقدما، فقد ارتفعت نسبة انتشار وسائل منع الحمل من 52 في المائة عام 1990 إلى 57 في المائة عام 1995 ثم إلى 61 في المائة عام 2000، أي أن الزيادة كانت بمعدل 0.9 في المائة سنويا في المتوسط.

هناك تفاوتات كبيرة في اتجاهات انتشار وسائل منع الحمل بين المناطق والأقاليم الرئيسية، ففي المناطق الأكثر تقدما، لم يحدث تغير كبير في استغلال هذه الوسائل في أوروبا وفي أستراليا ونيوزيلندا في التسعينات. ولكن هذا الاستعمال زاد بخطى سريعة في أمريكا الشمالية (بنسبة 1 في المائة سنويا). وفي المناطق الأقل تقدما، زاد هذا الاستعمال بسرعة في أفريقيا وفي أمريكا اللاتينية والكاريبي (بأكثر من 1 في المائة سنويا في المتوسط) وبسرعة أقل في آسيا (0.8 في المائة سنويا).

وفي العقد الماضي كانت الزيادة في انتشار وسائل منع الحمل ترتبط أساسا بالزيادة في الطرق الحديثة لمنع الحمل، حيث زاد انتشار هذه الطرق من 47 في المائة عام 1990 إلى 52 في المائة عام 1995 ثم إلى 56 في

المائة عام 2000. وفي المناطق الأكثر تقدما، لا سيما في أوروبا الشرقية والجنوبية كانت الزيادة في استعمال الطرق الحديثة مصحوبة بانخفاض في استعمال الطرق التقليدية.

وفي أفريقيا، ظلت مستويات استعمال وسائل منع الحمل منخفضة منذ أوائل السبعينات في بلدان أفريقيا الشرقية والوسطى والغربية. ولم تحدث زيادة ملموسة في هذه الأقاليم حتى أواخر الثمانينات وربما أوائل التسعينات، وهو تطور يفسر السبب في أن 87 في المائة من بلدان أفريقيا التي تتوافر عنها بيانات عن اتجاهات استعمال هذه الوسائل ما زالت تبين أن معدلات انتشار هذه الوسائل كان لا يزال دون 30 في المائة في عام 2000. وعلى النقيض من ذلك، فإن بلدان أفريقيا الشمالية وأفريقيا الجنوبية شهدت زيادة سريعة في استعمال هذه الوسائل منذ السبعينات.

وفي آسيا، وصلت معدلات انتشار وسائل منع الحمل في البلدان الواقعة في شرقي آسيا إلى مستويات عالية تراوحت ما بين 60 و 70 في المائة، في وقت متأخر من السبعينات وفي وقت مبكّر من الثمانينات من القرن الماضي ولكنها لم تشهد زيادة ذات شأن منذ ذلك الحين. وفي البلدان الواقعة جنوب آسيا الوسطى وجنوب شرقي آسيا كانت مستويات انتشار وسائل منع الحمل أقل كثيرا في السبعينات من القرن الماضي ولكنها زادت زيادة مطردة منذ ذلك الحين. وفي غربي آسيا، زاد استخدام وسائل منع الحمل بصورة رئيسية في التسعينات من القرن الماضي.

وشهدت بلدان أمريكا اللاتينية ومنطقة البحر الكاريبي أيضا زيادة في انتشار وسائل منع الحمل منذ عام 1970. وخلال التسعينات من القرن الماضي زاد انتشار وسائل منع الحمل بنسبة 1.0 في المائة على الأقل في السنة في زهاء ثلاثة أرباع البلدان في هذه المنطقة الرئيسية.

وفي البلدان الواقعة شمالي أوروبا، وغربيها وأمريكا الشمالية، فضلا عن أستراليا ونيوزيلندا، ظلت مستويات انتشار وسائل منع الحمل مرتفعة عن نسبة 70 في المائة أو أكثر لفترة طويلة. وفي البلدان الواقعة شرقي أوروبا وجنوبيها، كانت مستويات انتشار وسائل منع الحمل أقل من ذلك، حيث تراوحت ما بين 50 و 70 في المائة، منذ السبعينات من القرن الماضي. وإسبانيا هي الاستثناء، حيث أصبحت في الوقت الحاضر أحد

البلدان التي تسود فيها أعلى مستويات انتشار وسائل منع الحمل في العالم (أعلى من 80 في المائة).

الطرق المحددة المستخدمة لمنع الحمل

لم يحدث إلا في رُبع عدد البلدان التي توفرت بشأنها بيانات أن بلغت نسبة استخدام وسيلة منفردة من وسائل منع الحمل التي استخدمتها النساء اللاتي في سن الإنجاب المتزوجات أو المعاشرات، 50 في المائة أو أكثر، وكان ذلك في عام 1998. وفي جميع المناطق الرئيسية، حققت وسيلتان فقط من وسائل منع الحمل نسبة 50 في المائة أو أكثر من استخدام وسائل منع الحمل.

وفي الوقت الحاضر، يسود استخدام وسائل عصرية لمنع الحمل. وتستخدم الوسائل العصرية بقدر أكبر بصورة عامة في المناطق الأقل تقدما، حيث بلغت نسبتها 90 في المائة من بين جميع وسائل منع الحمل المستخدمة، وتستخدم بنسبة أقل في المناطق الأكثر تقدما حيث بلغت نسبة استخدامها 81 في المائة. والوسائل الثلاث الأكثر استخداما في العالم هي تعقيم الإناث، والوسيلة التي توضع داخل الرحم، وحبوب منع الحمل، التي تستخدم بنسبة 21 في المائة، و 14 في المائة، و 7 في المائة، على التوالي، وتستخدمها النساء اللاتي في سن الإنجاب، المتزوجات أو المعاشرات. وهذه الوسائل الثلاث مجتمعة تستخدمها امرأتان من كل ثلاث نساء في سن الإنجاب من المتزوجات أو المعاشرات ويستخدمن وسائل منع الحمل. وبلغ معدل انتشار جميع الوسائل التقليدية مجتمعة نسبة 7 في المائة فقط.

والوسائل الثلاث الأكثر استخداما شائعة بصفة خاصة في المناطق الأقل تقدما، حيث تعتمد نسبة 23 في المائة من النساء في سن الإنجاب المتزوجات أو المعاشرات على التعقيم، وتستخدم مجموعة إضافية نسبتها 15 في المائة الوسائل التي توضع داخل الرحم، ويستخدم 6 في المائة حبوب منع الحمل. وفي المناطق الأكثر تقدما، يشيع استخدام حبوب منع الحمل بقدر أكبر من استخدامها في المناطق الأقل تقدما، حيث بلغت نسبة انتشار استخدامها 16 في المائة. ويليها استخدام الرفالات (نسبة انتشار استخدام الرفالات 13 في المائة)، وتعقيم الإناث (10 في المائة) واستخدام الوسائل التي توضع داخل الرحم (8 في المائة).

وتدل مستويات الانتشار هذه في المناطق الأكثر تقدما، على أن 42 في المائة من الأزواج الذين يستخدمون وسائل منع الحمل يعتمدون على حبوب منع الحمل أو الرفالات. وفي المناطق الأكثر تقدما، تستخدم نسبة تزيد على ست نساء من كل 10 في سن الإنجاب ممن يستخدمن وسائل منع الحمل المتزوجات أو المعاشرات وسائل ذات مفعول قصير الأجل ويمكن العدول عنها (بما في ذلك الوسائل التقليدية لمنع الحمل)، في حين لا تعقم إلا امرأتين من كل عشر نساء وتستخدم امرأة واحدة من كل عشر نساء الوسائل التي توضع في الرحم. وعلى النقيض من ذلك، من المحتمل بقدر أكبر أن يعتمد الأزواج في المناطق الأقل تقدما على وسائل لمنع الحمل ذات مفعول طويل الأجل، ووسائل إكلينيكية ذات فعالية أكبر لمنع الحمل، ويعتمد زهاء ثلثي الإناث المتزوجات أو المعاشرات اللاتي يستخدمن وسائل منع الحمل في سن الإنجاب على التعقيم أو الوسائل التي توضع في الرحم. وتشيع معدلات عالية من النساء المعقمات في عدد من بلدان آسيا وأمريكا اللاتينية، في حين تسود معدلات مرتفعة من النساء اللاتي يستخدمن الوسائل التي توضع في الرحم في بلدان آسيا، ولا سيما في الصين.

وعلى صعيد العالم بأسره، يعتمد زوجان من كل خمسة أزواج ممن يستخدمون وسائل منع الحمل على وسائل تتطلب مشاركة الذكر (الرفال أو تعقيم الذكر) أو تعاون الذكر (التنظيم الطبيعي أو العزل). ويزيد انتشار الاعتماد على الوسائل التي يستخدمها الذكور في المناطق الأكثر تقدما، حيث يستخدمها زوجان من كل خمسة أزواج، عن معدل انتشارها في المناطق الأقل تقدما، حيث يعتمد زوجان من كل سبعة أزواج على هذه الوسائل.

اتجاهات استخدام وسائل منع الحمل في المستقبل

تدل التقديرات على أن نسبة انتشار استخدام وسائل منع الحمل بصورة عامة فيما بين عامي 2000 و 2025 على صعيد العالم يتعين أن تزيد من 63 في المائة إلى 67 في المائة لكي يصبح بالمستطاع تخفيض إجمالي الخصوبة من 2.8 طفل لكل امرأة إلى 2.3 طفل لكل امرأة وفقا للدلالة المستمدة من المتغير المتوسط في طبعة عام 2002 المنقحة من

التوقعات السكانية التي نشرتها الأمم المتحدة[2]. وبما أن انخفاض الخصوبة يقتصر على المناطق الأقل تقدما، من المتوقع أن تحدث زيادة ملحوظة في نسبة انتشار وسائل منع الحمل في تلك المناطق: حيث من المتوقع أن تزيد من 61 في المائة التي بلغتها في عام 2000 إلى 68 في المائة في عام 2025. وفي المناطق الأكثر تقدما، تدل الإسقاطات على أن نسبة مستويات الخصوبة يتعين أن تزيد زيادة طفيفة، من 1.6 طفل لكل امرأة في عام 2000 إلى 1.7 طفل لكل امرأة في عام 2025، غير أن التوقعات التي تذهب إلى أن استخدام وسائل منع الحمل سيحل محل بعض الحالات التي يُلتجأ فيها في الوقت الحاضر إلى الإجهاض ناجمة عن زيادة متوقعة في نسبة انتشار وسائل منع الحمل، من 70 في المائة في عام 2000 إلى 75 في المائة في عام 2025.

وفي المناطق الأقل تقدما، يتعين أن تحدث أكبر وأهم زيادة في انتشار وسائل منع الحمل في أفريقيا، حيث لا بد أن يزيد معدل انتشار استخدامها من 28 في المائة إلى 49 في المائة في ما بين عامي 2000 و 2025 إذا أريد تخفيض معدل الخصوبة من 5.1 طفل لكل امرأة إلى 3.4 طفل لكل امرأة حسب التقديرات المسقطة. وفي آسيا، حيث يتوقع أن تنخفض نسبة الخصوبة من 2.6 إلى 2.1 طفل لكل امرأة، من المتوقع أن تزيد نسبة انتشار استعمال وسائل منع الحمل زيادة معتدلة: من 65 في المائة إلى 71 في المائة. وفي أمريكا اللاتينية ومنطقة البحر الكاريبي، حيث تدل الإسقاطات على أن معدل الخصوبة سينخفض من 2.6 طفل لكل امرأة إلى 2.0 طفل لكل امرأة، من المتوقع أن يزيد معدل انتشار وسائل منع الحمل من 74 في المائة إلى 78 في المائة. الزيادات المعتدلة في معدل انتشار وسائل منع الحمل متوقعة أيضا في أوقيانوسيا (من 62 في المائة إلى 66 في المائة)، حيث تدل الإسقاطات على هبوط معدل الخصوبة الإجمالية من 2.4 طفل لكل امرأة في عام 2000 إلى 2.1 طفل لكل امرأة في عام 2025.

وفي أمريكا الشمالية، حيث تدل الإسقاطات على أن الخصوبة ستظل دون تغيير إلى حد كبير عند معدل طفلين لكل امرأة، من المتوقع أن يظل

(منشورات الأمم المتحدة، رقم المبيع A.03.XIII.6).

انتشار استعمال وسائل منع الحمل ثابتا عند نسبة 82 في المائة خلال الفترة 2000-2025. بيد أن من المتوقع أن تحدث زيادة معتدلة في معدل انتشار استعمال وسائل منع الحمل في أوروبا، (من 68 في المائة إلى 75 في المائة) بالرغم من أن من المتوقع أن تزيد الخصوبة فيها بين عامي 2000 و 2025 (من 1.4 إلى 1.6 طفل لكل امرأة). الزيادة المتوقعة في انتشار استعمال وسائل منع الحمل في أوروبا تستند إلى التوقعات التي تفيد بأن الزيادة في استعمال وسائل فعالة من شأنها أن تقلل احتمالات اللجوء إلى الإجهاض.

وفيما بين عامي 2000 و 2025، تدل الإسقاطات على أن عدد النساء المتزوجات اللاتي تستخدمن وسائل منع الحمل سيزيد من 654 مليونا إلى 846 مليونا على الصعيد العالمي، ومرد ذلك إلى حد كبير إلى النمو المتوقع في المناطق الأقل تقدما حيث من المتوقع أن يرتفع هذا الرقم من 535 مليونا إلى 746 مليونا. وعلى النقيض من ذلك، من المتوقع أن ينخفض عدد المتزوجين الذين يستخدمون وسائل منع الحمل في المناطق الأكثر تقدما من 119 مليونا إلى 99 مليونا بسبب الانخفاض المتوقع في عدد النساء اللاتي في سن الإنجاب - من 300 مليون في عام 2000 إلى 265 مليونا في عام 2025 - وإلى الانخفاض المتوقع في أعداد المتزوجين، على حد سواء.

وتدل الإسقاطات على أن عدد النساء اللاتي في سن الإنجاب المتزوجات واللاتي يستخدمن وسائل لمنع الحمل سيتضاعف ثلاث مرات في أفريقيا، أي أنه سيزيد من 33 مليون إلى 100 مليون، وسيزيد زيادة كبيرة في منطقتي آسيا وأمريكا اللاتينية والبحر الكاريبي، على حد سواء، ولكن بمعدل أقل: أي أنه سيزيد من 449 مليونا إلى 559 مليونا في آسيا ومن 61 مليونا إلى 84 مليونا في أمريكا اللاتينية ومنطقة البحر الكاريبي. ومن المتوقع أن تحدث زيادات مماثلة في أمريكا الشمالية (من 34 مليونا إلى 37 مليونا) وفي أوقيانوسيا (من 2.8 مليون إلى 3.2 مليون)، في حين تدل الإسقاطات على انخفاض العدد في أوروبا، من 74 مليونا إلى 64 مليونا، نتيجة للانخفاض المسقط في عدد النساء البالغات اللاتي ما بين 15 و 49 سنة ولانتشار الزواج، على حد سواء.

وإضافة إلى ذلك، تدل الإسقاطات على زيادة عدد النساء غير المتزوجات اللاتي في سن الإنجاب واللاتي يستخدمن وسائل لمنع الحمل على صعيد العالم فيما بين عامي 2000 و 2025، حيث سيزيد من 126 مليونا إلى 178 مليونا. ومن المتوقع أن تحدث أيضا زيادة في المناطق الأكثر تقدما (من 49 مليونا إلى 54 مليونا وفي المناطق الأقل نموا من 77 مليونا إلى 124 مليونا)، على حد سواء.

ديناميات استخدام وسائل منع الحمل

توضح الأدلة التي تقدمها الدراسات الاستقصائية الديموغرافية والصحية في البلدان النامية، على أن نسبة عالية من الأزواج الذين يستخدمون وسائل لمنع الحمل يتوقفون عن استخدامها بسبب الآثار الجانبية المترتبة عليها، أو لشواغل صحية أو مشاكل أخرى تتصل بالوسائل المستخدمة. ولكنهم مع ذلك، لا يتحولون على الفور إلى وسائل بديلة. ومتوسط احتمال التوقف في غضون فترة 12 شهرا من بداية استخدام وسيلة لمنع الحمل يمكن العدول عنها يصل إلى زهاء 50 في المائة للوسائل التي تستخدم الحقن والرفالات، و 34 في المائة لحبوب منع الحمل. واحتمالات التوقف عن الامتناع على فترات أو العزل أقل من ذلك. ونتيجة لذلك، يمكن أن تسهم هذه الوسائل إلى حد كبير في تنظيم الخصوبة. ومما يثير القلق بصفة خاصة ارتفاع نسبة احتمالات التوقف عن استعمال الرفالات في سياق استمرار انتشار الإصابة بعدوى فيروس نقص المناعة البشرية.

وتبرز أهمية استخدام وسائل منع الحمل التي توضع في الرحم لأن احتمال التوقف عن استخدامها أقل كثيرا، والقيمة المتوسطة هي مجرد 12 في المائة. وتتمثل العوامل التي من المحتمل أن تسهم في انخفاض احتمال التوقف عن استخدام الوسائل التي توضع في الرحم في انخفاض معدل الفشل وأن إزالة الوسائل التي توضع في الرحم تتطلب بصورة نمطية زيارة إلى مرفق طبي، ومن ثم فإنها تنطوي على قرار أكثر صرامة من جانب المستخدم بالتوقف عن الاستعمال.

وبصورة عامة، تقل احتمالات التخلي عن وسيلة ما بسبب عدم الارتياح لها بالنسبة للأزواج الذين يستخدمون وسائل منع الحمل لتحديد حمل الأطفال عن احتمالات الأزواج الذين يستخدمونها للمباعدة بين الولادات.

وتزيد نسبة احتمال تحول الأزواج الذين يعيشون في الحضر والحاصلين على قدر أكبر من التعليم، بعد تخليهم عن استعمال وسيلة ما، بسرعة إلى وسيلة بديلة عنها لدى نظرائهم في مناطق أخرى. ويعزى إلى هذه الخاصية زيادة مستويات استخدام وسائل منع الحمل بصورة عامة في الوقت الحاضر الملاحظة في المناطق الحضرية وفيما بين الأزواج الحاصلين على مستويات أفضل من التعليم. وتعد سهولة الحصول على وسائل بديلة للحاصلين على مستويات أفضل من التعليم، والقادرين على نحو أفضل على فهم الوسائل المتاحة، ولديهم الثقة الاجتماعية في الحصول عليها جميعا عوامل من المحتمل أن تشكل الفوارق الملحوظة.

سياسات الخصوبة ووسائل منع الحمل والسكان

أخذ دعم الحكومات لوسائل منع الحمل في الزيادة بصورة مطردة منذ عام 1975. وبحلول عام 2001، أيد 92 في المائة من جميع البلدان برامج تنظيم الأسرة وتوزيع وسائل منع الحمل، إما بصورة مباشرة من خلال مرافق الحكومة (75 في المائة)، أو بصورة غير مباشرة من خلال دعم أنشطة المنظمات غير الحكومية من قبيل رابطات تنظيم الأسرة (17 في المائة). وتعتمد سياسات جديدة تؤيد تنظيم الأسرة، بصورة رئيسية في البلدان النامية. ولقد زادت نسبة البلدان النامية التي تدعم استعمال وسائل منع الحمل من 73 في المائة في عام 1976 إلى 94 في المائة في عام 2001. وفيما بين أقل البلدان تقدما، كانت الزيادة أكبر إلى حد بعيد: من 57 في المائة في عام 1976 إلى 96 في المائة في عام 2001. وفيما بين البلدان المتقدمة النمو، ظلت النسبة المئوية لدعم برامج تنظيم الأسرة مستقرة، عند زهاء نسبة 80 في المائة، منذ عام 1976.

执行摘要

避孕是决定生育率的主要因素之一。自 1970 年以来，避孕法的使用一直在稳步增加，目前已经遍及世界各地。然而，在各个地理区域内所取得的进展有快有慢，并且就增加避孕药具使用率以满足某些区域目前的需要而言，以及就提供各种各样的避孕法以提高想要使用避孕法的夫妇长期有效避孕的能力而言，仍然面临着巨大的挑战。

这份由联合国秘书处经济和社会事务部人口司编写的关于《2002 年评估的避孕药具使用率和趋势》的报告，是人口司正在进行的同监测世界各国的生育率和趋势、婚姻情况和避孕药具使用率相关活动的一部分。它表明，虽然目前世界上绝大部分的国家已经核可支持计划生育的政策，但是它们的避孕药具使用率仍然存在着相当的差距。虽然较不发达区域的避孕药具使用率已经有很大幅度的增加，但这些区域总的使用率仍然低于较发达区域。正如本报告所引证的，在发展中国家停止使用一种避孕法后没有很快转用另一种避孕法的夫妇的比率很高，这表明只增加使用避孕药具的普及率并不必然意味着就会成功地避免发生意外妊娠或误算时间的妊娠。

避孕药具使用率

全世界的避孕普及率——在已婚或同居的育龄妇女中使用避孕法的妇女的百分比——估计于 1998 年达到 61%，这是目前得到的 160 个国家最新的平均比率。然而，这项全球的平均率却掩盖了各发展群体、主要地区和区域之间和之内的巨大差距。

较不发达地区的避孕普及率平均为 59%，低于较发达地区的 69%。在较不发达的地区，其中的亚洲、拉丁美洲和加勒比的普及率分别为 64%和 71%，其避孕率已经达到可以同较发达区域相比的地步，而非洲仍然远为落后，其普及率为 27%。整个撒哈拉以南非洲的平均普及率甚至更低，估计为 20%。在较发达区域，欧洲的普及率为 67%，低于北美洲、澳大利亚/新西兰的 76%。

各国的避孕普及率出入颇大。在非洲，虽然在所有国家中半数国家的普及率低于 20%，但有一些国家，包括佛得角、埃及、摩洛哥、南非和津巴布韦，避孕药具的使用率却相当高，其避孕普及率达到 50%至 60%不等;阿尔及利亚、留尼汪岛和突尼斯的普及率达到 60%至 70%不等;毛里求斯为 75%。

在亚洲，在所有国家中几近一半的国家避孕普及率达到 60%，甚至更高。其中的中国和香港(中国的特别行政区)避孕普及率为世界之最，分别为 84%和 86%。伊朗伊斯兰共和国、大韩民国、泰国和越南，就避孕普及率而言，也是名列前茅，其普及率高于 70%。除中国外，亚洲其他四个人口众多的国家——孟加拉、印度、印尼和日本——已经取得比较高的避孕普及率，也即达到或超过

50%。不过，八个国家——阿富汗、不丹、柬埔寨、伊拉克、阿曼、巴基斯坦、阿拉伯联合酋长国和也门——的普及率仍然低于 30%。

在拉丁美洲和加勒比，国家一级的变化要小于非洲或亚洲，其避孕普及率从海地、危地马拉和圭亚那的 30%到巴西、哥伦比亚、哥斯达黎加、古巴和波多黎各的 75%左右不等。

在欧洲，其中的东欧各国和前苏维埃社会主义共和国联盟(苏联)各继承国的避孕普及率一般都低于 50%，但在欧洲其他各国，其避孕普及率往往超过 70%。

在 1990 年代后期，在已婚或同居的育龄妇女使用现代避孕法的比率上，较发达区域(55%)同较不发达区域(54%)相近，但在较发达区域，其传统避孕法的普及率(13%)两倍于较不发达区域(6%)，从而导致较发达区域和较不发达区域之间的整个普及率产生这么大的差异。

避孕普及率的趋势

全世界的避孕普及率估计从 1990 年的 54%增至 1995 年的 59%，再增至 2000 年的 63%。根据关于 120 国家的可比数据得出的这种趋势，是由于较发达区域的增加速度远慢于较不发达区域造成的。在较发达区域，避孕普及率从 1990 年的 66%增至 1995 年的 68%，再增至 2000 年的 70%，也即在 1990 年代期间每年增加了 0.4%。在较不发达区域，避孕普及率从 1990 年的 52%增至 1995 年的 57%，再增至 2000 年的 61%，因此每年平均增加 0.9%。

在各主要地区和区域之间，避孕普及率的趋势存在着相当大的差异。在较发达区域，1990 年代期间的欧洲、澳大利亚和新西兰其避孕普及率的变化不大。然而，在北美洲却快速增加(每年 1.0%)。在较不发达区域，其中非洲、拉丁美洲和加勒比的避孕普及率迅速增加(每年平均超过 1.0%)，但在亚洲却增加缓慢(每年 0.8%)。

在过去十年期间，避孕普及率的增加主要是由于增加使用现代方法，其普及率从 1990 年的 47%增至 1995 年的 52%，再增至 2000 年的 56%。在较发达区域，特别是在东欧和南欧，伴随增加使用现代方法的却是减少使用传统方法。

在非洲，东非、西非和中部非洲的避孕药具使用率自 1970 年代初期以来一直偏低。在这些区域，在 1980 年代后期或 1990 年代初期之前一直都没有显著增加，这一发展说明了在具有关于趋势数据的非洲的国家中为什么 87%的国家在 2000 年避孕普及率仍然低于 30%。相比之下，北部非洲和南部非洲国家的避孕药具使用率自 1970 年代起却在迅速增加。

在亚洲，东亚各国的避孕普及率很高，在 1970 年代后期和 1980 年代初期从 60%到 70%不等，但此后即没有显著增加。1970 年代期间中南亚和东南亚各国

的避孕普及率非常之低，但是此后却一直在稳步增加。在西亚，避孕药具的使用率主要在 1990 年代时增加。

拉丁美洲和加勒比国家的避孕普及率自 1970 以来也一直在增加。在 1990 年代期间，这个主要地区几近四分之三的国家避孕普及率每年至少增加 1.0%。

在北欧、西欧和北美各国以及澳大利亚和新西兰，其避孕普及率长期以来一直保持在 70%以上。东欧和南欧各国的普及率自 1970 年代以来一直偏低，从 50%到 70%不等。西班牙是个例外，其避孕普及率目前是世界上最高的国家之一(超过 80%)。

所用的特定避孕法

在具有数据的国家中只有四分之一国家的单一方法占 1998 年已婚或同居的育龄妇女使用避孕药具的 50%以上。在所有主要地区，只有两种避孕法占避孕药具使用率的 50%左右或以上。

目前使用避孕药具主要是使用现代避孕法。较不发达区域要比较发达区域更常使用现代方法，在前一区域中现代法占所有避孕药具使用率的 90%，后者则占 81%。世界上最常用的三种方法是女性绝育、宫内避孕器（避孕环）和避孕药，其使用率在已婚或同居的育龄妇女中分别占 21%、14%和 7%。总的来说，在已婚或同居和使用避孕法的育龄妇女中，每三人中有两人使用这三种方法。所有传统方法加在一起其普及率只有 7%。

三种最常用的方法在较不发达区域特别受到欢迎，其中 23%的已婚或同居的育龄妇女依靠绝育，另外的 15%使用避孕环，6%使用避孕药。较发达区域要比较不发达区域更常使用避孕药，其普及率为 16%，其次是避孕套(13%)、女性绝育（10%）和避孕环(8%)。

这些普及率意味着在较发达区域，在使用避孕药具的夫妇中 42%或依靠避孕药，或依靠避孕套。在较发达区域，在使用避孕药具的已婚或同居的育龄妇女中每十人中有六人依靠短效的可逆转方法（包括传统避孕法），而每十人中只有两人绝育，每十人中有一人使用避孕环。相比之下，较不发达区域的夫妇更可能依靠长效和高度有效的临床避孕法，在所有已婚或同居的育龄女性避孕药具使用者中几乎有三分之二依靠绝育或避孕环。高绝育率在亚洲和拉丁美洲中的许多国家中司空见惯，而在亚洲各国特别是中国，高避孕环使用率更为常见。

在全世界使用避孕法的夫妇中每五人中约有一人依靠需要男性参与的方法（避孕套或男性绝育），或男性合作（安全期避孕法或体外射精）。较发达区域要比较不发达区域更常依靠男性主导的方法，前者每五对夫妇中有两对使用这种方法，而后者七对夫妇中只有一对依靠这种方法。

使用避孕药具的未来趋势

在2000年和2025年之间，一般估计全世界的总避孕普及率需要从63%增至67%，以便有可能如《2002年世界人口预测订正本》[1] 按中等变动所预测的，将生育率从每名妇女的2.8个子女降至2.3个子女。由于生育率的下降限于较不发达区域，预计这些区域的避孕普及率将显著增加：从2000年的61%增至2025年的68%。在较发达区域，生育率预计稍微增加，即从2000年每名妇女的1.6个子女增至2025年每名妇女的1.7个子女。然而，预期使用避孕法将会取代目前部分依靠人工流产，从而导致预期的避孕普及率的增加：即从2000年的70%增至2025年的75%。

在较不发达区域，避孕普及率必须在非洲取得最快速、最显著的增加，其中普及率必须在2000年和2025年之间从28%增至49%，才能使生育率如预计的从每名妇女的5.1个子女减至3.4个子女。在亚洲，预计生育率将从每名妇女的2.6个子女减至2.1个子女，避孕普及率预期将适度增加：即从65%增至71%。在拉丁美洲和加勒比，预计生育率将从每名妇女的2.6个子女减至2.0个子女，避孕普及率预期将从74%增至78%。预期大洋洲的避孕普及率也将适度增加（从62%增至66%），其中总生育率预计将从2000年每名妇女的2.4个子女下降至2025年的2.1个子女。

在北美洲，预计生育率大体不变，即每名妇女2个子女，避孕普及率也预期在2000年至2025年期间照旧不变，即为82%。然而，欧洲的避孕普及率预期将适度增加(从68%增至75%)，纵然其生育率预期将在2000年至和2025年期间将会增加(从每名妇女的1.4个子女增至1.6个子女)。预期欧洲的避孕普及率将会增加，其所根据的是预期增加使用有效的避孕法将会减少依靠人工流产的可能性。

在2000年和2025年之间，全世界使用避孕法的已婚妇女人数预计将从6.54亿增至8.46亿，主要是由于预计较不发达区域人数将会增加，即从5.35亿增至7.46亿。相比之下，较发达区域的已婚避孕药具使用者的人数预期将从1.19亿减至9 900万，因为既预计育龄妇女的人数减少——从2000年的3亿减至2025年的2.65亿，还预计已婚的比率将会下降。

非洲已婚和使用避孕药具的育龄妇女人数预计将增至三倍，即从3 300万增至1亿，在亚洲、拉丁美洲和加勒比也将显著增加，但幅度较小：即在亚洲从4.49亿增至5.59亿，在拉丁美洲和加勒比则从6 100万增至8 400万。预计北美洲(从3 400万增至3 700万)和大洋洲(从280万增至320万)增加较少，而欧洲预计将

[1] 《世界人口前景：2002 年订正本》，第一卷：《综合表》（联合国出版物，出售品编号：E.03.XIII.6）。

会减少，即从 7 400 万减至 6 400 万，因为预计 15 至 49 岁的妇女人数和婚姻的普及率均将减少。

此外，2000 年至 2025 年期间全世界使用避孕药具的未婚育龄妇女的人数预计也将增加，即从 1.26 亿增至 1.78 亿。预计较发达区域(从 4 900 万增至 5 400 万)和较不发达区域(从 7 700 万增至 1.24 亿)都将增加。

使用避孕药具的动态

《人口和保健调查》提供的证据表明，在发展中国家，使用可逆转避孕法的夫妇中很高比例的夫妇由于副作用、健康问题和其他同所用方法有关的问题而停止使用。然而，他们并没有立刻改用其他方法。使用一种可逆转避孕法后在开始使用 12 个月之内停止使用的平均或然率，就注射式避孕药和避孕套而言，几近 50%，就避孕药而言，则为 34%。停止排卵期避孕法和体外射精法的比率偏低。因此，这两种方法均非常有助于控制生育率。停止使用避孕套的比例很高，就艾滋病毒感染仍在蔓延而言，这种现象特别令人关切。

使用避孕环一支独秀，因为停止使用的可能性相当低，其平均值只有 12%。或许有助于促使停止使用避孕环的比率偏低的因素包括其失效率偏低，以及取出避孕环一般需要到一个医疗设施，从而需要使用者拿定停止使用的主意。

一般来说，使用避孕法来限制生育的夫妇同使用避孕法来间隔生育的夫妇相比，更可能由于对使用某种方法后不满意而放弃。城市里和教育程度较高的夫妇同非城市里和教育程度较低的夫妇相比，更有可能在放弃一种方法后很快改用另一种方法。这一特征或许可以说明，为什么目前在城市里和教育程度较高的夫妇中所看到的避孕药具使用率一般偏高的缘故。受过高等教育者易于取得其他方法，较了解现有的方法，以及社会上有信心取得这些方法，都是造成这种差异的因素。

生育率、避孕和人口政策

政府对避孕法的支持自 1975 年以来一直在稳步加强。在 2001 年之前,在所有国家中有 92%的国家，或直接通过政府设施(75%)，或间接通过非政府组织活动的支持,例如计划生育协会(17%)，支持计划生育方案和分发避孕药具。但主要是发展中国家实行新的政策，支持计划生育。发展中国家支持使用避孕法的比例从 1976 年的 73%增至 2001 年的 94%。在最不发达国家中，这种现象尤为明显：从 1976 年的 57%增至 2001 年的 96%。在发达国家中，支持计划生育方案的百分比自 1976 年以来一直保持在 80%左右不变。

主要调查结果

1. 全世界的避孕普及率——在已婚或同居的育龄妇女中使用避孕法的妇女的百分比——于 1998 年达到 61%，这是目前得到的 160 个国家最新的平均比率。由于较不发达区域的平均比率为 59%，其避孕普及率比较发达区域（69%）低十个百分点。

2. 在 1990 年代后期，非洲的普及率为 27%，是世界上避孕普及率最低的地区。撒哈拉以南非洲的平均普及率甚至更低，估计为 20%。相比之下，亚洲、拉丁美洲和加勒比的普及率分别为 64%和 71%，其避孕率已经达到可以同较发达区域相比的地步，其中欧洲的普及率为 67%，北美洲以及澳大利亚/新西兰的普及率为 76%。

3. 全世界的避孕普及率从 1990 年的 54%增至 1995 年的 59%，再增至 2000 年的 63%。较发达区域比较不发达区域增加缓慢，因为在 1980 年代已经取得比较高的避孕普及率，所以欧洲、澳大利亚/新西兰在 1990 年代的变化不大。然而，在北美洲却大幅增加(每年 1.0%)。在较不发达区域，其中的非洲、拉丁美洲和加勒比的避孕普及率快速增加(每年平均超过 1.0%)，但在亚洲却比较缓慢(每年约 0.8%)。

4. 全世界已婚或同居的育龄妇女中有 54%依靠现代避孕法，21%选择女性绝育，14%使用宫内避孕器（避孕环），7%依靠避孕药。在使用避孕药具的已婚或同居的妇女中使用现代避孕法所占的比例，在较不发达区域要大于较发达区域：也即 90%比 81%。三种最常用的避孕法——女性绝育、避孕环和避孕药——占全世界使用避孕药具的三分之二。

5. 在较发达区域的每十名女性的避孕药具使用者中，有六人以上依靠短效可逆转的方法，而十人中只有两人绝育，十人中一人使用避孕环。在较不发达区域，十人中有四人依靠绝育，十人中几近三人依靠避孕环。

6. 全世界约 20%的避孕药具使用者依靠一种需要男性参与或合作的方法。然而，依靠男性主导的方法在较发达区域的程度(约占全部避孕药具使用率的 40%)要大于较不发达区域(约占 14%)。

7. 在 2000 年至 2025 年之间，世界上的避孕普及率预计将缓慢增加，也即从 63%增至 67%，以便如《2002 年联合国人口预测订正本》[2] 按中等变动所预测的，将生育率从每名妇女 2.8 个子女降至 2.3 个子女。预计较不发达区域要比较

[2] 《世界人口前景：2002 年订正本》，第一卷：《综合表》（联合国出版物，出售品编号：E.03.XIII.6）。

发达区域增加稍快，也即整个发展中国家的普及率从 61%增至 68%，而发达国家则从 70%增至 75%。

8. 在较不发达区域，预期增加最快、最多的地方是非洲，其普及率需要在 2000 年至 2025 年之间从 28%增至 49%，以使生育率降低到预计的水平。在其他重要地区，预计普及率仅稍微增加：在亚洲，从 65%增至 71%；在拉丁美洲和加勒比，从 74%增至 78%；在大洋洲，从 62%增至 66%。在北美洲，预计 2000 年至 2025 年期间的普及率仍然一直保持为 82%，因为生育率也预计保持不变，即每名妇女生育子女二人。在欧洲，预计生育普及率从 68%增至 75%，虽然预计生育率于 2000 年至 2025 年之间稍微增加。普及率增加起因于预期普遍使用避孕方法将会减少对人工流产的依赖。

9. 在 2000 年至 2025 年之间，预计全世界使用避孕药具的已婚妇女人数将从 6.54 亿增至 8.46 亿，主要由于预计其人数在较不发达区域将会增加，其中预计使用避孕药具的已婚女性人数将从 5.35 亿增至 7.46 亿。在较发达区域，同时由于结婚比例下降和育龄人口减少这两项因素，预计使用避孕药具的已婚妇女人数将稍微减少，即从 1.19 亿减至 9 900 万。

10. 2000 年至 2025 年期间全世界使用避孕药具的未婚妇女人数将从 1.26 亿增至 1.78 亿。预计在较不发达区域(从 7 700 万增至 1.24 亿)和较发达区域(从 4 900 万增至 5 400 万)均将增加。

11. 由于使用可逆转的避孕法产生的副作用、使用有关方法引起的保健问题以及同所用方法有关的其他问题，生活在发达国家的夫妇有很大比例已经停止使用。然而，夫妇在放弃一种方法之后往往没有很快又转用另一种方法。从《人口和保健调查》获得的数据表明，使用一种方法后在 12 个月之内停止使用的平均或然率，就注射式避孕药和避孕套而言，几近 50%，就避孕药而言，则为 34%。停止排卵期避孕法和体外射精法的比率偏低。许多夫妇试用过可逆转法后往往又放弃使用，避孕环是个显著的例外。在 12 个月内停止使用避孕环的夫妇的平均比率为 12%，低于任何其他可逆转法。

12. 在 2001 年之前,在所有国家中有 92%的国家，或直接通过政府设施(75%)，或间接通过非政府组织活动的支持,例如计划生育协会(17%)，支持计划生育方案和分发避孕药具。

RÉSUMÉ

La contraception est l'un des grands déterminants des niveaux de fécondité. La pratique contraceptive, qui a augmenté régulièrement depuis 1970, est actuellement très répandue dans le monde entier. Mais les progrès ont été inégaux selon les régions géographiques, et il reste très difficile tant de faire augmenter les niveaux d'utilisation pour satisfaire les besoins existants dans certaines régions que de mettre à disposition des méthodes contraceptives suffisamment variées pour donner aux couples désirant recourir à la contraception de meilleures possibilités de le faire de manière suivie et efficace.

Le rapport qui suit, intitulé *Niveaux et tendances de l'utilisation de la contraception tels qu'évalués en 2002*, préparé par la Division de la population du Département des affaires économiques et sociales du Secrétariat de l'ONU, s'inscrit dans les activités que la Division consacre régulièrement à la surveillance des niveaux et des tendances de la fécondité, de la nuptialité et de la pratique contraceptive dans tous les pays du monde. Il fait apparaître que, bien que la grande majorité des pays du monde aient désormais adopté des politiques favorables à la planification familiale, il subsiste des disparités importantes entre leurs niveaux d'utilisation de la contraception. Comme le montre le rapport, il y a une forte proportion de couples des pays en développement qui cessent d'utiliser une méthode de contraception sans passer rapidement à une autre, ce qui donne à penser qu'une simple augmentation de la prévalence de la contraception ne signifie pas nécessairement que les couples arrivent à éviter les grossesses non désirées ou survenant au mauvais moment.

Niveaux d'utilisation de la contraception

À l'échelle mondiale, la prévalence de la contraception (c'est-à-dire le pourcentage de femmes en âge de procréer, mariées ou vivant en couple, qui pratiquent la contraception) a atteint 61 % en 1998, valeur et année moyennes basées sur les données les plus récentes de 160 pays. Mais cette moyenne mondiale occulte des disparités importantes, entre groupes de pays classés selon leur stade de développement, entre grandes zones et régions, mais aussi à l'intérieur de ces groupes, zones et régions.

La prévalence de la contraception dans les régions moins développées, de 59 % en moyenne, était plus faible que les 69 % que connaissaient les régions plus développées. Au sein des régions moins développées, les régions d'Asie et d'Amérique latine et Caraïbes, avec respectivement 64 % et 71 % de prévalence, étaient parvenues à des niveaux comparables à ceux des régions plus développées, alors que la région d'Afrique restait loin derrière, avec une prévalence de 27 %. La prévalence moyenne de l'Afrique subsaharienne dans son ensemble, estimée à 20 %, était encore plus faible. Dans les régions plus développées, la prévalence de la contraception était plus basse en Europe (67 %) qu'en Amérique du Nord, Australie et Nouvelle-Zélande (76 %).

La prévalence variait le plus entre pays. En Afrique, bien que la moitié des pays connaissent des taux inférieurs à 20 %, quelques-uns connaissaient une prévalence assez forte : en Afrique du Sud, au Cap-Vert, en Égypte, au Maroc et au Zimbabwe, elle s'établissait entre 50 % et 60 %; en Algérie, à la Réunion et en Tunisie, entre 60 % et 70 %; à Maurice, à 75 %.

En Asie, près de la moitié des pays enregistraient une prévalence de la contraception d'au moins 60 %. La Chine et Hong Kong (Région administrative spéciale de Chine) connaissaient les taux de prévalence les plus élevés du monde, respectivement 84 % et 86 %. La République islamique d'Iran, la République de Corée, la Thaïlande et le Vietnam étaient également dans le peloton de tête à cet égard, avec une prévalence supérieure à 70 %. Outre la Chine, quatre autres pays très peuplés d'Asie – le Bangladesh, l'Inde, l'Indonésie et le Japon – étaient parvenus à des prévalences relativement fortes, de 50 % ou plus. Pourtant, dans

huit pays elle était encore inférieure à 30 % : il s'agissait de l'Afghanistan, du Bhoutan, du Cambodge, des Émirats arabes unis, de l'Iraq, d'Oman, du Pakistan et du Yémen.

Dans la région d'Amérique latine et des Caraïbes, les variations à l'échelon des pays étaient moins marquées qu'en Afrique ou en Asie, avec une prévalence allant d'environ 30 % en Haïti, au Guatemala et au Guyana, à environ 75 % au Brésil, en Colombie, au Costa Rica, à Cuba et à Porto Rico.

En Europe, la prévalence de la contraception s'établissait en général à moins de 50 % dans les pays d'Europe orientale et les pays issus de l'ex-Union soviétique, mais dans les autres pays d'Europe, elle était généralement supérieure à 70 %.

Vers la fin des années 90, les taux d'utilisation des méthodes contraceptives modernes chez les femmes en âge de procréer, mariées ou vivant en couple, étaient analogues dans les régions plus développées (55 %) et moins développées (54 %), mais la prévalence des méthodes traditionnelles était deux fois plus forte dans les régions plus développées (13 %) que les moins développées (6 %), ce qui explique pour une bonne part la différence des prévalences globales entre ces régions.

Tendances de la prévalence de la contraception

À l'échelle mondiale, on estime que la prévalence de la contraception a augmenté de 54 % en 1990 à 59 % en 1995, et 63 % en 2000. Cette tendance, calculée à partir de données comparables relatives à 120 pays, procède d'une augmentation beaucoup plus lente dans les régions plus développées que dans les régions moins développées. Dans les premières, la prévalence est passée de 66 % en 1990 à 68 % en 1995 et 70 % en 2000, c'est à dire qu'elle a augmenté de 0,4 point de pourcentage par an dans les années 90. Dans les régions moins développées, elle est passée de 52 % en 1990 à 57 % en 1995 et 61 % en 2000, soit une progression annuelle de 0,9 point de pourcentage.

Les variations à l'intérieur des grandes zones et des régions sont marquées. Dans les régions plus développées, la prévalence n'a guère changé au cours des années 90 en Europe, en Australie et en Nouvelle-Zélande. Mais en Amérique du Nord, elle a progressé rapidement (d'un point de pourcentage par an). Dans les régions moins développées, elle a augmenté rapidement en Afrique et en Amérique latine et dans les Caraïbes (plus d'un point de pourcentage par an en moyenne), mais plus lentement en Asie (0,8 point de pourcentage par an).

Au cours des 10 dernières années, l'augmentation de la prévalence était surtout due à la progression des méthodes modernes, dont la prévalence est passée de 47 % en 1990 à 52 % en 1995 et 56 % en 2000. Dans les régions plus développées, surtout en Europe orientale et méridionale, l'utilisation croissante des méthodes modernes est allée de pair avec un recul des méthodes traditionnelles.

En Afrique, la prévalence de la contraception est restée faible depuis le début des années 70 dans les pays d'Afrique de l'Est et de l'Ouest. Ce n'est que vers la fin des années 80 ou le début des années 90 que l'on a vu une augmentation notable dans ces régions, ce qui explique que 87 % des pays d'Afrique pour lesquels on a des données sur les tendances enregistraient encore des taux de prévalence inférieurs à 30 % en 2000. En revanche, l'utilisation de la contraception a connu des progrès rapides dans les pays d'Afrique du Nord et d'Afrique australe à partir des années 70.

En Asie, les pays d'Asie orientale ont atteint vers la fin des années 70 et dans les années 80 des taux élevés, allant de 60 % à 70 %, mais n'ont guère progressé depuis. Dans les pays d'Asie du centre-sud et du Sud-Est, la prévalence, qui était beaucoup plus basse dans les années 70, a augmenté régulièrement depuis. En Asie occidentale, c'est surtout au cours des années 90 qu'on a constaté une augmentation de la prévalence.

Dans les pays d'Amérique latine et des Caraïbes, la prévalence a également augmenté régulièrement depuis 1970. Dans les années 90, elle a progressé d'au moins un point de pourcentage par an dans près des trois quarts des pays de cette grande zone.

Dans les pays d'Europe du Nord et de l'Ouest, comme en Amérique du Nord, en Australie et en Nouvelle-Zélande, il y longtemps que la prévalence a dépassé 70 %. Dans ceux d'Europe de l'Est et du Sud, elle est plus faible, s'établissant entre 50 % et 70 % depuis les années 70. L'Espagne fait exception, puisqu'elle connaît actuellement l'un des taux de prévalence les plus forts du monde (plus de 80 %).

Méthodes contraceptives utilisées

En 1998, ce n'était que dans un quart des pays pour lesquels on a des données qu'une seule méthode correspondait à 50 % ou plus de la prévalence d'utilisation de contraceptifs par des femmes en âge de procréer, mariées ou vivant en couple. Dans toutes les grandes zones, 50 % environ ou plus de la prévalence correspondaient à deux méthodes seulement.

L'utilisation de la contraception consiste en grande majorité, à l'heure actuelle, à celle de méthodes modernes. Ces dernières sont plus fréquemment utilisées dans les régions moins développées, où elles représentent 90 % de l'ensemble des utilisations, que dans les régions plus développées, où elles en représentent 81 %. Les trois méthodes les plus usitées sont la stérilisation féminine, le dispositif intra-utérin (DIU) et la pilule, respectivement utilisés par 21 %, 14 % et 7 % des femmes en âge de procréer, mariées ou vivant en couple. Considérées dans leur ensemble, ces trois méthodes sont utilisées par deux sur trois des femmes entrant dans cette catégorie qui recourent à la contraception. Toutes les méthodes traditionnelles ont une prévalence d'à peine 7 %.

Les trois méthodes les plus courantes sont particulièrement en vogue dans les régions moins développées, où 23 % des femmes en âge de procréer, mariées ou vivant en couple, ont recours à la stérilisation, 15 % au DIU, et 6 % à la pilule. Dans les régions plus développées, l'usage de la pilule est plus courant que dans les régions moins développées, avec une prévalence de 16 %. Vient ensuite le préservatif (13 %), la stérilisation féminine (10 %) et le DIU (8 %).

Ces taux de prévalence signifient que dans les régions plus développées, 42 % des couples utilisant la contraception ont recours soit à la pilule soit aux préservatifs. Dans ces mêmes régions, plus de six sur dix femmes en âge de procréer qui pratiquent la contraception et sont mariées ou vivent en couple ont recours à des méthodes réversibles à effet peu durable (y compris les méthodes contraceptives traditionnelles), alors qu'il n'y en a que deux sur dix qui se font stériliser et une sur dix à porter un DIU. En revanche, dans les régions moins développées, les couples ont plus recours à des méthodes contraceptives cliniques très efficaces, à effet durable, la stérilisation ou le DIU étant choisis par près des deux tiers de toutes les utilisatrices de contraception en âge de procréer qui sont mariées ou vivent en couple. Plusieurs pays d'Asie et d'Amérique latine connaissent des taux élevés de stérilisation féminine, tandis que les pays d'Asie, la Chine notamment, enregistrent des taux élevés de recours au DIU.

À l'échelle mondiale, environ un couple sur cinq a recours à des méthodes faisant appel à la participation masculine (préservatifs ou stérilisation masculine) ou à la participation masculine (méthode des rythmes ou retrait), parmi ceux qui pratiquent la contraception. Le recours aux méthodes faisant appel aux hommes est plus fréquent dans les régions plus développées, où il concerne deux couples sur cinq, que dans les régions moins développées, où ils ne sont qu'un couple sur sept à les utiliser.

Tendances futures de la pratique contraceptive

Entre 2000 et 2025, on estime que la prévalence globale de la contraception à l'échelle mondiale devra augmenter de 63 à 67 % pour que la fécondité totale soit ramenée de 2,8 enfants par femme à 2,3 enfants par femme, ce qui correspond à la variante moyenne dans les projections de *World Population Prospects: The 2002 Revision*[1]. La réduction de la fécondité ne concernant que les régions moins développées, on projette pour ces régions un progrès notable de la prévalence de la contraception, qui passerait de 61 % en 2000 à 68 % en 2025. Dans les régions plus développées, on prévoit une légère hausse des taux de fécondité, qui passeraient de 1,6 enfant par femme en 2000 à 1,7 enfant par femme en 2025, mais du fait qu'on s'attend à voir la contraception remplacer une partie du recours actuel à l'avortement, la prévalence de la contraception devrait progresser de 70 % en 2000 à 75 % en 2025.

Dans les régions moins développées, c'est en Afrique que la prévalence de la contraception devrait augmenter le plus vite et le plus, passant de 28 % à 49 % entre 2000 et 2025, pour que la fécondité recule de 5,1 à 3,4 enfants par femme, conformément aux projections. En Asie, où l'on prévoit que la fécondité passerait de 2,6 à 2,1 enfants par femme, la prévalence devrait connaître un progrès moyen : de 65 % à 71 %. Dans la région d'Amérique latine et des Caraïbes, la fécondité passerait selon les prévisions de 2,6 à 2 enfants par femme, et la prévalence de la contraception de 74 % à 78 %. On prévoit également une augmentation moyenne de la prévalence en Océanie (de 62 % à 66 %), où la fécondité est prévue baisser de 2,4 à 2,1 enfants par femme entre 2000 et 2025.

En Amérique du Nord (non compris les pays hispanophones), où l'on prévoit une fécondité à peu près stable (2 enfants par femme), on prévoit que la prévalence restera également constante, à 82 %, pendant la période 2000-2025. Mais on prévoit une augmentation moyenne de la prévalence en Europe (de 68 % à 75 %), malgré une augmentation prévue de la fécondité (de 1,4 à 1,6 enfant par femme). Si on prévoit en Europe une augmentation de la prévalence de la contraception, c'est qu'on compte que l'usage d'une contraception efficace rendra moins probable le recours à l'avortement.

Entre 2000 et 2025, le nombre de femmes mariées pratiquant la contraception devrait augmenter, passant de 654 millions à 846 millions à l'échelle mondiale, surtout du fait de l'accroissement prévu pour les régions moins développées, où ce nombre devrait passer de 535 millions à 746 millions. À l'inverse, on prévoit une baisse du nombre d'utilisatrices mariées de la contraception dans les régions plus développées, qui passeraient de 119 à 99 millions, tant à cause de la baisse prévue de l'effectif de la population des femmes en âge de procréer (de 300 millions en 2000 à 265 millions en 2025), qu'à cause d'une diminution prévue de la proportion de femmes mariées.

Le nombre de femmes en âge de procréer qui sont mariées et pratiquent la contraception devrait, selon les prévisions, tripler en Afrique (de 33 millions à 100 millions), et augmenter notablement en Asie comme dans la région d'Amérique latine et des Caraïbes, mais à un rythme moins rapide : de 449 millions à 559 millions en Asie, et de 61 à 84 millions en Amérique latine et aux Caraïbes. Pour l'Amérique du Nord (non compris les pays hispanophones), l'augmentation prévue est plus modeste (de 34 millions à 37 millions), de même que pour l'Océanie (de 2,8 millions à 3,2 millions), tandis qu'en Europe, leur nombre devrait décroître (de 74 millions à 64 millions), à cause de la diminution prévue du nombre de femmes âgées de 15 à 49 ans et de la prévalence du mariage.

De plus, on prévoit entre 2000 et 2025, à l'échelle mondiale, une augmentation du nombre de femmes non mariées en âge de procréer, pratiquant la contraception, qui de 126

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[1] *World Population Prospects: The 2002 Revision*, vol. I : *Comprehensive Tables* (publication des Nations Unies, numéro de vente : F.03.XIII.6).

millions passeraient à 178 millions. Une augmentation est prévue tant dans les régions plus développées (de 49 millions à 54 millions), que dans les régions moins développées (de 77 millions à 124 millions).

Dynamique de la pratique contraceptive

Les Enquêtes Démographiques et de Santé montrent que dans les pays en développement, une forte proportion des couples pratiquant des méthodes contraceptives réversibles les abandonne à cause de leurs effets secondaires, d'inquiétudes sur les effets pour la santé des méthodes utilisées, ou d'autres problèmes liés à leur utilisation. Ils ne passent pas immédiatement pour autant à d'autres méthodes. La probabilité médiane d'abandon d'une méthode contraceptive réversible dans les 12 mois suivant l'adoption est de près de 50 % pour les injectables et les préservatifs, et de 34 % pour la pilule. La probabilité d'abandon de l'abstinence périodique ou du retrait est plus faible. Ces deux méthodes peuvent donc exercer un effet non négligeable pour la régulation de la fécondité. La forte probabilité d'abandon du préservatif est particulièrement préoccupante dans les zones où l'infection à VIH continue à se propager.

Le DIU est à mettre à part, du fait que la probabilité de l'abandonner est beaucoup plus faible, la médiane étant d'à peine 12 %. Les facteurs qui expliquent ce phénomène sont sans doute, d'une part, que son taux d'échec est faible, et que d'autre part, l'enlèvement d'un DIU oblige à s'adresser à un centre médical, son abandon exigeant donc que l'utilisatrice soit plus fermement décidée que pour d'autres méthodes.

En règle générale, il était moins probable que les couples pratiquant la contraception pour limiter le nombre des naissances abandonnent une méthode dont ils ne sont pas satisfaits que ceux qui la pratiquent pour les espacer. Il était plus probable que les couples citadins et ayant un niveau d'instruction plus élevé passent rapidement à une autre méthode après avoir abandonné celle qu'ils pratiquaient. C'est probablement ce qui explique les taux de pratique contraceptive courante plus élevés qu'on observait dans les zones urbaines et parmi les couples ayant un niveau d'instruction plus élevé. Ces derniers ont plus facilement accès à d'autres méthodes, comprennent mieux les méthodes disponibles, et n'hésitent pas à se procurer le nécessaire, éléments qui jouent très probablement en faveur des différences observées.

Politiques en matière de fécondité, de contraception et de population

L'appui des pouvoirs publics aux méthodes contraceptives a augmenté régulièrement depuis 1975. En 2001, 92 % des pays du monde supportaient des programmes de planification familiale et de distribution de contraceptifs, soit directement par l'intermédiaire de services publics (75 %), soit indirectement, en soutenant l'activité d'organisations non gouvernementales telles que les associations de planification familiale (17 %). C'est surtout dans les pays en développement que des politiques nouvelles, favorables à la planification familiale, ont été adoptées. La proportion de pays en développement qui soutiennent la pratique contraceptive est passée de 73 % à 94 % entre 1976 et 2001. Parmi les pays les moins avancés, l'augmentation a été encore plus nette : de 57 % en 1976 à 96 % en 2001. Parmi les pays développés, le pourcentage des gouvernements qui soutiennent des programmes de planification familiale est resté stable, aux alentours de 80 %, depuis 1976.

PRINCIPALES CONCLUSIONS

1. À l'échelle mondiale, la prévalence de la contraception (c'est-à-dire le pourcentage de femmes en âge de procréer, mariées ou vivant en couple, qui pratiquent la contraception) a atteint 61 % en 1998, valeur et année moyennes basées sur les données les plus récentes de 160 pays. Dans les régions moins développées, la prévalence moyenne était de 59 %, soit 10 points de pourcentage de moins que dans les régions plus développées (où elle était de 69 %).

2. Vers la fin des années 90, c'était en Afrique que la prévalence, de 27 %, était la plus faible du monde. La prévalence moyenne en Afrique au sud du Sahara, estimée à 20 %, était encore plus faible. En revanche, les régions d'Asie et d'Amérique latine et des Caraïbes, où la prévalence atteignait respectivement 64 et 71 %, connaissaient des taux comparables à ceux des régions plus développées, l'Europe enregistrant 67 % et l'Amérique du Nord (pays hispanophones non compris) avec l'Australie et la Nouvelle-Zélande 76 %.

3. Pour ce qui est de la prévalence mondiale, elle est passée de 54 % en 1990 à 59 % en 1995 et 63 % en 2000. L'augmentation a été plus lente dans les régions plus développées que dans les régions moins développées, car, ayant déjà atteint des prévalences élevées dans les années 80, l'Europe, l'Australie et la Nouvelle-Zélande n'ont pas vu de grands changements dans les années 90. Mais l'augmentation a été rapide en Amérique du Nord (1 point de pourcentage par an). Dans les régions moins développées, l'augmentation a été rapide en Afrique et dans la région d'Amérique latine et des Caraïbes (plus d'un point de pourcentage par an en moyenne) mais plus lente en Asie (environ 0,8 point de pourcentage par an).

4. À l'échelle mondiale, 54 % des femmes mariées ou vivant en couple utilisent des méthodes contraceptives modernes avec 21 % ayant opté pour la stérilisation féminine, 14 % portant un dispositif intra-utérin (DIU) et 7 % prenant la pilule. Les méthodes contraceptives modernes sont utilisées par une proportion plus importante de femmes mariées ou vivant en couple des régions moins développées que de celles des régions plus développées : 90 % contre 81 %. Aux trois méthodes les plus courantes (stérilisation féminine, DIU et pilule) correspondent les deux tiers de la prévalence de la contraception à l'échelle mondiale.

5. Sur dix femmes qui utilisent la contraception dans les régions plus développées, six ont recours à des méthodes réversibles et à court terme. Seulement deux femmes sur dix y sont stérilisées et une sur dix porte un DIU. Dans les régions moins développées, quatre femmes sur 10 ont recours à la stérilisation et près de trois sur dix au DIU.

6. À l'échelle mondiale, 20 % environ des utilisatrices de contraception ont recours à une méthode faisant appel à la participation ou à la coopération de leur partenaire masculin. Mais le recours aux méthodes axées sur les hommes est plus fréquent dans les régions plus développées (40 % environ de la prévalence globale) que dans les régions moins développées (14 % environ).

7. Entre 2000 et 2025, on prévoit que la prévalence de la contraception augmentera lentement de 63 % à 67 %, la fécondité passant dans le même temps de 2,8 à 2,3 enfants par femme selon les prévisions correspondant à la variante moyenne des projections démographiques de l'Organisation des Nations Unies[2]. L'augmentation devrait être un peu plus rapide dans les régions moins développées que dans les régions plus développées, la prévalence passant de 61 % à 68 % dans les pays en développement pris dans leur ensemble, et de 70 % à 75 % dans les pays développés.

8. Dans les régions moins développées, l'augmentation la plus rapide et la plus importante devrait se produire en Afrique, où il faudrait que la prévalence passe de 28 % à

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[2] *World Population Prospects: The 2002 Revision*, vol. I : *Comprehensive Tables* (publication des Nations Unies, numéro de vente : F.03.XIII.6).

49 % entre 2000 et 2025 pour que la fécondité atteigne les taux projetés pour ce continent. Dans les autres grandes régions, la prévalence ne devrait connaître qu'une légère augmentation : de 65 % à 71 % en Asie, de 74 % à 78 % en Amérique latine et aux Caraïbes, et de 62 % à 66 % en Océanie. En Amérique du Nord (pays hispanophones non compris), on prévoit que la prévalence restera stable, à 82 %, de 2000 à 2025, car les prévisions donnent une fécondité stable de 2 enfants par femme. En Europe, on prévoit une augmentation de la prévalence, de 68 % à 75 %, malgré une fécondité en légère hausse de 2000 à 2025. Cela s'explique par le fait que l'utilisation plus large des méthodes de contraception ferait reculer le recours à l'avortement.

9. De 2000 à 2025, le nombre de femmes mariées pratiquant la contraception devrait augmenter pour l'ensemble du monde, passant de 654 millions à 846 millions, surtout du fait de l'augmentation de leur nombre dans les régions moins développées, où l'on prévoit que le nombre de femmes mariées utilisant des méthodes contraceptives passera de 535 millions à 746 millions. Dans les régions plus développées, leur nombre devrait reculer légèrement, baissant de 119 millions à 99 millions, d'une part parce que la proportion de femmes mariées devrait baisser, et d'autre part du fait que la population en âge de procréer sera moins nombreuse.

10. Le nombre de femmes non mariées utilisant des méthodes contraceptives devrait augmenter entre 2000 et 2025, passant de 126 millions à 178 millions pour l'ensemble du monde. On prévoit une augmentation dans les régions moins développées (77 millions à 124 millions) comme dans les régions plus développées (49 millions à 54 millions).

11. Une proportion importante des couples vivant dans les pays en développement cessent d'utiliser les méthodes contraceptives réversibles à cause de leurs effets secondaires, d'inquiétudes sur les effets pour la santé des méthodes utilisées, ou d'autres problèmes liés à leur utilisation. Mais il est fréquent que les couples ne passent pas rapidement à une autre méthode lorsqu'ils en abandonnent une. Les chiffres livrés par les Enquêtes Démographiques et de Santé montrent que la probabilité médiane d'abandon dans les 12 mois suivant l'adoption d'une méthode était proche de 50 % pour les injectables et les préservatifs, et de 34 % pour la pilule. L'abandon de l'abstinence périodique et du retrait était moins fréquent. Le DIU constitue l'exception notable à la règle qui veut que les méthodes réversibles soient souvent abandonnées par bon nombre des couples qui les utilisent. La proportion médiane des couples abandonnant l'utilisation du DIU dans les 12 mois suivant l'adoption était de 12 %, plus faible donc que pour toutes les autres méthodes réversibles.

12. En 2001, 92 % des pays du monde supportaient des programmes de planification familiale et de distribution de contraceptifs, soit directement par le biais de services publics (75 %), soit indirectement, en supportant les activités d'organisations non gouvernementales telles que les associations de planification familiale (17 %).

Резюме

Контрацепция выступает одним из главных факторов, определяющих уровни рождаемости. Использование контрацептивов с 1970 года постоянно растет и в настоящее время широко распространено по всему миру. Однако в разных географических районах отмечается различный прогресс, и сохраняются крупные проблемы как в том, что касается повышения уровня использования противозачаточных средств для удовлетворения существующих потребностей в определенных регионах, так и в том, что касается обеспечения доступа к использованию достаточно разнообразных методов контрацепции в целях обеспечения лучших возможностей для пар, желающих пользоваться противозачаточными средствами, делать это на постоянной основе и с высокой эффективностью.

Настоящий доклад о «Масштабах и тенденциях применения противозачаточных средств по состоянию на 2002 год» подготовлен Отделом народонаселения Департамента по экономическим и социальным вопросам Секретариата Организации Объединенных Наций в рамках осуществляемой Отделом народонаселения деятельности, связанной с наблюдением за уровнями рождаемости, брачности и применения противозачаточных средств и тенденциями в их изменении во всех странах мира. В нем показано, что, хотя страны мира в своем подавляющем большинстве к настоящему времени взяли на вооружение политику в поддержку планирования размеров семьи, все еще сохраняются значительные различия в уровнях применения противозачаточных средств. Хотя применение противозачаточных средств в менее развитых регионах очень сильно выросло, общий уровень применения противозачаточных средств в этих регионах все еще ниже соответствующего уровня в более развитых регионах. Как отмечается в этом докладе, высокая доля пар в развивающихся странах прекращает использование одного метода контрацепции без быстрого перехода к другому, и это говорит о том, что сам по себе рост уровня применения противозачаточных средств не обязательно означает успешное избежание нежелательных или несвоевременных беременностей.

Уровни применения противозачаточных средств

Уровень применения противозачаточных средств во всем мире — процентный показатель числа женщин, применяющих противозачаточные средства, по отношению к общему числу женщин в репродуктивном возрасте, состоящих в официально оформленном или гражданском браке, — по оценкам, в 1998 году, являющемся усредненной датой, на которую имелись самые свежие данные по 160 странам, достиг 61 процента. Однако за этим средним глобальным показателем скрываются немаловажные различия в показателях между группами, основными районами и регионами разного уровня развития и внутри них.

Уровень применения противозачаточных средств в менее развитых регионах, составлявший в среднем 59 процентов, был ниже соответствующего показателя в более развитых регионах, который составил 69 процентов. Среди менее развитых регионов, в странах Азии и Латинской Америки и Карибского бассейна показатели применения противозачаточных средств, составившие, соответственно, 64 процента и 71 процент, достигли уровней, сопоставимых с показателями по более развитым регионам, в то время как показатель применения противозачаточных средств в Африке был значительно ниже и составлял 27 процентов. Средний уровень в странах Африки к югу от Сахары, вместе взятых, был еще ниже и составлял, по оценкам, 20 процентов. Что касается более развитых регионов, то в Европе уровень применения противозачаточных средств, составлявший 67 процентов, был ниже уровня в Северной Америке, Австралии и Новой Зеландии, где он составил 76 процентов.

Уровень применения противозачаточных средств значительно различался по странам. В Африке, в то время как в половине всех стран уровни применения противозачаточных средств были ниже 20 процентов, в некоторых странах отмечались достаточно высокие уровни применения противозачаточных средств, в том числе — в Египте, Зимбабве, Кабо-Верде, Марокко и Южной Африке, где уровни применения противозачаточных средств составляли от

50 до 60 процентов; в Алжире, Реюньоне и Тунисе, где уровни составляли от 60 до 70 процентов; и в Маврикии, где уровень составлял 75 процентов.

В Азии почти в половине всех стран уровень применения противозачаточных средств составлял 60 процентов или выше. Среди них, в Китае и Гонконге (Специальном административном районе Китая) были достигнуты самые высокие в мире уровни применения противозачаточных средств, составившие 84 процента и 86 процентов, соответственно. Вьетнам, Исламская Республика Иран, Республика Корея и Таиланд также были среди стран, лидирующих по уровням применения противозачаточных средств, при уровнях выше 70 процентов. В дополнение к Китаю четыре другие страны Азии с большой численностью населения — Бангладеш, Индия, Индонезия и Япония — достигли относительно высоких показателей применения противозачаточных средств на уровне 50 процентов или выше. Однако в восьми странах уровни применения противозачаточных средств были все еще ниже 30 процентов, а именно в Афганистане, Бутане, Ираке, Йемене, Камбодже, Объединенных Арабских Эмиратах, Омане и Пакистане.

В Латинской Америке и Карибском бассейне различия на страновом уровне были меньше, чем в Африке или Азии, при этом уровень применения противозачаточных средств варьировался от приблизительно 30 процентов в Гватемале, Гаити и Гайане до приблизительно 75 процентов в Бразилии, Колумбии, Коста-Рике, Кубе и Пуэрто-Рико.

В Европе уровень применения противозачаточных средств был в целом ниже 50 процентов в странах Восточной Европы и в государствах — бывших республиках Союза Советских Социалистических Республик (СССР), но в остальных странах Европы уровень применения противозачаточных средств был обычно выше 70 процентов.

В конце 90-х годов уровень использования современных методов контрацепции среди женщин в репродуктивном возрасте, состоящих в официально оформленном или гражданском браке, был почти одинаковым в более развитых регионах (55 процентов) и в менее развитых регионах (54 процента), но уровень использования традиционных методов контрацепции был вдвое выше в более развитых регионах (13 процентов), чем в менее развитых регионах (6 процентов), и этим в значительной мере объясняются различия в общем уровне применения противозачаточных средств между более развитыми и менее развитыми регионами.

Тенденции в изменении уровня применения противозачаточных средств

Уровень применения противозачаточных средств во всем мире, по оценкам, возрос с 54 процентов в 1990 году до 59 процентов в 1995 году и 63 процентов в 2000 году. Эта тенденция, рассчитанная на основе сопоставимых данных по 120 странам, определяется последствиями гораздо меньшего прироста в более развитых регионах по сравнению с менее развитыми регионами. В более развитых регионах уровень применения противозачаточных средств вырос с 66 процентов в 1990 году до 68 процентов в 1995 году и 70 процентов в 2000 году, т.е. на протяжении 90-х годов он рос на 0,4 процента в год. В менее развитых регионах уровень применения противозачаточных средств вырос с 52 процентов в 1990 году до 57 процентов в 1995 году и 61 процента в 2000 году, и следовательно, рос в среднем на 0,9 процента в год.

Наблюдаются большие различия в тенденциях изменения уровня применения противозачаточных средств по основным районам и регионам. Что касается более развитых регионов, то показатели применения противозачаточных средств за 90-е годы не претерпели значительных изменений в Европе и в Австралии и Новой Зеландии. Однако в Северной Америке этот показатель рос быстрыми темпами (на 1,0 процента в год). В менее развитых регионах показатели применения противозачаточных средств росли быстрыми темпами в странах Африки и Латинской Америки и Карибского бассейна (в среднем более чем на 1,0 процента в год), но более медленными темпами в Азии (на 0,8 процента в год).

За прошлое десятилетие рост уровня применения противозачаточных средств был связан главным образом с расширением использования современных методов, показатель применения

которых вырос с 47 процентов в 1990 году до 52 процентов в 1995 году и 56 процентов в 2000 году. В более развитых регионах, особенно в Восточной и Южной Европе, рост использования современных методов сопровождался сокращением использования традиционных методов.

В Африке низкие уровни применения противозачаточных средств сохранялись с начала 70-х годов в странах Восточной, Центральной и Западной Африки. Значительный рост в этих регионах начался лишь в конце 80-х или начале 90-х годов, и этим объясняется то, что в 87 процентах африканских стран, по которым имелись данные о тенденциях, в 2000 году все еще наблюдались уровни применения противозачаточных средств ниже 30 процентов. В отличие от этого, в странах Северной Африки и южной части Африки начиная с 70-х годов наблюдались быстрые темпы роста показателей применения противозачаточных средств.

Что касается Азии, то страны Восточной Азии достигли высоких уровней применения противозачаточных средств в конце 70-х и начале 80-х годов от 60 до 70 процентов, но с тех пор в них не происходило существенного роста. В странах южной части Центральной Азии и Юго-Восточной Азии уровни применения противозачаточных средств в 70-е годы были значительно ниже, но с тех пор они неуклонно растут. В Западной Азии уровень применения противозачаточных средств повышался главным образом в 90-х годах.

В странах Латинской Америки и Карибского бассейна начиная с 1970 года также происходил устойчивый рост уровня применения противозачаточных средств. На протяжении 90-х годов почти в 75 процентах стран этого значительного региона уровень применения противозачаточных средств повышался по меньшей мере на 1,0 процента в год.

В странах Северной Европы, Западной Европы и Северной Америки, а также в Австралии и Новой Зеландии в течение долгого времени сохраняются показатели применения противозачаточных средств на уровне 70 процентов и выше. В странах Восточной и Южной Европы с начала 70-х годов уровни применения противозачаточных средств были ниже и составляли от 50 до 70 процентов. Исключением является Испания, в которой на настоящий момент отмечается один из самых высоких в мире уровней применения противозачаточных средств (более 80 процентов).

Применяемые методы контрацепции

Лишь в одной четверти стран, по которым имеются данные, в 1998 году 50 или более процентов случаев применения противозачаточных средств женщинами в репродуктивном возрасте, состоящими в официально оформленном или гражданском браке, приходилось на один-единственный метод. Во всех основных районах около 50 или более процентов случаев применения противозачаточных средств приходилось всего на два метода контрацепции.

В настоящее время в применении противозачаточных средств преобладает использование современных методов контрацепции. Современные методы более широко используются в менее развитых странах, в которых на них приходится 90 процентов всего применения противозачаточных средств, по сравнению с более развитыми регионами, в которых на них приходится 81 процент всего применения. Тремя наиболее часто используемыми во всем мире методами являются стерилизация женщин, внутриматочные противозачаточные средства (ВМС) и таблетки, по которым уровни применения противозачаточных средств женщинами репродуктивного возраста, состоящими в официально оформленном или гражданском браке, составляют, соответственно, 21 процент, 14 процентов и 7 процентов. Вместе взятые эти три метода используются двумя из трех женщин репродуктивного возраста, состоящими в официально оформленном или гражданском браке и применяющими противозачаточные средства. Для всех традиционных методов вместе взятых уровень применения противозачаточных средств составляет лишь 7 процентов.

Эти три наиболее часто используемые метода особенно популярны в менее развитых регионах, где 23 процента женщин репродуктивного возраста, состоящих в официально оформленном или гражданском браке, прибегают к стерилизации, еще 15 процентов

пользуются ВМС и 6 процентов — таблетками. В более развитых регионах использование таблеток распространено более широко по сравнению с менее развитыми регионами, и уровень их применения составляет 16 процентов. Вслед за этим наиболее распространено применение презерватива (уровень применения — 13 процентов), стерилизация женщин (10 процентов) и ВМС (8 процентов).

Эти уровни применения противозачаточных средств позволяют сделать вывод о том, что в более развитых регионах 42 процента пар, использующих противозачаточные средства, полагаются либо на таблетки, либо на презервативы. В более развитых регионах свыше шести из десяти женщин, пользующихся противозачаточными средствами и состоящих в официально оформленном или гражданском браке, полагаются на краткосрочные методы, имеющие обратимые последствия (включая традиционные методы контрацепции), тогда как только две женщины из десяти прибегают к стерилизации и одна из десяти пользуется ВМС. В отличие от этого в менее развитых регионах пары имеют тенденцию к использованию более долгосрочных, высокоэффективных клинических методов контрацепции, и почти две трети всех женщин в репродуктивном возрасте, пользующихся противозачаточными средствами и состоящих в официально оформленном или гражданском браке, полагаются на стерилизацию или ВМС. Высокие уровни женской стерилизации — распространенное явление в ряде стран Азии и Латинской Америки, в то время как высокие уровни применения ВМС более часто встречаются в странах Азии, в частности в Китае.

Примерно одна из пяти пар, пользующихся противозачаточными средствами во всем мире, полагается на методы, предполагающие мужское участие (использование презерватива или стерилизация мужчин) или содействие (использование ритмического метода или прерывание полового акта). Использование методов, рассчитанных на участие мужчины, шире распространено в более развитых регионах, где на них полагаются две пары из пяти, по сравнению с менее развитыми регионами, где эти методы используются только одной парой из семи.

Тенденции применения противозачаточных средств в будущем

По оценкам, в период 2000–2025 годов необходимо повысить общемировой уровень применения противозачаточных средств с 63 до 67 процентов в целях обеспечения возможности сокращения всеобщей рождаемости с 2,8 до 2,3 ребенка на одну женщину, как предусмотрено в варианте среднего уровня демографических прогнозов Организации Объединенных Наций в издании 2002 года (“2002 Revision”)[1]. Поскольку задача сокращения рождаемости ограничивается менее развитыми регионами, для них предусматривается заметный рост уровня применения противозачаточных средств: с 61 процента в 2000 году до 68 процентов в 2025 году. В более развитых регионах прогнозируется небольшой рост уровней рождаемости с 1,6 ребенка на одну женщину в 2000 году до 1,7 ребенка на одну женщину в 2025 году, однако, исходя из того, что распространенное в настоящее время применение абортов, как ожидается, будет частично заменено использованием противозачаточных средств, ожидается рост уровня применения противозачаточных средств с 70 процентов в 2000 году до 75 процентов в 2025 году.

Что касается менее развитых регионов, то самый быстрый и значительный рост уровня распространения противозачаточных средств должен произойти в Африке, где в период 2000–2025 годов он должен повыситься с 28 до 49 процентов, с тем чтобы могло быть обеспечено прогнозируемое сокращение рождаемости с 5,1 до 3,4 ребенка на одну женщину. В Азии, где прогнозируется снижение рождаемости с 2,6 до 2,1 ребенка на одну женщину, произойдет, как ожидается, умеренный рост уровня применения противозачаточных средств: с 65 процентов до 71 процента. В странах Латинской Америки и Карибского бассейна, где прогнозируется снижение рождаемости с 2,6 до 2,0 ребенка на одну женщину, ожидается повышение уровня

[1] *World Population Prospects: The 2002 Revision*, vol. I: *Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6).

применения противозачаточных средств с 74 до 78 процентов. Незначительное повышение уровня применения противозачаточных средств ожидается также в Океании (с 62 до 66 процентов), где прогнозируется снижение общей рождаемости с 2,4 ребенка на одну женщину в 2000 году до 2,1 ребенка на одну женщину в 2025 году.

В Северной Америке, где прогнозируемая рождаемость останется в основном неизменной на уровне 2 детей на одну женщину, в период 2000–2025 годов показатель применения противозачаточных средств, как ожидается, также останется без изменений на уровне 82 процентов. Вместе с тем ожидается умеренный рост уровня применения противозачаточных средств в Европе (с 68 до 75 процентов), хотя в период 2000–2025 годов ожидается рост рождаемости (с 1,4 до 1,6 ребенка на одну женщину). Прогнозируемый рост уровня применения противозачаточных средств в Европе основывается на том предположении, что более широкое использование эффективных методов контрацепции приведет к сокращению числа абортов.

В мировом масштабе на период 2000–2025 годов прогнозируется увеличение числа замужних женщин, пользующихся противозачаточными средствами, с 654 миллионов до 846 миллионов человек, главным образом в результате роста, который, по прогнозам, произойдет в менее развитых регионах, где число замужних женщин, пользующихся противозачаточными средствами, как ожидается, вырастет с 535 миллионов до 746 миллионов. В более развитых регионах, напротив, число замужних женщин, пользующихся противозачаточными средствами, как ожидается, уменьшится со 119 до 99 миллионов человек вследствие прогнозируемого уменьшения численности женщин в репродуктивном возрасте (с 300 миллионов человек в 2000 году до 265 миллионов в 2025 году) и прогнозируемого сокращения доли замужних женщин.

Число женщин в репродуктивном возрасте, состоящих в браке и пользующихся противозачаточными средствами, по прогнозам, увеличится втрое в Африке, с 33 миллионов до 100 миллионов человек, и значительно вырастет, но более медленными темпами, как в Азии, так и в Латинской Америке и Карибском бассейне: с 449 миллионов до 559 миллионов человек в Азии и с 61 миллиона до 84 миллионов человек в Латинской Америке и Карибском бассейне. Менее значительный рост прогнозируется для Северной Америки (с 34 миллионов до 37 миллионов человек) и Океании (с 2,8 миллиона до 3,2 миллиона человек), в то время как в Европе прогнозируется сокращение с 74 миллионов до 64 миллионов человек, что объясняется как прогнозируемым сокращением численности женщин в возрасте от 15 до 49 лет, так и прогнозируемым уменьшением доли замужних женщин.

Кроме того, в период 2000–2025 годов число незамужних женщин в репродуктивном возрасте, пользующихся противозачаточными средствами, по прогнозам, также вырастет в мировом масштабе со 126 миллионов до 178 миллионов человек. Рост прогнозируется как в более развитых регионах (с 49 миллионов до 54 миллионов человек), так и в менее развитых регионах (с 77 миллионов до 124 миллионов человек).

Динамика изменений в пользовании противозачаточными средствами

Данные, полученные в результате обследований в области народонаселения и здравоохранения, указывают на то, что в развивающихся странах значительная доля пар, пользующихся методами контрацепции, имеющими обратимые последствия, прекращает их использование по причине оказываемых ими побочных эффектов, сомнений в безопасности применяемых методов для здоровья или других проблем, связанных с использованием того или иного метода. Однако пары не осуществляют немедленного перехода к альтернативному методу. Усредненная вероятность отказа от определенного метода контрацепции в течение 12 месяцев после начала его использования составляет около 50 процентов для инъекционных средств и презервативов и 34 процента — для таблеток. Вероятность отказа от периодической абстиненции или от прерывания полового акта является более низкой. Вследствие этого оба эти метода могут выступать в качестве важного фактора регулирования рождаемости. Высокая

вероятность прекращения пользования презервативами вызывает особую обеспокоенность в контексте продолжающегося распространения инфекции ВИЧ.

ВМС отличаются от других противозачаточных средств тем, что вероятность прекращения их применения значительно ниже и ее усредненный показатель составляет всего лишь 12 процентов. К числу факторов, которые, по-видимому, способствуют низкой вероятности прекращения использования ВМС, относится их высокая степень надежности и тот факт, что для изъятия ВМС обычно необходимо посетить медицинское учреждение, а это предполагает наличие у пользователя более твердой решимости прекратить их использование.

В общем для пар, которые пользуются противозачаточными средствами для ограничения числа рождаемых детей, вероятность отказа от какого-либо метода из-за неудовлетворенности им меньше, чем для пар, которые пользуются противозачаточными средствами для увеличения промежутков времени между рождением детей. Для городских жителей и более образованных людей больше вероятность быстрого перехода к альтернативному методу после отказа от прежнего метода, чем для сельских жителей и менее образованных людей. Этим фактором, вероятно, определяется то, что в городских районах и среди более образованных пар в настоящее время в целом наблюдаются более высокие уровни пользования противозачаточными средствами. Более легкий доступ к альтернативным методам среди более образованного населения, лучшее понимание существующих методов и социальные гарантии возможностей их применения являются теми факторами, которые могут определять наблюдаемые различия.

Рождаемость, противозачаточные средства и политика в области народонаселения

Начиная с 1975 года неуклонно растет правительственная поддержка методов контрацепции. К 2001 году 92 процента всех стран поддерживали программы планирования размеров семьи и распространение противозачаточных средств либо непосредственно через правительственные учреждения (75 процентов), либо косвенно — на основе поддержки деятельности неправительственных организаций, таких, как ассоциации, занимающиеся вопросами планирования семьи (17 процентов). Принятие новой политики в поддержку планирования размеров семьи происходило в основном в развивающихся странах. Доля развивающихся стран, поддерживающих использование методов контрацепции, возросла с 73 процентов в 1976 году до 94 процентов в 2001 году. Среди наименее развитых стран этот рост был более ярко выраженным: с 57 процентов в 1976 году до 96 процентов в 2001 году. Среди развитых стран процентная доля стран, поддерживающих программы планирования семьи, оставалась неизменной с 1976 года, на уровне около 80 процентов.

Основные выводы

1. Уровень применения противозачаточных средств во всем мире — процентный показатель числа женщин, применяющих противозачаточные средства, по отношению к общему числу женщин в репродуктивном возрасте, состоящих в официально оформленном или гражданском браке, — в 1998 году, являющемся усредненной датой, на которую имелись самые свежие данные по 160 странам, достиг 61 процента. Средний уровень применения противозачаточных средств в менее развитых регионах, составлявший 59 процентов, был на 10 пунктов ниже соответствующего показателя в более развитых регионах (69 процентов).

2. В конце 90-х годов уровень применения противозачаточных средств в Африке составлял 27 процентов, что представляет собой самый низкий показатель во всем мире. Средний уровень в странах Африки к югу от Сахары был еще ниже и составлял, по оценкам, 20 процентов. В отличие от этого, в странах Азии и Латинской Америки и Карибского бассейна показатели применения противозачаточных средств, составившие, соответственно, 64 процента и 71 процент, достигли уровня показателей по более развитым регионам, среди которых в Европе отмечались показатели на уровне 67 процентов и в Северной Америке вместе с Австралией/Новой Зеландией — на уровне 76 процентов.

3. Уровень применения противозачаточных средств во всем мире возрос с 54 процентов в 1990 году до 59 процентов в 1995 году и 63 процентов в 2000 году. В более развитых регионах рост показателей происходил более медленно, чем в менее развитых регионах, в связи с тем, что показатели применения противозачаточных средств в Европе и Австралии/Новой Зеландии, достигшие относительно высоких уровней еще в 80-х годах, не изменились заметным образом в 90-е годы. Однако в Северной Америке этот показатель рос быстрыми темпами (в среднем на 1 процент в год). В менее развитых регионах показатели применения противозачаточных средств росли быстрыми темпами в странах Африки и Латинской Америки и Карибского бассейна (в среднем более чем на 1 процент в год), но более медленными темпами — в Азии (примерно на 0,8 процента в год).

4. Во всем мире 54 процента женщин репродуктивного возраста, состоящих в официально оформленном или гражданском браке, полагаются на современные методы контрацепции, при этом 21 процент женщин отдает предпочтение стерилизации, 14 процентов — внутриматочным противозачаточным средствам (ВМС) и 7 процентов — таблеткам. Доля современных методов контрацепции в общем использовании противозачаточных средств женщинами, состоящими в официально оформленном или гражданском браке, выше для менее развитых регионов по сравнению с более развитыми регионами: 90 процентов и 81 процент, соответственно. На три наиболее часто используемых метода — стерилизацию женщин, ВМС и таблетки — приходится две трети всех применяемых противозачаточных средств в мире.

5. В более развитых регионах свыше шести из каждых десяти женщин, пользующихся противозачаточными средствами, полагаются на краткосрочные методы, имеющие обратимые последствия, тогда как только две женщины из десяти прибегают к стерилизации и одна из десяти пользуется ВМС. В менее развитых регионах четыре из десяти женщин полагаются на стерилизацию и примерно три из десяти — на ВМС.

6. Около 20 процентов всех тех, кто пользуется противозачаточными средствами во всем мире, полагаются на метод, требующий участия или содействия мужчины. Однако использование методов, рассчитанных на участие мужчины, шире распространено в более развитых регионах (около 40 процентов всего применения противозачаточных средств), чем в менее развитых регионах (около 14 процентов).

7. На период 2000–2025 годов прогнозируется медленный рост уровня применения противозачаточных средств во всем мире, с 63 до 67 процентов, в целях сокращения коэффициента рождаемости с 2,8 до 2,3 ребенка на одну женщину, как предусмотрено в среднем варианте демографического прогноза Организации Объединенных Наций в издании

2002 года ("2002 Revision")[2]. В менее развитых регионах, по прогнозам, рост будет происходить немного быстрее, чем в более развитых регионах, с повышением уровня применения противозачаточных средств в развивающихся странах в целом с 61 процента до 68 процентов и в развитых странах — с 70 до 75 процентов.

8. Что касается менее развитых регионов, то самый быстрый и значительный рост показателей ожидается в Африке, где в период 2000–2025 годов уровень должен повыситься с 28 до 49 процентов, с тем чтобы могло быть достигнуто прогнозируемое сокращение рождаемости. В других основных регионах этот уровень, как ожидается, возрастет лишь незначительно: с 65 процентов до 71 процента в Азии, с 74 до 78 процентов в странах Латинской Америки и Карибского бассейна и с 62 до 66 процентов в Океании. В Северной Америке, по прогнозам, в период 2000–2025 годов показатель применения противозачаточных средств останется без изменений на уровне 82 процентов в связи с тем, что прогнозируемая рождаемость также останется неизменной и составит 2 ребенка на одну женщину. Уровень применения противозачаточных средств в Европе, по прогнозам, вырастет с 68 до 75 процентов, хотя на период 2000–2025 годов прогнозируется небольшой рост рождаемости. Прогнозы роста уровня применения противозачаточных средств основываются на предположении, что более широкое использование методов контрацепции приведет к сокращению числа абортов.

9. В мировом масштабе на период 2000-2025 годов прогнозируется рост числа замужних женщин, пользующихся противозачаточными средствами, с 654 миллионов до 846 миллионов человек, главным образом в результате роста, который, по прогнозам, произойдет в менее развитых регионах, где число замужних женщин, пользующихся противозачаточными средствами, как ожидается, вырастет с 535 миллионов до 746 миллионов человек. В более развитых регионах число замужних женщин, пользующихся противозачаточными средствами, как ожидается, немного уменьшится, со 119 миллионов до 99 миллионов человек, в результате того, что сократится доля замужних женщин и, наряду с этим, уменьшится численность населения в репродуктивном возрасте.

10. В период 2000–2025 годов число незамужних женщин, пользующихся противозачаточными средствами, по прогнозам, вырастет со 126 до 178 миллионов человек в мировом масштабе. Рост прогнозируется как в менее развитых регионах (с 77 миллионов до 124 миллионов человек), так и в более развитых регионах (с 49 миллионов до 54 миллионов человек).

11. Значительная доля супружеских пар, проживающих в развивающихся странах, прекращает пользоваться методами контрацепции, имеющими обратимые последствия, по причине оказываемых ими побочных эффектов, сомнений в безопасности применяемых методов для здоровья или других проблем, связанных с использованием того или иного метода. Однако после того, как супруги отказываются от одного из методов, часто не происходит быстрого перехода к другому методу. Данные, полученные в результате обследований в области народонаселения и здравоохранения, указывают на то, что усредненная вероятность отказа от определенного метода в течение 12 месяцев после начала его использования составляла около 50 процентов для инъекционных средств и презервативов и 34 процента — для таблеток. Показатели отказа от периодической абстиненции и прерывания полового акта были ниже. ВМС выступали заметным исключением из общего правила, согласно которому пары, которые испробовали методы, имеющие обратимые последствия, часто отказываются от них. Усредненная доля пар, прекращающих пользоваться ВМС в течение 12 месяцев, составляла 12 процентов, что меньше показателей по любому другому методу, имеющему обратимые последствия.

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[2] *World Population Prospects: The 2002 Revision*, vol. I*: Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6).

12. К 2001 году 92 процента всех стран поддерживали программы планирования размеров семьи и распространение противозачаточных средств либо непосредственно через правительственные учреждения (75 процентов), либо косвенно — на основе поддержки деятельности неправительственных организаций, таких, как ассоциации, занимающиеся вопросами планирования размеров семьи (17 процентов).

RESUMEN EJECUTIVO

El uso de anticonceptivos es uno de los principales determinantes de los niveles de fecundidad. Ha venido aumentando constantemente desde 1970 y en la actualidad está generalizado en el mundo. Sin embargo, el progreso ha sido desigual en las diferentes zonas geográficas y subsisten grandes problemas, tanto en lo que respecta al aumento del uso de anticonceptivos como a la satisfacción de las necesidades en algunas regiones y al suministro de una variedad suficiente de métodos anticonceptivos para que las parejas que deseen utilizarlos estén en mejores condiciones de hacerlo en forma sistemática y eficiente.

El presente informe sobre los niveles y las tendencias del uso de anticonceptivos medidos en 2002, que ha sido preparado por la División de Población del Departamento de Asuntos Económicos y Sociales de la Secretaría de las Naciones Unidas, es parte de las actividades en curso de la División de Población para el estudio de los niveles y las tendencias de la fecundidad, la nupcialidad y el uso de anticonceptivos en todos los países del mundo. Demuestra que aunque en la actualidad la gran mayoría de los países del mundo han adoptado políticas en apoyo de la planificación de la familia, aún existen diferencias considerables en el nivel de uso de anticonceptivos. Aunque el uso de anticonceptivos ha aumentado enormemente en las regiones menos desarrolladas, el nivel de uso general en esas regiones es aún inferior que en las regiones más desarrolladas. Como demuestra este informe, un elevado porcentaje de parejas de los países en desarrollo deja de utilizar un método anticonceptivo sin adoptar otro inmediatamente, lo que indica que los simples aumentos de la prevalencia del uso de anticonceptivos no necesariamente significan que se eviten los embarazos no deseados o inoportunos.

Niveles de uso de anticonceptivos

En el mundo, la prevalencia del uso de anticonceptivos, es decir, el porcentaje de mujeres en edad reproductiva casadas o en unión consensual que usa anticonceptivos, alcanzó el 61% en 1998, fecha media de los datos más recientes disponibles sobre 160 países. No obstante, este promedio mundial encubre diferencias importantes entre grupos de países, zonas y regiones con distinto nivel de desarrollo y dentro de ellos.

La prevalencia del uso de anticonceptivos en las regiones menos desarrolladas, del 59% en promedio, era inferior a la de las regiones más desarrolladas, donde se mantuvo en el 69%. Entre las regiones menos desarrolladas, Asia y América Latina y el Caribe, con prevalencias del 64% y el 71%, respectivamente, habían alcanzado niveles de utilización de anticonceptivos comparables a los de las regiones más desarrolladas, en tanto que África seguía rezagada, con una prevalencia del 27%. La prevalencia media en el África subsahariana en conjunto, estimada en el 20%, era aun inferior. En las regiones más desarrolladas, la prevalencia del uso de anticonceptivos era menor en Europa (67%), que en América del Norte, Australia y Nueva Zelandia (76%).

La prevalencia del uso de anticonceptivos variaba considerablemente entre los países. En África, aunque la mitad de los países tenían una prevalencia inferior al 20%, unos pocos tenían tasas bastante elevadas de uso de anticonceptivos, como Cabo Verde, Egipto, Marruecos, Sudáfrica y Zimbabwe, que tenían una prevalencia de entre el 50% y el 60%; Argelia, Reunión y Túnez, con prevalencias de entre el 60% y el 70%; y Mauricio, con un 75%.

En Asia, casi la mitad de los países tenían una prevalencia del uso de anticonceptivos del 60% o más. Entre ellos, en China y Hong Kong (Región Administrativa Especial de China) se habían alcanzado las tasas más altas de uso de anticonceptivos del mundo, el 84% y el 86% respectivamente. La República de Corea, la República Islámica del Irán, Tailandia y Viet Nam figuraban también entre los primeros países en cuanto a la prevalencia del uso de anticonceptivos, con tasas superiores al 70%. Además de China, otros cuatro países populosos de Asia, a saber, Bangladesh, la India, Indonesia y el Japón, habían alcanzado niveles relativamente altos de prevalencia del uso de anticonceptivos, del 50% o más. No obstante, la prevalencia seguía por debajo del 30% en ocho países: el Afganistán, Bhután, Camboya, los Emiratos Árabes Unidos, el Iraq, Omán, el Pakistán y el Yemen.

En América Latina y el Caribe, la variación a nivel de país era menor que en África o en Asia: la prevalencia variaba del 30% aproximadamente en Haití, Guatemala y Guyana al 75% en el Brasil, Colombia, Costa Rica, Cuba y Puerto Rico.

En Europa, la prevalencia era en general inferior al 50% en los países de Europa oriental y en los Estados sucesores de la ex Unión de Repúblicas Socialistas Soviéticas, pero en los países del resto de Europa, la prevalencia del uso de anticonceptivos generalmente era de más del 70%.

Hacia finales del decenio de 1990, el nivel de uso de métodos anticonceptivos modernos entre las mujeres en edad reproductiva casadas o en unión consensual era parecido en las regiones más desarrolladas (55%) y en las regiones menos desarrolladas (54%), pero la prevalencia de los métodos anticonceptivos tradicionales era el doble en las regiones más desarrolladas (13%) que en las menos desarrolladas (6%), lo que explica en gran medida la diferencia entre la prevalencia total en las regiones más desarrolladas y las menos desarrolladas.

Tendencias de la prevalencia del uso de anticonceptivos

A nivel mundial, se estima que la prevalencia del uso de anticonceptivos aumentó del 54% en 1990 al 59% en 1995 y al 63% en 2000. Esa tendencia, basada en datos comparables sobre 120 países, es el resultado de un aumento mucho más lento en las regiones más desarrolladas que en las menos desarrolladas. En las regiones más desarrolladas, la prevalencia del uso de anticonceptivos aumentó del 66% en 1990 al 68% en 1995 y al 70% en 2000, es decir, aumentó en 0,4 puntos porcentuales por año en el decenio de 1990. En las regiones menos adelantadas, la prevalencia aumentó del 52% en 1990 al 57% en 1995 y al 61% en 2000, un aumento anual medio de 0,9 puntos porcentuales.

Hay variaciones considerables en las tendencias de la prevalencia del uso de anticonceptivos entre las regiones y zonas principales. En las regiones más desarrolladas, la prevalencia no varió mucho en Europa y Australia y Nueva Zelandia en el decenio de 1990. Sin embargo, aumentó a un ritmo rápido en América del Norte (en 1,0 puntos porcentuales por año). En las regiones menos desarrolladas, la prevalencia aumentó rápidamente en África y América Latina y el Caribe (más de 1,0 puntos porcentuales por año, en promedio) pero más lentamente en Asia (en 0,8 puntos porcentuales por año).

En el último decenio, el aumento de la prevalencia del uso de anticonceptivos se debió principalmente a la mayor utilización de métodos modernos, cuya prevalencia aumentó del 47% en 1990 al 52% en 1995 y al 56% en 2000. En las regiones más desarrolladas, especialmente en Europa oriental y meridional, la mayor utilización de métodos modernos se vio acompañada de una disminución del uso de los métodos tradicionales.

En África, los niveles bajos de uso de anticonceptivos de comienzos del decenio de 1970 se han mantenido en los países del África oriental, central y occidental. No comenzaron a registrarse aumentos importantes en esas regiones hasta fines del decenio de 1980 o comienzos del de 1990, lo cual explica por qué en el 87% de los países de África con datos sobre tendencias seguía habiendo niveles de prevalencia inferiores al 30% en 2000. En cambio, los países del África septentrional y meridional experimentaron aumentos rápidos del uso de anticonceptivos a partir del decenio de 1970.

En Asia, los países del Asia oriental alcanzaron niveles elevados de prevalencia del uso de anticonceptivos, de entre el 60% y el 70%, a fines del decenio de 1970 y comienzos del decenio de 1980, pero no han experimentado un aumento importante desde entonces. En los países del Asia centromeridional y sudoriental, los niveles de prevalencia del uso de anticonceptivos eran muy inferiores en el decenio de 1970, pero han aumentado sostenidamente desde entonces. En el Asia occidental, el uso de anticonceptivos aumentó principalmente en el decenio de 1990.

Los países de América Latina y el Caribe han experimentado también aumentos sostenidos de la prevalencia desde 1970. En el decenio de 1990, aumentó un mínimo de 1,8 puntos porcentuales por año en casi las tres cuartas partes de los países de esta zona importante.

En los países de Europa septentrional, Europa occidental y América del Norte, así como en Australia y Nueva Zelandia, se han mantenido durante mucho tiempo niveles de prevalencia del 70% o más. En los países de Europa oriental y meridional, los niveles han sido inferiores, de entre el 50% y el 70%, desde el decenio de 1970. España es la excepción: en la actualidad tiene uno de los niveles de prevalencia más altos del mundo (más del 80%).

Métodos anticonceptivos utilizados

En 1998, únicamente en la cuarta parte de los países con datos disponibles un solo método era utilizado por el 50% o más de las mujeres en edad reproductiva casadas o en unión. En todas las zonas principales, sólo dos métodos anticonceptivos eran usados por el 50% o más de los usuarios.

En el uso actual de anticonceptivos predominan los métodos modernos. Estos se usan más en las regiones menos desarrolladas, donde representan el 90% del uso total, que en las regiones más desarrolladas, donde representan el 81%. Los tres métodos más utilizados en el mundo son la esterilización femenina, el dispositivo intrauterino y los anticonceptivos orales, que son utilizados por el 21%, el 14% y el 7%, respectivamente, de las mujeres en edad reproductiva casadas o en unión. Dos de cada tres mujeres en edad reproductiva casadas o en unión que usan métodos anticonceptivos usan uno de estos tres métodos. Todos los métodos tradicionales combinados tienen un nivel de prevalencia de sólo el 7%.

Los tres métodos más comúnmente utilizados son particularmente populares en las regiones menos desarrolladas, donde el 23% de las mujeres en edad reproductiva casadas o en unión recurren a la esterilización, el 15% usa el dispositivo intrauterino y el 6% usa anticonceptivos orales. En las regiones más desarrolladas, el uso de los anticonceptivos orales es más común que en las regiones menos desarrolladas y la prevalencia es del 16%. Le sigue el uso del preservativo (13% de prevalencia), la esterilización femenina (10%) y el dispositivo intrauterino (8%).

Estos niveles de prevalencia indican que en las regiones más desarrolladas el 42% de las parejas que usan anticonceptivos usan anticonceptivos orales o preservativos. En las regiones más desarrolladas, más de seis de cada diez mujeres en edad reproductiva que usan anticonceptivos y están casadas o en unión recurren a métodos reversibles de acción corta (incluidos los métodos anticonceptivos tradicionales), en tanto que sólo dos de cada diez se esterilizan y una de cada diez utiliza el dispositivo intrauterino. En las regiones menos desarrolladas, en cambio, las parejas tienden a usar métodos de acción más prolongada y de alta eficiencia clínica: casi las dos terceras partes de las mujeres en edad reproductiva casadas o en unión que usan anticonceptivos recurren a la esterilización o al dispositivo intrauterino. Las tasas altas de esterilización femenina son comunes en varios países de Asia y América Latina, mientras que las tasas altas de uso del dispositivo intrauterino son más comunes en países de Asia, sobre todo China.

A nivel mundial, una de cada cinco parejas que utilizan anticonceptivos recurre a métodos que requieren la participación del hombre (preservativo o esterilización masculina) o su cooperación (método del ritmo o coito interrumpido). El uso de métodos orientados al hombre es más común en las regiones más desarrolladas, donde dos de cada cinco parejas los utilizan, que en las regiones menos desarrolladas, donde sólo una de cada siete parejas emplea esos métodos.

Tendencias futuras del uso de anticonceptivos

Se estima que la prevalencia total del uso de anticonceptivos en el mundo debe aumentar del 63% al 67% entre 2000 y 2025 para que la tasa total de fecundidad se pueda reducir de 2,8 hijos por mujer a 2,3 hijos por mujer, según lo proyectado en la variante media de la *Revisión de 2002* de las proyecciones de población de las Naciones Unidas[1]. Dado de que la reducción de la tasa de fecundidad se limita a las regiones menos desarrolladas, se proyecta un aumento importante de la prevalencia del uso de anticonceptivos en esas regiones, del 61% en 2000 al 68% en 2025. En las regiones

[1] *World Population Prospects: The 2002 Revision*, vol. I: *Comprensive Tables* (publicación de las Naciones Unidas, número de venta: E.03.XIII.6).

más desarrolladas, los niveles de fecundidad, según las proyecciones, aumentarán levemente, de 1,6 hijos por mujer en 2000 a 1,7 hijos por mujer en 2025, pero la premisa de que el uso de anticonceptivos reducirá el número de abortos permite proyectar un aumento de la prevalencia del uso de anticonceptivos, del 70% en 2000 al 75% en 2025.

En las regiones menos desarrolladas, los aumentos más rápidos y más importantes de la prevalencia deben tener lugar en África, donde debe aumentar del 28% al 49% entre 2000 y 2025 para que la tasa de fecundidad disminuya de 5,1 hijos por mujer a 3,4 hijos por mujer, según lo proyectado. En Asia, donde se proyecta que la tasa de fecundidad disminuirá de 2,6 a 2,1 hijos por mujer, se prevé que la prevalencia aumente en forma moderada: del 65% al 71%. En América Latina y el Caribe, donde se proyecta que la tasa de fecundidad pasará de 2,6 a 2,0 hijos por mujer, se prevé que la prevalencia aumente del 74% al 78%. Se prevé también un aumento moderado de la prevalencia del uso de anticonceptivos en Oceanía (del 62% al 66%) donde, según las proyecciones, la tasa de fecundidad disminuirá de 2,4 hijos por mujer en 2000 a 2,1 hijos por mujer en 2025.

En América del Norte, donde se proyecta que la tasa de fecundidad seguirá siendo de 2 hijos por mujer, se prevé también que la prevalencia del uso de anticonceptivos se mantenga constante en el 82% en el período 2000-2025. No obstante, se prevé un aumento moderado de la prevalencia en Europa (del 68% al 75%), aunque se prevé que la tasa de fecundidad aumente entre 2000 y 2025 (de 1,4 a 1,6 hijos por mujer). El aumento proyectado de la prevalencia del uso de anticonceptivos en Europa se basa en la premisa de que la utilización de métodos eficaces hará que se recurra en menor medida al aborto.

Se proyecta que entre 2000 y 2025 el número de mujeres casadas que usan anticonceptivos aumentará de 654 millones a 846 millones a nivel mundial, en gran medida como resultado del aumento proyectado para las regiones menos desarrolladas, donde se prevé que aumente de 535 millones a 746 millones. En cambio, se prevé que el número de casados que usan anticonceptivos en las regiones más desarrolladas disminuya de 119 millones a 99 millones debido a la disminución proyectada del número de mujeres en edad reproductiva, de 300 millones en 2000 a 265 millones en 2025, y a la reducción proyectada del porcentaje de casados.

Se proyecta que el número de mujeres en edad reproductiva casadas que usan anticonceptivos se triplicará en África, de 33 millones a 100 millones, y que aumentará considerablemente en Asia y América Latina y el Caribe, aunque a un ritmo más lento: de 449 millones a 559 millones en Asia y de 61 millones a 84 millones en América Latina y el Caribe. Se proyectan aumentos menores para América del Norte (de 34 millones a 37 millones) y Oceanía (de 2,8 millones a 3,2 millones), en tanto que para Europa se proyecta una disminución de 74 millones a 64 millones, debido a la reducción proyectada del número de mujeres de 15 a 49 años y de la prevalencia del matrimonio.

Además, se proyecta también que el número de mujeres no casadas en edad reproductiva que usan anticonceptivos aumentará a nivel mundial entre 2000 y 2025 de 126 millones a 178 millones. Se proyectan aumentos en las regiones más desarrolladas (de 49 millones a 54 millones) y en las menos desarrolladas (de 77 millones a 124 millones).

Dinámica del uso de anticonceptivos

Los resultados de las encuestas demográficas y de salud señalan que en los países en desarrollo un alto porcentaje de las parejas que adoptan métodos anticonceptivos reversibles dejan de usarlos debido a los efectos secundarios, a las preocupaciones respecto de sus consecuencias para la salud o a otros problemas relacionados con los métodos en cuestión. No obstante, esas parejas no adoptan inmediatamente otros métodos. La probabilidad media de que se abandone un método anticonceptivo reversible en los 12 meses desde la iniciación es de casi el 50% en el caso de los métodos inyectables y los preservativos, y del 34% en el de los anticonceptivos orales. La probabilidad de que se abandone la abstinencia periódica o el coito interrumpido es menor. En consecuencia, esos dos métodos pueden contribuir de manera importante a la regulación de la fecundidad. La alta probabilidad de que se abandone el uso de preservativos es particularmente inquietante en contextos en que la infección del VIH sigue propagándose.

El uso de dispositivos intrauterinos se diferencia porque la probabilidad de abandono es mucho menor, con un valor medio de apenas el 12%. Entre los factores que probablemente contribuyan a la baja probabilidad de que se deje de usar el dispositivo intrauterino cabe señalar una baja tasa de falla y el hecho de que retirar el dispositivo normalmente exige una visita a un servicio de salud, lo que entraña una decisión más firme del usuario.

En general, la probabilidad de abandono de un método por insatisfacción es menor entre las parejas que usan anticonceptivos para limitar la procreación que entre las que los usan para espaciar los nacimientos. Las parejas de zonas urbanas y con más educación tienen más probabilidades que las demás de adoptar rápidamente un método nuevo cuando abandonan otro. Tal vez a eso se deba que en la actualidad las tasas de uso de anticonceptivos sean en general más altas en las zonas urbanas y entre las parejas con más educación. El acceso más fácil a métodos alternativos para los más educados, la mejor comprensión de los métodos disponibles y la actitud de confianza para obtenerlos son factores que probablemente configuran las diferencias observadas.

Fecundidad, métodos anticonceptivos y políticas de población

El apoyo gubernamental a los métodos anticonceptivos ha venido aumentando sostenidamente desde 1975. En 2001, el 92% de los países apoyaban programas de planificación de la familia y distribución de anticonceptivos, ya fuera directamente, mediante servicios públicos (75%), o indirectamente, mediante el apoyo a las actividades de organizaciones no gubernamentales como las asociaciones de planificación de la familia (17%). Las políticas nuevas en apoyo de la planificación de la familia se han adoptado principalmente en los países en desarrollo. El porcentaje de países en desarrollo que apoyan el uso de métodos anticonceptivos aumentó del 73% en 1976 al 94% en 2001. Entre los países menos adelantados, el aumento fue más pronunciado: del 57% en 1976 al 96% en 2001. Entre los países desarrollados, el porcentaje de apoyo a los programas de planificación de la familia ha permanecido estable en alrededor del 80% desde 1976.

PRINCIPALES CONCLUSIONES

1. A nivel mundial, la prevalencia del uso de anticonceptivos, es decir, el porcentaje de mujeres en edad reproductiva casadas o en unión consensual que usan anticonceptivos, alcanzó el 61% en 1998, fecha media de los datos más recientes disponibles sobre 160 países. Con un nivel medio del 59%, las regiones menos desarrolladas tenían un nivel de prevalencia del uso de anticonceptivos 10 puntos porcentuales menor que el de las regiones más desarrolladas (69%).

2. Hacia finales del decenio de 1990, África, con una prevalencia del 27%, tenía el menor nivel de prevalencia del uso de anticonceptivos en el mundo. La prevalencia media en el África subsahariana, estimada en el 20%, era aun inferior. En cambio, Asia y América Latina y el Caribe, con prevalencias del 64% y el 71%, respectivamente, habían alcanzado niveles de uso de anticonceptivos comparables a los de las regiones más desarrolladas, en las que Europa tenía un 67% y América del Norte, con Australia y Nueva Zelandia, un 76%.

3. A nivel mundial, la prevalencia del uso de anticonceptivos aumentó del 54% en 1990 al 59% en 1995 y al 63% en 2000. El aumento fue más lento en las regiones más desarrolladas que en las menos desarrolladas porque, tras haber alcanzado niveles relativamente altos en el decenio de 1980, la prevalencia del uso de anticonceptivos no cambió mucho en Europa y Australia y Nueva Zelandia en el decenio de 1990. No obstante, aumentó a un ritmo rápido en América del Norte (en 1,0 puntos porcentuales por año). En las regiones menos desarrolladas, la prevalencia del uso de anticonceptivos aumentó rápidamente en África y América Latina y el Caribe (en más de 1,0 puntos porcentuales por año, en promedio), pero más lentamente en Asia (en alrededor de 0,8 puntos porcentuales por año).

4. A nivel mundial, el 54% de las mujeres en edad reproductiva casadas o en unión utiliza métodos anticonceptivos modernos; el 21% ha optado por la esterilización femenina, el 14% utiliza el dispositivo intrauterino y el 7% anticonceptivos orales. Los métodos anticonceptivos modernos constituyen una proporción mayor de los anticonceptivos usados por las mujeres casadas o en unión en las regiones menos desarrolladas que en las más desarrolladas: el 90% en comparación con el 81%. Los tres métodos más comúnmente utilizados, a saber, la esterilización femenina, el dispositivo intrauterino y los anticonceptivos orales, constituyen las dos terceras partes de los anticonceptivos utilizados a nivel mundial.

5. Más de seis de cada diez usuarias de anticonceptivos de las regiones más desarrolladas usan métodos reversibles de acción corta, en tanto que sólo dos de cada diez recurren a la esterilización y una de cada diez utiliza el dispositivo intrauterino. En las regiones menos desarrolladas, cuatro de cada diez recurren a la esterilización y casi tres de cada diez utilizan el dispositivo intrauterino.

6. A nivel mundial, cerca del 20% de los usuarios de anticonceptivos utilizan un método que requiere la participación o cooperación del hombre. No obstante, el uso de métodos orientados al hombre es mayor en las regiones más desarrolladas (alrededor del 40% del uso total de anticonceptivos) que en las regiones menos desarrolladas (alrededor del 14%).

7. Se prevé que entre 2000 y 2025 la prevalencia del uso de anticonceptivos en el mundo aumentará lentamente, del 63% al 67%, para reducir la tasa de fecundidad de 2,8 a 2,3 hijos por mujer, según la proyección de variante media de la *Revisión de 2002* de las proyecciones de población de las Naciones Unidas[2]. Se proyectan aumentos un poco más rápidos en las regiones menos desarrolladas que en las más desarrolladas: la prevalencia aumentará del 61% al 68% en los países en desarrollo en conjunto y del 70% al 75% en los países desarrollados.

8. En las regiones menos desarrolladas, se prevé que el aumento más rápido y más importante se produzca en África, donde la prevalencia debe aumentar del 28% al 49% entre 2000 y 2025 para que se logren las reducciones de la tasa de fecundidad proyectadas. En las demás zonas principales, se prevé que la prevalencia aumente sólo levemente: del 65% al 71% en Asia, del 74% al 78% en América Latina y el Caribe, y del 62% al 66% en Oceanía. En América del Norte se proyecta que la pre-

[2] *World Population Prospects: The 2002 Revision*, vol. I: *Comprehensive Tables* (publicación de las Naciones Unidas, número de venta: E.03.XIII.6).

valencia se mantendrá al nivel constante del 82% en 2000-2025 porque se prevé que la tasa de fecundidad de dos hijos por mujer también permanecerá estable. En Europa, se proyecta que la prevalencia del uso de anticonceptivos aumentará del 68% al 75%, aunque sólo se prevé un ligero aumento de la tasa de fecundidad entre 2000 y 2025. El aumento de la prevalencia se basa en la premisa de que el uso más generalizado de los métodos anticonceptivos disminuirá el número de abortos.

9. Según las proyecciones, entre 2000 y 2025 el número de mujeres casadas que usan anticonceptivos aumentará de 654 millones a 846 millones a nivel mundial, principalmente como resultado del crecimiento proyectado en las regiones menos desarrolladas, donde se prevé que el número de mujeres casadas que usan anticonceptivos aumente de 535 millones a 746 millones. Se prevé que en las regiones más desarrolladas el número de mujeres casadas que usan anticonceptivos disminuya levemente, de 119 millones a 99 millones, como resultado de la disminución del porcentaje de mujeres casadas y de la población en edad reproductiva.

10. Según las proyecciones, entre 2000 y 2025 el número de mujeres no casadas que usan métodos anticonceptivos aumentará de 126 millones a 178 millones a nivel mundial. Se proyectan aumentos en las regiones menos desarrolladas (de 77 millones a 124 millones) y en las más desarrolladas (de 49 millones a 54 millones).

11. Un alto porcentaje de las parejas que viven en países en desarrollo deja de utilizar métodos anticonceptivos reversibles debido a sus efectos secundarios, a preocupaciones acerca de sus consecuencias para la salud o a otros problemas relacionados con el uso del método. Ahora bien, las parejas no suelen adoptar rápidamente otro método en reemplazo del que abandonan. Los datos de las encuestas demográficas y de salud señalan que la probabilidad media de que se deje de usar un método en los primeros 12 meses desde el inicio era del 50% en el caso de los anticonceptivos inyectables y los preservativos, y del 34% en el de los anticonceptivos orales. El abandono de la abstinencia periódica y el coito interrumpido era inferior. Los dispositivos intrauterinos son la excepción notable a la norma de que los métodos reversibles con frecuencia son abandonados por muchas de las parejas que intentan usarlos. La proporción media de parejas que dejan de utilizar los dispositivos intrauterinos en los 12 meses siguientes a la inserción fue del 12%, porcentaje inferior al del abandono de los demás métodos reversibles.

12. En 2001, el 92% de los países apoyaban programas de planificación de la familia y distribución de anticonceptivos, ya fuera directamente en servicios públicos (75%) o indirectamente mediante el apoyo a las actividades de organizaciones no gubernamentales, como las asociaciones de planificación de la familia (17%).

I. LEVELS OF CONTRACEPTIVE USE

This chapter provides a comparative description of the extent to which contraception is being practised in the world at the global, regional and country levels. The sources of data are nationally representative sample surveys, including the series of surveys conducted under the programmes entitled: (1) Arab Maternal and Child Health Surveys; (2) Contraceptive Prevalence Surveys (CPS); (3) Demographic and Health Surveys (DHS); (4) Fertility and Family Surveys (FFS); (5) Gulf Family Health Surveys; (6) Multiple Indicator Cluster Surveys (MICS), and (7) Reproductive Health Surveys. Data on contraceptive use referring to 1980 or later dates and pertaining to women reproductive age (usually aged 15-49) who were married or in a consensual union at the time of the survey are available for 160 countries, 125 of which are developing countries and 35 developed countries. In 2000, these 160 countries accounted for 96 per cent of all women of reproductive age who were married or in a consensual union in the world. In the developing world, the 125 countries with data accounted for 98 per cent of all relevant women and in the developed world, the 35 countries with data accounted for 83 per cent of those women. Among major areas or regions, data coverage relative to the number of women of reproductive age who were married or in union varied between 51 per cent in Eastern Europe and 100 per cent in Asia or Northern America (table 1). Coverage was particularly low in Europe, where the countries with data available accounted for just 74 per cent of the women of reproductive age who were married or in union, mainly as a result of the lack of information on contraceptive use in the Russian Federation and other countries of Eastern Europe.

This report considers both modern and traditional methods of contraception. Modern methods are normally more effective at preventing pregnancy but can only be obtained through family planning services, medical facilities or as pharmaceutical supplies. They include female and male sterilization, oral contraceptive pills, intra-uterine devices (IUD), condoms, injectables, implants and vaginal barrier methods (diaphragm, cervical caps, spermicidal foams, jelly, creams and sponges). The use of the female condom and the emergency contraception pill, two recently developed modern methods of contraception, is not documented in this report because of the limited data available on their use.

Traditional methods of contraception are those that can be used without having recourse to formal family planning services or formal sources of supplies. They include mainly periodic abstinence (also known as the rhythm or the calendar method) and withdrawal (also called *coitus interruptus*). Other methods such as douching, postpartum abstinence, the lactational amenorrhoea method (LAM), and folk methods believed to prevent pregnancy (such as herbs, amulets, charms, spells etc.) also fall in the category of traditional methods.

Throughout this report, contraceptive prevalence is defined as the percentage of women currently using a method of contraception among all women of reproductive age (i.e., those aged 15 to 49 years, unless otherwise stated) who are in a marital or consensual union[1]. The contraceptive prevalence estimate for a region is the weighted average of the contraceptive prevalence levels of the countries of that region, the weights being the estimated number of women of reproductive age who are married or in union in 2000. The prevalence estimate for a major area is the weighted average of the contraceptive prevalence levels of the regions constituting that major area. The prevalence estimate at the world level is computed as the weighted average of the contraceptive prevalence levels of all the major areas. It is assumed that when a country does not have data available, its contraceptive prevalence is similar to the average prevalence of the region it belongs to.

This chapter focuses on the contraceptive behaviour of women who are married or in union because comparable contraceptive use data are more widely available for that group of women than for single women or those not in union. Data are also more commonly available for women than for men. However, beginning in the mid-1980s, many national surveys have also inquired about current contraceptive practice among unmarried women. Analyses of those data will be touched upon briefly in chapter IV. Starting in the early 1990s, the contraceptive practice of men has also been the subject of inquiry by various surveys. However,

TABLE 1. WOMEN AGED 15-49 WHO WERE MARRIED OR IN A CONSENSUAL UNION IN 2000, BY MAJOR AREA AND REGION

Major area and region	*Women aged 15-49 who are married on in a consensual union in 2000 (thousands)*	*Percentage of women aged 15-49 who were married or in union in 2000 in countries with data on contraceptive use*
World	1 043 265	96
More developed regions	170 043	83
Less developed regions	873 223	98
Least developed countries	107 665	99
Africa	117 120	98
Eastern Africa	36 975	96
Middle Africa	14 213	92
Northern Africa	25 590	100
Southern Africa	4 923	100
Western Africa	35 419	100
Asia	688 738	100
Eastern Asia	293 294	100
South-central Asia	275 510	100
South-eastern Asia	89 587	100
Western Asia	30 347	98
Europe	109 277	74
Eastern Europe	51 321	51
Northern Europe	11 529	96
Southern Europe	22 077	80
Western Europe	24 350	100
Latin America and the Caribbean	81 810	86
Caribbean	5 648	98
Central America	21 747	100
South America	54 415	79
Northern America	42 029	100
Oceania	4 292	91
Australia/New Zealand	2 989	100
Melanesia/Micronesia/Polynesia	1 303	71

Source: Compiled from data on marital status contained in the Marriage Database maintained by the Population Division of the United Nations.

owing to the relatively low number of comparable data sets on male contraceptive practice, this report does not cover an analysis of such data.

A. Contraceptive prevalence at the world level

At the world level, contraceptive prevalence reached 61 per cent in 1998 (table 2). Given the pace at which contraceptive use has been rising, especially in the less developed regions, it is estimated that by 2000 at least 63 per cent of all women aged 15-49 who were married or in a consensual union were practicing contraception.

The estimate of contraceptive prevalence at the world level is a population-weighted average and is therefore strongly influenced by the level of contraceptive use in the less developed regions, where the majority of the world's women of reproductive age lives. In the less developed regions, contraceptive prevalence averaged 59 per cent at the end of the 1990s but it varied widely among major areas, ranging from 27 per cent in Africa and developing Oceania to 64 per cent in Asia and 71 per cent in Latin America and the Caribbean (table 2). The group of least developed countries, most of which are located in sub-Saharan African, had an estimated contraceptive prevalence of 28 per cent. In the more developed regions, contraceptive prevalence stood at an estimated 69 per cent, but it varied from 56 per cent in Japan to 67 per cent in Europe and 76 per cent in Northern America and Australia/New Zealand.

In 1998, the worldwide prevalence of use of modern contraceptive methods reached 54 per cent. The level of use of modern methods was similar in the more and the less developed regions. Thus, 54 per cent of women of reproductive age who are married or in union were using a modern form of contraception in the less developed regions in the late 1990s compared with 55 per cent in the more developed world. In contrast, the level of use of traditional methods of contraception differs markedly between the more and the less developed regions. Prevalence of traditional methods in the less developed regions is half that in the more developed regions—6 per cent vs. 13 per cent. Consequently, traditional methods account for a lower percentage of all use in the less developed regions than in the more developed regions—9 per cent vs. 19 per cent. However, in the group of least developed countries traditional methods of contraception account for 27 per cent of all contraceptive use, a proportion far higher than that in the more developed regions.

The greater use of traditional contraceptive methods in developed countries implies that they have a lower percentage of users relying on modern contraceptive methods (81 per cent) that developing countries as a whole do (90 per cent), although the prevalence of modern methods is almost the same in both regional groups (figure I). Historical reasons explain the greater reliance by couples in developed countries on traditional contraceptive methods. Because the transition from high to low fertility in those countries occurred largely before modern contraceptive methods were invented, couples had to control their fertility by relying on traditional methods, especially withdrawal, various forms of periodic abstinence and contraceptive douching. Use of these methods, therefore, got firmly established among the populations of developed countries and are still being used by modern generations. Furthermore, in some developed countries, particularly those in Eastern Europe and the successor States of the former Union of Soviet Socialist Republics (USSR), current levels of use of traditional methods also reflect the limited availability of modern methods (Popov, Visser and Ketting, 1993). Although declining, the proportion of users in developed countries relying on traditional contraceptive accounts for almost 85 per cent of the difference in average prevalence between the more developed and the less developed regions. The next sections review in some detail the state of contraceptive use and levels of contraceptive prevalence in each major area of the world.

B. Contraceptive prevalence in Africa

Africa has the lowest contraceptive prevalence among all the major areas of the world, with only 27 per cent of women of reproductive age who are married or in union using contraception. This level compares unfavourably with the levels of 60 per cent or more exhibited by the two other major areas in the developing world. Furthermore, contraceptive prevalence is even lower in sub-Saharan Africa, where it averaged barely 20 per cent in the late 1990s.

TABLE 2. CONTRACEPTIVE PREVALENCE[a], BY MAJOR AREA AND REGION

Major area and region	*Year*	*Percentage of married women[b] currently using*		*Percentage of contraceptive users[c] relying on modern methods*
		Any Method	*Modern method*	
World	1998	60.9	54.0	89
More developed regions	1996	68.5	55.3	81
Less developed regions	1998	59.4	53.7	90
Least developed countries	1999	27.6	20.1	73
Africa	1999	26.8	19.8	74
Eastern Africa	1999	21.8	16.8	77
Middle Africa	2000	22.8	4.8	21
Northern Africa	1997	47.3	41.9	89
Southern Africa	1998	52.6	51.4	98
Western Africa	1999	14.5	7.9	54
Asia	1998	63.5	58.4	92
Eastern Asia	1997	81.9	80.6	98
South-central Asia	1999	48.0	41.3	86
South-eastern Asia	1998	57.2	49.2	86
Western Asia	1996	46.8	28.3	60
Europe	1995	67.0	48.9	73
Eastern Europe	1996	61.0	35.1	57
Northern Europe	1998	79.0	74.5	94
Southern Europe	1995	67.3	46.4	69
Western Europe	1993	74.4	70.6	95
Latin America and the Caribbean	1997	70.5	61.7	87
Caribbean	1999	60.5	56.9	94
Central America	1995	63.7	55.2	87
South America	1997	74.3	64.8	87
Northern America	1995	76.2	70.8	93
Oceania	1990	61.7	57.2	93
Australia/New Zealand	1988	75.9	72.2	95
Melanesia/Micronesia/Polynesia	1996	27.0	21.0	78

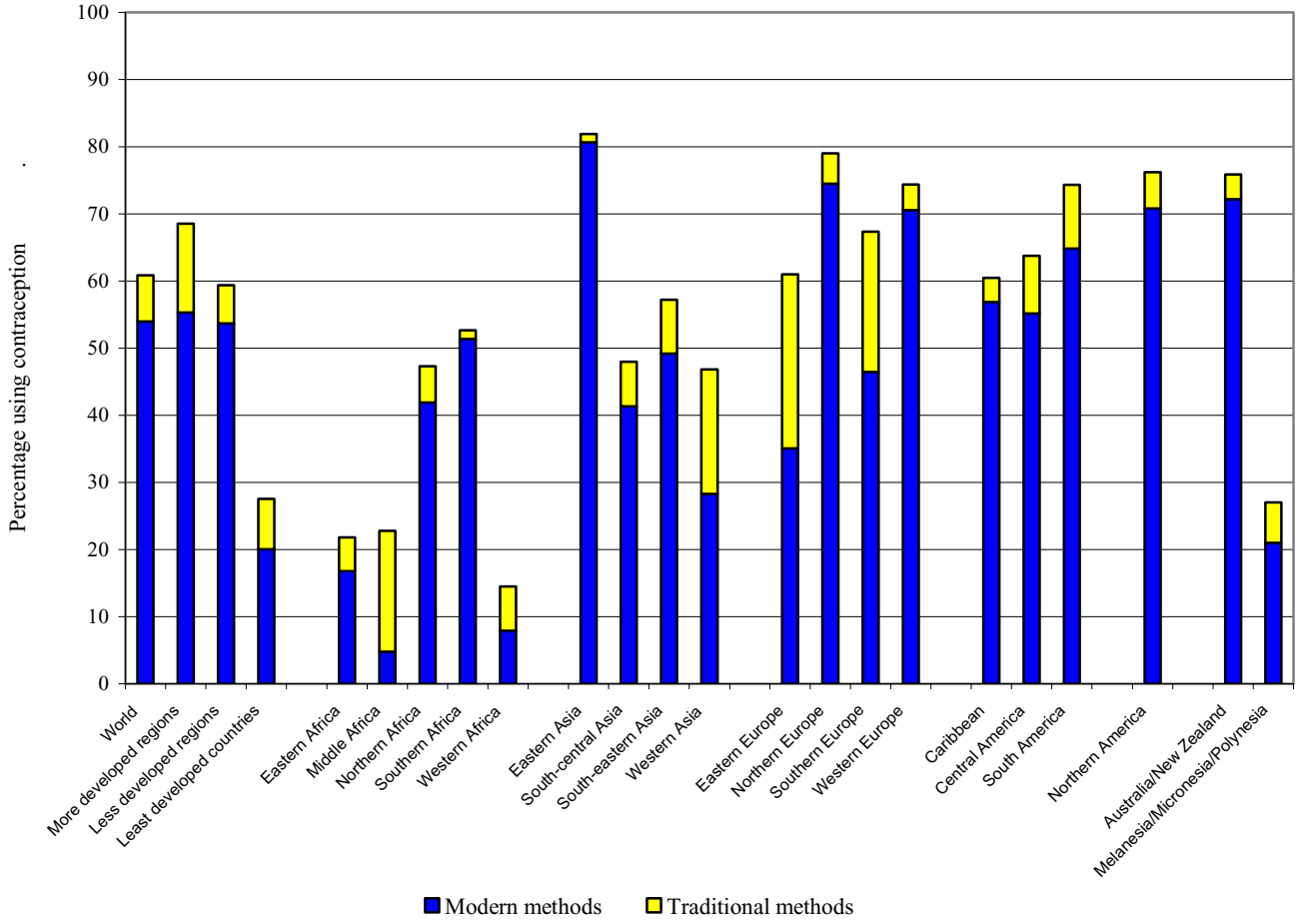
Sources: World Contraceptive Use 2003 and *World Population Prospects 2002,* databases maintained by the Population Division of the United Nations.

[a] Percentage of women of reproductive age in a marital or consensual union, who are currently using contraception.

[b] Women aged 15-49 who are married or in a consensual or visiting union.

[c] Women of reproductive age who are married or in a consensual or visiting union and who are using contraception.

Figure I. Percentage of women of reproductive age in a marital or consensual union who are currently using contraception, by region



Africa includes three of the four regions with the lowest contraceptive prevalence in the world (below 25 per cent, as shown in table 2 and figure I). Western Africa has the lowest contraceptive prevalence, at 15 per cent. It is followed by Eastern Africa and Middle Africa with prevalence levels of 22 per cent and 23 per cent respectively. The other two regions of Africa exhibited considerably higher levels of contraceptive prevalence, though still lower than the average for the less developed regions. Thus 47 per cent of women of reproductive age who were married or in union in the Northern Africa in the late 1990s and 53 per cent of those in Southern Africa used some method of contraception.

Not only are levels of overall contraceptive use low in Africa but, in addition, few women use modern contraceptive methods. In the continent as whole, only 20 per cent of women of reproductive age, married or in union, were using modern methods of contraception by the late 1990s. The prevalence of modern methods was particularly low in Middle Africa and Western Africa (less than 10 per cent in each) and in Eastern Africa (less than 20 per cent). However, women relying on modern methods were estimated to account for 77 per cent of all contraceptive users in Eastern Africa, 89 per cent in Northern Africa and 98 per cent in Southern Africa. Women using modern methods constituted a moderate proportion of all contraceptive users in Western Africa (54 per cent) but in Middle Africa they accounted for only 21 per cent of the total.

Low levels of contraceptive use are still common in much of Africa, and particularly in sub-Saharan Africa, because of a history of weak governmental support for family planning programmes, the relatively recent start of those programmes in a number of countries, inadequate resources devoted to family planning, weak absorptive capacity and the continued desire for large families by a large segment of Africa's population (National Research Council, 1993).

At the country level, half of the 49 countries in Africa with data available had less than 20 per cent prevalence and in a quarter prevalence was below 10 per cent in the 1990s (figure II). With the exception of Southern Africa, where all countries had contraceptive prevalence levels higher than 25 per cent, all other regions of Africa had some countries with very low prevalence levels (table 3). Countries with the lowest levels include Sierra Leone with 4 per cent prevalence and Mozambique with under 6 per cent; Angola, Chad, Guinea, Guinea-Bissau and Liberia whose prevalence levels ranged from 6 per cent to 8 per cent; and Eritrea, Ethiopia, Gambia, Mali, Mauritania and Sudan with prevalence levels ranging between 8 per cent and 9 per cent.

At the other end of the spectrum, some countries in Africa exhibited fairly high levels of contraceptive prevalence. Most of these countries were islands or were located in Northern Africa and Southern Africa. They include Cape Verde, Egypt, Morocco, South Africa and Zimbabwe with prevalence levels ranging from 50 per cent to 60 per cent; Algeria, Réunion and Tunisia whose levels of prevalence ranged from 60 per cent to 70 per cent; and Mauritius with 75 per cent prevalence. In sub-Saharan Africa, the six countries with the highest levels of contraceptive use—Cape Verde, Kenya, Mauritius, Réunion, South Africa and Zimbabwe—were also among those with the lowest fertility levels, the highest levels of schooling, the lowest child mortality rates, and the widest availability of family planning services (National Research Council, 1993).

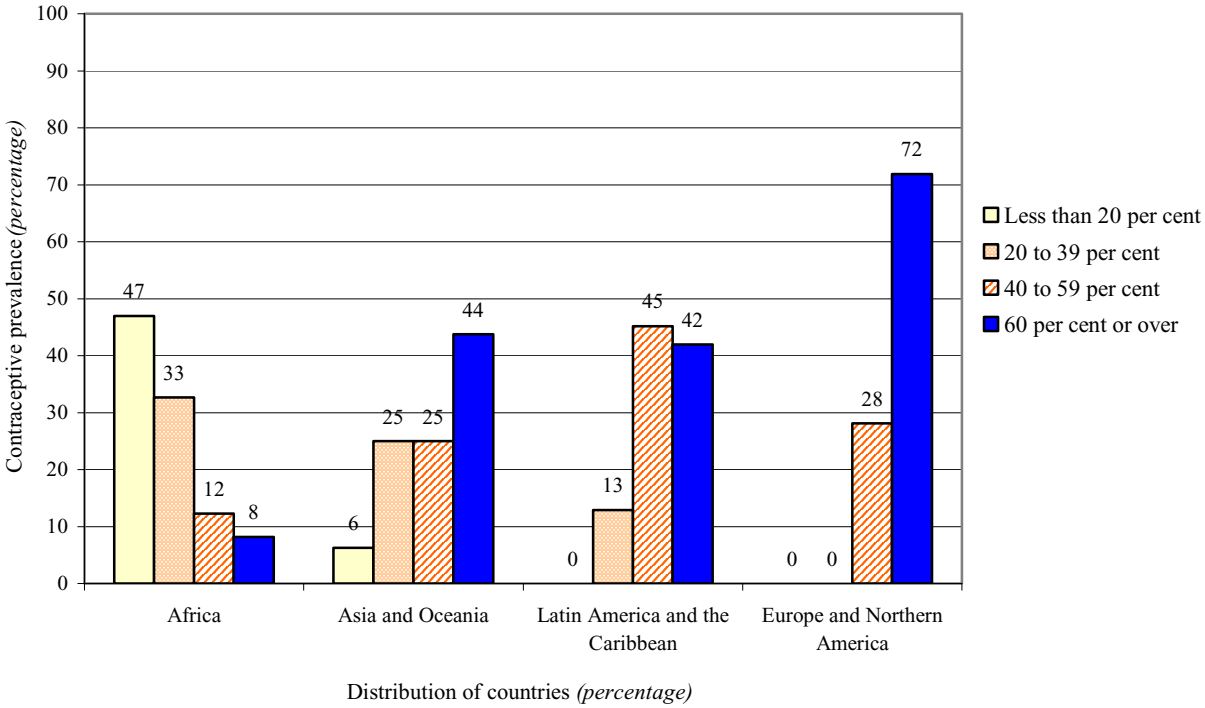
Wide variations in levels of contraceptive prevalence exist within the regions of Africa. Differences are highest in Eastern Africa, where contraceptive prevalence ranges from 6 per cent in Mozambique to 75 per cent in Mauritius. In Middle Africa, the range of variation is from 6 per cent in Angola to 33 per cent in Gabon, similar in size if not in level to that of Southern Africa (from 28 per cent in Swaziland to 56 per cent in South Africa). In Northern Africa, nearly all countries in the region have fairly high prevalence levels (40 per cent or higher) except for the Sudan (8 per cent). In Western Africa, the gap in prevalence among countries is also wide, with contraceptive prevalence varying from 4 per cent in Sierra Leone to 53 per cent in Cape Verde.

Levels of use of modern contraceptive methods are still very low in the majority of countries in Africa. In 65 per cent of the 49 countries with data available, the prevalence of modern methods is lower than 20 per cent, and in half of them it is lower than 10 per cent. However, among users of contraception, reliance on modern methods tends to be high. Thus, in almost three-quarters of the 49 countries with data available, at least 6 out of 10 contraceptive users rely on modern contraceptive methods, and in half of the countries, at least 7 out of every 10 contraceptive users report using modern methods. In only a quarter of the countries with data do less than half of contraceptive users rely on modern methods (table 3). Those countries include Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, Guinea-Bissau, Niger, Rwanda and Togo. They are all located in Eastern Africa, Middle Africa and Western Africa, the three regions with the lowest average levels of contraceptive prevalence.

C. Contraceptive prevalence in Asia

In Asia, 64 per cent of women of reproductive age who are married or in union used contraception in the late 1990s. This level of prevalence is comparable to that of Oceania and just slightly lower than those of Europe or Latin America and the Caribbean. Among the Asian regions, Eastern Asia, with 82 per cent of contraceptive prevalence, exhibited the highest level of contraceptive use in the world. Eastern Asia's level is strongly influenced by contraceptive prevalence in China (84 per cent in 1997), a country that accounts for 90 per cent of the female population of reproductive age in the region. In the rest of Asia, contraceptive prevalence levels are lower and comparable to those of Northern Africa and Southern Africa. Thus, 58 per cent of women of reproductive age, married or in union, used contraception in South-eastern Asia, 48 per cent did so in South-central Asia, and 47 per cent in Western Asia at the end of the 1990s (table 2).

Figure II. Percentage distribution of countries, by major area and contraceptive prevalence



With 58 per cent of all women of reproductive age who are married or in union relying on modern methods of contraception, Asia has surpassed Europe in the overall use of modern methods. Furthermore, most contraceptives users in Asia employ modern methods. In Eastern Asia, modern methods account for 98 per cent of all contraceptive use. In South-central Asia and South-eastern Asia they represent 86 per cent of use in each region. Only in Western Asia is the use of modern methods less common, accounting for just 60 per cent of overall use.

But average levels of contraceptive use in the regions of Asia mask large differences at the country level. Thus, whereas Asia comprises countries or areas such as China and Hong Kong Special Administrative Region (SAR) of China, which have achieved the world's highest levels of contraceptive use (84 per cent and 86 per cent, respectively), it also encompasses countries such as Afghanistan, Bhutan or Iraq where contraceptive prevalence is still very low (5 per cent, 14 per cent and 19 per cent, respectively, in the late 1990s).

In addition to China, four other populous countries of Asia—Bangladesh, India, Indonesia and Japan—have achieved relatively high levels of contraceptive use (around 50 per cent or higher) [2] and the Islamic Republic of Iran, the Republic of Korea, Thailand and Viet Nam are all among the countries with the highest contraceptive prevalence levels in the world (above 70 per cent).

In contrast with Africa, where most countries tend to have low levels of contraceptive prevalence, those of Asia tend to concentrate in the higher prevalence levels (figure II). In only a third of the countries of Asia is contraceptive prevalence lower than 40 per cent, compared with 80 per cent of those in Africa. Furthermore, 4 out of every 10 countries in Asia have prevalence levels of 60 per cent or higher, whereas only 8 per cent of those in Africa have similar levels.

Regarding the use of modern methods, only 8 out of the 44 countries of Asia with data available have levels below 20 per cent. However, in half of the 44 countries, use of modern methods remains below 40 per cent. Among users of contraception, reliance on modern methods tends to be high. In almost three-quarters of the 44 Asian countries with data, at least 7 out of every 10 contraceptive users employ modern methods. Only in four countries—Armenia, Azerbaijan, Georgia and Yemen—do less than 50 per cent of contraceptive users rely on a

TABLE 3. RECENT ESTIMATES OF CONTRACEPTIVE PREVALENCE[a] BY COUNTRY

Major area, region and country	*Number of married[b] women aged 15-49 in 2000 (thousands)*	*Year*	*Age group*	*Percentage of married women currently using*		*Percentage of contraceptive users[c] relying on modern methods*	*Source[d]*
				Any method	*Modern methods*		
Africa							
Eastern Africa							
Burundi	749	2000	15-49	15.7	10.0	64	MICS
Comoros	92	2000	15-49	25.7	19.3	75	MICS
Eritrea	555	2002	15-49	8.0	5.1	64	DHS
Ethiopia	9 453	2000	15-49	8.1	6.3	78	DHS
Kenya	4 488	1998	15-49	39.0	31.5	81	DHS
Madagascar	2 344	2000	15-49	18.8	11.8	63	MICS
Malawi	1 838	2000	15-49	30.6	26.1	85	DHS
Mauritius	210	1991	15-44	74.7	48.9	65	CPS
Mozambique	3 221	1997	15-49	5.6	5.1	91	DHS
Réunion[q]	78	1990	15-49	66.6	61.7	93	RES
Rwanda	942	2000	15-49	13.2	4.3	33	DHS
Uganda	3 254	2001	15-49	22.8	18.2	80	DHS
United Republic of Tanzania	5 228	1999	15-49	25.4	16.9	67	DHS
Zambia	1 366	2002	15-49	34.2	22.6	66	DHS
Zimbabwe	1 809	1999	15-49	53.5	50.4	94	DHS
Middle Africa							
Angola	1 789	2001	15-49	6.2	4.5	73	MICS
Cameroon	2 271	1998	15-49	19.3	7.1	37	DHS
Central African Republic	594	2000	15-49	27.9	6.9	25	MICS
Chad	1 436	2000	15-49	7.9	2.1	27	MICS
Democratic Republic of the Congo	7 364	2001	15-49	31.4	4.4	14	MICS
Gabon	167	2000	15-49	32.7	11.8	36	DHS
Sao Tome and Principe	19	2000	15-49	29.3	27.4	94	MICS
Northern Africa							
Algeria	3 656	2000	15-49	64.0	50.1	78	MICS
Egypt	10 921	2000	15-49	56.1	53.9	96	DHS
Libyan Arab Jamahiriha	486	1995	15-49	39.7	25.6	64	AHS
Morocco	4 265	1995	15-49	50.3	42.4	84	DHS
Sudan[f]	4 899	1993	15-49	8.3	6.9	83	AHS
Tunisia	1 322	1994[e]	15-49	60.0	51.0	85	AHS
Southern Africa							
Botswana	176	2000	15-49	40.4	38.8	96	MICS
Lesotho	245	2000[e]	15-49	30.4	29.5	97	MICS
Namibia	181	1992	15-49	28.9	26.0	90	DHS
South Africa	4 166	1998	15-49	56.3	55.1	98	DHS
Swaziland	155	2000	15-49	27.7	26.0	94	MICS
Western Africa							
Benin	1 060	2001	15-49	18.6	7.2	39	DHS
Burkina Faso	2 076	1999	15-49	11.9	4.8	40	DHS

TABLE 3 (*continued*)

Major area, region and country	*Number of married[b] women aged 15-49 in 2000 (thousands)*	*Year*	*Age group*	*Percentage of married women currently using*		*Percentage of contraceptive users[c] relying on modern methods*	*Source[d]*
				Any method	*Modern methods*		
Cape Verde	46	1998	15-49	52.9	46.0	87	CDC
Côte d'Ivoire	2 141	1999	15-49	15.0	7.3	49	DHS
Gambia	223	2000	15-49	9.8	9.0	92	MICS
Ghana	2 834	1999	15-49	22.0	13.3	60	DHS
Guinea	1 486	1999	15-49	6.2	4.2	68	DHS
Guinea-Bissau	207	2000	15-49	7.6	3.6	47	MICS
Liberia	390	1986	15-49	6.4	5.5	86	DHS
Mali	2 163	2001	15-49	8.1	5.7	70	DHS
Mauritania	362	2001	15-49	8.0	5.1	64	DHS
Niger	1 898	2000	15-49	14.0	4.3	31	MICS
Nigeria	17 682	1999	15-49	15.3	8.6	56	DHS
Senegal	1 470	1997	15-49	12.9	8.1	63	DHS
Sierra Leone	698	2000	15-49	4.3	3.9	91	MICS
Togo	680	2000	15-49	25.7	9.3	36	MICS
Asia							
Eastern Asia							
China	263 325	1997	15-49	83.8	83.3	99	FHS
China, Hong Kong SAR[g]	1 153	1992	15-49	86.2	79.7	92	RES
Democratic People's Republic of Korea	4 210	1992	15-49	61.8	53.0	86	RES
Japan	15 748	2000	15-49	55.9	51.0	91	FHS
Mongolia	425	2000	15-49	67.4	54.3	81	MICS
Republic of Korea	8 405	1997	15-44	80.5	66.9	83	RES
South-central Asia							
Afghanistan[h]	3 558	2000	15-49	4.8	3.6	75	MICS
Bangladesh	26 254	2000	10-49	53.8	43.4	81	DHS
Bhutan[p]	283	1994	15-49	18.8	18.8	100	FHS
India[i]	195 818	1999	15-49	48.2	42.8	89	FHS
Iran (Islamic Republic of)	10 579	1997	15-49	72.9	56.0	77	RES
Kazakhstan	2 621	1999	15-49	66.1	52.7	80	DHS
Kyrgyzstan	748	1997	15-49	59.5	48.9	82	DHS
Nepal	4 296	2001	15-49	39.3	35.4	90	DHS
Pakistan	21 825	2001[e]	15-49	27.6	20.2	73	FHS
Sri Lanka	2 750	1993	15-49	66.1	43.6	66	DHS
Tajikistan	1 143	2000	15-49	33.9	27.3	81	MICS
Turkmenistan	822	2000	15-49	61.8	53.1	86	DHS
Uzbekistan	4 792	2000	15-49	67.2	62.5	93	MICS
South-eastern Asia							
Cambodia	1 795	2000	15-49	23.8	18.5	78	DHS
Indonesia	40 114	1997	15-49	57.4	54.7	95	DHS
Lao People's Democratic Republic	893	2000	15-49	32.2	28.9	90	FHS
Malaysia[j]	3 573	1994	15-49	54.5	29.8	55	SES
Myanmar	7 069	1997	15-49	32.7	28.4	87	FHS

TABLE 3 (*continued*)

Major area, region and country	*Number of married[b] women aged 15-49 in 2000 (thousands)*	*Year*	*Age group*	*Percentage of married women currently using*		*Percentage of contraceptive users[c] relying on modern methods*	*Source[d]*
				Any method	*Modern methods*		
Philippines	11 301	1998	15-49	46.5	28.2	61	DHS
Singapore	702	1997	15-44	62.0	53.0	85	FHS
Thailand	10 862	1997	15-44	72.2	69.8	97	CPS
Viet Nam	13 141	2002	15-49	78.2	56.7	73	DHS
Western Asia							
Armenia	577	2000	15-49	60.5	22.3	37	DHS
Azerbaijan[u]	1 474	2001	15-44	55.4	11.9	21	CDC
Bahrain[o]	100	1995	15-49	61.8	30.6	50	AHS
Georgia	892	2000	15-44	40.5	19.8	49	CDC
Iraq[o]	2 984	1989	15-49	13.7	10.4	76	AHS
Israel[k]	838	1988	18-39	68.0	51.9	76	RES
Jordan	641	2002	15-49	55.8	38.6	69	DHS
Kuwait[o]	288	1996	15-49	50.2	40.9	81	AHS
Lebanon	629	1996	15-49	61.0	37.0	61	AHS
Oman[o]	329	1995	15-49	23.7	18.2	77	AHS
Qatar[o]	70	1998	15-49	43.2	32.3	75	AHS
Saudi Arabia[o]	2 987	1996	15-49	31.8	28.5	90	AHS
Syrian Arab Republic	2 639	1993	15-49	36.1	28.3	78	AHS
Turkey	12 283	1998	15-49	63.9	37.7	59	DHS
United Arab Emirates[o]	361	1995	15-49	27.5	23.6	86	AHS
Yemen	2 668	1997	15-49	20.8	9.8	47	DHS
Europe							
Eastern Europe							
Belarus	1 634	1995[e]	18-34	50.4	42.1	84	TPI
Bulgaria	1 235	1997	18-45	41.5	25.4	61	FFS
Czech Republic	1 755	1997	15-44	72.0	62.6	87	FFS
Hungary	1 704	1993	18-41	77.4	68.4	88	FFS
Poland	6 064	1991	20-49	49.4	19.0	38	FFS
Republic of Moldova	838	2000	15-49	62.4	42.8	69	MICS
Romania	3 704	1999	15-44	63.8	29.5	46	CDC
Slovakia[r]	832	1991	15-44	74.0	41.0	55	RES
Ukraine	8 546	1999	15-44	67.5	37.6	56	CDC
Northern Europe							
Denmark[r]	556	1988	15-44	78.0	72.0	92	RES
Estonia[s]	211	1994	20-49	70.3	56.4	80	FFS
Finland	515	1989	25-49	77.4	75.4	97	FFS
Latvia	339	1995	18-49	48.0	39.3	82	FFS
Lithuania	559	1995	18-49	46.6	30.5	65	FFS
Norway	601	1989	[t]	73.8	69.2	94	FFS
Sweden[r]	1 321	1981	20-44	78.0	72.0	92	FFS
United Kingdom[l]	6 927	2002	16-49	84.0	81.0	96	FHS

TABLE 3 (*continued*)

Major area, region and country	*Number of married[b] women aged 15-49 in 2000 (thousands)*	*Year*	*Age group*	*Percentage of married women currently using*		*Percentage of contraceptive users[c] relying on modern methods*	*Source[d]*
				Any method	*Modern methods*		
Southern Europe							
Albania	256	2000[e]	15-49	57.5	15.3	27	MICS
Bosnia and Herzegovina	702	2000[e]	15-49	47.5	15.7	33	MICS
Italy[v]	8 000	1996	20-49	60.2	38.9	65	FFS
Portugal	1 587	1980	15-49	66.3	32.8	49	WFS
Serbia and Montenegro[m]	1 573	2000	15-49	58.3	32.8	56	MICS
Slovenia	358	1994	15-44	73.8	59.1	80	FFS
Spain	6 898	1995	18-49	80.9	67.4	83	FFS
Western Europe							
Austria	1 233	1996	20-49	50.8	46.8	92	FFS
Belgium[n, v]	1 323	1992	21-39	78.4	74.3	95	FFS
France	8 781	1994	20-49	74.6	69.3	93	FFS
Germany	9 971	1992	20-39	74.7	71.8	96	TPI
Netherlands	2 034	1993	18-42	78.5	75.6	96	FFS
Switzerland[v]	937	1995	20-49	82.0	77.5	95	FFS
Latin America and the Caribbean							
Caribbean							
Antigua and Barbuda[q]	10	1988	15-44	52.6	50.6	96	CPS
Bahamas[q]	30	1988	15-44	61.7	60.1	97	CPS
Barbados[q]	16	1988	15-44	55.0	53.2	97	CPS
Cuba	1 879	2000	15-49	73.3	72.1	98	MICS
Dominica[q]	12	1987	15-44	49.8	48.2	97	CPS
Dominican Republic	1 344	2000	15-49	64.7	62.5	97	MICS
Grenada[q]	36	1990	15-44	54.3	NA	NA	RES
Haiti	1 132	2000	15-49	27.4	21.4	78	DHS
Jamaica[q]	344	1997	15-49	65.9	62.6	95	CDC
Montserrat[q]	2	1984	15-44	52.6	52.2	99	CPS
Puerto Rico	576	1996	15-49	77.7	67.6	87	CDC
Saint Kitts and Nevis[q]	6	1984	15-44	40.6	37.0	91	CPS
Saint Lucia[q]	7	1988	15-44	47.3	46.1	97	CPS
Saint Vincent and the Grenadines[q]	6	1988	15-44	58.3	54.6	94	CPS
Trinidad and Tobago[q]	149	2000	15-49	38.2	33.2	87	MICS
Central America							
Belize[q]	23	1991	15-44	46.7	41.8	90	CDC
Costa Rica	769	1993	15-49	75.0	64.6	86	FHS
El Salvador	934	1998	15-44	59.7	54.1	91	CDC
Guatemala	1 719	1999	15-49	38.2	30.9	81	DHS
Honduras	926	2001[e]	15-44	61.8	50.8	82	CDC
Mexico	16 295	1995	15-49	66.5	57.5	86	RES
Nicaragua	640	2001	15-49	68.7	66.2	96	DHS
Panama	441	1984	15-44	58.2	54.2	93	CDC

TABLE 3 (*continued*)

Major area, region and country	*Number of married[b] women aged 15-49 in 2000 (thousands)*	*Year*	*Age group*	*Percentage of married women currently using*		*Percentage of contraceptive users[c] relying on modern methods*	*Source[d]*
				Any method	*Modern methods*		
South America							
Bolivia	1 188	2000	15-49	53.4	27.3	51	MICS
Brazil	29 020	1996	15-49	76.7	70.3	92	DHS
Colombia	6 004	2000	15-49	76.9	64.0	83	DHS
Ecuador	1 928	1999	15-49	65.8	50.1	76	CDC
Guyana	70	2000	15-49	37.3	36.0	97	MICS
Paraguay	870	1998	15-44	57.4	47.7	83	CDC
Peru	3 733	2000	15-49	68.9	50.4	73	DHS
Suriname	68	2000	15-49	42.1	40.6	96	MICS
Northern America							
Canada	4 270	1995	15-49	74.7	73.3	98	FFS
United States of America	37 740	1995	15-44	76.4	70.5	92	RES
Oceania							
Australia/New Zealand							
Australia	2 456	1986	20-49	76.1	72.2	95	RES
New Zealand	533	1995[e]	20-49	74.9	72.0	96	TPI
Melanesia/Micronesia/Polynesia							
Cook Islands	3	1996	15-49	63.2	60.4	96	FHS
Papua New Guinea	924	1996	15-49	25.9	19.6	76	FHS

Sources: *World Contraceptive Use 2003* and *World Population Prospects 2002*, databases maintained by the Population Division of the United Nations.

NOTE: This table shows the most recent data (collected in 1980 or later) available as of September 2003.

[a] Percentage of married or in-union women of reproductive age currently using contraception.

[b] In a marital or consensual union.

[c] Women of reproductive age who are married or in a consensual or visiting union and who are using contraception.

[d] The data were compiled from nationally representative surveys of women of reproductive age, including the Gulf Family Health Surveys and Pan-Arab Child Health Surveys (AHS), surveys carried out with the assistance of the US Centers for Disease Control and Prevention (CDC) such as the Reproductive Health Surveys, the Contraceptive Prevalence Surveys (CPS), the Demographic and Health Surveys (DHS), the Fertility and Family Surveys (FFS), national fertility and/or family planning surveys (FHS), the Multiple Indicator Cluster Surveys (MICS), national socioeconomic and/or demographic surveys (SES) and the World Fertility Surveys (WFS). Other sources of data are research papers or publications, including United Nations publications (RES) and tabulations provided by individuals or institutions (TPI).

[e] Preliminary or provisional.

[f] Northern.

[g] As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

[h] Eastern.

[i] Excluding the state of Tripura.

[j] Peninsular.

[k] Jewish population.

[l] Excluding Northern Ireland.

[m] Data pertain to former Yugoslavia, excluding the province of Kosovo and Metohija.

[n] Flemish population.

[o] Data pertain to nationals of the country.

[p] Data pertain to all women.

[q] Including visiting unions.

[r] Data pertain to all sexually active women.

[s] Data pertain to women sexually active within last month.

[t] Born in 1945, 1950, 1955, 1960, 1965 or 1968.

[u] Including emergency contraception.

[v] Including some cases of sterilization for non-contraceptive reasons.

modern method (table 3). These countries all belong to Western Asia, the region with the lowest contraceptive prevalence in Asia.

A strong government commitment to family planning programmes is the main reason behind the success of many Asian countries in achieving high contraceptive prevalence. In addition, most countries with strong programmes have policies that promote small families, as in the cases of Bangladesh, China, the Islamic Republic of Iran and Viet Nam.

D. Contraceptive prevalence in Latin America and the Caribbean

Latin America and the Caribbean has the highest level of contraceptive prevalence of any major area in the developing world, with 71 per cent of women of reproductive age who are married or in union using contraception. As already noted, this level of prevalence is higher than that in Europe.

Just as in Europe, all regions of Latin America and the Caribbean have relatively high levels of contraceptive prevalence. The Caribbean has the lowest prevalence (61 per cent), followed by Central America (64 per cent) and South America (73 per cent). The level for Latin America and the Caribbean as a whole is strongly influenced by the level in South America, where two-thirds of the area's women of reproductive age who are married or in union live (table 1). Within South America, Brazil, with 77 per cent prevalence in 1997, influences heavily the regional average since it accounts for over half of the female population of reproductive age in the region. Similarly, contraceptive prevalence in Mexico (68 per cent in 1997), which accounts for three-quarters of the women of reproductive age who are married or in union in Central America, largely determines average prevalence in that region.

In Latin America and the Caribbean, 62 per cent of women of reproductive age who are married or in union rely on modern methods of contraception. The vast majority of contraceptive users in the regions of Latin America and the Caribbean use modern methods. In the Caribbean, 94 per cent do. In both Central America and South America, the proportion of contraceptive users relying on mother methods is 87 per cent in each region. Hence, the regions of Latin America and the Caribbean not only have contraceptive prevalence levels comparable to those of the regions of Europe but, in addition, tend to rely almost exclusively on modern contraceptive methods in sharp contrast with the practice in Europe.

Although Latin America and the Caribbean has, on average, reached a level of contraceptive use as high as that of the more developed regions, 58 per cent of its 31 countries with data available still have prevalence levels below 60 per cent (figure II). No country in this major area has a prevalence level below 20 per cent but ten countries, including Haiti and Guatemala, still have prevalence levels below 50 per cent (table 3). In general, the Caribbean countries have lower prevalence levels than the countries of Central America and South America[3]. Compared to Africa and Asia, variation at the country level is smaller in Latin America and the Caribbean, with countries at the lower end of the scale having prevalence levels ranging from 27 per cent to 38 per cent (e.g. Haiti, Guatemala and Guyana in order of prevalence) and those at the higher end having prevalence levels ranging from 73 per cent to 78 per cent (e.g., Brazil, Colombia, Costa Rica, Cuba and Puerto Rico).

With regard to the use of modern methods, 61 per cent of the 31 countries with data available and located in Latin America and the Caribbean have levels above 50 per cent. Moreover, with the exception of Bolivia, the proportion of contraceptive users relying on modern methods is high in all countries—above 70 per cent—, and even in Bolivia the equivalent proportion is 51 per cent.

E. Contraceptive prevalence in the least developed countries

The group of 50 least developed countries includes countries in all the developing regions of the world. However, it is worth considering them as a group because they are among the countries exhibiting the lowest levels of contraceptive use and the highest fertility levels in the world. Recent data for 40 of the 50 least developed countries indicated that, on average, 28 per cent of women of reproductive age who are married or in union in those countries use contraception. However, this population-weighted average is strongly influenced by the relatively high level of contraceptive use in populous Bangladesh. Contraceptive prevalence is over 50 per cent in Bangladesh and Cape Verde but it is less than 10 per cent in 14 of the least developed countries, including Afghanistan, Angola, Chad, Eritrea, Ethiopia, Gambia, Guinea,

Guinea-Bissau, Liberia, Mali, Mauritania, Mozambique, Sierra Leone and Sudan. In 55 per cent of the least developed countries contraceptive prevalence is below 20 per cent. Furthermore, 85 per cent of the world's countries with contraceptive prevalence below 20 per cent are least developed.

Levels of use of modern methods also tend to be low in the least developed countries, averaging 20 per cent in the group as a whole. Once more, this average is strongly influenced by the high level of use of modern methods in Bangladesh. Whereas modern methods are used by over 40 per cent of married women of reproductive age in Bangladesh and Cape Verde, there are 10 least developed countries where modern methods are used by less than 5 per cent of women of reproductive age who are married or in union. Indeed, in 58 per cent of the least developed countries the prevalence of use of modern methods is lower than 10 per cent. Yet, despite these low prevalence levels, the tendency is for contraceptive users in the least developed countries to rely mostly on modern methods. Only in nine of the 40 least developed countries with data available do less than half of all contraceptive users rely on modern methods.

F. Contraceptive prevalence in Europe and Northern America

In Europe, 67 per cent of women reproductive age who were married or in union at the end of the 1990s used contraception. Therefore, Europe exhibits the lowest level of contraceptive prevalence in the developed world. In fact, it is lower than that of Latin America and the Caribbean, one of the major areas of the developing world. It also contrasts markedly with the level in the other major developed area, Northern America, where contraceptive prevalence was 76 per cent in the late 1990s (table 2).

All the regions of Europe exhibit moderate or high levels of contraceptive prevalence. Northern Europe had the highest prevalence (79 per cent) in the late 1990s, followed by Western Europe (74 per cent), Southern Europe (67 per cent) and Eastern Europe (61 per cent). However, the estimate for Eastern Europe may be upwardly biased because data for the Russian Federation are lacking and, since its population of reproductive age accounts for a very large share of the region's population of reproductive age, errors in the estimate used for the Russian Federation would have a considerable impact on the estimate for the whole region. The regional estimate presented here is based on the assumption that the Russian Federation has a level of contraceptive use similar to that of other Eastern European countries having the required information. In 1999, a survey of three Russian cities recorded prevalence levels ranging from 70 per cent to 75 per cent (Russian Centre for Public Opinion and Market Research, Centers for Disease Control and Prevention, United States Agency for International Development, 2000) but the nationwide level is likely to be much lower (Barkalov and Darsky, 1994).

Another important feature of contraceptive prevalence in Europe is the high reliance of couples on traditional contraceptive methods. For Europe as a whole, just 49 per cent of women of reproductive age who are married or in union relied on modern contraceptive methods in the late 1990s. This level of use of modern methods is lower than that recorded in Asia, although proportionately more women of reproductive age and in union use contraception in Europe than in Asia. In Northern America, prevalence of modern contraceptive methods is very high, at 71 per cent. That is, fully 93 per cent of all contraceptive users in Northern America rely on modern methods.

In Europe, there are very significant differences among the regions in the percentage of contraceptive users relying on modern methods. Thus, whereas reliance on modern contraceptive methods is close to universal in Northern Europe (94 per cent) and Western Europe (95 per cent), it is much lower in Southern Europe (69 per cent) and, particularly, in Eastern Europe (57 per cent). Lack of ready access to modern contraceptive methods in parts of Europe is partly responsible for these differences.

Among the 32 countries with data available in Europe and Northern America, contraceptive prevalence ranged from 42 per cent to 84 per cent (table 3). Countries in these regions tend to concentrate at the higher end of the distribution (figure II), with almost three-quarters of them having prevalence levels above 60 per cent and more than half having levels above 70 per cent, including Canada and the United States of America where contraceptive prevalence was at least 75 per cent in 1995. Only 15 per cent of the countries in Europe had contraceptive prevalence levels below 50 per cent.

In Europe, very high contraceptive prevalence tends to characterize the countries of Northern Europe and Western Europe. In other regions of

Europe, Spain stands out as having reached a prevalence of 81 per cent prevalence in 1995, among the highest in the world. At the opposite end of the distribution, less than half of women of reproductive age who are married or in union report using contraception in Belarus, Bosnia and Herzegovina, Bulgaria, Latvia, Lithuania and Poland. These relatively low levels of prevalence are probably related to the limited availability of contraceptive supplies (Popov, Visser and Ketting, 1993).

The use of modern contraceptive methods in the countries of Europe and Northern America is generally high. More than half of all women of reproductive age who are married or in union use modern methods in 57 per cent of the countries of Europe and Northern America. However, the use of modern methods is still low in a few countries, including Albania, Bosnia and Herzegovina, Bulgaria, Poland and Romania where it ranges from 15 per cent to 30 per cent. With the exception of Lithuania, the proportion of contraceptive users relying on modern methods is very high in all countries Northern Europe and Western Europe—80 per cent or over. The same is true for the countries of Northern America. The equivalent proportions are lower in countries of Eastern Europe and Southern Europe. In Albania, Bosnia and Herzegovina, Poland, Portugal and Romania, less than half of all contraceptive users rely on modern methods.

To date, no nationwide survey to assess contraceptive prevalence and practice has been conducted in the Russian Federation. A review of small-scale surveys indicates prevalence levels of 70 per cent to 80 per cent in the 1980s and early 1990s for the city of Moscow and other major urban areas (Barkalov and Darsky, 1994). The Russia Women's Reproductive Health Survey, carried out in 1996 and followed up in 1999, gathered information from representative samples of women aged 15 to 44 in Ivanovo Oblast (including Ivanovo City), Yekaterinburg City and Perm City. The results of this survey show that in 1999, contraceptive prevalence among married women was high (70 per cent to 75 per cent) in these three urban centres, with modern methods being used by 49 per cent to 58 per cent of women (Russian Centre for Public Opinion and Market Research, Centers for Disease Control and Prevention, United States Agency for International Development. 2000). However, the review conducted by Barkalov and Darsky (1994) shows a much lower contraceptive prevalence in other urban and rural areas, ranging between 27 per cent and 57 per cent. These authors estimate that the prevalence of use of modern methods (mainly intrauterine devices and oral pills) is at least 25 per cent in the Russian Federation but they suggest that the prevalence of overall use is substantially overestimated due to the relaxed definition of traditional methods of contraception used in some surveys.

G. Contraceptive prevalence in Oceania

In Oceania, 62 per cent of women of reproductive age who are married or in union use contraception, a level of contraceptive prevalence slightly lower than that in Asia. However, average prevalence in Oceania masks great disparities among regions. Australia and New Zealand, being developed countries, have jointly a very high level of contraceptive prevalence (76 per cent). In contrast, the three less developed regions of Melanesia, Micronesia and Polynesia have very low levels of prevalence, averaging only 27 per cent, a level comparable to that in Africa.

Melanesia, Micronesia and Polynesia have been grouped into one unit because only two countries in them, the Cook Islands and Papua New Guinea, have recent data on contraceptive use. These two countries have strikingly different levels of contraceptive prevalence, with 63 per cent of women of reproductive age and married or in union using contraception in the Cook Islands and just 26 per cent doing so in Papua New Guinea (table 3). Since that country accounts for 79 per cent of the women of reproductive age who are married or in union in Melanesia, Micronesia and Polynesia, it exerts a strong influence on average prevalence for those regions. Because of lack of data, a regional estimate based solely on the information for the Cook Islands and Papua New Guinea would likely underestimate contraceptive prevalence because Fiji, one of the other populous countries in the area, already had a contraceptive prevalence of 41 per cent in 1974 and is likely to have attained higher levels of prevalence by the late 1990s. Therefore, to calculate a regional estimate, it was assumed that the group of countries lacking recent data had a contraceptive prevalence of 30 per cent. As a result, the average contraceptive prevalence for Melanesia, Micronesia and Polynesia was estimated at 27 per cent.

In Oceania as a whole, 57 per cent of women of reproductive age who were married or in union in the late 1990s relied on modern methods. The use of modern contraceptive methods was much higher in Australia and New Zealand (72 per cent) than in Melanesia, Micronesia and Polynesia considered jointly (21 per cent). Virtually all women using contraception in Australia, New Zealand and the Cook Islands relied on modern methods (95 per cent or more). Only in Papua New Guinea did a relatively high proportion of women using contraception still rely on traditional methods (24 per cent).

NOTES

[1] Throughout this report, "married women", "women of reproductive age, in a marital or consensual union" and "women of reproductive age who are married or in union" are used interchangeably to mean women aged 15-49 (unless otherwise stated) who are married or living in a consensual union.

[2] Pakistan is the only populous country with a low contraceptive prevalence (28 per cent).

[3] It should be noted, however, that for eight of the 15 Caribbean countries with data, the latest estimates of contraceptive prevalence available refer to the 1980s.

[4] The least developed countries are a group of 50 developing countries that have been identified by the United Nations as "least developed" in view of their low GDP per capita, their weak human capital assets and their high degree of economic vulnerability. As of December 2003, the group includes 34 countries in Africa, ten in Asia, one in Latin America and the Caribbean and five in Oceania. The full list can be found in the explanatory notes at the beginning of this report.

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II. TRENDS IN CONTRACEPTIVE USE

This chapter reviews changes in contraceptive prevalence at the global, regional and country levels. Comparable data on contraceptive use are available for at least two periods for 116 countries, 30 more than in the 1998 assessment of world contraceptive use (United Nations, 2000). These countries include 95 developing countries and 21 developed countries and their data span the period 1970 to 2002. Yet only 68 countries, including 44 developing countries and 21 developed countries, have data pertaining to both the first half of the period (1970-1984) and the second half (1985-2002), and they are by no means representative of the countries of the world or of their respective major areas or regions. For instance, they include just 19 countries in Africa and 21 in Asia. Moreover, they tend to represent countries with relatively high prevalence levels within their respective regions. Consequently, the overview on trends of contraceptive use presented below may present a more positive picture of the evolution of contraceptive use worldwide than would be the case if a better coverage of the experience of all countries were possible.

A. GLOBAL AND REGIONAL TRENDS

Many countries, especially the developing ones, did not have data on contraceptive prevalence until the late 1980s. Consequently, restricting the analysis of global trends to the 68 countries that have comparable data pertaining to both 1970-1984 and 1985-2002 would produce estimates that could not be claimed to be representative of all the countries of the world. For that reason, the focus of this chapter will be mainly on trends over a more recent period, focusing on contraceptive prevalence estimates for 1990, 1995 and 2000 derived using linear interpolation or extrapolation on the basis of the estimates available for each country for the reference dates of national surveys (see annex table A.1). The regional and global estimates for 1990, 1995 and 2000 are weighted averages of country estimates.

The countries for which interpolated or extrapolated estimates were obtained include all those whose most recent data derived from national surveys refer to the late 1980s or later periods. This restriction led to the exclusion of one country, Panama, from the analysis of recent trends. Bulgaria, Poland and Trinidad and Tobago were also excluded because their trend data show steep decreases in contraceptive prevalence which are more likely the result of lack of data comparability between the different sources rather than a reflection of real trends. Iraq was also excluded because its trend data show a decrease in contraceptive prevalence and its most recent data refer to 1989. A projection of past trends in that case was not felt to be appropriate, especially given the situation prevailing in Iraq after the Gulf War.

Worldwide contraceptive prevalence is estimated to have increased from 54 per cent in 1990 to 59 per cent in 1995 and 63 per cent in 2000. This trend implies a fairly rapid pace of increase, amounting to 0.9 percentage points per year over the decade (table 4) and is the result of a slower increase in the more developed regions than in the less developed regions. In the more developed regions, contraceptive prevalence went from 66 per cent in 1990 to 68 per cent in 1995 and 70 per cent in 2000, that is, it rose by 0.4 percentage points annually during 1990-2000. In the less developed regions, contraceptive prevalence went from 52 per cent in 1990 to 57 per cent in 1995 and 61 per cent in 2000, thus increasing at a pace of 0.9 percentage points per year.

These global trends mask wide variations across major areas and regions. In Europe and Australia/New Zealand, contraceptive prevalence barely changed between 1990 and 2000, but it increased rapidly in Northern America (by 1.0 percentage point per year). In the less developed world, contraceptive prevalence increased rapidly in Africa and Latin America and the Caribbean (by over 1.0 percentage point per year, on average) but more slowly in Asia (by 0.8 percentage points per year). Within Africa, the regions of Eastern Africa, Middle Africa and Northern Africa experienced very rapid increases over the past decade, rising by 1.0 percentage point or more per year, although by 2000 Eastern Africa and Middle Africa were still characterized by fairly low levels of prevalence. The regions of Central America and South America in Latin America and the Caribbean and the regions of South-central Asia and South-eastern Asia in Asia experienced similarly rapid increases.

TABLE 4. ESTIMATED TRENDS IN CONTRACEPTIVE PREVALENCE[a], BY MAJOR AREA AND REGION

Major area and region	Overall contraceptive prevalence (percentage) 1990	2000	Annual change in contraceptive prevalence 1990-2000 (percentage points)	Prevalence of modern contraceptive methods (percentage) 1990	2000	Annual change in prevalence of modern methods 1990-2000 (percentage points)
World	**61**	**62.6**	**0.9**	**47.4**	**55**	**0.8**
More developed regions	66.0	70.1	0.4	51.2	58.1	0.7
Less developed regions	51.9	61.3	0.9	46.9	55.4	0.8
Africa	**16.6**	**27.9**	**1.1**	**12.6**	**20.6**	**0.8**
Eastern Africa	12.6	22.8	1.0	8.1	17.8	1.0
Middle Africa	8.2	22.8	1.5	2.2	4.8	0.3
Northern Africa	36.2	52.0	1.6	33.0	45.7	1.3
Southern Africa	47.2	54.0	0.7	45.7	52.8	0.7
Western Africa	6.8	15.4	0.9	3.3	8.4	0.5
Asia	**56.7**	**65**	**0.8**	**53.2**	**60.0**	**0.8**
Eastern Asia	77.9	83.6	0.6	76.7	82.3	0.6
South-central Asia	38.7	49.0	1.0	33.0	42.2	0.9
South-eastern Asia	47.2	59.7	1.3	40.3	51.4	1.1
Western Asia	43.3	49.1	0.6	24.8	30.6	0.6
Europe	**65**	**68**	**0.2**	**48**	**50**	**0.8**
Eastern Europe	58.5	62.7	0.4	29.9	38.6	0.9
Northern Europe	78.5	79.1	0.1	74.2	74.6	0.0
Southern Europe	66.6	68.0	0.1	39.3	53.5	1.4
Western Europe	74.4	74.4	0.0	68.9	74.4	0.6
Latin America and the Caribbean	**62.1**	**74**	**1.2**	**56**	**65**	**1.3**
Caribbean	53.7	61.3	0.8	50.1	57.7	0.8
Central America	56.9	70.5	1.4	48.7	61.7	1.3
South America	66.1	77.8	1.2	55.3	68.9	1.4
Northern America	**71.0**	**74**	**1.0**	**67.5**	**74**	**0.7**
Australia/New Zealand [b]	**76.5**	**79.4**	**0.3**	**73**	**78**	**0.6**

Sources: *World Contraceptive Use 2003,* database maintained by the Population Division of the United Nations, and tables 1 and 3.

[a] Contraceptive prevalence is the percentage of women of reproductive age in a marital or consensual union who are using contraception. The prevalence of modern methods is the percentage of women of reproductive age in a marital or consensual union who are using a modern contraceptive method. The regional and global estimates are weighted averages of estimates at the country level for 1990 and 2000.

[b] Because there are only two countries in the Australia/New Zealand region and only New Zealand has trends data on contraceptive use, the average contraceptive prevalence levels for the Australia/New Zealand region were computed by also taking the unique data point for Australia into account.

Globally, the use of modern contraceptive methods increased at a pace similar to that of overall contraceptive prevalence between 1990 and 2000, rising on average by 0.8 percentage points per year (from 47 per cent in 1990 to 52 per cent in 1995 and 56 per cent in 2000). In the more developed regions, the use of modern methods increased faster than overall contraceptive prevalence, at 0.7 percentage points per year. Concomitantly, the use of traditional methods decreased. This trend is driven mainly by changes in Europe and particularly in Eastern Europe and Southern Europe where, although overall prevalence is changing little, couples are increasingly opting to use modern contraceptive methods instead of traditional methods. In the less developed regions, the use of modern methods has been increasing more slowly than overall contraceptive prevalence, by 0.8 percentage points annually compared to the annual gain of 0.9 percentage points in overall prevalence. Yet by 2000 an estimated 55 per cent of all women in less developed regions who were married or in union were relying on modern methods.

1. Recent trends in developing countries

Most developing countries with trend data show a substantial increase in contraceptive use between 1990 and 2000. In 45 per cent of those countries, increases in contraceptive prevalence range from 1.0 to 1.9 percentage points annually, while in 13 per cent of them the average annual gain in contraceptive prevalence during the 1990s was 2.0 percentage points or higher (table 5). Compared to an earlier assessment of trends in contraceptive use, which showed that 57 per cent of developing countries had experienced increases ranging from 1.0 to 1.9 percentage points per year and 11 per cent had shown increases of at least 2.0 percentage points per year between roughly the late 1970s and the early 1990s (United Nations, 2000), the more recent data indicate that more countries have experienced rapid increases in contraceptive use. In 1990, just 12 of the 95 developing countries with the relevant data had contraceptive prevalence estimated at 65 per cent or higher. By 2000, 28 countries had those levels. This shift to higher levels of prevalence has been accompanied by a reduction in the number of countries with low prevalence. In 1990, 36 of the 95 developing countries with data had a contraceptive prevalence below 20 per cent but by 2000, just 19 had still showed those low levels of prevalence (table 6).

Although there is considerable variation in the average annual gains in contraceptive prevalence made by developing countries during the 1990s, countries with low initial levels of contraceptive prevalence tended to experience a slower rise in prevalence than countries with initial prevalence levels in the intermediate range (table 7). Countries with high initial levels of prevalence also experienced slower growth in contraceptive use than those starting at intermediate levels.

Among countries with low initial prevalence (below 20 per cent), more than half experienced increases of less than 1.0 percentage point per year. Except for Afghanistan, the countries with low initial prevalence and slow increases all belong to sub-Saharan Africa, particularly to Western Africa. There is also a significant number of countries with low prevalence in 1990 (13 countries out of 36) that experienced fast growth in contraceptive use, with gains averaging 1.5 percentage points or more during the decade. Half of these countries are located in sub-Saharan Africa and half in Asia.

Countries with high prevalence (65 per cent or higher) in 1990 almost uniformly experienced slow growth in contraceptive use. Ten of the 12 countries in this group recorded an average annual increase of less than 1.0 percentage point during 1990-2000 and none experienced an average annual increase above 1.5 percentage points.

As already noted, countries with intermediate levels of prevalence in 1990 (ranging from 20 per cent to 64 per cent) tended to experience the most rapid rises in contraceptive use. In particular, 19 of the 23 countries with an initial prevalence ranging from 20 per cent to 44 per cent recorded increases of at least 1.0 percentage point per year during 1990-2000 and 11 of them registered increases averaging over 1.5 percentage points per year (table 7). Among the 24 countries with initial prevalence levels ranging from 45 per cent to 64 per cent, 17 experienced increases averaging over 1.0 percentage point a year and two of them—Grenada and the Islamic Republic of Iran—maintained a more rapid pace of change, gaining over 2 percentage points a year during 1990-2000.

In the majority of the developing countries with trend data, overall contraceptive prevalence tended to increase more rapidly than the prevalence of use of modern contraceptive methods. However, the difference in pace was small, amounting to just 0.1 of a percentage point per year in favour of overall

TABLE 5. ESTIMATED TRENDS IN CONTRACEPTIVE PREVALENCE[a], BY COUNTRY, 1990, 1995 AND 2000
(*Percentage*)

Country	*Estimated contraceptive prevalence[b] of any method (percentage)*			*Estimated contraceptive prevalence[b] of modern methods (percentage)*			*Estimated annual change in prevalence, 1990-2000 (percentage points)*	
	1990	*1995*	*2000*	*1990*	*1995*	*2000*	*Any method*	*Modern methods*
Africa								
Eastern Africa								
Burundi	10.3	13.0	15.7	3.2	6.6	10.0	0.5	0.7
Comoros	14.0	19.8	25.7	0.0	9.4	19.3	1.2	1.9
Eritrea	8.0	8.0	8.0	3.2	4.0	4.8	0.0	0.2
Ethiopia	4.3	6.2	8.1	2.6	4.5	6.3	0.4	0.4
Kenya	28.4	35.2	41.5	20.2	29.0	33.2	1.3	1.3
Madagascar	15.6	18.3	18.8	3.3	7.9	11.8	0.3	0.9
Malawi	11.5	19.7	30.6	5.8	12.7	26.1	1.9	2.0
Mauritius	74.8	74.3	73.8	48.1	52.0	55.8	-0.1	0.8
Rwanda	18.7	15.6	13.2	10.2	8.6	4.3	-0.6	-0.6
Uganda	6.6	14.8	21.5	3.4	7.8	16.5	1.5	1.3
United Rep. of Tanzania	8.8	16.8	27.7	5.3	12.0	18.1	1.9	1.3
Zambia	9.9	23.2	26.1	6.2	13.0	19.3	1.6	1.3
Zimbabwe	44.1	49.2	54.6	37.3	43.8	52.0	1.1	1.5
Middle Africa								
Angola	10.4	8.5	6.6	3.4	3.9	4.4	-0.4	0.1
Cameroon	15.0	17.9	20.2	4.0	5.9	7.9	0.5	0.4
Central African Republic	1.7	14.8	27.9	0.0	3.3	6.9	2.6	0.7
Chad	0.0	1.6	7.9	0.0	0.6	2.1	0.8	0.2
Dem. Rep. of the Congo	5.3	17.2	29.0	1.8	3.0	4.2	2.4	0.2
Northern Africa								
Algeria	44.8	56.9	64.0	38.5	49.4	50.1	1.9	1.2
Egypt	41.1	47.9	56.1	39.9	45.5	53.9	1.5	1.4
Morocco	39.3	50.3	65.0	32.9	42.4	53.9	2.6	2.1
Sudan	8.7	10.6	12.4	5.6	6.5	7.3	0.4	0.2
Tunisia	53.2	61.7	70.2	43.9	52.8	61.6	1.7	1.8
Southern Africa								
Botswana	34.2	37.3	40.4	32.9	35.8	38.8	0.6	0.6
Lesotho	20.8	25.9	30.4	16.7	22.9	29.5	1.0	1.3
South Africa	51.0	54.3	57.6	49.7	53.1	56.4	0.7	0.7
Swaziland	21.2	24.5	27.7	18.7	22.3	26.0	0.7	0.7
Western Africa								
Benin	13.8	16.0	18.2	0.0	2.6	6.4	0.4	0.6
Burkina Faso	5.9	9.2	12.6	3.9	4.4	4.9	0.7	0.1
Côte d'Ivoire	8.8	12.1	15.7	3.1	4.8	7.9	0.7	0.5
Gambia	11.8	10.7	9.6	6.7	7.8	8.9	-0.2	0.2
Ghana	15.9	20.9	22.3	7.2	11.2	13.8	0.6	0.7
Guinea	0.0	3.2	7.0	0.0	2.1	4.7	0.7	0.5
Mali	5.4	6.5	7.8	2.4	4.1	5.5	0.2	0.3
Mauritania	3.8	5.9	8.0	1.1	3.1	5.0	0.4	0.4

TABLE 5 *(continued)*

Country	Estimated contraceptive prevalence[b] of any method (percentage)			Estimated contraceptive prevalence[b] of modern methods (percentage)			Estimated annual change in prevalence, 1990-2000 (percentage points)	
	1990	1995	2000	1990	1995	2000	Any method	Modern methods
Niger	3.1	6.3	14.0	1.5	3.5	4.3	1.1	0.3
Nigeria	6.0	11.2	16.3	3.5	6.3	9.2	1.0	0.6
Senegal	9.1	10.2	17.0	3.8	6.5	10.6	0.8	0.7
Togo	14.4	20.1	25.7	3.8	5.8	9.3	1.1	0.6
Asia								
Eastern Asia								
China	77.8	83.6	84.0	77.2	83.3	83.4	0.6	0.6
Hong Kong, China SAR	84.0	84.0	84.0	77.8	82.5	82.5	0.0	0.5
Japan[c]	58.0	57.5	55.9	51.9	51.7	51.0	-0.2	-0.1
Mongolia	69.3	63.4	67.4	8.3	31.7	54.3	-0.2	4.6
Republic of Korea	78.7	78.4	83.6	69.7	66.8	67.0	0.5	-0.3
South-central Asia								
Afghanistan	3.6	4.2	4.8	2.9	3.2	3.6	0.1	0.1
Bangladesh	35.4	46.1	53.8	27.2	38.0	43.4	1.8	1.6
India	42.0	43.1	49.5	37.3	38.4	43.9	0.8	0.7
Iran (Islamic Rep. of)	54.2	69.6	77.9	33.3	51.4	62.8	2.4	3.0
Kazakhstan	50.4	59.1	69.4	37.9	46.1	54.6	1.9	1.7
Nepal	20.9	27.3	37.1	20.2	25.2	33.5	1.6	1.3
Pakistan	11.1	17.8	26.7	8.6	12.6	19.4	1.6	1.1
Sri Lanka	64.1	67.5	70.9	42.1	44.6	47.2	0.7	0.5
Uzbekistan	38.2	52.7	67.2	34.5	48.5	62.5	2.9	2.8
South-eastern Asia								
Cambodia	1.2	12.5	23.8	0.0	6.8	18.5	2.3	1.9
Indonesia	49.2	55.6	60.3	46.3	53.0	57.3	1.1	1.1
Lao People's Dem. Rep.	12.8	22.5	32.2	9.0	19.0	28.9	1.9	2.0
Malaysia	50.4	55.5	60.7	30.9	29.5	28.2	1.0	-0.3
Myanmar	10.4	26.3	42.2	7.7	22.5	37.3	3.2	3.0
Philippines	37.7	42.6	49.1	22.9	26.2	29.5	1.1	0.7
Singapore	65.8	63.2	60.2	51.0	52.2	54.2	-0.6	0.3
Thailand	70.7	73.1	70.9	68.9	71.0	68.0	0.0	-0.1
Viet Nam	57.1	68.4	74.2	38.1	47.8	55.7	1.7	1.8
Western Asia								
Azerbaijan	52.1	53.6	55.1	..	..	..	0.3	..
Bahrain	54.8	61.8	68.8	30.4	30.6	30.9	1.4	0.1
Jordan	35.0	47.6	54.5	26.9	34.6	38.2	2.0	1.1
Kuwait	39.8	48.5	57.1	34.8	39.9	45.0	1.7	1.0
Lebanon	59.1	60.7	62.3	33.6	36.4	39.2	0.3	0.6
Oman	12.9	23.7	34.5	10.6	23.7	25.8	2.2	1.5
Qatar	35.3	40.2	45.2	29.8	31.4	32.9	1.0	0.3
Syrian Arab Republic	32.8	38.3	43.7	25.6	30.1	34.5	1.1	0.9
Turkey	63.0	63.1	64.4	32.5	35.8	39.0	0.1	0.7
Yemen	6.3	15.4	29.0	5.3	8.3	12.0	2.3	0.7

TABLE 5 *(continued)*

Country	Estimated contraceptive prevalence[b] of any method (percentage)			Estimated contraceptive prevalence[b] of modern methods (percentage)			Estimated annual change in prevalence, 1990-2000 (percentage points)	
	1990	1995	2000	1990	1995	2000	Any method	Modern methods
Europe								
Eastern Europe								
Czech Republic	70.4	71.6	77.1	52.9	59.8	66.8	0.7	1.4
Hungary	75.6	78.6	81.7	65.8	70.1	74.5	0.6	0.9
Republic of Moldova	65.3	71.3	77.3	40.5	47.3	54.1	1.2	1.4
Romania	57.4	59.5	64.9	12.6	19.5	32.0	0.7	1.9
Northern Europe								
Denmark	79.2	82.3	85.3	74.0	79.0	84.0	0.6	1.0
Finland	77.2	76.1	75.0	75.2	74.1	73.0	-0.2	-0.2
Norway	74.0	75.2	76.4	69.6	71.3	73.1	0.2	0.4
United Kingdom[c]	81.6	82.0	80.0	80.3	82.0	80.0	-0.2	0.0
Southern Europe								
Italy	66.5	61.2	56.0	36.5	38.5	40.5	-1.0	0.4
Serbia and Montenegro	56.9	57.6	58.3	24.1	28.5	32.8	0.1	0.9
Spain	70.2	80.9	87.0	52.7	67.4	82.1	1.7	2.9
Western Europe								
Austria	59.6	52.3	44.9	50.9	47.5	44.1	-1.5	-0.7
Belgium	78.8	77.9	82.6	72.2	77.4	82.6	0.4	1.0
France	79.0	73.5	72.0	67.5	69.8	72.0	-0.7	0.5
Germany	75.6	76.1	76.6	70.6	73.6	76.6	0.1	0.6
Netherlands	77.0	79.5	82.0	72.8	77.4	82.0	0.5	0.9
Switzerland	78.4	82.0	85.6	73.3	77.5	81.7	0.7	0.8
Latin America and the Caribbean								
Caribbean								
Antigua and Barbuda	56.5	66.3	76.1	54.5	64.1	73.7	2.0	1.9
Barbados	57.4	63.5	69.6	55.7	61.8	67.9	1.2	1.2
Cuba	70.8	72.0	73.3	68.2	70.1	72.1	0.3	0.4
Dominica	50.2	50.9	51.5	48.7	49.5	50.4	0.1	0.2
Dominican Republic	55.1	62.2	64.7	50.7	57.7	62.5	1.0	1.2
Grenada	54.3	77.0	77.0	..	..	..	2.3	..
Haiti	11.5	18.0	27.4	10.4	13.2	21.4	1.6	1.1
Jamaica	56.5	64.0	68.8	53.1	60.5	65.8	1.2	1.3
Puerto Rico	74.6	77.2	79.8	65.2	67.2	69.2	0.5	0.4
Saint Lucia	48.6	51.9	55.2	47.8	52.0	56.2	0.7	0.8
St. Vincent and the Grenadines	63.1	68.2	73.3	58.9	65.5	72.1	1.0	1.3
Central America								
Costa Rica	72.6	76.6	80.7	62.0	66.3	70.7	0.8	0.9
El Salvador	49.6	55.9	62.3	45.5	50.7	56.4	1.3	1.1
Guatemala	26.3	31.4	39.9	22.0	26.9	31.9	1.4	1.0
Honduras	44.3	49.2	59.4	34.0	39.4	48.8	1.5	1.5
Mexico	57.9	66.5	71.3	49.4	57.5	62.5	1.3	1.3
Nicaragua	44.8	54.5	65.8	40.9	51.2	63.2	2.1	2.2
South America								
Bolivia	33.3	46.1	53.4	13.3	19.7	27.3	2.0	1.4
Brazil	70.2	75.6	81.1	62.1	68.9	75.7	1.1	1.4

TABLE 5 *(continued)*

Country	*Estimated contraceptive prevalence[b] of any method (percentage)*			*Estimated contraceptive prevalence[b] of modern methods (percentage)*			*Estimated annual change in prevalence, 1990-2000 (percentage points)*	
	1990	*1995*	*2000*	*1990*	*1995*	*2000*	*Any method*	*Modern methods*
Colombia	66.1	72.2	76.9	54.7	59.3	64.0	1.1	0.9
Ecuador	53.7	58.6	67.6	42.3	46.6	51.0	1.4	0.9
Guyana	34.9	36.1	37.3	32.9	34.5	36.0	0.2	0.3
Paraguay	44.1	49.6	64.1	35.2	40.3	54.1	2.0	1.9
Peru	54.6	62.9	68.9	29.5	39.2	50.4	1.4	2.1
Northern America								
Canada	74.0	74.7	75.4	71.7	73.3	74.9	0.1	0.3
United States of America	70.7	76.4	82.1	67.0	70.5	74.0	1.1	0.7
Oceania (developed)								
Australia/New Zealand								
New Zealand	73.4	74.9	76.3	69.2	72.0	74.8	0.3	0.6

Sources: *World Contraceptive Use 2003* and *World Population Prospects 2002,* databases maintained by the Population Division of the United Nations.

NOTE: Two dots (..) indicate that the information is not available.

[a] Contraceptive prevalence is the percentage of women of reproductive age in a marital or consensual union who are using contraception. The prevalence of modern methods is the percentage of women of reproductive age in a marital or consensual union who are using a modern contraceptive method.

[b] For each country, the estimated contraceptive prevalence levels for 1990, 1995 and 2000 were interpolated and extrapolated from the two to four most recent data available. For example, Rwanda's prevalence estimates for 1990, 1995 and 2000 were computed from data collected in 1983, 1992 and 2000: the 1990 estimate was obtained from interpolating the 1983 and 1992 data values and the 2000 estimate was obtained from the 2000 data value. The data used for the estimations are given in annex table A.1.

[c] Contraceptive methods were used in combination so the prevalence estimates could be slightly overestimated.

TABLE 6. DISTRIBUTION OF DEVELOPING COUNTRIES[a] BY ESTIMATED CONTRACEPTIVE PREVALENCE[b] IN 1990 AND 2000

	1990		*2000*	
Contraceptive prevalence[b]	*Percentage*	*Number*	*Percentage*	*Number*
Less than 20 per cent	38	36	20	19
20 per cent to 44 per cent	24	23	26	25
45 per cent to 64 per cent	25	24	24	23
65 per cent or more	13	12	29	28
Total	100	95	100	95

Source: Table 5.

[a] Countries with comparable contraceptive use data for at least two periods.
[b] Percentage of women of reproductive age in a marital or consensual union who are using contraception.

prevalence. That is, despite this slower pace of increase in levels of use of modern contraceptive methods, it was the expansion in the use of these methods that accounted for most of the recent rise in contraceptive use in developing countries.

2. The effect of the lactational amenorrhoea method on recent trends

Because breastfeeding is associated with a reduction of fecundability resulting from the suppression of ovulation during the lactation period, one can consider that breastfeeding is a contraceptive method. As such, it is usually referred to as the "lactational amenorrhoea method" or LAM for short. For a woman to be considered as using the LAM method, she needs to meet the three LAM criteria outlined below. When those criteria are met, LAM is a very effective contraceptive method, with a failure rate of about 2 per cent during the first six months after childbirth (Technical Guidance/Competence Working Group and World Health Organization/Family Planning and Population Unit, 1996). The three LAM criteria are:

(1) *Full or nearly full breastfeeding*. The baby must be exclusively breastfed (that is, fed nothing but breast milk) or, at the very least, be breastfed for almost all feedings, day and night, and on demand. The more intense the breastfeeding, especially during the first weeks and months after the birth of a child, the more effective LAM is and the longer the period of its effectiveness;

(2) *Amenorrhoea*. The breastfeeding woman should be amenorrhoeic, that is, she should not have menses. The return of the menses occurs when the woman experiences at least two consecutive days of bleeding or spotting at least two months after the birth;

(3) *Less than 6 months postpartum*. The baby must be less than 6 months old.

Use of other contraceptive methods to prevent pregnancy is not necessary as long as the LAM criteria are met. However, a woman may use another contraceptive method as back-up during the period of LAM protection if she so wishes. Back-up methods should be limited to those appropriate for breastfeeding women. That is, non-hormonal methods are recommended because they have no effect on either lactation or the infant. The World Health Organization discourages the use of progestin-only methods during the first 6 weeks after birth because of concerns about steroid transmission in breast milk, and contraceptives based on estrogen should not be used by breastfeeding women during the first 6 months after birth because they reduce the quantity and quality of breast milk. Couples relying on LAM to prevent pregnancy should nevertheless use condoms or other barrier methods to protect against the risk of sexually transmitted infections, including HIV/AIDS.

TABLE 7. DEVELOPING COUNTRIES WITH TREND DATA CLASSIFIED ACCORDING TO AVERAGE ANNUAL INCREASE IN CONTRACEPTIVE PREVALENCE[a] BY ESTIMATED LEVEL OF CONTRACEPTIVE USE IN 1990

Contraceptive prevalence[a] in 1990	*Average annual increase in contraceptive prevalence[a] between 1990 and 2000 (percentage points)*				
	< 0.5	*0.5-0.9*	*1.0-1.4*	*1.5-1.9*	*2.0 or more*
Less than 20 per cent	Afghanistan Angola Benin Burundi Eritrea Ethiopia Gambia Madagascar Mali Mauritania Rwanda Sudan	Burkina Faso Cameroon Chad Côte d'Ivoire Ghana Guinea Senegal	Comoros Niger Nigeria Togo	Haiti Lao People's Dem. Rep. Malawi Pakistan Uganda United Rep. of Tanzania Yemen Zambia	Central African Rep. Cambodia Dem. Rep. of the Congo Myanmar Oman
20-44 per cent	Guyana	Botswana India Swaziland	Egypt Guatemala Kenya Lesotho Philippines Qatar Syrian Arab Rep. Zimbabwe	Algeria Bangladesh Honduras Jordan Kuwait Nepal	Bolivia Morocco Nicaragua Paraguay Uzbekistan
45-64 per cent	Azerbaijan Dominica Lebanon Turkey	Saint Lucia South Africa Sri Lanka	Indonesia Bahrain Barbados Dominican Rep. Ecuador El Salvador Jamaica Malaysia Mexico Peru St. Vincent and Grenadines	Antigua and Barbuda Kazakhstan Tunisia Viet Nam	Iran (Islamic Rep. of) Grenada
65 per cent or more	Cuba Mauritius Mongolia Singapore Thailand	China Costa Rica Hong Kong, SAR of China Puerto Rico Rep. of Korea	Brazil Colombia		

Source: Table 5.
[a] Percentage of women aged 15-49, married or in union, who are using contraception.

The duration of LAM use can be extended for a few months beyond the usual six if the woman is still amenorrhoeic and maintains intensive breastfeeding practices. When breastfeeding is prolonged and intense, amenorrhoea may last up to 15 months (Singh and Ferry, 1984). While the risk of pregnancy during lactational amenorrhoea is higher once six months after the birth have elapsed, the failure rate for lactational amenorrhoea between 6 and 12 months after birth is comparable to the perfect-use failure rates for other reversible contraceptive methods. However, more research is needed to establish the efficacy of use of LAM beyond six months after birth in actual populations.

Although the effect of breastfeeding in reducing fecundability has been well known for a long time, LAM was not recognized as part of the array of contraceptive methods until the late 1980s or early 1990s (Kennedy and Visness, 1992). Considering LAM a natural and effective contraceptive method, a series of surveys conducted in the late 1980s and early 1990s began to gather information on the use of LAM. Thus, the Gulf Child Health Surveys conducted in the late 1980s, the Arab Maternal and Child Health Surveys conducted in the early 1990s, and the Gulf Family Health Surveys conducted during 1995-1999 systematically included questions about past and current use of LAM, or breastfeeding, as a method of contraception. The Demographic and Health Surveys did not include LAM until the late 1990s. Thus, in many countries, the latest contraceptive prevalence figures include LAM, whereas most of the surveys conducted in previous decades do not.

For this reason, the trends presented in table 5 overestimate the increase in contraceptive prevalence in the case of 33 countries where LAM was included only in the most recent survey. As table 8 indicates, LAM's contribution to the most recent overall contraceptive prevalence in these countries ranges from 0.1 per cent in Cuba to 54 per cent in Chad. LAM makes major contributions to recent contraceptive prevalence in Rwanda (11 per cent), Burundi (14 per cent), Mali (15 per cent), Togo (16 per cent), the Central African Republic (17 per cent), Uganda and the Democratic Republic of Congo (18 per cent each), Eritrea (26 per cent), Niger (49 per cent) and Chad (54 per cent), but in 20 of the 33 countries considered, the share of LAM in contraceptive prevalence is lower than 5 per cent. Consequently, adjusted estimates of the pace of change in contraceptive prevalence derived by excluding LAM from the most recent data show considerable differences with respect to the unadjusted estimates mainly for the countries listed above. For instance, the adjusted figures for Eritrea indicate that there was a reduction in contraceptive prevalence rather than the unchanging levels shown in table 5. In Chad, the adjusted estimates indicate that contraceptive prevalence dropped instead of increasing; and in Niger, according to the adjusted figures, contraceptive prevalence rose by a mere 0.3 percentage points per year during 1990-2000 rather than by more than 1.0 percentage point per year as estimated before. In the other countries, the exclusion of LAM does not have such significant effects on the previously estimated changes in prevalence. Furthermore, because the practice of intensive breastfeeding has generally been widespread in those of the 33 countries with high LAM prevalence today, especially among those in sub-Saharan Africa, contraceptive levels in the past would have been higher if LAM had been included, even if the gains made thereafter are not as large as initially estimated.

3. Recent trends in developed countries

Contraceptive use in developed countries increased slowly after 1990, averaging a gain of 0.4 percentage points per year. Most of the increase occurred in Northern America and in particular in the United States where overall contraceptive prevalence rose by 1.1 percentage points per year during the decade. In contrast, in Europe as a whole, contraceptive prevalence barely changed, rising from 66 per cent in 1990 to 68 per cent in 2000, that is, increasing at an average annual pace of 0.2 percentage points. Within Europe, the major increase occurred in countries of Eastern Europe, a region whose contraceptive prevalence rose from 59 per cent in 1990 to 63 per cent in 2000, rising therefore at 0.4 percentage points per year. There was virtually no change in the contraceptive prevalence level of Western Europe and very low gains in Northern Europe and Southern Europe. Because most developed countries already had high levels of contraceptive use in 1990, there was little room for further growth.

The most notable change in contraceptive use in European countries is the shift from traditional methods to modern contraceptive methods. Thus, the growth in prevalence of modern methods was considerably higher than that of overall contraceptive use, particularly in Southern Europe and Eastern Europe, where the prevalence of modern methods rose at 0.9 percentage points and

TABLE 8. CHANGE IN CONTRACEPTIVE PREVALENCE WITH AND WITHOUT ADJUSTMENT FOR THE LACTATIONAL AMENORRHOEA METHOD (LAM) IN THE MOST RECENT DATA, SELECTED COUNTRIES

		Most recent contraceptive prevalence including LAM (percentage)		*Lactational amenorrhoea method (LAM)*		*Most recent prevalence estimate adjusted to exclude LAM (percentage)*		*Annual change in 1990-2000 including LAM (percentage points)*		*Annual change in 1990-2000 excluding LAM (percentage points)*	
Country	*Year*	*Any method*	*Modern methods*	*Prevalence (percentage)*	*As percentage of overall contraceptive prevalence*	*Any method*	*Modern methods*	*Any method*	*Modern methods*	*Any method*	*Modern methods*
Eastern Africa											
Burundi	2000	15.7	10.0	2.2	14.0	13.5	10.0	0.5	0.7	0.4	0.7
Comoros	2000	25.7	19.3	1.6	6.2	24.1	19.3	1.2	1.9	0.8	2.0
Eritrea	2002	8.0	5.1	2.1	26.3	5.9	5.1	0.0	0.2	-0.3	0.2
Madagascar	2000	18.8	11.8	0.6	3.2	18.2	11.8	0.3	0.9	0.2	0.8
Malawi	2000	30.6	26.1	0.4	1.3	30.2	25.7	1.9	2.0	1.9	2.0
Rwanda	2000	13.2	4.3	1.4	10.6	11.8	4.3	-0.6	-0.6	-0.7	-0.6
Uganda	2001	22.8	18.2	4.2	18.4	18.6	14.0	1.5	1.3	1.1	1.0
United Rep. of Tanzania	1999	25.4	16.9	1.9	7.5	23.5	16.9	1.9	1.3	1.6	1.3
Zimbabwe	1999	53.5	50.4	0.2	0.4	53.3	50.2	1.1	1.5	1.0	1.5
Middle Africa											
Angola	2001	6.2	4.5	0.3	4.8	5.9	4.5	-0.4	0.1	-0.4	0.1
Central African Republic	2000	27.9	6.9	4.8	17.2	23.1	6.9	2.6	0.7	1.7	0.7
Chad	2000	7.9	2.1	4.3	54.4	3.6	2.1	0.8	0.2	-0.2	0.3
Dem. Rep. of the Congo	2001	31.4	4.4	5.8	18.5	25.6	4.4	2.4	0.2	1.8	0.2
Southern Africa											
Lesotho	2000	30.4	29.5	0.1	0.3	30.3	29.5	1.0	1.3	0.9	1.3
Swaziland	2000	27.7	26.0	0.1	0.4	27.6	26.0	0.7	0.7	0.6	0.7
Western Africa											
Benin	2001	18.6	7.2	0.4	2.2	18.2	7.2	0.4	0.6	0.4	0.8
Ghana	1999	22.0	13.3	0.5	2.3	21.5	12.8	0.6	0.7	0.6	0.7
Mali	2001	8.1	5.7	1.2	14.8	6.9	5.7	0.2	0.3	0.1	0.3
Niger	2000	14.0	4.3	6.9	49.3	7.1	4.3	1.1	0.3	0.3	0.3
Togo	2000	25.7	9.3	4.0	15.6	21.7	9.3	1.1	0.6	0.7	0.6
Eastern Asia											
Mongolia	2000	67.4	54.3	4.7	7.0	62.7	54.3	-0.2	4.6	-0.3	4.6
South-central Asia											
Kazakhstan	1999	66.1	52.7	1.6	2.4	64.5	52.7	1.9	1.7	1.4	1.7
Uzbekistan	2000	67.2	62.5	1.1	1.6	66.1	62.5	2.9	2.8	2.6	2.8

TABLE 8 *(continued)*

Country	Year	*Most recent contraceptive prevalence including LAM (percentage)*		*Lactational amenorrhoea method (LAM)*		*Most recent prevalence estimate adjusted to exclude LAM (percentage)*		*Annual change in 1990-2000 including LAM (percentage points)*		*Annual change in 1990-2000 excluding LAM (percentage points)*	
		Any method	*Modern methods*	*Prevalence (percentage)*	*As percentage of overall contraceptive prevalence*	*Any method*	*Modern methods*	*Any method*	*Modern methods*	*Any method*	*Modern methods*
South-eastern Asia											
Cambodia	2000	23.8	18.5	0.3	1.3	23.5	18.5	2.3	1.9	2.3	1.9
Eastern Europe											
Republic of Moldova	2000	62.4	42.8	0.9	1.4	61.5	42.8	1.2	1.4	1.2	1.4
Southern Europe											
Serbia and Montenegro	2000	58.3	32.8	1.2	2.1	57.1	31.6	0.1	0.9	0.1	0.8
Caribbean											
Cuba	2000	73.3	72.1	0.1	0.1	73.2	72.1	0.3	0.4	0.3	0.4
Dominican Republic	2000	64.7	62.5	0.3	0.5	64.4	62.5	1.0	1.2	1.0	1.2
Haiti	2000	27.4	21.4	0.6	2.2	26.8	21.4	1.6	1.1	1.5	1.1
Central America											
Nicaragua	2001	68.6	66.1	1.8	2.6	66.8	64.3	2.1	2.2	2.1	2.2
South America											
Bolivia	2000	53.4	27.3	3.2	6.0	50.2	27.3	2.0	1.4	1.8	1.4
Guyana	2000	37.3	36.0	0.3	0.8	37.0	36.0	0.2	0.3	0.2	0.3
Peru	2000	68.9	50.4	0.7	1.0	68.2	49.7	1.4	2.1	1.6	1.9

Sources: *World Contraceptive Use 2003,* database maintained by the Population Division of the United Nations, and table 5.

NOTE: Contraceptive prevalence is the percentage of women of reproductive age in a marital or consensual union who are using contraception. The prevalence of modern methods is the percentage of women of reproductive age in a marital or consensual union who are using modern contraceptive methods.

1.4 percentage points, respectively. However, in Northern Europe and Northern America, the use of modern methods rose less rapidly than that of all methods, indicating that there is still considerable heterogeneity in trends of contraceptive use in the regions of the developed world.

B. Trends in contraceptive prevalence at the country level

1. Africa

Trends in contraceptive use in the countries of Africa are shown in figure III and annex table A.1. Countries in Eastern Africa, Middle Africa and Western Africa tend to cluster at the bottom of the graph, vividly illustrating the persistence of low levels of contraceptive use (below 10 per cent) in those three regions since 1970. Significant increases did not start until the late 1980s or early 1990s. As a result of this recent start in contraceptive uptake, 26 of the 30 countries of Africa with trend data still had a contraceptive prevalence level below 30 per cent in 2000. The four exceptions, all located in Eastern Africa, are Kenya with 42 per cent prevalence, Malawi with 31 per cent, Mauritius with 74 per cent and Zimbabwe with 55 per cent. Kenya, Mauritius and Zimbabwe have relatively strong family planning programmes.

About half the countries of Eastern Africa with trend data (6 out of 13 when data are adjusted to exclude LAM) experienced rapid increases in contraceptive prevalence during the 1990s, amounting to at least 1.0 percentage point per year. Among them, Malawi, Uganda, the United Republic of Tanzania and Zambia started with very low levels (below 12 per cent in 1990) and reached levels ranging between 22 per cent and 31 per cent by 2000 when LAM is included in the most recent estimates. Burundi, Ethiopia and Madagascar, in contrast, saw their contraceptive levels rise very little so that by 2000, contraceptive prevalence in Ethiopia was estimated at just 8 per cent, it was 16 per cent in Burundi and 19 per cent in Madagascar.

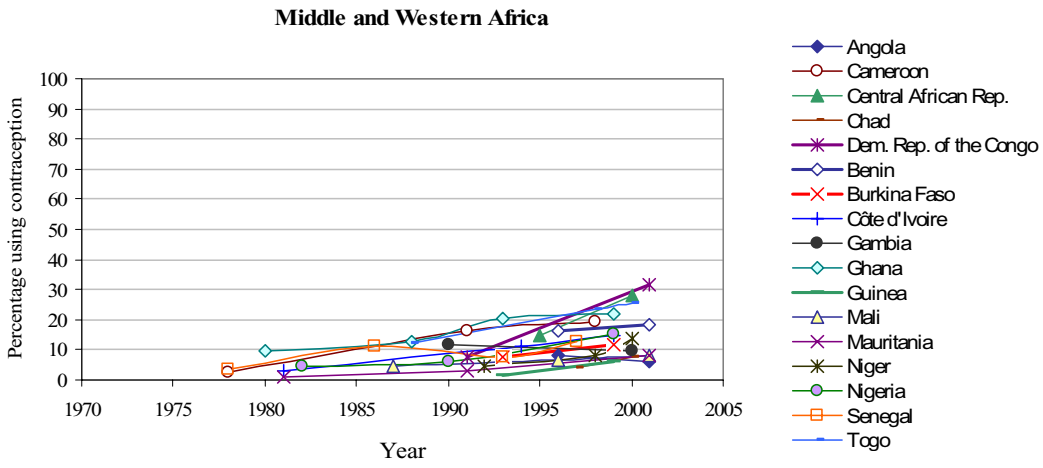
Contraceptive prevalence appears to have declined in three countries: Eritrea, Mauritius and Rwanda. Mauritius had already reached a very high prevalence by 1990 (75 per cent) so the decline recorded is trivial. In Eritrea, a decline is noticeable when the most recent data are adjusted to exclude LAM. Otherwise, contraceptive prevalence in Eritrea appears not to have changed over the decade, remaining at a low 8 per cent. In Rwanda the estimated reduction in contraceptive prevalence between 1990 and 2000 is marked, with a drop amounting to 0.6 percentage points per year, reducing contraceptive prevalence from 21 per cent to 13 per cent. This reduction has occurred mainly in rural areas as a result of a drop in the use of injectables and, to a lesser extent, of the pill (Office National de la Population and ORC Macro, 2001).

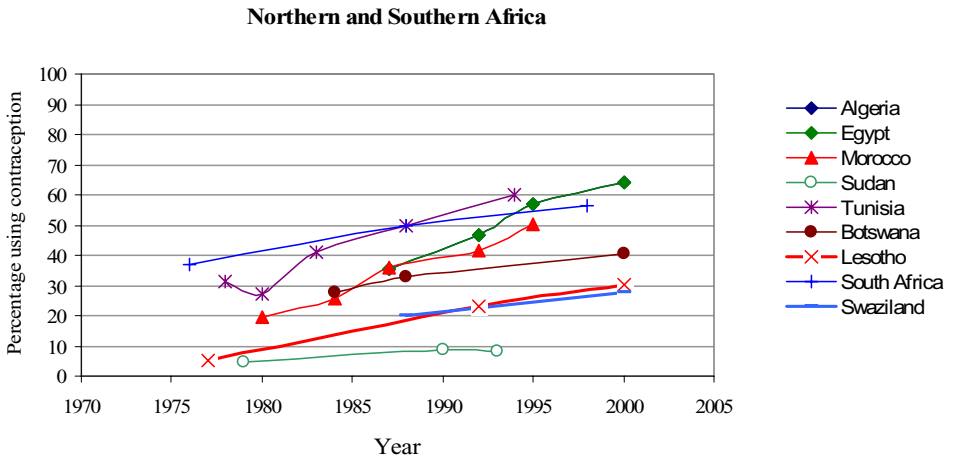
In contrast with the general stagnation of contraceptive levels in other regions of Africa, the countries of Northern Africa and Southern Africa have experienced rapid increases in contraceptive use since 1970. With the exception of Sudan, where prevalence has stagnated at around 10 per cent since the 1970s, prevalence has risen steadily in all the other countries in those regions having trends data. Thus, whereas in the 1970s contraceptive prevalence in the countries of Northern Africa and Southern Africa ranged from 0 to 30 per cent, it ranged from 30 per cent to 70 per cent in 2000 (excluding Sudan). During 1990-2000, the countries of Northern Africa continued to experience rapid increases in prevalence, averaging over 1.5 percentage points per year. In Southern Africa, the gains were smaller, ranging from 0.6 percentage points to 1.0 percentage point per year.

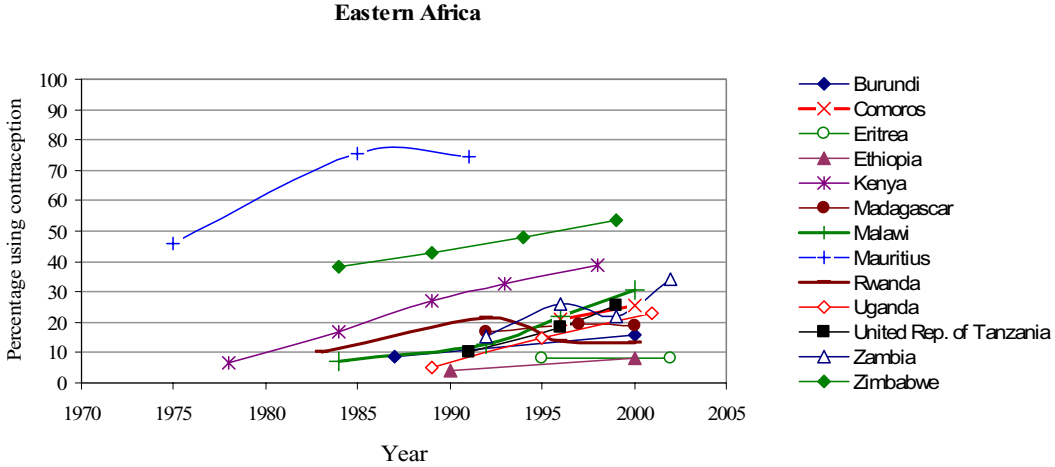
The low levels of contraceptive use still common in sub-Saharan Africa in general, and in Eastern Africa, Middle Africa and Western Africa in particular, are related to the context in which family planning programmes have been operating in these regions. Factors such as weak governmental support, relatively recent programme implementation, inadequate resources and weak absorptive capacity are among the main reasons for the slow uptake of family planning (Caldwell and Caldwell, 2002). Thus, although by the late 1990s almost all the Governments of countries in Africa reported providing either direct or indirect support for the distribution of contraceptives, the situation had been very different in the early 1970s: only 26 out of the 48 countries surveyed reported providing such a support, and most of them were in Northern Africa and Southern Africa (see chapter VI). In the majority of countries in Eastern Africa, Middle Africa and Western Africa, family planning programmes started much later than in other regions —no earlier than the late 1970s and often later—the exceptions being Ghana, Kenya and Mauritius where family planning programmes were established in 1969, 1967 and 1957 respectively.

The commitment of Governments to existing programmes also tends to be weaker in sub-Saharan

Figure III. Trends in contraceptive prevalence in countries of Africa, by region







Africa than elsewhere in the developing world. Sub-Saharan African countries are characterized by low scores in overall family planning programme effort according to assessments of national family planning activities based on contraceptive availability, policy statements, and the accessibility of services (Ross, Stover and Willard, 1999). For example, sub-Saharan Africa has the lowest percentage of countries where at least one contraceptive method is accessible to at least half of the married female population. In addition, available data suggest that per capita funding for family planning activities in sub-Saharan Africa is less than half that in Asia or Latin America (National Research Council, 1993).

Weak Government support for family planning programmes is particularly prevalent in francophone Africa where the majority of countries did not adopt a national family planning policy or a national population policy to promote family planning until the late 1980s or 1990s: For instance, Burkina Faso did so in 1986, Senegal in 1991, Mali in 1994, Madagascar in 1997 and Côte d'Ivoire in 1999 (Population Council, 2004). Despite the adoption of these policies, many legal barriers for the provision or advertisement of family planning services remain. By the mid-1990s, the 1920 French Law[1] that prohibits the sale and advertising of contraceptive methods and which was applied to the colonies in the 1930s was still in place in half a dozen countries (Futures Group International, 2003). In African countries where that law has already been repealed or modified, its legacy has persisted in the form of negative attitudes and passivity toward reproductive health issues. In Burkina Faso, for instance, the Penal Code still prohibits the provision of information on contraception despite the National Family Planning Policy adopted in 1986. In Cameroon, there is a law prohibiting contraceptive advertising by pharmacists. Only recently, after a Symposium held in Cotonou, Benin, in March 1997 to discuss legal barriers to family planning and reproductive health, did several countries began to take steps to enact laws to promote family planning and reproductive health. Such laws were adopted by Guinea in 2000, Chad and Mali in 2002, and Benin in 2003 (Futures Group International, 2003).

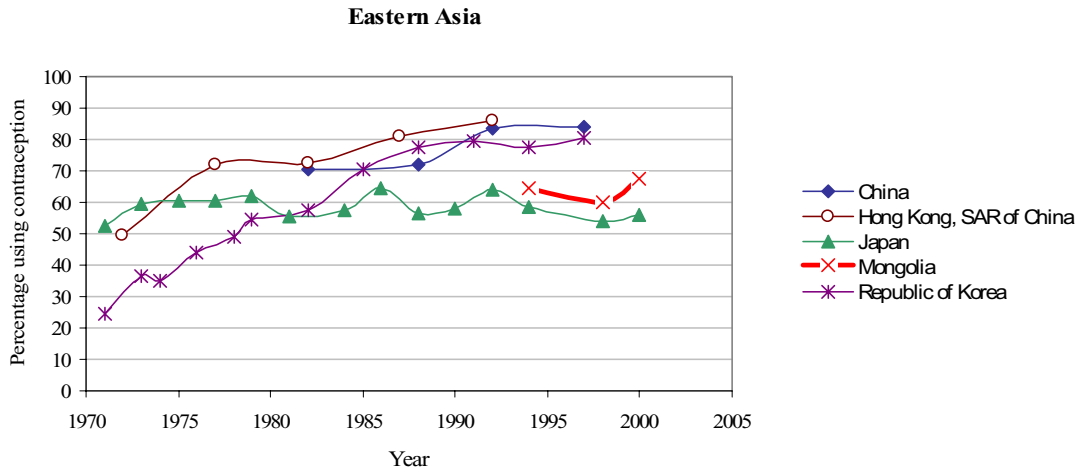
Weak Government support for family planning reflects the weak absorptive capacity for family planning in sub-Saharan African societies, which is in turn related to their low socio-economic development and constraints imposed by low levels of human capital. Sub-Saharan Africa has the lowest per capita availability of health personnel, which is precisely the personnel needed to provide family planning services and distribute modern contraceptive methods. Sub-Saharan Africa also continues to have high rates of infant and child mortality, a factor militating against a reduction of family size since couples feel compelled to have large numbers of children to ensure that a sufficient number survive to adulthood. The Demographic and Health Surveys conducted in African countries since 1990 indicate that between 150 and 250 out of every 1000 births die before the age of 5 in the majority of countries in sub-Saharan Africa. In addition, sub-Saharan Africa is characterized by very high levels of illiteracy and low levels of educational attainment, particularly among girls and women. Both low educational attainment among women and high mortality in childhood are associated with high desired fertility and low contraceptive use (United Nations, 2003a). Women in sub-Saharan Africa still report that their ideal number of children is between 5 and 8, compared with a range of 2 to 4 in the rest of the world, and men in sub-Saharan Africa report wanting even more children than women do.

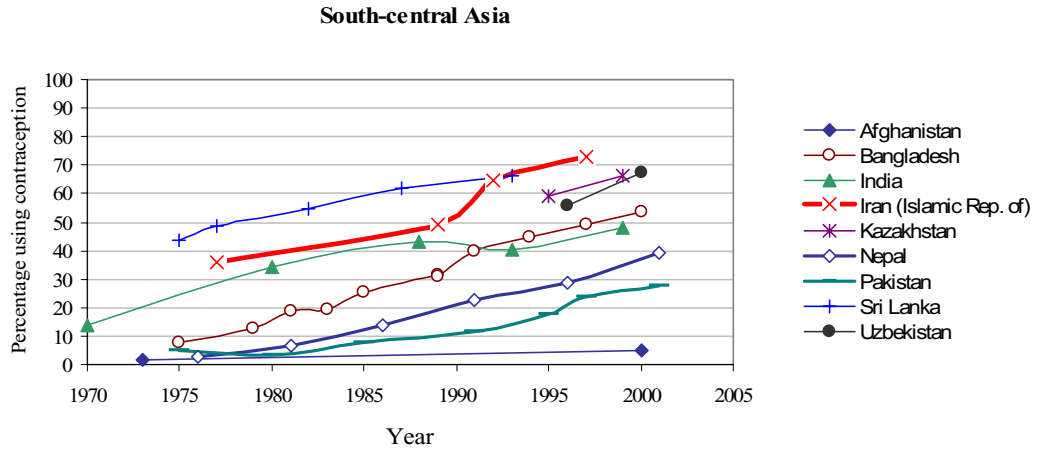
2. Asia

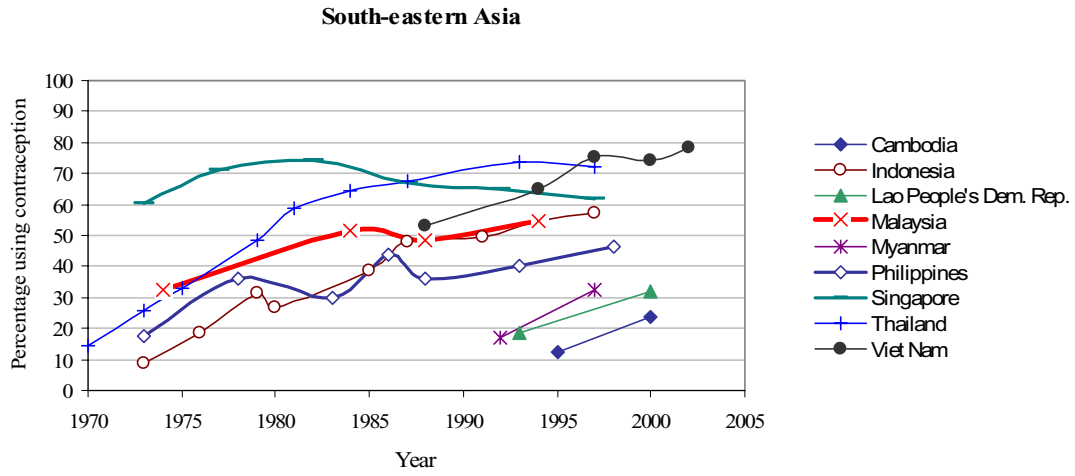
Trends in contraceptive use in the countries of Asia are displayed in figure IV. In the five countries or areas of Eastern Asia with trend data—China, Hong Kong SAR of China, Japan, Mongolia and the Republic of Korea—most of the increase in prevalence occurred in the 1970s and high levels of contraceptive use (ranging from 50 per cent to 70 per cent) have prevailed since 1980. Although the Republic of Korea had a contraceptive prevalence of just 20 per cent in 1970, it had caught up with China and Hong Kong SAR of China by the late 1980s. In contrast, Japan, which had reached a relatively high level of contraceptive prevalence by 1970, has experienced a virtual stagnation of its contraceptive level and has currently one of the lowest levels of contraceptive prevalence in the developed world (56 per cent in 2000).

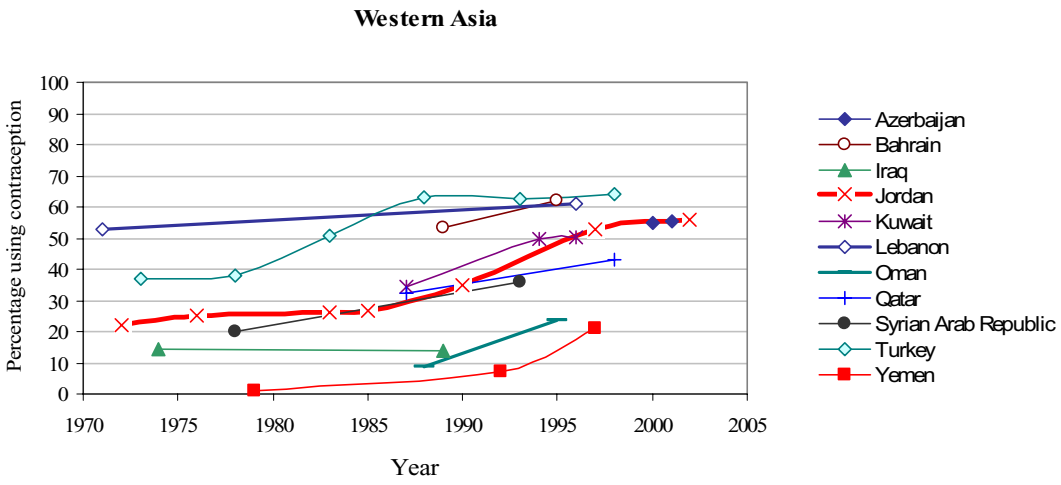
Countries in the other three regions of Asia generally started at lower levels of contraceptive prevalence in the 1970s than those of Eastern Asia and have not converged as yet to uniformly high levels. In South-central Asia, contraceptive use has stagnated in Afghanistan at very low levels. In 2000, the country was estimated to have just 5 per cent prevalence. But in other countries of the

Figure IV. Trends in contraceptive prevalence in countries of Asia, by region









region, contraceptive prevalence has risen markedly, generally averaging increases of over 1.5 percentage points per year during the 1990s. The fastest growth was recorded by the Islamic Republic of Iran between 1989 and 1997, at 3.0 percentage points per year on average, and by Uzbekistan during 1996-2000, at 2.9 percentage points per year (or 2.6 percentage points when LAM is excluded from recent estimates of prevalence). According to the most recent data, four countries in South-central Asia had attained prevalence levels higher than 66 per cent: Kazakhstan, the Islamic Republic of Iran, Sri Lanka and Uzbekistan, all of which had levels of around 30 per cent in the early 1970s.

In South-eastern Asia, five of the nine countries with trend data have also experienced marked increases in contraceptive prevalence between 1970 and 2000. Around 2000, only three countries—Cambodia, the Lao People's Democratic Republic and Myanmar—had contraceptive prevalence levels below 33 per cent. However, all three plus Viet Nam experienced the fastest growth in contraceptive use in the region during recent years, averaging annual increases of 1.7 to 3.2 percentage points. The fastest growth was experienced by Myanmar, whose contraceptive prevalence nearly doubled during 1992-1997, passing from 17 per cent to 33 per cent. Cambodia's prevalence also rose rapidly, from 13 per cent in 1995 to 24 per cent in 2000. The increase in prevalence in the Lao People's Democratic Republic was slightly slower: from 19 per cent to 32 per cent between 1993 and 2000. But all three countries still have moderately low levels of contraceptive prevalence. That is not the case of Viet Nam, whose contraceptive prevalence increased from an estimated 53 per cent in 1988 to a remarkably high level of 78 per cent in 2002, the highest level recorded in South-eastern Asia so far. This development owes much to Government of Viet Nam's promotion of small families, which started in 1993, and to the establishment of an effective family planning programme based on mass mobilization and activities involving information, education and counselling (United Nations Economic and Social Commission for Asia and the Pacific, 2002b).

In contrast with these rapid increases in contraceptive practice, former star performers have seen their contraceptive prevalence stagnate or even decrease in recent years. Thailand, for instance, had recorded the most dramatic increase in contraceptive prevalence in the world during the 1970s and early 1980s, averaging annual gains of close to 4.0 percentage points (United Nations, 2000), but such pace of growth could not be maintained forever and it slowed down during the 1980s after prevalence had reached 65 per cent. In Malaysia, contraceptive use declined somewhat during the 1980s as a result of pro-natalist policies adopted by the Government in the early 1980s. As a consequence, the decline of fertility among the Malay population slowed down between 1985 and 1995 (Gubhaju and Moriki-Durand, 2003). In Singapore, contraceptive prevalence reached 74 per cent in 1982 when the two-child family was being vigorously promoted as a norm, but after the adoption of a pro-natalist policy in 1987,

prevalence fell to 67 per cent. The decline continued through the 1990s so that by 1997, contraceptive prevalence in Singapore was down to 62 per cent (Chuan, 1999).

In countries of Western Asia, the growth in contraceptive use has taken place mostly in the 1990s. Yet contraceptive prevalence remains low in Iraq, Oman and Yemen (below 24 per cent) despite the relatively rapid increases that Oman experienced between 1988 and 1995 and that Yemen recorded from 1979 to 1997. Iraq, in contrast, experienced a reduction of contraceptive prevalence between 1974 and 1989, the most recent year for which data are available. In five countries of Western Asia— Azerbaijan, Bahrain, Jordan, Lebanon and Turkey—contraceptive prevalence is above 55 per cent and it has grown fairly slowly in Lebanon since 1971 and in Turkey during 1988-1998.

A strong government commitment to family planning programmes is the main reason behind the success of many Asian countries in achieving high levels of contraceptive prevalence. Thus, China's level of 84 per cent in 1997 was achieved in large measure because of the sustained efforts by the Government to provide family planning services to the whole country. This commitment is closely linked to a policy that promotes small families in order to control population growth. Since the early 1980s, the Government of China has adopted a series of laws to ensure that family planning and population targets are implemented properly and in a consistent way. In practice, family planning workers are sent to visit households in rural areas and in urban areas family planning and reproductive health services are provided at the district and county level using community facilities. In the 1990s, as the economy of China boomed, the Government's strategy shifted to setting up and developing a network of family planning associations at all levels, associations that are playing a role similar to that of some non-governmental organizations in other countries. In particular, they have contributed to increase the quality of care and services while maintaining high levels of contraceptive use (United Nations Economic and Social Commission for Asia and the Pacific, 2002a).

The very rapid increase in contraceptive prevalence in the Islamic Republic of Iran, which made it rise to the top level of prevalence in South-central Asia, is the consequence of a change in policy accompanied by the revitalization of the family planning programme that started in 1989. Soon after the 1979 Islamic Revolution, the family planning programme in Iran was suspended and a pro-natalist policy was espoused. However, the revival of the family planning programme in 1989 gained the support of high-ranking religious leaders who have since been involved in promoting smaller families by, among other things, citing that goal as a social responsibility in their weekly sermons (Abbasi-Shavazi, 2002, Mehryar and others, 2002). As a result, contraceptive prevalence in the Islamic Republic of Iran rose from 49 per cent in 1989 to 65 per cent in 1992 and has since increased further to reach 73 per cent in 1997, a level similar to those typical of developed countries. This rise in contraceptive use has been accompanied by a sharp reduction in fertility levels.

The success of Bangladesh, a least developed country, in achieving a contraceptive prevalence of 54 per cent in 2000 merits attention. Successive Governments have attached high priority to the reduction of the rate of population growth and, consequently, have strengthened and intensified the family planning programme (Barkat-e-Khuda, Roy and Rahman, 2000). Health and family welfare clinics have been built all over the country, thousands of female workers have been trained to provide family planning advice by visiting households, and mass media campaigns have been used to generate and increase awareness about family planning. That is, as in other countries, strong political commitment to family planning from the Government of Bangladesh plus the outreach approach to the delivery of family planning services supported by non-govermental organizations with coordinated assistance from donors have contributed to raise contraceptive prevalence from 8 per cent in 1975 to 54 per cent in 2000. As a result, fertility levels have also dropped markedly, from 6.3 children per woman in 1971-1975 to 3.3 children per woman in 1994-1996 (Barkat-e-Khuda, Roy and Rahman, 2000). Despite these successes, major challenges persist, including high rates of maternal mortality, the need to improve the quality and accessibility of care, and the need to reduce the strong preference for sons. It has been suggested that these factors have contributed to slow down the rise in contraceptive use and to stall the fertility transition in Bangladesh (Rahman and Da Vanzo, 2002), suggesting that without a major improvement in the socio-economic situation of the population, fertility may not continue to decline (Bongaarts, 2002).

3. Latin America and the Caribbean

Trends in contraceptive prevalence in the countries of Latin American and the Caribbean are depicted by region in figure V. The countries of this major area have experienced sustained increases in contraceptive prevalence since 1970. In 18 of the 25 countries with data, this growth continued during the most recent period, with contraceptive prevalence rising by at least 1.0 percentage point per year. In the Caribbean, with the exception of Haiti and Trinidad and Tobago, contraceptive prevalence has reached levels above 45 per cent in all countries with data. In Cuba and Puerto Rico, prevalence is above 70 per cent, a level comparable to those of developed countries. Yet these countries plus Dominica have experienced relatively slow increases in prevalence since the 1980s. The most rapid increases have been recorded by Antigua and Barbuda and Grenada, averaging 2 percentage points or more during the most recent period. Haiti has also experienced a rapid growth in contraceptive prevalence between 1989 and 2000, but because it started from a very low level (10 per cent), it has only reached 27 per cent by 2000.

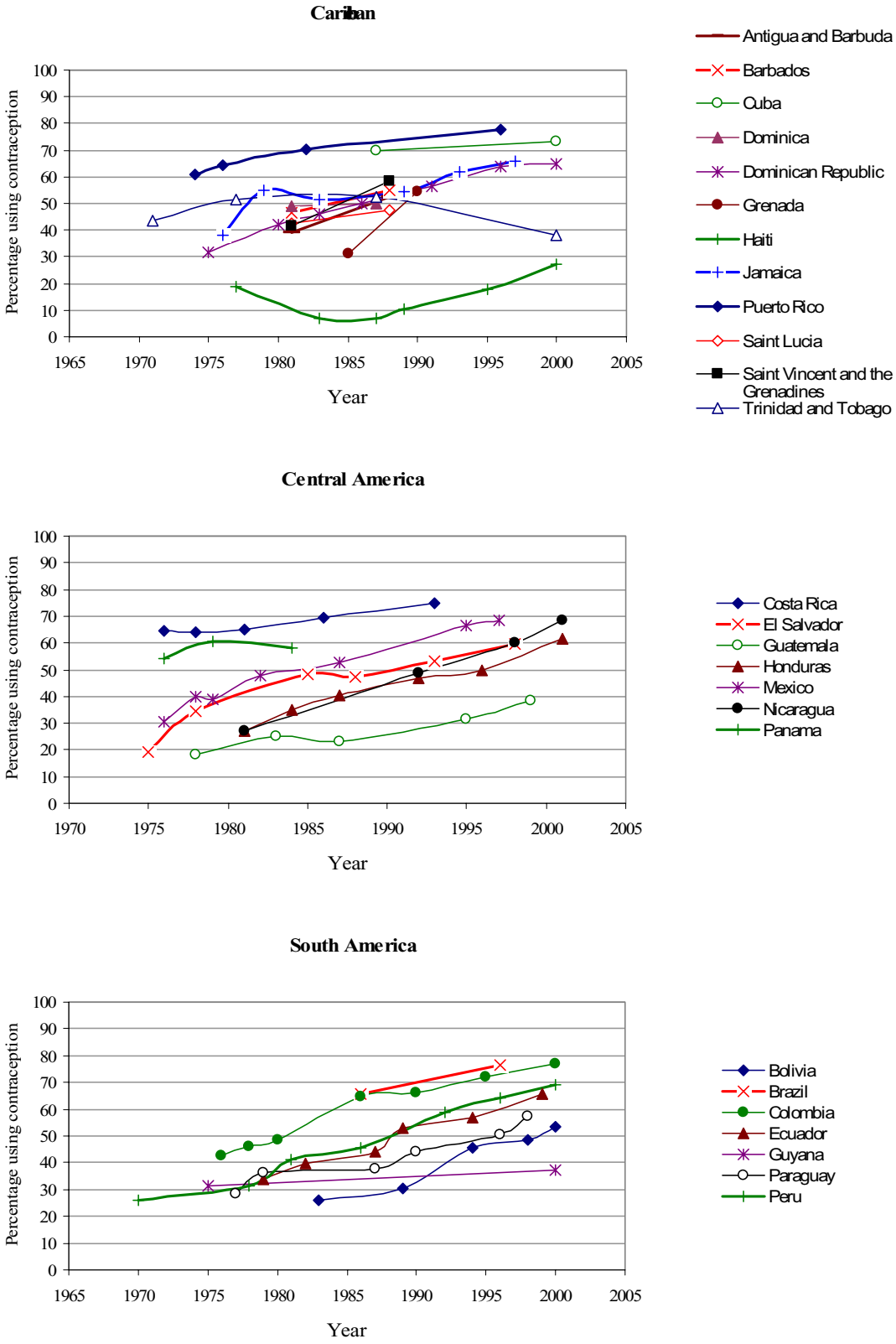
In Central America, Costa Rica had already attained a high level of contraceptive prevalence by 1975 and so had Panama, which lacks data for recent periods. So in both of these countries, increases in contraceptive prevalence since then have been modest (in Panama, contraceptive prevalence seems to have declined slightly in the early 1980s). Larger gains in prevalence were recorded in the other five countries of Central America, averaging at least 1.3 percentage points per year. Nevertheless, by 1999 contraceptive prevalence in Guatemala was still below 40 per cent.

Among the seven countries in South America with recent data on trends, only one, Guyana, experienced an average increase in contraceptive prevalence lower than 1.0 percentage point per year. Guyana is also the country in South America with the lowest prevalence in 2000, at 37 per cent. In contrast, Bolivia, which used to have a considerably lower prevalence than Guyana, has seen its contraceptive prevalence rise to 53 per cent. Contraceptive levels have kept on increasing even in countries such as Brazil, Colombia and Ecuador, that had reached levels above 50 per cent in the late 1980s. The case of Brazil is worth noting because its level of contraceptive use rose from 66 per cent in 1986 to 77 per cent level in 1996, thus becoming one of the highest levels in the world.

The high contraceptive prevalence achieved by the majority of the Latin American and Caribbean countries is the result of a situation where family planning services are widely available through a mix of private and public services, including pharmacies, all of which supply contraceptive methods large numbers of users. Organized family planning programmes in Latin America date as far back as the 1960s for most countries. However, they were originally small in scale, largely private and semi-experimental in nature. They involved at first the provision of information and education by the medical community with support from external funding sources (mainly the International Planned Parenthood Federation and the United Nations Population Fund), and provided services mostly to the urban middle and upper-classes. Many Governments in Latin America and the Caribbean did not start incorporating family planning into their public health services until after the 1974 World Population Conference held in Bucharest, Romania. In some countries, such as Brazil, the Government opposed or took a passive attitude toward the provision of family planning services. Today, family planning services are mainly provided by the private sector in much of Latin America. The most notable exception is Mexico, where the Government strongly supports—politically and financially—public-sector family planning programmes (Mundigo, 1996). Thus, in Mexico, family planning services and contraceptive supplies are available free of charge and in 1995, 72 per cent of Mexican women who used contraceptive methods obtained them from clinics run by the Ministry of Health and the Mexican Social Security Institute and other outreach programmes supported by the Government. In Peru, the Government began to provide free family planning services in 1996 and it is estimated that, by 2004, the Ministry of Health and the Peruvian Institute of Social Security covered the contraceptive needs of 70 per cent of all women using contraception in Peru (Center for Reproductive Law and Policy, 1997).

However, contraceptive prevalence in the countries of Latin America and the Caribbean does not seem to be strongly associated with the strength and scope of their family planning programmes. In Mexico, for instance, contraceptive prevalence is 70 per cent, lower than that of Brazil (75 per cent) where the Government has not played a major role in supporting family planning. The Dominican

Figure V. Trends in contraceptive prevalence in countries of Latin America and the Caribbean, by region



Republic and Trinidad and Tobago provide two additional examples of countries with moderately strong family planning programmes whose contraceptive prevalence levels are still below 70 per cent. To a large extent, high contraceptive prevalence in many Latin American countries is possible because women can buy contraceptive supplies in pharmacies (Mundigo, 1996).

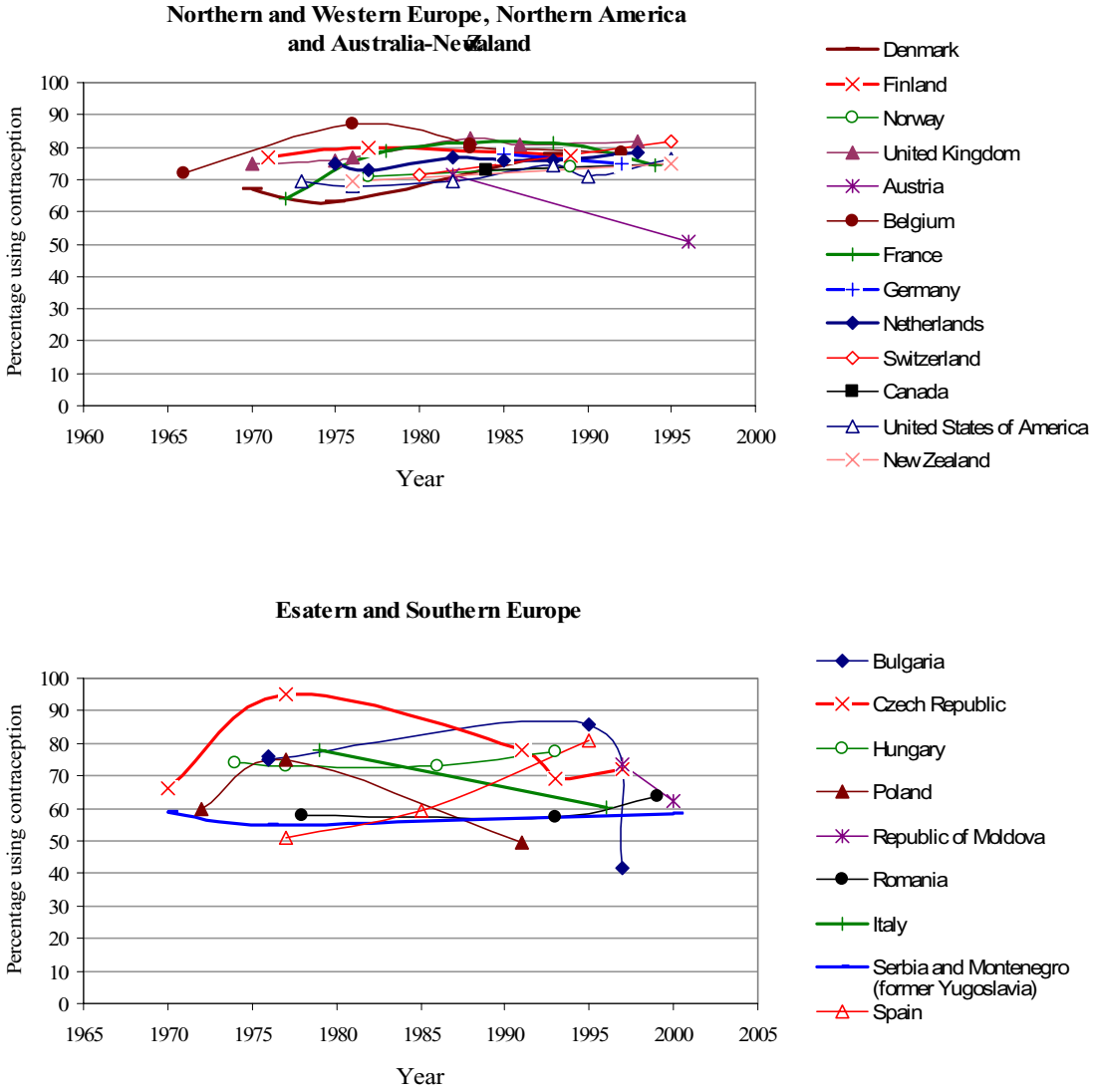
4. Europe, Northern America and Australia/New Zealand

In countries of Northern Europe, Western Europe, Northern America and Australia/New Zealand, contraceptive prevalence appears to have remained generally stable, at least since 1985 (see figure VI). The only exception is Austria, whose contraceptive prevalence appears to have dropped from 71 per cent in 1982 to 51 per cent in 1996. This unexpected trend is caused by the lack of comparability of the data available for Austria, as will be explained below.

Trends in countries of Eastern Europe and Southern Europe appear distorted because of differences in how the data on contraceptive use were gathered by different surveys. In the Czech Republic, for instance, the 1977 estimates overestimate prevalence because respondents were asked which method they had used "most often" and all those who answered the question citing a method were counted as current users (Berent, 1982). The same type of distortion occurred in Austria, Bulgaria, Italy, the Republic of Moldavia and Poland. In Italy, for instance, the 1979 survey asked women to report which contraceptive methods they had used since the end of the last pregnancy or, if they had never been pregnant, since the date of their marriage, and the answers to those questions were used to calculate proportions of users, which are clearly not appropriate as indicators of the proportions of current users (De Sandre and others, 2000).

These distortions lead to spurious changes in contraceptive prevalence over time. Given the high levels of contraceptive use that most European countries had already attained by the 1970s, it seems safe to conclude that actual contraceptive use has remained fairly stable or increased slowly in most European countries since 1970. Two countries, however, stand out as exceptions to this pattern. In Spain, contraceptive prevalence has increased markedly since the 1970s, with the most rapid growth occurring in the 1990s. As a result, in 1995, Spain was among the countries with the highest levels of contraceptive use in the world: above 80 per cent. The United States also experienced a rapid rise in contraceptive use during the early 1990s, amounting to 1.1 percentage points per year, and leading to a rise form 71 per cent in 1990 to 76 per cent in 1995. This rapid increase in contraceptive prevalence in the United States is related to an equally rapid increase in the number of women who received their family planning services at publicly funded clinics. The latter offer free or highly subsidized high quality contraceptive and reproductive health care to millions of women (Frost and others, 2001). The publicly funded family planning programme of the United States was established in 1970 to address the unmet need for family planning of low-income women. Today, it serves women with low to moderate incomes as well as teenagers. The programme received rapidly increasing funding during the 1970s. However, during the 1980s, administrative restrictions led to cuts in funding. By the late 1980s, the Congress of the United States reinstated support for the programme and there was a rapid increase in the number of its users (The Alan Guttmacher Institute, 1998).

Figure VI. Trends in contraceptive prevalence in countries of Europe, Northern America and Australia/New Zealand, by region



NOTE

[1] The Law of 31 July 1920 suppressing the encouragement of abortion and the promotion of birth control, French West Africa Gazette (Journal Officiel de l'Afrique occidentale française), 1933, p. 624.

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III. SPECIFIC CONTRACEPTIVE METHODS USED

This chapter provides a description of recent levels and trends in the use of specific contraceptive methods, as well as method mix, at the global, regional and country levels. Although method mix is also used in the literature to refer to the array of contraceptive methods available through a family planning programme, in this review method mix refers to the distribution of methods used among the population of female contraceptive users, that is, women of reproductive age who are married or in a consensual union and who use contraception. Thus, method mix will be described in terms of the share that each method has in overall contraceptive use.

The International Conference on Population and Development stressed the importance of providing couples and individuals with a wide range of contraceptive methods and of ensuring that users have the information needed to choose a method on the basis of their needs and preferences. Having access to a wide array of methods is often associated with increases in contraceptive practice and a more consistent use of contraception. Progress has been made since 1990 in providing such access, as suggested by the finding that only in a quarter of the 162 countries with data did a single method account for 50 per cent or more of contraceptive use in 1997, down from as many as a third of the countries considered in the previous assessment (United Nations, 2000). However, more progress is necessary because at the level of major areas, two methods generally account for at least half of all contraceptive use.

A. PREVALENCE OF USE OF DIFFERENT CONTRACEPTIVE METHODS AT THE WORLD LEVEL

Two major features characterize the global use of specific contraceptive methods. First, the use of modern methods predominates. The upper panel of table 9 and figure VII show that the four methods with the highest prevalence are female sterilization (21 per cent), the IUD (14 per cent), the pill (7 per cent) and the condom (5 per cent). All traditional methods combined have a prevalence of only 7 per cent, and the other modern methods (male sterilization, injectables, vaginal barriers and implants, considered together) are used by 7 per cent of women of reproductive age who are married or in union. Thus, the three female-oriented methods most commonly used at the world level are: female sterilization, the IUD and the pill. These three methods account for two-thirds of use worldwide (table 9, lower panel). In fact, it is in the less developed regions that these three methods are the most popular with a prevalence of 23 per cent for female sterilization, 15 per cent for the IUD, and 6 per cent for the pill. In the more developed regions, where the pill is the most commonly used method (16 per cent prevalence), condom use occupies second place (13 per cent), followed by female sterilization (10 per cent) and the IUD (8 per cent).

There are sharp differences in method mix between the more developed regions and the less developed regions. As already noted, traditional methods are more commonly used in the more developed regions (13 per cent prevalence) than in the less developed regions (6 per cent prevalence). That is, the contribution of traditional methods to overall contraceptive use is nearly twice as high, at 19 per cent, in the more developed regions than in the less developed regions, where they account for just 10 per cent of overall use. Consequently, in relative terms, more contraceptive users rely on modern methods in the less developed regions (90 per cent) than in the more developed regions (81 per cent) even if the prevalence of modern methods among all women of reproductive age who are married or in union is almost the same in these two development groups—54 per cent and 55 per cent, respectively. Despite a decreasing trend, the use of traditional methods in the more developed regions still accounts for most of the difference in overall prevalence between the more developed regions and the less developed regions.

More developed regions and less developed regions also differ in the types of methods that are currently dominant in each (table 10 and figure VII). In the more developed regions, method mix is heavily dominated by two reversible and short-acting supply methods—oral pills and condoms—which together account for 42 per cent of all contraceptive use in those regions. That is, six out of every ten female contraceptive users in the more developed regions rely on these methods, while only two out of every ten rely on sterilization and one out of ten uses the IUD. In the less developed regions, by contrast, the dominant methods are longer-acting and highly effective clinical methods: 63 per cent of users rely currently on sterilization or

TABLE 9. PREVALENCE OF USE OF SPECIFIC CONTRACEPTIVE METHODS AND METHOD MIX BY MAJOR AREA AND REGION
(Based on the most recent available survey data, average date 1998)

		Modern methods										Traditional methods			
			Sterilization												
Major area or region	*Any method*	*Any modern method*	*Female*	*Male*	*Pill*	*IUD*	*Condom*	*Inject-ables*	*Implants*	*Vaginal barrier methods*	*Other modern methods*	*Any traditional method*	*Rhythm*	*With-drawal*	*Other traditional methods*
	A. Percentage of women of reproductive age in a marital or consensual union who are using contraception (prevalence)														
World	60.9	54.0	20.5	3.6	7.3	14.1	4.9	2.3	0.6	0.5	0.1	6.9	3.9	2.4	0.7
More developed regions	68.5	55.3	9.7	5.6	15.7	8.1	13.1	0.2	0.5	2.3[a]	0.1	13.2	4.5	8.0	0.7
Less developed regions	59.4	53.7	22.7	3.2	5.8	15.3	3.2	2.7	0.6	0.1	0.1	5.7	3.6	1.5	0.6
Africa	26.8	19.8	1.9	0.1	7.3	4.7	1.3	4.1	0.1	0.1	0.2	7.0	3.7	1.3	2.0
Eastern Africa	21.8	16.8	2.0	0.0	5.9	0.6	1.3	6.2	0.2	0.0	0.5	5.0	2.5	1.4	1.2
Middle Africa	22.8	4.8	0.6	0.1	1.6	0.2	1.6	0.5	0.0	0.1	0.1	18.0	8.4	2.8	6.7
Northern Africa	47.3	41.9	2.3	0.0	17.7	17.8	1.2	2.7	0.1	0.2	0.0	5.4	2.6	1.3	1.5
Southern Africa	52.6	51.4	14.0	1.8	10.4	1.8	1.9	21.4	0.0	0.0	0.0	1.3	0.3	0.6	0.4
Western Africa	14.5	7.9	0.4	0.0	2.7	1.3	1.1	2.0	0.1	0.2	0.1	6.6	4.2	0.7	1.7
Asia	63.5	58.4	24.6	3.9	4.5	17.7	4.2	2.3	0.7	0.4	0.1	5.1	2.5	2.1	0.5
Eastern Asia	81.9	80.6	30.8	7.3	1.7	33.6	5.6	0.3	0.4	1.0	0.0	1.3	0.7	0.4	0.1
South-central Asia	48.0	41.3	26.6	1.6	4.8	3.5	3.4	1.2	0.1	0.0	0.1	6.6	3.4	2.7	0.6
South-eastern Asia	57.2	49.2	6.9	0.7	12.8	9.9	2.0	13.1	3.7	0.0	0.1	8.0	3.8	2.9	1.3
Western Asia	46.8	28.3	2.8	0.0	6.4	13.2	4.5	0.5	0.0	0.5	0.4	18.6	2.4	14.2	2.0
Europe	67.0	48.9	4.0	2.8	17.4	12.2	11.0	0.3	0.0	1.0	0.2	18.1	5.9	11.7	0.5
Eastern Europe	61.0	35.1	1.8	0.7	6.9	13.7	10.5	0.0	0.0	1.3	0.2	25.9	9.8	16.0	0.1
Northern Europe	79.0	74.5	11.4	13.4	19.2	10.0	17.0	1.8	0.0	0.9	0.7	4.5	1.4	3.0	0.1
Southern Europe	67.3	46.4	6.0	2.4	11.8	11.8	13.6	0.4	0.0	0.5	0.0	20.9	3.7	16.5	0.7
Western Europe	74.4	70.6	3.1	2.6	48.2	10.0	5.5	0.4	0.0	0.9	0.0	3.8	1.2	1.5	1.2
Latin America and the Caribbean	70.5	61.7	30.7	1.6	13.8	7.4	4.4	3.4	0.1	0.2	0.2	8.8	4.9	3.4	0.5
Caribbean	60.5	56.9	21.7	0.4	7.6	18.5	4.2	3.5	0.7	0.1	0.1	3.6	1.7	1.5	0.5
Central America	63.7	55.2	27.3	1.1	7.5	11.5	3.7	3.8	0.0	0.1	0.1	8.6	4.7	3.7	0.1
South America	74.3	64.8	33.1	1.9	17.1	4.4	4.7	3.2	0.0	0.3	0.2	9.5	5.3	3.5	0.7
Northern America	76.2	70.8	24.5	13.4	15.5	0.9	12.9	0.0	1.9	1.7	0.0	5.4	2.1	2.1	1.2

TABLE 9 *(continued)*

Major area or region	*Any method*	*Modern methods*										*Traditional methods*			
		Any modern method	*Sterilization*		*Pill*	*IUD*	*Condom*	*Inject-ables*	*Implants*	*Vaginal barrier methods*	*Other modern methods*	*Any traditional method*	*Rhythm*	*With-drawal*	*Other traditional methods*
			Female	*Male*											
Oceania	61.7	57.2	20.3	8.5	17.9	3.3	4.3	2.2	0.0	0.6	0.0	4.5	2.2	1.2	1.0
Australia/New Zealand	75.9	72.2	25.4	11.8	23.3	4.6	5.8	0.4	0.0	0.8	0.0	3.7	2.0	1.5	0.2
Melanesia/Micronesia/Polynesia	27.0	21.0	8.1	0.2	4.7	0.1	0.5	7.3	0.0	0.0	0.0	6.0	2.8	0.6	2.7
B. Percentage distribution of women of reproductive age in a marital or consensual union who are using contraception by method used (method mix)															
World	100	88.7	33.7	5.9	12.1	23.2	8.1	3.8	0.9	0.8	0.1	11.3	6.4	3.9	1.1
More developed regions	100	80.7	14.1	8.1	22.9	11.8	19.2	0.3	0.7	3.3	0.2	19.3	6.6	11.6	1.1
Less developed regions	100	90.4	38.2	5.4	9.8	25.8	5.4	4.5	1.0	0.2	0.1	9.6	6.1	2.5	1.0
Africa	100	74.0	7.2	0.3	27.2	17.5	4.8	15.4	0.4	0.4	0.7	26.0	13.7	4.9	7.3
Eastern Africa	100	76.9	9.1	0.1	27.2	2.9	6.1	28.3	0.9	0.0	2.3	23.1	11.5	6.2	5.4
Middle Africa	100	21.1	2.5	0.3	7.0	1.0	7.2	2.4	0.0	0.4	0.2	78.9	37.0	12.5	29.4
Northern Africa	100	88.6	5.0	0.0	37.4	37.6	2.5	5.7	0.2	0.4	0.0	11.4	5.5	2.7	3.1
Southern Africa	100	97.6	26.5	3.4	19.8	3.5	3.7	40.7	0.0	0.0	0.0	2.4	0.5	1.1	0.8
Western Africa	100	54.4	2.8	0.0	18.3	8.6	7.8	14.0	0.7	1.4	0.6	45.6	29.0	4.7	11.9
Asia	100	92.0	38.8	6.1	7.1	27.9	6.6	3.7	1.1	0.7	0.1	8.0	3.9	3.3	0.8
Eastern Asia	100	98.5	37.7	8.9	2.0	41.0	6.8	0.4	0.5	1.2	0.0	1.5	0.9	0.5	0.1
South-central Asia	100	86.1	55.5	3.4	10.0	7.4	7.1	2.5	0.1	0.0	0.2	13.9	7.0	5.5	1.3
South-eastern Asia	100	86.0	12.1	1.3	22.4	17.2	3.4	22.9	6.5	0.0	0.1	14.0	6.7	5.0	2.3
Western Asia	100	60.4	5.9	0.0	13.6	28.2	9.5	1.1	0.0	1.2	0.8	39.6	5.0	30.4	4.2
Europe	100	73.0	6.0	4.2	26.0	18.2	16.4	0.5	0.0	1.5	0.2	27.0	8.8	17.5	0.7
Eastern Europe	100	57.5	2.9	1.2	11.4	22.5	17.2	0.0	0.0	2.1	0.3	42.5	16.1	26.2	0.2
Northern Europe	100	94.3	14.4	17.0	24.3	12.7	21.5	2.3	0.0	1.2	0.9	5.7	1.8	3.7	0.1
Southern Europe	100	69.0	8.9	3.6	17.5	17.5	20.3	0.5	0.0	0.7	0.0	31.0	5.5	24.5	1.0
Western Europe	100	94.9	4.1	3.5	64.8	13.4	7.4	0.5	0.0	1.2	0.0	5.1	1.6	2.0	1.6

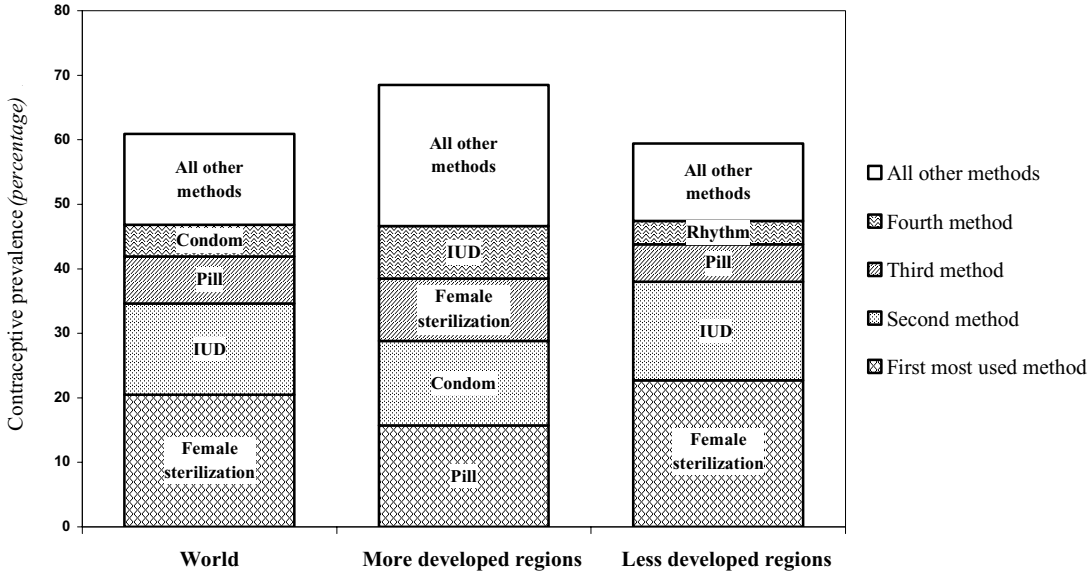
TABLE 9 *(continued)*

Major area or region	Any method	Modern methods										Traditional methods			
		Any modern method	Sterilization		Pill	IUD	Condom	Inject-ables	Implants	Vaginal barrier methods	Other modern methods	Any traditional method	Rhythm	With-drawal	Other traditional methods
			Female	Male											
Latin America and the Caribbean	100	87.5	43.5	2.3	19.5	10.5	6.2	4.8	0.1	0.3	0.2	12.5	6.9	4.9	0.7
Caribbean	100	94.0	35.9	0.6	12.5	30.6	7.0	5.8	1.2	0.2	0.2	6.0	2.8	2.4	0.8
Central America	100	86.6	42.8	1.8	11.8	18.1	5.8	6.0	0.0	0.2	0.2	13.4	7.5	5.8	0.2
South America	100	87.2	44.5	2.6	22.9	5.9	6.3	4.3	0.1	0.3	0.2	12.8	7.1	4.8	0.9
Northern America	100	92.9	32.2	17.6	20.3	1.2	16.9	0.0	2.5	2.2	0.0	7.1	2.8	2.8	1.5
Oceania	100	92.8	33.0	13.7	29.1	5.4	7.0	3.6	0.0	1.0	0.0	7.2	3.6	2.0	1.6
Australia/New Zealand	100	95.1	33.5	15.5	30.7	6.1	7.7	0.5	0.0	1.1	0.0	4.9	2.6	2.0	0.3
Melanesia/Micronesia/Polynesia	100	77.8	30.0	0.8	17.6	0.4	2.0	27.0	0.0	0.0	0.0	22.2	10.2	2.1	9.9

Source: World Contraceptive Use 2003, database maintained by the Population Division of the United Nations.

[a] Japan's very high prevalence for vaginal barrier methods is responsible for the relatively high prevalence level of these methods in the more developed regions as a whole.

Figure VII. Prevalence of the four most used methods among women of reproductive age, married or in union, for the world and major development groups



the IUD. A major factor contributing to this outcome is the high prevalence of female sterilization in Asia and Latin America and the Caribbean as well as a high reliance on the IUD in Asia.

Lastly, reliance on male oriented methods is higher in the more developed regions than in the less developed regions. Worldwide, about 20 per cent of couples using contraception rely on a method that requires male participation (condom or male sterilization) or cooperation (rhythm and withdrawal). But that proportion reaches 40 per cent in more developed regions and is just 14 per cent of overall contraceptive use in the less developed regions.

B. PREVALENCE OF USE OF DIFFERENT CONTRACEPTIVE METHODS BY MAJOR AREA AND REGION

In all major areas and regions, two modern methods account for at least 40 per cent of contraceptive use (table 10). This finding suggests that there may be constraints on access to a variety of contraceptive methods, particularly in the less developed countries. In Africa and Europe, the two most commonly used methods are the pill and the IUD, which combined are used by about 45 per cent of women using contraception.In Asia, female sterilization and the IUD are the methods most commonly used and together account for 67 per cent of overall contraceptive use. In Latin America and the Caribbean, Northern America and Oceania, the two most commonly used contraceptive methods are female sterilization and the pill, which combined are used by between 52 per cent and 64 per cent of all contraceptive users.

Two methods are also sufficient to account for 40 per cent or more of contraceptive use at the regional level (table 10). However, there is considerable variation in the types of methods most commonly used by region. In Africa, the pill and the IUD, which are the two most commonly used methods at the level of the continent are also the two most popular methods in Northern Africa, but in Eastern Africa and Southern Africa, injectables account for the largest share of use, and in Middle Africa and Western Africa, the rhythm method is the most used. The pill is the second most used method in Eastern Africa and Western Africa, while female sterilization is the second most commonly used method in Southern Africa.

In Asia, female sterilization and the IUD are the two most commonly used methods in Eastern Asia. Sterilization is also the main method used in South-central Asia, where half of all contraceptive users rely on it, but the pill and injectables each account

TABLE 10. THE TWO MOST COMMONLY USED CONTRACEPTIVE METHODS IN EACH MAJOR AREA AND REGION

Major area or region	*First method*	*Share of method in overall use (percentage)*	*Second method*	*Share of method in overall use (percentage)*	*Share of both methods (percentage)*
World	Female sterilization	34	IUD	23	57
More developed regions	Pill	23	Condom	19	42
Less developed regions	Female sterilization	38	IUD	26	64
Africa	Pill	27	IUD	18	45
Eastern Africa	Injectables	28	Pill	27	55
Middle Africa	Rhythm	37	Other traditional methods	29	66
Northern Africa	IUD	38	Pill	37	75
Southern Africa	Injectables	41	Female sterilization	27	68
Western Africa	Rhythm	29	Pill	18	47
Asia	Female sterilization	39	IUD	28	67
Eastern Asia	IUD	41	Female sterilization	38	79
South-central Asia	Female sterilization	56	Pill	10	66
South-eastern Asia	Injectables	23	Pill	22	45
Western Asia	Withdrawal	30	IUD	28	58
Europe	Pill	26	IUD	18	44
Eastern Europe	Withdrawal	26	IUD	23	49
Northern Europe	Pill	24	Condom	22	46
Southern Europe	Withdrawal	25	Condom	20	45
Western Europe	Pill	65	IUD	13	78
Latin America and the Caribbean	Female sterilization	44	Pill	20	64
Caribbean	Female sterilization	36	IUD	31	67
Central America	Female sterilization	43	IUD	18	61
South America	Female sterilization	45	Pill	23	68
Northern America	Female sterilization	32	Pill	20	52
Oceania	Female sterilization	33	Pill	29	62
Australia/New Zealand	Female sterilization	34	Pill	31	65
Melanesia/Micronesia/Polynesia	Female sterilization	30	Injectables	27	57

Source: Table 9, lower panel.

for a greater share of contraceptive use than the IUD in that region. In Western Asia, the IUD and withdrawal are the two most commonly used methods, and in South-eastern Asia, injectables are used as often as the pill and both methods are the most commonly used.

In Latin America and the Caribbean, female sterilization is used by more than a third of all contraceptive users in each of three regions of this major area. The pill, which ranks second at the overall level, ranks also second in South America, but IUD use is higher than that of the pill in the Caribbean and in Central America.

In Europe, where the pill and the IUD are the two most popular methods, the pill accounts for 65 per cent of contraceptive use in Western Europe. In Northern Europe, the pill also ranks first but its importance is similar to that of the condom. In Eastern Europe and Southern Europe, withdrawal is the most used method, but its share of contraceptive use is similar to that of the IUD in Eastern Europe and to that of the condom in Southern Europe.

In Oceania, where female sterilization and the pill are the two most commonly used methods at the overall level, female sterilization also accounts for the major share of contraceptive use in both Melanesia/Micronesia/Polynesia and Australia/New Zealand. Sterilization is the method of choice of about a third of all contraceptive users. In Australia/New Zealand, the pill is almost as commonly used as female sterilization, but in Melanesia/Micronesia/Polynesia, injectables rank second and their share is considerably lower than that of female sterilization.

In sum, female sterilization accounts for the largest share of contraceptive use in many regions including South-central Asia, all regions of Latin America and the Caribbean, Northern America and all regions of Oceania. The IUD is most commonly used method in Eastern Asia and Northern Africa, whereas the pill is that in Western Europe, the rhythm in Middle Africa, and injectables in Southern Africa.

Although traditional methods are more commonly used in the more developed regions than in the less developed regions, there are considerable differences in the use of traditional methods among the regions of the developed world. For instance, in Europe 27 per cent of contraceptive users rely on traditional methods but in Northern America just 7 per cent do. Within Europe, traditional methods are more commonly used in Eastern Europe (43 per cent) and Southern Europe (31 per cent) than in other regions.

In the less developed regions, the proportion of contraceptive users relying on traditional methods is high in Africa (26 per cent), comparable to that of Europe, but low in Asia (8 per cent) and in Latin America and the Caribbean (13 per cent). Within Africa, 79 per cent of contraceptive users in Middle Africa rely on traditional methods and 46 per cent do so in Western Africa. Similarly, in Western Asia, 40 per cent of contraceptive users opt for traditional methods. Thus, the higher overall share of modern methods among contraceptive users in the developing world results from a high reliance on modern methods in the regions where contraceptive prevalence is higher. Developing regions with low to moderate contraceptive prevalence are more likely to rely still on traditional methods of contraception.

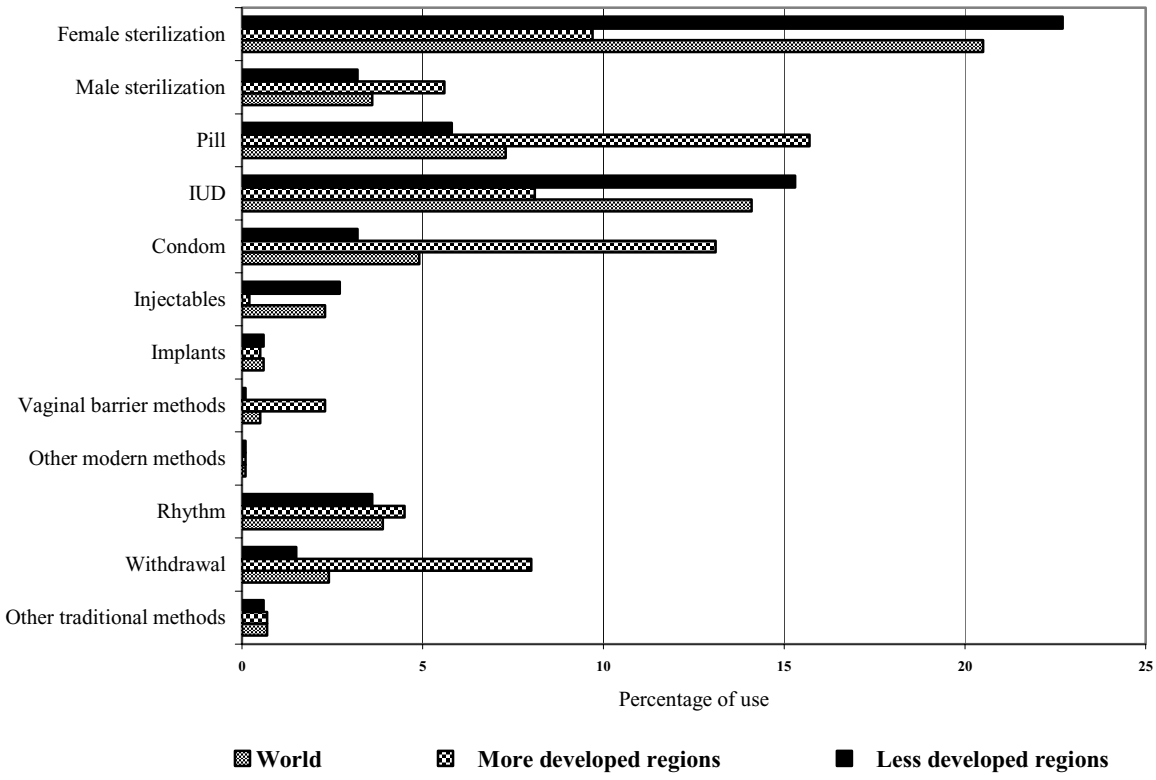
C. USE OF SPECIFIC CONTRACEPTIVE METHODS

1. Female sterilization

Female sterilization ranks first among contraceptive methods in terms of its prevalence at the world level (table 9, upper panel and figure VIII). Globally, one fifth of women of reproductive age who are married or in union are sterilized and a third of those using contraception rely on sterilization (table 9, lower panel). The prevalence of female sterilization in the less developed regions is twice as high as that in the more developed regions (23 per cent vs. 10 per cent). However, the prevalence of female sterilization varies considerably among major areas and regions. Female sterilization is more commonly used in Asia, Latin America and the Caribbean, Northern America and Australia/New Zealand, where its prevalence is above 20 per cent, than in Africa or Europe where its prevalence is below 5 per cent.

At the regional level, the highest prevalence of female sterilization is found in South America (33 per cent), followed by Eastern Asia (31 per cent) and then Central America and South-central Asia with 27 per cent prevalence each. In Northern America and Australia/New Zealand about a quarter of women of reproductive age, married or in union, rely on sterilization and in the Caribbean 22 per cent use that method. Although female sterilization is rarely used in Africa and Europe as a whole, its prevalence is 14 per cent in Southern

Figure VIII. Prevalence of method use among women of reproductive age, married or in union, for the world and major development groups



Africa and 11 per cent in Northern Europe. In terms of method mix, the share of female sterilization among of methods used is particularly high in South-central Asia, Central America and South America, where more than 40 per cent of all contraceptive users rely on it.

The prevalence of female sterilization is highest in Puerto Rico (46 per cent), the Dominican Republic (43 per cent) and Brazil (40 per cent). In Canada, China, El Salvador, India, Mexico and Panama it ranges between 30 per cent and 34 per cent (table 11). Female sterilization is also commonly used in Colombia, Ecuador and Nicaragua, whose prevalence levels range from 22 per cent to 27 per cent. In Asia, the data for the Republic of Korea, Sri Lanka and Thailand show that the prevalence of female sterilization is higher than 20 per cent, though still lower than the 34 per cent reached by China and India. In Africa, although female sterilization is not commonly used as a contraceptive method, its prevalence ranges from 13 per cent to 16 per cent in Cape Verde, South Africa and Tunisia. In Europe, where the use of female sterilization is also low on average, Belgium, Finland, Norway, Spain, Switzerland and the United Kingdom report prevalence levels ranging from 10 per cent to 15 per cent, and the prevalence of female sterilization ranges from 24 per cent to 31 per cent in Australia, Canada and the United States.

In countries where female sterilization has high prevalence it also tends to account for a large share of overall contraceptive use (table 11). This share is particularly high in India (71 per cent), the Dominican Republic (66 per cent), Puerto Rico (59 per cent), Panama (56 per cent), El Salvador (54 per cent) and Brazil (52 per cent). In China, female sterilization accounts for 40 per cent of all contraceptive use. By contrast, in only three developed countries does female sterilization account for more than 20 per cent of contraceptive use: Australia, Canada and the United States of America.

TABLE 11. PREVALENCE OF FEMALE STERILIZATION AND SHARE OF FEMALE STERILIZATION AS PERCENTAGE OF TOTAL CONTRACEPTIVE USE, SELECTED COUNTRIES

Country	*Prevalence of female sterilization (percentage)*	*Female sterilization as percentage of total use*
Puerto Rico 1995/96	46	59
Dominican Republic 2000	43	66
Brazil 1996	40	52
India 1998/99	34	71
China 1997	34	40
El Salvador 1998	32	54
Panama 1984	32	56
Canada 1995	31	41
Mexico 1997	30	44
Australia 1986	28	36
Colombia 2000	27	35
Nicaragua 2001	25	37
Republic of Korea 1997	24	30
United States of America 1995	24	31
Sri Lanka 1993	24	36
Ecuador 1999	23	34
Thailand 1996/97	22	30

Source: Annex table A.2.

2. Male sterilization

At the world level, only about 3.6 per cent of women report that their partner is sterilized (table 9, upper panel and figure VIII). In contrast with the pattern observed for female sterilization, the prevalence of male sterilization in the more developed regions is twice that in the less developed regions (5.6 per cent vs. 3.2 per cent). At the regional level, the prevalence of male sterilization exceeds 10 per cent only in three regions: Northern Europe, Northern America and Australia/New Zealand.

The prevalence of male sterilization is highest in six developed countries: Australia, Canada, the Netherlands, New Zealand, the United Kingdom and the United States of America, where it ranges from 10 per cent to 19 per cent. Only the Republic of Korea in the developing world has comparable levels of male sterilization. The share of male sterilization in overall contraceptive use is also highest in these countries as well as in Nepal (16 per cent) and in Bhutan, where male sterilization accounts for the highest percentage to overall contraceptive use: 43 per cent (annex table A.2, lower panel).

Whereas in the less developed regions male sterilization, with just 3 per cent prevalence, is rare compared to the use of female sterilization, whose prevalence is 23 per cent, in Europe both types of sterilization have comparable levels of prevalence (4 per cent for female sterilization and 2.8 per cent for male sterilization). Moreover, in Northern Europe the prevalence of male sterilization is slightly higher than that of female sterilization (13.4 per cent vs. 11.4 per cent).

3. The intrauterine device (IUD)

With a 14 per cent prevalence worldwide, the IUD is the second most widely used contraceptive method (table 9, upper panel and figure VIII). It accounts for almost a quarter of all contraceptive use (table 9, lower panel). The use of the IUD is more common in less developed regions than in more developed regions (15 per cent vs. 8 per cent). However, there are large variations among major areas. Whereas IUD use is common in Asia and Europe and to a lesser extent in Latin America and the Caribbean, its use is rare in Africa, Northern America and Oceania where IUD prevalence ranges between 1 per cent and 5 per cent.

IUD prevalence also varies considerably at the regional level. In Africa, IUD prevalence is lower than 2 per cent in all regions except in Northern Africa where it reaches 18 per cent. In Asia, the prevalence of the IUD is particularly high in Eastern Asia (34 per cent), but it is just 3.5 per cent in South-central Asia. In the Caribbean IUD prevalence is 18.5 per cent and in Central America it is 11.5 per cent, both considerably higher than in South America where IUD use is below 5 per cent. In Europe, IUD prevalence ranges from 10 per cent to 14 per cent in its four regions, with Eastern Europe having the highest prevalence, and in Northern America the IUD is used by barely 1 per cent of women of reproductive age who are married or in union, a prevalence level comparable to that in most African regions.

In the Democratic Republic of Korea and Uzbekistan, over 40 per cent of women of reproductive age who are married or in union rely on the IUD. Other countries where IUD prevalence is fairly high include China, Cuba, Egypt, Estonia, Israel, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Turkmenistan, and Viet Nam where more than 30 per cent of married women use the IUD. In Belarus, Finland, Jordan, Norway, Slovenia, Sweden, Tajikistan and Tunisia, the prevalence of IUD use varies from 20 per cent to 29 per cent (annex table A.2, upper panel). These countries, along with those where IUD prevalence falls between 10 per cent and 19 per cent, are mostly located in Asia or Europe, and their concentration in those continents is responsible for the higher average prevalence of IUD use found in them.

Countries in Asia and Europe are also those where the share of IUD use in overall contraceptive use is highest. For instance, in Uzbekistan, 84 per cent of contraceptive users rely on the IUD, 79 per cent do so in the Democratic People's Republic of Korea, and 74 per cent in Tajikistan (table 12). In addition, there are more countries where at least 30 per cent of contraceptive users rely on the IUD than there are countries where female sterilization accounts for similarly high proportions of use, meaning that, at the country level, the IUD is often more popular than female sterilization, even if the overall prevalence of IUD use is lower than that of female sterilization.

4. Oral contraceptive pills (the pill)

The pill is the third most widely used contraceptive method. Worldwide, it is used by 7 per cent of women of reproductive age who are married or in union (table 9, upper panel and figure VIII) and by 12 per cent of contraceptive users (table 9, lower panel). The prevalence of oral pill use is more than twice as high in the more developed regions than in the less developed regions (16 per cent vs. 6 per cent). The share of the pill in contraceptive use is also higher in the more developed regions, where the method is selected by more than one out of every five contraceptive users, compared to its use by one out of every ten contraceptive users in the less developed regions.

Among the more developed regions, pill use ranges from 7 per cent in Eastern Europe to 48 per cent in Western Europe. However, in all the other regions of the developed world the range of variation of pill use among women of reproductive age who are married or in union is narrower, going from 12 per cent in Southern Europe to 23 per cent in Australia/New Zealand.

Among the less developed regions, the pill is used by between 1.6 per cent and 18 per cent of women of reproductive age who are married or in union. High levels of pill prevalence are found in Northern Africa (17.7 per cent) and South America (17.1 per cent). Two other regions have prevalence above 10 per cent: Southern Africa with 10.4 per cent and South-eastern Asia with 12.8 per cent. Pill use is particularly low in Middle Africa, Western Africa and Eastern Asia, where at most 3 per cent of women of reproductive age who are married or in union rely on it.

The pill enjoys the widest geographic distribution of use of any method. Its popularity is especially evident at the country level. Pill prevalence varied between 20 per cent and 60 per cent in five countries in Africa, four countries in Asia, eight countries in Latin American and the Caribbean, twelve countries in Europe and three countries in Oceania (annex table A.2, upper panel). The countries with the highest prevalence of pill use (from 40 per cent to 59 per cent) include Algeria, Belgium, Germany, the Netherlands, and Réunion. However, Eastern Africa, Middle Africa, Eastern Asia and South-central Asia all have numerous countries where the prevalence of pill use is below 5 per cent.

Regarding the share of the pill in contraceptive use, there are countries in all major areas where pill use accounts for high proportions of overall contraceptive use (table 12). Thus, in five countries in Africa, one in Asia and four in Europe, the pill accounts for between 60 per cent and 78 per cent of contraceptive use. In addition, the share of the pill

TABLE 12. COUNTRIES WHERE A SINGLE CONTRACEPTIVE METHOD ACCOUNTS FOR AT LEAST HALF OF CURRENT CONTRACEPTIVE USE

	Female sterilization		*Pill*		*Injectables*		*IUD*	
Major Area	*Country*	*Share of method in overall use (percentage)*	*Country*	*Share of method in overall use (percentage)*	*Country*	*Share of method in overall use (percentage)*	*Country*	*Share of method in overall use (percentage)*
			Algeria	69	Malawi	54	Egypt	63
			Zimbabwe	66				
			Morocco	64				
			Sudan	61				
			Réunion	60				
			Sierra Leone	58				
			Sao Tome and Principe	57				
			Liberia	52				
Asia	India	71	Saudi Arabia	62			Uzbekistan	84
			Kuwait	57			Dem. People's Rep. of Korea	79
							Tajikistan	74
							Kazakhstan	64
							Kyrgyzstan	64
							Turkmenistan	63
Europe			Germany	78			Belarus	58
			Netherlands	62			Rep. of Moldova	55
			Austria	61				
			Belgium	60				
Latin America and the Caribbean	Dominican Rep.	66	Montserrat	58	Haiti	50	Cuba	59
	Puerto Rico	59	Suriname	58				
	Panama	56	Bahamas	51				
	El Salvador	54	Antigua and Barbuda	50				
	Brazil	52						

TABLE 12 (*continued*)

	Condom		*Rhythm*		*Withdrawal*	
Major Area	*Country*	*Share of method in overall use(percentage)*	*Country*	*Share of method in overall use(percentage)*	*Country*	*Share of method in overall use(percentage)*
Africa			Dem. Rep. of the Congo	55		
			Central African Rep.	53		
			Cameroon	50		
Asia	Japan	75			Azerbaijan	73
					Armenia	53
Europe					Bosnia and Herzegovina	57
					Albania	55
Latin America and the Caribbean						

Source: Annex table A.2, lower panel.

varies between 30 per cent and 60 per cent in fourteen countries in Africa, eight in Asia, six in Europe, twelve in Latin American and the Caribbean, and two in Oceania (annex table A.2, lower panel). There are more countries where at least 30 per cent of contraceptive users rely on the pill than those in which the same share of contraceptive use corresponds to the IUD or female sterilization. That is, the pill is more popular than the IUD or female sterilization in many countries, even if the prevalence of pill use is, on average, lower than that of the IUD or female sterilization.

5. Condom

The male condom is the fourth most widely used contraceptive method. Worldwide, it is used by 5 per cent of couples where the woman if of reproductive age (table 9, upper panel and figure VIII) and accounts for 8 per cent of overall contraceptive use (table 9, lower panel). As in the case of the pill, the prevalence of condom use is higher in the more developed regions than in the less developed regions (13 per cent vs. 3 per cent). Condom prevalence is lowest in Africa (1 per cent); slightly higher in Asia, Latin America and the Caribbean, and Oceania (about 4 per cent in each) and highest in Europe (12 per cent) and Northern America (13 per cent).

Variation in condom use among regions within a major area tends to be small. In Europe, Western Europe is the only region with low condom prevalence (5.5 per cent) and in Oceania, condom prevalence is higher in Australia/New Zealand (6 per cent) than in Melanesia/Micronesia/Polynesia (0.5 per cent).

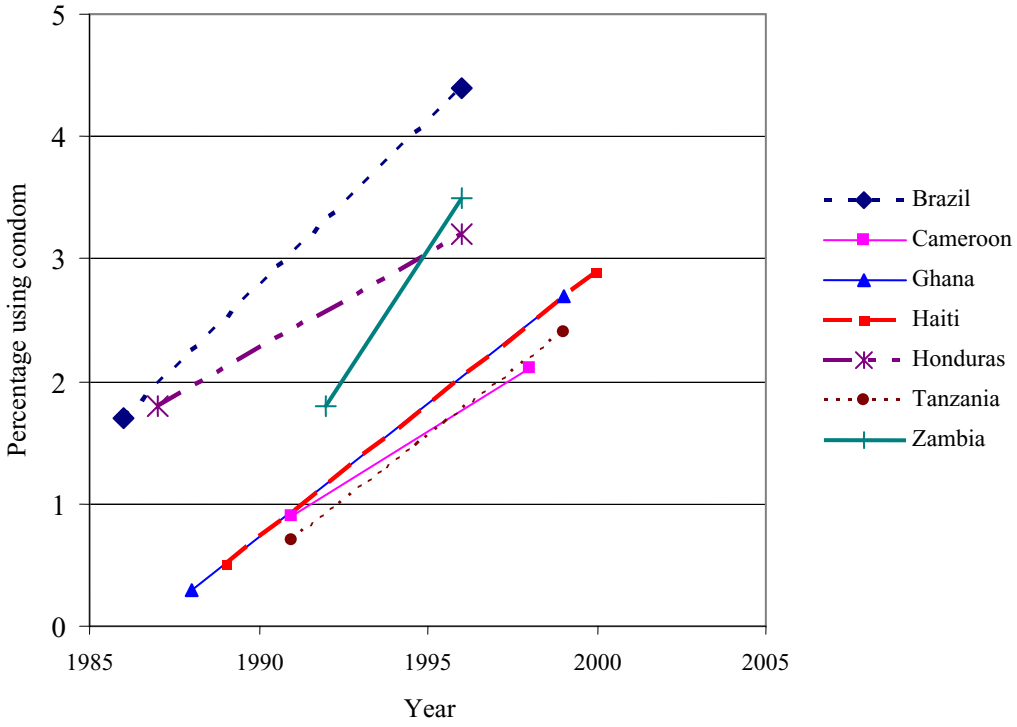
In Japan, where 42 per cent of couples with the woman of reproductive rely on condoms, the prevalence of condom use is the highest in the world. Other countries or areas with high levels of condom use include Denmark, Finland, Grenada, Hong Kong SAR of China, Singapore, Slovakia, Spain and Sweden, whose condom prevalence levels range from 20 per cent to 35 per cent. At the country level, the condom is not usually among the methods with the two highest prevalence levels. Only in Japan do three-quarters of contraceptive users rely on condoms. In Grenada, Hong Kong SAR of China, Singapore, Spain, Sweden and Trinidad and Tobago, condom use accounts for between 30 and 40 per cent of all contraceptive use (annex table A.2).

Available trend data indicate that condom use has increased in the majority of developing countries since the late 1980s, probably as a result of campaigns promoting condom use to prevent HIV infection or contagion by other sexually transmitted diseases (STDs). Among the countries highly affected by HIV/AIDS, prevalence of condom use rose from 1.7 per cent in 1986 to 4.4 per cent in 1996 in Brazil; from 0.9 per cent in 1991 to 2.1 per cent in 1998 in Cameroon; from 0.3 per cent in 1988 to 2.7 per cent in 1999 in Ghana; from 0.5 per cent in 1989 to 2.9 per cent in 2000 in Haiti; from 1.8 per cent in 1987 to 3.2 per cent in 1996 in Honduras; from 0.7 per cent in 1991 to 2.4 per cent in 1999 in the United Republic of Tanzania, and from 1.8 per cent in 1992 to 3.5 per cent in 1996 in Zambia (figure IX). Among the other developing countries, the largest increase was observed in Hong Kong SAR of China, where condom use rose from 15 per cent to 35 per cent between 1982 and 1992.

In the developed world, condom use has increased in Northern America, New Zealand, and in some countries of Europe, but it has declined in several countries in Europe. A particularly sharp increase was registered in Spain, where condom use rose from 12 per cent in 1985 to 24 per cent in 1995.

This review of condom use is limited to women's reports of condom use for contraceptive purposes within recognized marital or consensual unions. Such information excludes a substantial portion of condom use. Surveys that have interviewed both men and women show that men report higher levels of condom use than women do, whether in developing or developed countries. Statistics relating to the supply of contraceptives distributed through various sources routinely suggest greater use of condoms than is reported in contraceptive prevalence surveys (Smith, 1992). Furthermore, the reported level of condom use would be higher if respondents were asked about its use for either pregnancy prevention or for the prevention of sexually transmitted diseases rather than focussing exclusively on its use for contraceptive purposes. Likewise, reported condom use would be higher if surveys inquired explicitly about its use with any sexual partner, as opposed to suggesting that use with the spouse or primary partner is the main concern (McFarlane, Friedman and Morris, 1994). Current condom use may also be understated if respondents used condoms in conjunction with other contraceptive methods, especially more

Figure IX. Trends in condom prevalence in selected countries with high AIDS prevalence



effective ones, because in the majority of surveys only the most effective method used is registered if a combination of methods is reported. Lastly, condom use statistics as reported here refer to the use of the male condom because it is the only type that has been routinely covered by surveys on contraceptive prevalence.

6. *Rhythm (periodic abstinence)*

At the world level, the rhythm or the periodic-abstinence method is used by 4 per cent of women of reproductive age who are married or in union (table 9, upper panel and figure VIII) so that it accounts for 6 per cent of all contraceptive use (table 9, lower panel). The rhythm method is used by a somewhat higher proportion of couples in the more developed regions (4.5 per cent) than in the less developed regions (3.6 per cent) and contributes approximately the same share of overall contraceptive use in the more developed regions as in the less developed regions (6.6 per cent and 6.1 per cent, respectively). Among the major areas of the world, rhythm prevalence varies within a narrow range, from 2 per cent in Northern America and Oceania to 6 per cent in Europe. However, there is a larger variation in the prevalence of rhythm by region, with Southern Africa having just 0.3 per cent prevalence and Eastern Europe exhibiting nearly 10 per cent. In terms of rhythm's share of method mix, it accounts for a fairly high proportion of contraceptive use in regions where overall contraceptive use is low, such as Western Africa or Middle Africa, where 29 per cent and 37 per cent, respectively, of all couples using contraception rely on the rhythm method. Rhythm also accounts for relatively high proportions of contraceptive use in Eastern Africa (11.5 per cent) and in Eastern Europe (16 per cent).

Both Africa and Europe show wide differences in the prevalence of rhythm use among their respective regions. In Europe, rhythm prevalence in Eastern Europe is, as mentioned above, close to 10 per cent but in Northern Europe and Western Europe it is well below 2 per cent. In Africa, rhythm prevalence is low in Southern Africa (0.3 per cent) and Northern Africa (2.6 per cent) but reaches 8.4 per cent in Middle Africa.

At the country level, only twelve countries, located mainly in Africa and Europe, have a rhythm prevalence of at least 10 per cent. Among them, Bolivia and Slovakia have the highest levels, above 20 per cent (annex table A.2, upper panel). Similarly, rhythm contributes between 30 per cent and 55 per cent of overall use in sixteen countries which, except for Bolivia, Poland and Slovakia, are located mainly in Africa (annex table A.2, lower panel).

7. Withdrawal

The withdrawal method is used by only 2.4 per cent of women of reproductive age who are married or in union (table 9, upper panel and figure VIII) and accounts for just 4 per cent of all contraceptive use worldwide (table 9, lower panel). Unlike the rhythm method, which is as popular in the more developed regions as in the less developed regions, withdrawal as a method of contraception is more prevalent in the more developed regions than in the less developed regions (8 per cent vs. 1.5 per cent). Similarly, its share of method mix is over four times as high in the more developed regions (11.6 per cent) as in the less developed regions (2.5 per cent).

The prevalence of withdrawal as a contraceptive method is under 4 per cent in all major areas except Europe, where withdrawal's prevalence ascends to nearly 12 per cent. Within Europe, withdrawal is practiced by 16 per cent of couples of reproductive age in Eastern Europe and in Southern Europe, but its use is less common in other regions of the continent. Outside Europe, high prevalence of withdrawal is only found in Western Asia, where it is practiced by 14 per cent of couples of reproductive age.

Withdrawal rarely accounts for high proportions of overall contraceptive use. Given its high prevalence in Eastern Europe and Southern Europe, it is not surprising to find that it is the method of choice of about a quarter of all couples using contraception in those regions. It also accounts for 30 per cent of overall contraceptive use in Western Asia. In Middle Africa, about one in every eight couples using contraception relies on withdrawal as their method of choice.

At the country level, 19 countries, located mainly in Western Asia and Eastern Europe, have a prevalence of withdrawal of at least 10 per cent, and in seven of those 19 countries, its prevalence exceeds 25 per cent (annex table A.2, upper panel). However, the number of countries where the share of withdrawal in overall contraceptive use is high (between 30 and 73 per cent) is lower. These countries include Armenia, Azerbaijan, Bahrain, and Turkey in Western Asia; Bulgaria and Romania in Eastern Europe; and Albania, Bosnia and Herzegovina, and Portugal in Southern Europe (annex table A.2, lower panel).

8. Injectables

Injectable hormonal methods are not as widely available as other modern methods and are currently used by only 2.3 per cent of women of reproductive age who are married or in union (table 9, upper panel and figure VIII). Most of the users of injectables live in the less developed regions, where prevalence is 2.7 per cent. In more developed regions, injectables are rarely used, having a prevalence of just 0.2 per cent. There are two regions where the prevalence of injectables is high: Southern Africa with 21 per cent and South-eastern Asia with 13 per cent. Lower but still important levels of use are found in Eastern Africa with 6 per cent prevalence and in Melanesia/Micronesia/ Polynesia with 7 per cent.

In terms of method mix at the world level, injectables account for 4 per cent of overall contraceptive use, a share comparable to that of withdrawal (table 9, lower panel). In less developed regions, the share of injectables is 4.5 per cent but in the more developed regions their share is minimal (0.3 per cent). Within the less developing regions, the contribution of injectables to overall contraceptive use is higher in Africa (15.4 per cent) than in Asia (3.7 per cent) or in Latin America and the Caribbean (4.8 per cent). Injectables account for a substantial proportion of contraceptive use in Southern Africa (41 per cent), Eastern Africa (28 per cent), Melanesia/Micronesia/Polynesia (27 per cent), South-eastern Asia (23 per cent), and Western Africa (14 per cent)

At the country level, only 16 countries, all located in the less developed regions, have a prevalence of injectables of at least 10 per cent. In only four of those countries—the Cook Islands, Indonesia, Mongolia and South Africa—is the prevalence of injectables higher than 20 per cent (annex table A.2, upper panel). Injectables account for sizeable shares of overall contraceptive use in 35 countries where between 20 per cent and 55 per cent of women using contraception rely on injectables. These

countries are mainly located in Africa and tend to have low overall levels of contraceptive use (annex table A.2, lower panel).

9. Other methods

Vaginal Barrier Methods. Vaginal barrier methods, which include the diaphragm, cervical caps and spermicides in the form of foams, jellies, cream or the contraceptive sponge, are used by a very small proportion of women of reproductive age who are married or in union (0.5 per cent worldwide) and account for only a half per cent of overall contraceptive use (table 9). Current use of vaginal barrier methods is likely to be understated, however, because these methods are usually used in combination with other methods (particularly condoms). Use of barrier methods is more common in the more developed regions where their prevalence is 2.3 per cent than in the less developed regions where their prevalence is scarcely 0.1 per cent. The use of vaginal barrier methods is uniformly low in all major areas and regions, and their prevalence rarely exceeds 1 per cent. The highest levels of use are found in Eastern Europe (1.3 per cent prevalence) and in Northern America (1.7 per cent prevalence). At the country level, however, Japan stands out with its very high prevalence (15.4 per cent in 2000) and it is the latter that is behind the 2.3 per cent prevalence for the more developed regions as a whole even though none of the individual more developed regions has a prevalence that reaches 2.0 per cent.

Other Modern Methods. These methods include the implant and the lactational amenorrhea method (LAM) which is considered as a modern method if it is so classified by the survey gathering information on contraceptive use. These methods are used by 0.1 per cent of women of reproductive age who are married or in union and account for scarcely 0.1 per cent of all contraceptive use worldwide. The prevalence of these methods is similar in the more developed and the less developed regions (table 9).

Other Traditional Methods. These methods include douching, postpartum abstinence and folk methods (that is, the use of herbs, amulets, charms, spells, etc.). Breastfeeding for contraceptive purposes and the lactational amenorrhea method (LAM) in particular are also included in this group of methods if they are classified as traditional methods in the surveys gathering information on contraceptive use. At the world level, these methods are used by 0.7 per cent of women of reproductive age who are married or in union (table 9, upper panel) and they account for 1.1 per cent of contraceptive use worldwide (table 9, lower panel). Like the other modern methods, they have similar levels of prevalence in the more developed and in the less developed regions. Among major areas, however, they are more prevalent in Africa (2 per cent), Northern America (1.2 per cent) and Oceania (1 per cent). They have greater prevalence in some of the regions with the lower levels of overall contraceptive prevalence, including Middle Africa (6.7 per cent) and Melanesia/Micronesia/Polynesia (2.7 per cent). At the country level, Lebanon and Togo exhibit high levels of use of other traditional methods: 24 per cent and 10 per cent, respectively (annex table A.2, upper panel).

The share of other traditional methods in overall contraceptive use is similar in the more developed and the less developed regions. Among regions, other traditional methods account for a large share of contraceptive use in Middle Africa (29 per cent), Western Africa (12 per cent), Melanesia/Micronesia /Polynesia (10 per cent), and Eastern Africa (5 per cent). In the majority of the other regions, other traditional methods account for no more than 2 per cent of all contraceptive use. At the country level, other traditional methods account for high shares of contraceptive use in several developing countries, including Niger (69 per cent), Chad (56 per cent), Togo (41 per cent), Lebanon (39 per cent), Yemen (39 per cent), Senegal (28 per cent), Eritrea (26 per cent), the Democratic Republic of the Congo (22 per cent) and Mali (21 per cent) (annex table A.2, lower panel).

D. NUMBER OF USERS OF SPECIFIC METHODS BY MAJOR AREA AND REGION

Assuming that the overall levels of contraceptive prevalence estimated for the year 2000 are those shown in table 4, and that the method mix estimated for each country for 1998, as shown in the lower panel of table 9, remains unchanged, it is possible to calculate the number of women using each method in 2000 provided independent estimates of the number of women aged 15-49 who are married or in union are available. Such estimates were derived from observed proportions married or in union (annex table A.3) and the female population in 2000 as presented in *World Population Prospects: The 2002 Revision* (United Nations, 2003). Table 13 displays the set of estimates obtained by major area and region.

TABLE 13. ESTIMATED NUMBER OF WOMEN OF REPRODUCTIVE AGE, MARRIED OR IN UNION, WHO ARE USING CONTRACEPTION BY MAJOR AREA, REGION AND METHOD USED, 2000 (*millions*)

		Modern methods										*Traditional methods*			
			Sterilization												
Major area or region	*Any method*	*Any modern method*	*Female*	*Male*	*Pill*	*IUD*	*Condom*	*Injectables*	*Implants*	*Vaginal barrier methods*	*Other modern methods*	*Any traditional method*	*Rhythm*	*Withdrawal*	*Other traditional methods*
World	654	580	221	39	79	152	53	25	6	5	1	74	42	25	7
More developed regions	119	96	17	10	27	14	23	0	1	4	0	23	8	14	1
Less developed regions	535	484	204	29	52	138	29	24	5	1	1	51	32	13	5
Africa	33	25	2	0	9	6	2	5	0	0	0	9	5	2	2
Eastern Africa	8	6	1	0	2	0	1	2	0	0	0	2	1	1	0
Middle Africa	3	1	0	0	0	0	0	0	0	0	0	3	1	0	1
Northern Africa	13	12	1	0	5	5	0	1	0	0	0	2	1	0	0
Southern Africa	3	3	1	0	1	0	0	1	0	0	0	0	0	0	0
Western Africa	5	3	0	0	1	0	0	1	0	0	0	2	2	0	1
Asia	449	413	174	27	32	125	29[a]	16	5	3	0	36	17	15	3
Eastern Asia	245	241	92	22	5	101	17[a]	1	1	3	0	4	2	1	0
South-central Asia	135	116	75	5	13	10	10	3	0	0	0	19	9	7	2
South-eastern Asia	53	46	6	1	12	9	2	12	4	0	0	7	4	3	1
Western Asia	15	9	1	0	2	4	1	0	0	0	0	6	1	5	1
Europe	74	54	4	3	19	14	12	0	0	1	0	20	7	13	1
Eastern Europe	32	18	1	0	4	7	6	0	0	1	0	14	5	8	0
Northern Europe	9	9	1	2	2	1	2	0	0	0	0	1	0	0	0
Southern Europe	15	10	1	1	3	3	3	0	0	0	0	5	1	4	0
Western Europe	18	17	1	1	12	2	1	0	0	0	0	1	0	0	0
Latin America and the Caribbean	61	53	27	1	12	6	4	3	0	0	0	8	4	3	0
Caribbean	3	3	1	0	0	1	0	0	0	0	0	0	0	0	0
Central America	15	13	7	0	2	3	1	1	0	0	0	2	1	1	0
South America	42	37	19	1	10	2	3	2	0	0	0	5	3	2	0

TABLE 13 *(continued)*

Major area or region	Any method	Modern methods										Traditional methods			
		Any modern method	Sterilization		Pill	IUD	Condom	Injectables	Implants	Vaginal barrier methods	Other modern methods	Any traditional method	Rhythm	Withdrawal	Other traditional methods
			Female	Male											
Northern America	34	32	11	6	7	0	6	0	1	1	0	2	1	1	1
Oceania	3	3	1	0	1	0	0	0	0	0	0	0	0	0	0
Australia/New Zealand	2	2	1	0	1	0	0	0	0	0	0	0	0	0	0
Melanesia/Micronesia/Polynesia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Sources: Annex table A.3, table 4 and table 9.
NOTE: 0 means less than 1 million.
[a] Japan's very high condom prevalence is responsible for the high number of users of condoms in Asia, particularly in Eastern Asia.

According to these estimates, in 2000, an estimated 654 million women of reproductive age who were married or in union were using contraception: Among them, 580 million were using a modern method of contraception and 74 million a traditional method. More than four times as many women using contraception lived in the less developed regions (535 million) than in the more developed regions (119 million). The majority of contraceptive users lived in Asia (449 million) and the second largest group was found in Europe (74 million).

At the global level, the most used method was female sterilization, with 221 million women relying on that method. It was followed by the IUD with 152 million users, the pill with 79 million, the condom with 79 million and the rhythm method with 42 million. Because the majority of contraceptive users live in developing countries, the global estimates are largely determined by the method mix in the less developed regions as a whole. In 2000, an estimated 204 million women in the less developed regions relied on sterilization, 138 million used the IUD, 52 million used the pill, 32 million relied on the rhythm method, and 29 million couples relied on condoms. In the more developed regions, there were more pill users than users of any other method (27 million), followed by the number of condom users (23 million), and those relying on female sterilization (17 million). The IUD and withdrawal were used by about the same number of women in more developed regions (14 million users each).

The great majority of users of each contraceptive method lived in Asia. Thus, over eight out of every ten users of the IUD, three-quarters of all sterilized women of reproductive age, almost two-thirds of the women using injectables or vaginal barrier methods, two-thirds of the couples relying on withdrawal, and about half of the users of each, the pill, the condom and the rhythm method, lived in Asia. Within Asia, the largest numbers of users of female and male sterilization, the IUD and the condom lived in Eastern Asia, whereas the largest numbers of users of the pill, the rhythm method and withdrawal lived in South-central. In addition, the highest number of women relying on injectables and implants lived in South-eastern Asia.

In the more developed regions, the largest numbers of users of female and male sterilization, implants and vaginal barrier methods lived in Northern America, whereas the largest numbers of users of the pill, the IUD, the condom, the rhythm method and withdrawal lived in Europe, mainly in Eastern Europe and Western Europe.

Although the less developed regions have most of the contraceptive users in the world (82 per cent), for certain methods the proportion of users in the developed world is higher than would be expected. That is the case for the pill, 34 per cent of whose users live in the more developed regions, and for the condom, 43 per cent of whose users are inhabitants of developed countries. It also bears noting that over 90 per cent of the users of female sterilization, the IUD and injectables live in developing countries.

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IV. FUTURE TRENDS IN CONTRACEPTIVE USE

Future trends in contraceptive use provide a way of predicting the future needs in family planning, in terms of both the amount and the types of methods that will likely be used. The projection of contraceptive prevalence will be based on the fact that contraception is the most important of the direct (or proximate) determinants of cross-national differences in fertility (Bongaarts and Potter 1983; Casterline and others, 1984; United Nations, 1987), thus allowing the prediction of future trends in contraceptive prevalence based on future trends in fertility. The projection of the number of contraceptive users will be carried out for each marital status group and will assume that the ratio of prevalence among women not currently in a union to prevalence among women who are in a marital or consensual union remains constant throughout the entire projection period (2000-2025). It should be noted that in this review, projections are not done at the country level but only at the major area and regional levels.

A. FUTURE TRENDS IN CONTRACEPTIVE PREVALENCE

1. Methodology

It is well-known that fertility levels (as measured by the total fertility rate or TFR) are strongly correlated to contraceptive prevalence at the aggregate level. Thus, when country-level measures of contraceptive prevalence are plotted against the corresponding TFRs, the resulting regression line could be used to estimate future contraceptive prevalence given a projected level of TFR. The procedure to be followed in this assessment will not however rely on this statistical relationship but on another approach already used in previous United Nations assessments (United Nations, 1996 and 2000). The latter approach consists in using the Bongaarts model of proximate determinants of fertility (Bongaarts and Potter, 1983; Bongaarts, 1984), which estimates TFR as a multiplicative function of four indices (representing fertility-reducing effects, thus with values ranging from 0 to 1) and a hypothetical maximum level of fertility:

$$TFR = C_m \,.\, C_c \,.\, C_a \,.\, C_i \,.\, TF$$

where C_m is an index of the fertility-reducing effect of the time that women spend outside marriage or union (that is, unexposed to pregnancy) during their reproductive years,

C_c is an index of the fertility-reducing effect of contraception,

C_a is an index of the fertility-reducing effect of induced abortion, and

C_i is an index of the fertility-reducing effect of post-partum infecundability.

TF is the total fecundity rate, or the expected fertility rate in the absence of any fertility-inhibiting effects of marriage patterns, contraception, abortion or post-partum infecundability. This "maximum fertility" rate is estimated to average 15.3 births over a woman's reproductive lifetime (Bongaarts and Potter, 1983).

From the above model, it can be derived that changes in fertility levels between two time points, time 1 and time 2, are a function of changes in the four proximate determinants of fertility:

$$\frac{TFR(2)}{TFR(1)} = \frac{C_m(2)}{C_m(1)} \cdot \frac{C_c(2)}{C_c(1)} \cdot \frac{C_a(2)}{C_a(1)} \cdot \frac{C_i(2)}{C_i(1)} \cdot \frac{TF(2)}{TF(1)} \quad .$$

In the above equation, it can be assumed that the maximum reachable fertility does not vary over time. It can also be assumed, for the purpose of these projections, that the combined impact on fertility of changes in marriage patterns, abortion practices and duration of post-partum infecundability remains constant over time or that the individual changes even out. As a result, it is assumed that the only factor that determines fertility change during the projection period is the change in contraceptive prevalence[1].

Thus, $\frac{TFR(2)}{TFR(1)} = \frac{C_c(2).}{C_c(1)}$

The index of the effect of contraception, C_c, is calculated as:

$$C_c = 1 - 1.08.\,CP.\,UE$$

where CP is the proportion of women of reproductive age, married or in union, using contraception (that is, contraceptive prevalence),

and UE is the estimated average use-effectiveness of the contraceptive methods currently used (Bongaarts and Potter, 1983).

Evidence shows that contraceptive use-effectiveness depends both on the methods of contraception used and on the way users follow the requirements needed to obtain the theoretical maximum efficiency attached to each method. In this report, however, the following average method-specific use-effectiveness are assumed, following Bongaarts and Potter (1983):

	Use-effectiveness
Sterilization ……	1.00
Pill, injectable, Norplant, implant ……..	0.90
Intra-uterine device …….	0.95
Other ……..	0.70

Given the above values and the distribution of contraceptive use by method shown in Table 9 (previous chapter), the average estimated world and regional use-effectiveness values are estimated as follows for 1998:

	Average Use-effectiveness
World ……..	0.91
More developed regions……..	0.84
Less developed regions ……..	0.93
Africa …….	0.85
Eastern Africa ……	0.85
Middle Africa ……	0.73
Northern Africa …….	0.90
Southern Africa …….	0.92
Western Africa ……..	0.80
Asia ……	0.93
Eastern Asia ……...	0.95
South-central Asia …….	0.92
South-eastern Asia …….	0.89
Western Asia …….	0.82
Latin America and the Caribbean ….	0.91
Caribbean …….	0.92
Central America ……	0.91
South America ……..	0.91
Melanesia/Micronesia/Polynesia ..	0.88

The projections assume that, within each of the regions shown, average use-effectiveness will increase linearly to reach 0.95 by 2025, that is the maximum estimated for Eastern Asia in 1998. Contraceptive prevalence has then been projected using the following formula, which is derived from the previous ones:

$$CP(2) = \frac{1 - [TFR(2)/TFR(1).\ (1 - 1.08.\ CP(1).UE(1))]}{1.08.\ UE(2)}$$

where time 2 varies from 2005 to 2025 and time 1 corresponds to the year 2000.

For the year 2000, contraceptive prevalence figures by region and major area are taken from table 4 of chapter II, where they were estimated based on country-level contraceptive use trends data. Since the existing trends data did not allow the estimation of the 2000 contraceptive prevalence for Melanesia/Micronesia/Polynesia and Oceania as a whole, the above formula is used to estimate the 2000 contraceptive prevalence in these two geographical groupings.

Given its very low TFR, Eastern Asia gets a different treatment from the other less developed regions. Its contraceptive prevalence is assumed to remain at 84 per cent (the level estimated for 2000) throughout the entire projection range because its TFR is projected to remain at 1.8 from 1998 to 2025.

The more developed regions are treated differently from the less developed regions in the projections of prevalence. In these regions, contraceptive prevalence is assumed to continue to rise slightly, to 75 per cent in 2015, and stabilize at that level. The exception is Eastern Europe, where contraceptive prevalence is assumed to attain 75 per cent only in 2020, given that its 2000 figure is much lower than that of the other European region. In regions where prevalence passes over the 75 per cent threshold before 2015, prevalence is assumed to stay at the higher level until 2025.

2. World and major areas

The results of the prevalence projections are shown in table 14 and figure X. Between 2000 and 2025, contraceptive prevalence is projected to increase from 63 to 67 per cent in the world as a whole in order to attain the changes in fertility that were projected for that period as presented in *World Population Prospects: The 2002 Revision*, medium variant (United Nations, 2003). Contraceptive prevalence is projected to be always higher in the more developed regions than in the less developed regions over the 25-year period, although the magnitude of the increases in prevalence will be similar in these two areas: prevalence will rise from 70 to 75 per cent in the former area and from 61 to 68 per cent in the latter. These absolute increases in contraceptive use imply a relatively slow annual growth—an increase of 0.2 percentage point per

TABLE 14. ESTIMATES AND PROJECTIONS OF TOTAL FERTILITY RATE AND CONTRACEPTIVE PREVALENCE[a], BY MAJOR AREA AND REGION

	Year					
Major area and region	*2000*	*2005*	*2010*	*2015*	*2020*	*2025*
			A. Total fertility rate			
World	2.8	2.6	2.5	2.5	2.4	2.3
More developed regions	1.6	1.6	1.6	1.6	1.7	1.7
Less developed regions	3.0	2.8	2.7	2.6	2.5	2.4
Africa	5.1	4.7	4.4	4.0	3.7	3.4
Eastern Africa	5.8	5.4	5.0	4.5	4.1	3.7
Middle Africa	6.3	6.1	5.8	5.3	4.9	4.4
Northern Africa	3.4	3.1	2.8	2.6	2.4	2.2
Southern Africa	2.9	2.7	2.4	2.3	2.1	2.0
Western Africa	5.8	5.3	4.8	4.3	3.9	3.5
Asia	2.6	2.5	2.4	2.3	2.2	2.1
Eastern Asia	1.8	1.8	1.8	1.8	1.8	1.8
South-central Asia	3.4	3.1	2.8	2.6	2.4	2.2
South-eastern Asia	2.7	2.5	2.3	2.2	2.1	2.0
Western Asia	3.6	3.3	3.1	2.9	2.7	2.6
Latin America and the Caribbean	2.6	2.4	2.3	2.2	2.1	2.0
Caribbean	2.4	2.4	2.3	2.2	2.2	2.1
Central America	2.9	2.6	2.4	2.3	2.1	2.0
South America	2.5	2.4	2.2	2.1	2.0	2.0
Europe	1.4	1.4	1.4	1.4	1.5	1.6
Eastern Europe	1.2	1.2	1.2	1.3	1.4	1.5
Northern Europe	1.6	1.6	1.6	1.6	1.7	1.7
Southern Europe	1.3	1.3	1.3	1.4	1.5	1.6
Western Europe	1.5	1.6	1.6	1.6	1.7	1.7
Northern America	2.0	2.0	2.0	2.0	2.0	2.0
Oceania	2.4	2.3	2.2	2.1	2.1	2.1
Australia/New Zealand	1.8	1.7	1.7	1.7	1.7	1.8
Melanesia/Micronesia/Polynesia	3.7	3.3	3.0	2.7	2.5	2.4
			B. Contraceptive prevalence[a] (percentage)			
World	62.6	63.8	64.6	65.3	66.0	66.6
More developed regions	70.1	71.0	72.0	73.0	74.0	75.0
Less developed regions	61.3	63.1	64.5	65.8	67.0	68.0
Africa	27.9	32.4	37.1	41.8	45.9	49.3

TABLE 14 *(continued)*

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Eastern Africa	22.8	28.0	33.4	38.8	43.7	48.1
Middle Africa	22.8	24.7	28.8	33.4	37.9	42.4
Northern Africa	52.0	55.7	59.1	62.2	64.3	65.8
Southern Africa	54.0	58.0	61.1	63.5	65.2	66.6
Western Africa	15.4	22.1	29.3	36.2	41.9	46.0
Asia	65.2	66.9	68.2	69.2	70.0	70.7
Eastern Asia	83.6	84.0	84.0	84.0	84.0	84.0
South-central Asia	49.0	54.0	57.8	60.8	63.2	65.0
South-eastern Asia	59.7	62.6	64.4	65.5	66.3	66.7
Western Asia	49.1	52.2	54.6	56.4	57.4	57.6
Europe	68.2	71.0	73.0	75.0	75.0	75.0
Eastern Europe	62.7	67.0	70.0	73.0	75.0	75.0
Northern Europe	79.1	79.1	79.1	79.1	79.1	79.1
Southern Europe	68.0	71.0	73.0	75.0	75.0	75.0
Western Europe	74.4	74.6	74.8	75.0	75.0	75.0
Latin America and the Caribbean	74.1	75.4	76.3	76.9	77.3	77.5
Caribbean	61.3	62.2	62.9	63.5	64.1	64.8
Central America	70.5	72.6	74.2	75.4	76.3	76.9
South America	77.8	78.8	79.4	79.7	79.8	79.7
Northern America	81.4	81.5	81.5	81.5	81.5	81.5
Oceania	62.4	63.8	64.8	65.2	65.4	65.6
Australia/New Zealand	79.4	79.5	79.5	79.5	79.5	79.5
Melanesia/Micronesia/Polynesia	30.6	37.2	42.8	47.3	50.6	53.0

Source: Total fertility rates are linearly interpolated from estimates and projections, medium variant, presented in *World Population Prospects: The 2002 Revision, vol. I, Comprehensive Tables* (United Nations publication, Sales No. E.03.XIII.6).

[a] Percentage of women of reproductive age in a marital or consensual union who are currently using contraception.

Figure X. Projected contraceptive prevalence, by major area and region

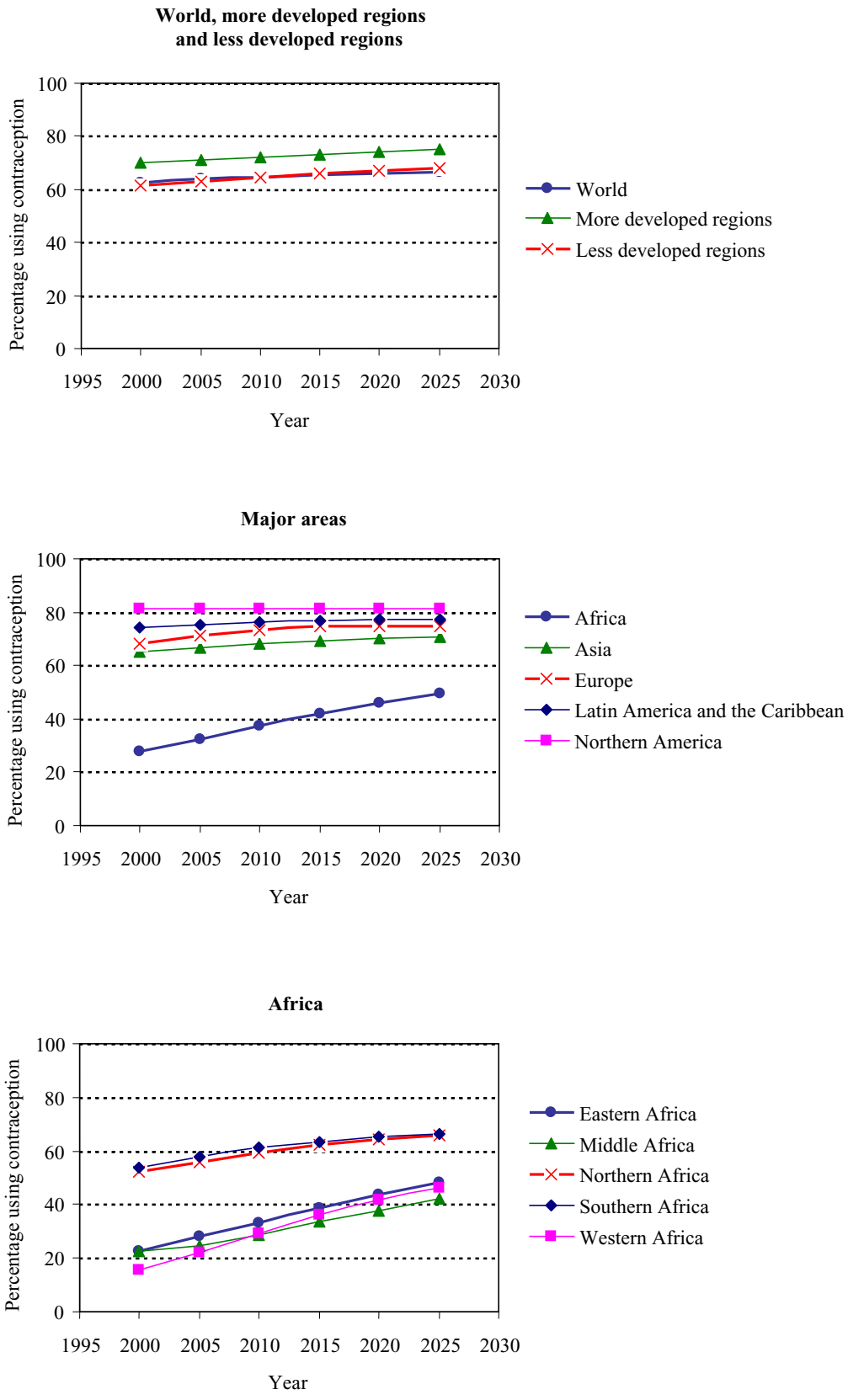
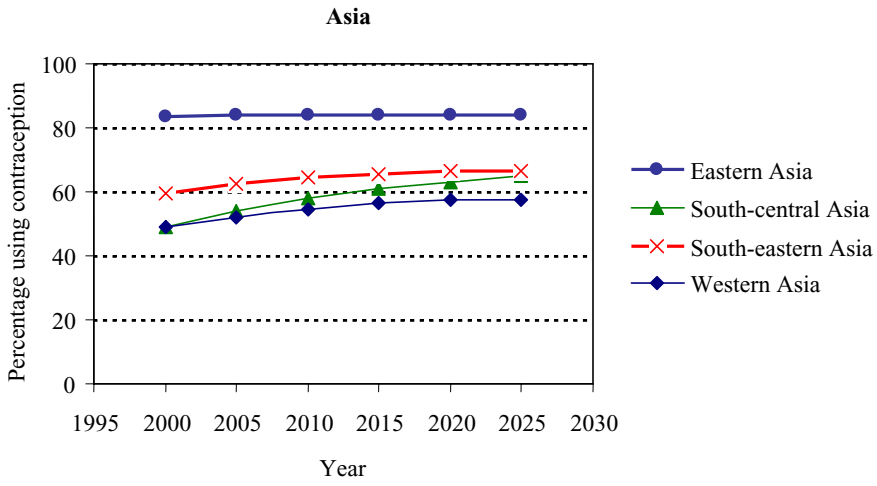
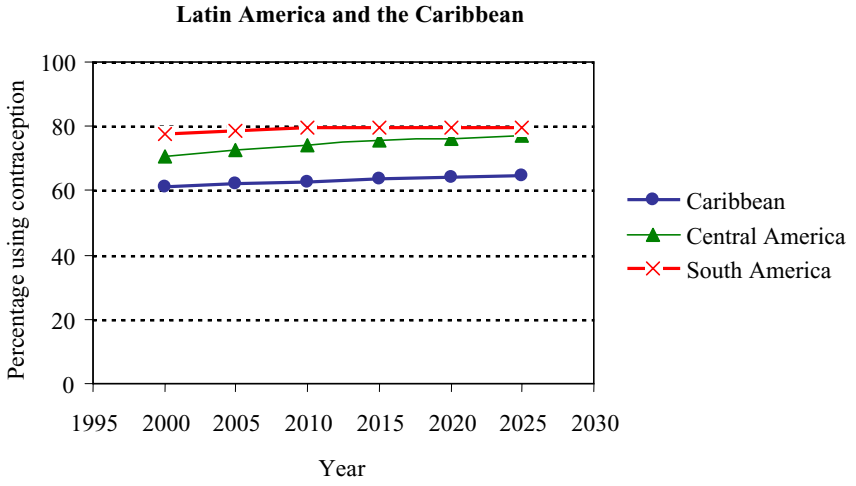


Figure X *(continued)*





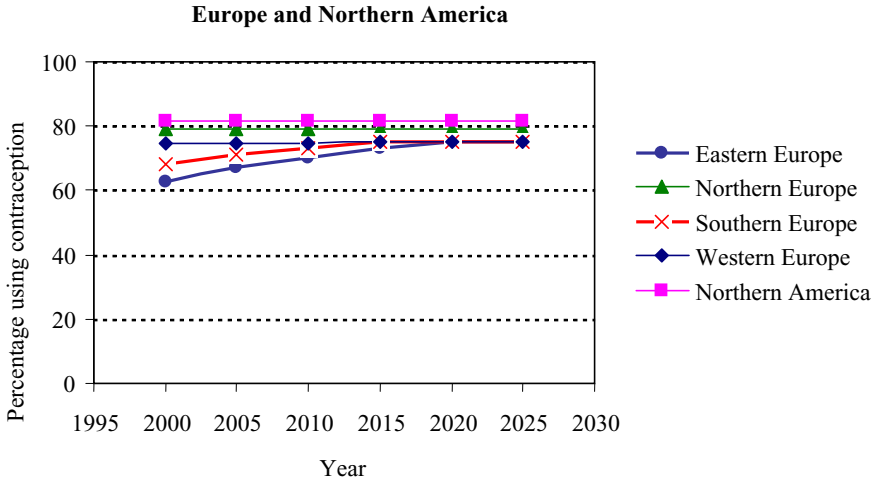
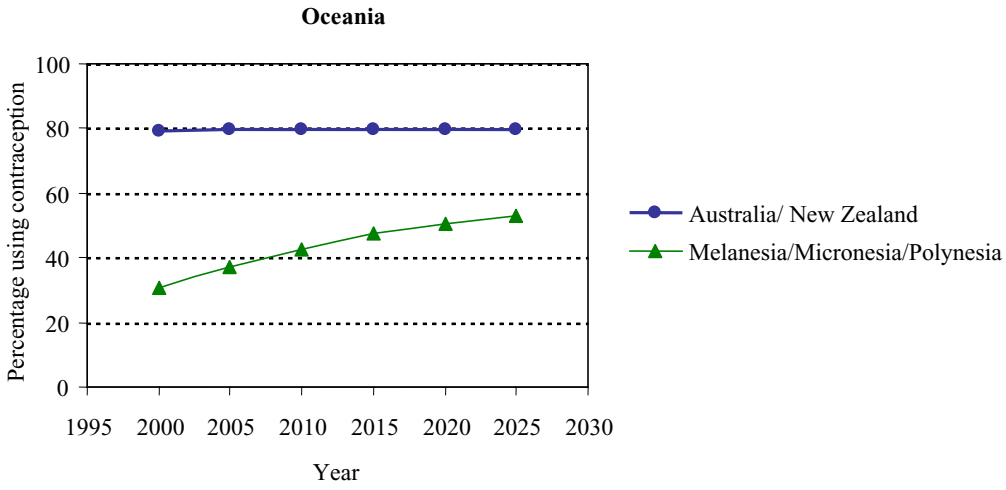


Figure X (*continued*)



year—in the world as a whole, as well as in the more developed regions as a whole. The corresponding annual increase is slightly higher—0.3 percentage point per year—in the less developed regions.

In Africa, prevalence has to rise tremendously from 28 per cent to 49 per cent between 2000 and 2025, that is, almost double, in order to meet the change in fertility levels projected for that major area. In the other major areas, prevalence has to increase only slightly—by 4 to 8 percentage points in total: from 65 per cent to 71 per cent in Asia, from 68 to 75 per cent in Europe, from 74 per cent to 78 per cent in Latin America and the Caribbean, and from 62 per cent to 66 per cent in Oceania. In Northern America, prevalence is assumed to remain at 82 per cent starting in 2000 because TFR is projected to remain at 2.0 during the entire 25-year projection period.

These increases in contraceptive use required at the major area level imply a fast annual growth for Africa—an increase of 0.8 percentage point per year, as illustrated in figure X. In the other major areas, the needed annual growths are much more modest: 0.3 percentage point per year in Europe and 0.2 percentage point per year in Asia, Latin America and the Caribbean, and Oceania.

In sum, contraceptive prevalence is expected to increase moderately between 2000 and 2025 at the world level. Faster increases are expected to happen in the less developed regions than in the more developed regions because contraceptive prevalence was already at relatively high levels in the latter regions. In the less developed regions, the fastest and most significant increases are projected to happen in Africa, where prevalence should almost double between 2000 and 2025 in order to achieve the reductions of fertility projected for that major area. Consequently, prevalence at the global (major area) level is assumed to be within a narrower interval in the future: while in 2000, prevalence ranged from 28 per cent in Africa to 81 per cent in Northern America (a difference of 53 percentage points), in 2025, prevalence is expected to only range from 49 per cent in Africa to 81 per cent in Northern America (a difference of 32 percentage points).

3. Future regional trends in contraceptive prevalence

While the most rapid increase in contraceptive prevalence is projected for Africa, considerable variations exist however between the African regions. On the one hand, prevalence is projected to triple in Western Africa (rising from 15 per cent to 46 per cent) and to double in Eastern Africa and Middle Africa (rising from 23 per cent to 48 per cent and 42 per cent, respectively) between 2000 and 2025. On the other hand, prevalence is projected to increase slowly in Northern Africa and Southern Africa but is likely to remain higher than in the other African regions. In 2000, prevalence was at 52 per cent and 54 per cent, respectively, in these two regions. In 2025, prevalence is projected

to reach 66 per cent and 67 per cent, respectively. These increases imply very fast annual growths for each of the three African regions where prevalence levels are projected to be the lowest: between 0.8 and 1.2 percentage points per year in Eastern Africa, Middle Africa and Western Africa. The implied annual growths expected for Northern Africa and Southern Africa are much smaller—0.6 and 0.5 percentage point per year, respectively—although as the figures in table 14 show, these annual growths are still high compared to that of the majority of the regions of the other major areas.

Oceania is another major area with a large variation in prevalence between its regions, in terms of both projected prevalence levels and the speed at which prevalence is expected to increase by 2025 as figure X depicts clearly. In Melanesia/Micronesia/ Polynesia, prevalence is projected to almost double between 2000 and 2025, rising from 31 per cent to 53 per cent. This absolute increase implies an annual growth for Melanesia/Micronesia/Polynesia as fast as that found in the African regions: 0.9 percentage point per year. In Australia/New Zealand, on the other hand, prevalence was already high in 1998 (76 per cent) so it is expected to remain close to its estimated 2000 level (80 per cent) throughout the entire projection period.

In the other major areas, there is less variation between regions. In addition, very little or no growth is expected, as suggested by the flat graphs showed in figure X for the regions of Asia, Latin America and the Caribbean, Europe and Northern America. The exception is South-central Asia where prevalence has to increase from 49 per cent to 65 per cent by 2025 to achieve the reductions of fertility projected for that region. This implies an annual growth for this region as fast as that of Northern and Southern Africa—0.6 percentage point per year. In the rest of the regions, prevalence is projected to increase annually by 0.5 percentage point in Eastern Europe, by 0.3 percentage point to 0.4 percentage point per year in South-eastern Asia, Western Asia and Southern Europe, by 0.2 percentage point in the Caribbean and Central America, and by a mere 0.1 percentage point in South America. In Eastern Asia, Northern Europe, Western Europe and Northern America, practically no growth in contraceptive prevalence is expected since contraceptive prevalence levels were already high in these regions in 2000.

In sum, as figure X shows, under the assumptions made, contraceptive prevalence is projected to continue to increase in many less developed regions. In particular, it is projected to increase significantly in all the African regions and in South-central Asia and Melanesia/Micronesia/Polynesia. In South-eastern Asia and Western Asia, contraceptive prevalence is supposed increase much slower, at half the rate expected for the previous regions. On the other hand, very little or no increase is projected for Eastern Asia and all three regions of Latin America and the Caribbean. In the more developed regions, prevalence is assumed to increase slowly in Eastern Europe and Southern Europe but not in Northern Europe, Western Europe, Northern America and Australia/New Zealand. Finally, prevalence at the regional level is assumed to range within a narrower interval in 2025: while in 2000, prevalence ranged from 15 per cent in Western Africa to 84 per cent in Eastern Asia (a difference of 69 percentage points), in 2025, prevalence is projected to range from 42 per cent in Middle Africa to 84 per cent in Eastern Asia (a difference of 42 percentage points).

B. Future trends in the number of married contraceptive users

1. Methodology

Future numbers of contraceptive users among women who are married or in union (referred to, in this section, as married contraceptive users) are the results of three parameters: future numbers of all women aged 15-49, the percentage of women aged 15-49 who are married or in union, and the percentage of women of reproductive age, married or in union, who are using contraception. The estimated and projected numbers of women aged 15-49 are taken from *World Population Prospects: The 2002 Revision*, medium variant (United Nations, 2003). The current proportions married or in union among all women aged 15-49 were estimated by age-group from recent census and survey data and then projected by age-group following a method described in Annex I. The current and future proportions of contraceptive users among women of reproductive age who are married or in union have just been examined (table 14, lower panel).

When interpreting the results obtained on the numbers of married contraceptive users presented in table 15, it should be noted that the levels of the proportions married or in union among all women aged 15-49 vary quite significantly from one region to another. In 2000, these proportions varied from

TABLE 15. ESTIMATED AND PROJECTED NUMBERS OF WOMEN AND FEMALE CONTRACEPTIVE USERS, BY MARITAL STATUS
(*thousands*)

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
			A. All women aged 15-49			
World	1 553 650	1 662 574	1 753 146	1 818 756	1 867 954	1 915 778
More developed regions	300 110	298 435	291 398	281 514	273 346	265 353
Less developed regions	1 253 541	1 364 140	1 461 748	1 537 242	1 594 609	1 650 425
Africa	189 134	213 705	238 621	265 726	296 452	329 189
Eastern Africa	58 322	65 802	74 219	84 020	95 002	106 835
Middle Africa	20 922	23 949	27 380	31 324	36 228	41 773
Northern Africa	44 824	50 478	55 205	59 315	63 585	67 489
Southern Africa	13 567	14 108	13 872	13 472	13 247	13 132
Western Africa	51 499	59 367	67 945	77 595	88 392	99 960
Asia	952 262	1 025 347	1 087 384	1 127 385	1 146 490	1 163 405
Eastern Asia	401 246	412 593	417 826	408 809	385 784	365 286
South-central Asia	363 439	405 716	445 861	481 603	512 709	540 974
South-eastern Asia	139 990	152 905	163 559	171 311	176 703	180 426
Western Asia	47 587	54 134	60 138	65 662	71 295	76 720
Europe	184 198	181 919	174 746	165 316	156 647	148 192
Eastern Europe	80 517	79 337	74 775	69 774	65 777	61 185
Northern Europe	22 589	22 725	22 696	22 147	21 463	21 021
Southern Europe	36 689	35 965	34 571	32 607	30 429	28 003
Western Europe	44 403	43 892	42 703	40 788	38 978	37 983
Latin America and the Caribbean	139 572	151 071	160 580	167 719	173 591	177 448
Caribbean	9 879	10 421	10 742	10 746	10 713	10 681
Central America	35 960	39 732	43 165	46 090	48 275	49 437
South America	93 733	100 919	106 673	110 883	114 604	117 330
Northern America	80 631	82 315	83 227	83 738	85 645	88 248
Oceania	7 853	8 217	8 588	8 872	9 128	9 296
Australia/New Zealand	5 867	6 003	6 093	6 103	6 112	6 070
Melanesia/Micronesia/Polynesia	1 986	2 214	2 495	2 769	3 016	3 226
			B. Married[a] *women aged 15-49*			
World	1 043 265	1 097 427	1 151 442	1 192 049	1 214 596	1 229 572
More developed regions	170 043	150 037	144 481	138 973	135 353	132 408
Less developed regions	873 223	947 391	1 006 960	1 053 076	1 079 243	1 097 164
Africa	117 120	129 763	143 785	159 930	178 125	197 336
Eastern Africa	36 975	41 184	46 264	52 226	58 750	65 520

TABLE 15 *(continued)*

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Middle Africa	14 213	15 701	17 390	19 398	21 900	24 976
Northern Africa	25 590	28 425	31 269	33 986	36 570	38 604
Southern Africa	4 923	4 400	3 712	3 328	3 312	3 558
Western Africa	35 419	40 053	45 149	50 992	57 593	64 678
Asia	688 738	727 001	766 143	791 053	794 831	790 486
Eastern Asia	293 294	291 883	293 863	286 663	265 546	244 453
South-central Asia	275 510	302 864	329 248	352 635	371 099	383 417
South-eastern Asia	89 587	98 335	105 607	111 201	114 568	116 166
Western Asia	30 347	33 919	37 425	40 554	43 617	46 450
Europe	109 277	105 526	100 678	95 094	89 851	84 572
Eastern Europe	51 321	49 245	46 718	44 422	42 266	38 963
Northern Europe	11 529	10 917	10 416	9 926	9 592	9 588
Southern Europe	22 077	22 275	21 762	20 468	18 831	17 059
Western Europe	24 350	23 089	21 782	20 278	19 161	18 962
Latin America and the Caribbean	81 810	89 191	95 459	100 369	104 406	107 322
Caribbean	5 648	6 004	6 174	6 238	6 281	6 393
Central America	21 747	24 241	26 435	28 373	29 857	30 625
South America	54 415	58 946	62 849	65 757	68 268	70 304
Northern America	42 029	41 645	41 049	41 204	42 824	45 128
Oceania	4 292	4 301	4 328	4 399	4 559	4 729
Australia/New Zealand	2 989	2 866	2 754	2 675	2 678	2 709
Melanesia/Micronesia/Polynesia	1 303	1 436	1 574	1 724	1 882	2 021
	C. Unmarried[b] women aged 15-49					
World	510 385	565 147	601 704	626 707	653 359	686 205
More developed regions	130 067	148 398	146 916	1425 41	137 993	132 945
Less developed regions	380 318	416 749	454 788	484 166	515 366	553 260
Africa	72 015	83 942	94 836	105 796	118 327	131 853
Eastern Africa	21 347	24 618	27 955	31 794	36 252	41 315
Middle Africa	6 709	8 248	9 989	11 925	14 328	16 798
Northern Africa	19 235	22 054	23 936	25 329	27 015	28 885
Southern Africa	8 645	9 708	10 159	10 144	9 935	9 574
Western Africa	16 080	19 314	22 797	26 603	30 798	35 282
Asia	263 524	298 345	321 242	336 332	351 660	372 919
Eastern Asia	107 952	120 710	123 964	122 147	120 237	120 834
South-central Asia	87 929	102 851	116 614	128 968	141 610	157 556
South-eastern Asia	50 403	54 569	57 952	60 110	62 135	64 260
Western Asia	17 240	20 215	22 713	25 108	27 678	30 270
Europe	74 921	76 393	74 068	70 222	66 797	63 620
Eastern Europe	29 195	30 092	28 057	25 352	23 511	22 222

TABLE 15 *(continued)*

Major area and region	Year					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Northern Europe	11 060	11 809	12 280	12 221	11 871	11 433
Southern Europe	14 612	13 690	12 809	12 139	11 598	10 944
Western Europe	20 054	20 803	20 922	20 510	19 817	19 021
Latin America and the Caribbean	57 762	61 880	65 121	67 350	69 185	70 126
Caribbean	4 231	4 417	4 567	4 508	4 432	4 288
Central America	14 213	15 490	16 729	17 717	18 418	18 812
South America	39 318	41 973	43 824	45 125	46 335	47 027
Northern America	38 602	40 671	42 178	42 534	42 821	43 120
Oceania	3 561	3 916	4 260	4 472	4 569	4 566
Australia/New Zealand	2 878	3 137	3 338	3 428	3 434	3 361
Melanesia/Micronesia/Polynesia	683	778	922	1 044	1 134	1 205
D. All female contraceptive users aged 15-49						
World	780 484	848 178	907 998	955 967	992 223	1 023 743
More developed regions	168 524	163 422	161 148	157 640	155 303	153 149
Less developed regions	611 960	684 756	746 850	798 327	836 920	870 594
Africa	43 842	57 505	74 116	93 648	115 318	137 956
Eastern Africa	12 094	16 684	22 459	2 9491	37 568	46 425
Middle Africa	4 388	5 404	7 158	9 477	12 385	1 5931
Northern Africa	13 917	16 578	19 337	22 067	24 570	26 531
Southern Africa	6 154	6 774	6 926	6 940	7 019	7 149
Western Africa	7 289	12 065	18 236	25 673	33 776	41 920
Asia	459 027	500 148	538 973	565 128	573 338	5747 67
Eastern Asia	250 643	251 265	253 092	246 953	22 9119	211 430
South-central Asia	137 674	166 911	194 415	219 218	239 862	255 447
South-eastern Asia	5 5291	63 623	70 277	7 5225	78 388	80 111
Western Asia	15 418	18 349	21 188	23 732	25 969	27 778
Europe	101 649	103 332	101 825	98 821	94 728	89 565
Eastern Europe	38 749	40 252	39 773	39 091	38 048	35 222
Northern Europe	15 424	15 367	15 239	14 818	14 354	14 101
Southern Europe	18 603	19 315	19 253	18 629	17 255	15 749
Western Europe	28 872	28 398	27 560	26 284	25 072	24 493
Latin America and the Caribbean	70 645	78 124	84 443	89 273	93 160	95 776
Caribbean	4 030	4 342	4 513	4 588	4 652	4 757
Central America	17 529	20 078	22 359	24 343	25 864	26 729
South America	49 086	53 704	57 570	60 342	62 644	64 289
Northern America	56 803	57 806	58 205	58 540	60 029	62 082
Oceania	4 442	4 643	4 822	4 965	5 117	5 225

TABLE 15 *(continued)*

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Australia/New Zealand	4 018	4 074	4 101	4 089	4 095	4 077
Melanesia/Micronesia/Polynesia	425	569	721	876	1 022	1 148
E. Married[a] female contraceptive users aged 15-49						
World	654 321	704 481	754 003	794 610	823 150	845 696
More developed regions	119 262	106 526	104 027	101 450	100 161	99 306
Less developed regions	535 058	597 955	649 976	693 160	722 989	746 390
Africa	33 090	42 649	54 442	68 421	83 785	99 617
Eastern Africa	8 439	11 519	15 455	20 247	25 682	31 519
Middle Africa	3 241	3 877	5 003	6 486	8 308	10 589
Northern Africa	13 317	15 841	18 488	21 123	23 527	25 391
Southern Africa	2 656	2 552	2 269	2 112	2 160	2 369
Western Africa	5 438	8 860	13 227	18 453	24 108	29 749
Asia	448 711	488 048	525 695	551 051	558 486	558 912
Eastern Asia	245 228	245 181	246 845	240 797	223 059	205 340
South-central Asia	135 087	163 578	190 370	214 510	234 493	249 301
South-eastern Asia	53 485	61 573	68 037	72 862	75 918	77 538
Western Asia	14 910	17 716	20 443	22 882	25 016	26 733
Europe	74 433	74 673	73 125	70 842	67 784	63 825
Eastern Europe	32 162	32 994	32 703	32 428	31 700	29 222
Northern Europe	9 123	8 639	8 243	7 855	7 590	7 587
Southern Europe	15 023	15 816	15 887	15 351	14 123	12 794
Western Europe	18 125	17 224	16 293	15 208	14 371	14 221
Latin America and the Caribbean	61 138	67 771	73 421	77 789	81 306	83 735
Caribbean	3 460	3 737	3 881	3 958	4 027	4 145
Central America	15 325	17 604	19 627	21 403	22 774	23 547
South America	42 353	46 430	49 913	52 427	54 505	56 042
Northern America	34 192	33 940	33 455	33 581	34 901	36 779
Oceania	2 771	2 812	2 863	2 943	3 081	3 224
Australia/New Zealand	2 373	2 278	2 190	2 127	2 129	2 153
Melanesia/Micronesia/Polynesia	399	533	673	816	952	1 070
F. Unmarried[b] female contraceptive users aged 15-49						
World	126 163	143 697	153 995	161 357	169 073	178 047
More developed regions	49 261	56 896	57 121	56 190	55 142	53 843
Less developed regions	76 902	86 802	96 874	105 168	113 931	124 205
Africa	10 752	14 856	19 674	25 228	31 533	38 339
Eastern Africa	3 654	5 164	7 004	9 244	11 885	14 906
Middle Africa	1 147	1 527	2 155	2 991	4 077	5 341
Northern Africa	601	737	849	945	1 043	1 140

TABLE 15 *(continued)*

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Southern Africa	3 498	4 223	4 657	4 828	4 859	4 780
Western Africa	1 851	3 204	5 009	7 220	9 669	12 171
Asia	10 316	12 100	13 278	14 076	14 852	15 855
Eastern Asia	5 416	6 084	6 248	6 156	6 060	6 090
South-central Asia	2 587	3 333	4 046	4 707	5 369	6 147
South-eastern Asia	1 806	2 050	2 240	2 363	2 470	2 574
Western Asia	508	633	744	850	952	1 045
Europe	27 215	28 659	28 701	27 979	26 944	25 740
Eastern Europe	6 587	7 258	7 070	6 662	6 348	6 000
Northern Europe	6 301	6 728	6 996	6 963	6 763	6 514
Southern Europe	3 580	3 499	3 366	3 277	3 131	2 955
Western Europe	10 747	11 174	11 268	11 076	10 701	10 271
Latin America and the Caribbean	9506	1 0353	11 021	11 485	11 855	12 041
Caribbean	570	605	632	629	625	612
Central America	2 203	2 475	2 732	2 940	3 091	3 182
South America	6 733	7 274	7 657	7 915	8 139	8 247
Northern America	22 611	23 865	24 750	24 959	25 127	25 303
Oceania	1 671	1 831	1 959	2 022	2 036	2 001
Australia/New Zealand	1 645	1 796	1 911	1 962	1 966	1 924
Melanesia/Micronesia/Polynesia	26	35	48	60	70	78

Sources: Table 14 and *World Population Prospects: The 2002 Revision, vol. II, Sex and Age Distribution of Populations* (United Nations publication, Sales No. E.03.XIII.7).
NOTE: Numbers of married women and numbers of contraceptive users are projected as explained in the text.
[a] In a marital or consensual union.
[b] Not in a union.

36.3 per cent in Southern Africa to 75.8 per cent in South-central Asia (annex table A.3). It should also be noted that the projected proportions follow different trends, which yield to decreases in these proportions in most regions of the world, but to stagnations in Northern Africa, South-eastern Asia, Eastern Europe and Southern Europe, and to increases in all the regions of Latin America and the Caribbean.

2. Global trends

At the world level, the number of married contraceptive users is projected to increase from 654 million to 846 million between 2000 and 2025 (table 15), or a 29 per cent increase, as a result of the projected increase in contraceptive prevalence and the projected increase in the number of women aged 15-49 who are married or in union. This growth in the number of users is the result of the growth projected for the less developed regions. In these regions, the number of married contraceptive users is projected to increase from 535 million to 746 million, a 39 per cent increase, as a result of both the projected increase in contraceptive prevalence and the projected increase in the number of married or in union women aged 15-49. In the more developed regions, by contrast, the number of married contraceptive users is projected to decrease from 119 million to 99 million, that is, a 17 per cent decrease. The latter decrease is not related to future trends in contraceptive prevalence because contraceptive prevalence in the more developed regions is projected to increase during the 25-year period (see first section of this chapter). The decrease in the number of married contraceptive users in the more developed regions is due to a projected decrease in the number of women aged 15-49 who are married or in union as a result of both the decrease in the number of women aged 15-49 and the decrease in the proportion of married women.

Between 2000 and 2025, the number of married contraceptive users is projected to triple in Africa (from 33 million to 100 million) and to increase significantly but at much lower paces in Asia (from 449 million to 559 million) and Latin America and the Caribbean (from 61 million to 84 million). By contrast, the number of married contraceptive users is projected to increase only slightly in Northern America (from 34 million to 37 million) and in Oceania (from 2.8 million to 3.2 million). It is projected to decrease from 74 million to 64 million in Europe as a consequence of the projected decrease in the number of all women aged 15-49 and the projected decrease in the proportion of women aged 15-49 who are married or in union.

In sum, the largest proportional increase in the number of contraceptive users at the global (major area) level is expected to occur in Africa where the projections yield to a three-fold increase between 2000 and 2025. In absolute numbers, however, the largest increase in married contraceptive users is projected for Asia where 110 million more users are expected by 2025 compared to only 67 million more users in Africa.

3. Regional trends

The regions where the number of married contraceptive users is projected to increase the most, in relative terms, are located in Africa (table 15, panel E). However, there is considerable variation between the African regions. Under the assumptions made, the number of married users is expected to increase six-fold in Western Africa, from 5.4 million to 30 million between 2000 and 2025. In Eastern Africa, the number of married contraceptive users is expected to almost quadruple, from 8.4 million to 32 million, and to triple in Middle Africa, from 3.2 million to 11 million. By contrast, the number of married contraceptive users is expected to only double in Northern Africa, from 13 million to 25 million, and decrease slightly in Southern Africa, from 2.7 million to 2.4 million, as a result of a decrease in the number of women who are married or in union.

Oceania is another major area with great variation between its regions, in terms of relative change in the number of married contraceptive users. In the less developed regions of Melanesia, Micronesia and Polynesia, the number of married users is expected to almost triple between 2000 and 2025, rising from 0.4 million to 1 million. In Australia and New Zealand, by contrast, the number of married users is expected to decrease slightly from 2.4 million to 2.2 million throughout the 25-year projection period.

In the other major areas, there is less variation between regions. In Asia, the number of married users is projected to almost double in all the regions, except in Eastern Asia, where it is projected to decrease by 16 per cent, from 245 million to 205 million. In Latin America and the Caribbean, the number of married contraceptive users is projected to increase in all three regions, by

20 per cent to 54 per cent. Lastly, in Europe, the number is projected to decrease slightly in all the regions.

C. Future trends in the number of unmarried contraceptive users

1. Methodology

Contraceptive prevalence among the women not currently in a union (referred to, hereafter, as unmarried) is derived by computing an average ratio of prevalence among the unmarried to prevalence among the married based on available survey data and by assuming that this ratio remains constant throughout the entire projection period. Data coverage and assumptions used in deriving the estimates of the ratios are described below. It is mainly in sub-Saharan Africa and to a lesser extent in Latin America and the Caribbean that survey data on the contraceptive behaviour of unmarried women have been collected whereas, such data are scarce for countries in Asia and Northern Africa as well as for the developed countries.

(a) Sub-Saharan Africa

Information about contraceptive use by unmarried women was available for 35 sub-Saharan African countries (table 16). The prevalence ratio, that is, the ratio of the contraceptive prevalence among unmarried women to the contraceptive prevalence among women who are married or in union, for these countries covers a wide range, from almost 0 in Mauritania and Mauritius to around 2 or over in Côte d'Ivoire, Guinea and Liberia. Ratios over 1, indicating a higher prevalence among the unmarried than among those in a union, were observed in ten countries (Burkina Faso, Cameroon, Côte d'Ivoire, Gabon, Guinea, Liberia, Mali, Mozambique, Nigeria and Togo). For the countries with data, the average prevalence ratio was 0.77 and the median prevalence ratio was 0.65. The median ratio of 0.65 was assumed for the countries lacking data. The resulting average prevalence ratio for the sub-Saharan region as a whole was 0.75.

(b) Asia and Northern Africa

Direct information about the level of current contraceptive use among unmarried women was available for only nine countries of Asia (table 16). In this region, contraceptive prevalence among unmarried women is much lower than that among married or in-union women: the prevalence ratio for the countries with data was close to 0, except in Kazakhstan and Mongolia where the prevalence ratios were slightly over 0.20. For the countries with data, the average prevalence ratio was 0.08 and the median prevalence ratio was 0.05. Given that sexual activity outside marriage tends to be viewed as highly unacceptable for women (although not necessarily for men) in most societies of Asia and Northern Africa, these results are considered as representative of these two regions even though they are based on a small number of countries. Thus, the median ratio of 0.05 was assumed for countries lacking data and the resulting average prevalence ratio for Asia and Northern Africa as a whole was 0.06.

(c) Latin America and the Caribbean

Information about contraceptive use by unmarried women was available for 16 Latin American and Caribbean countries (table 16). In this region, too, prevalence among unmarried women use is much lower than that of married or in-union women but higher than that of Asian women. The prevalence ratio for the countries with data ranges from 0.04 in Honduras to 0.31 in Trinidad and Tobago. When numbers of users and women were summed up for the countries with data, the average and median prevalence ratios for countries with data were both 0.22. The ratio of 0.22 was thus assumed for the countries lacking data and the resulting average prevalence ratio for the Latin American and Caribbean region as a whole was also 0.22.

(d) Melanesia/Micronesia/Polynesia

Only one country, Papua New Guinea, had information on contraceptive use by marital status in the regions of Melanesia, Micronesia and Polynesia (table 16). In this country, unmarried women use less contraception than their married counterparts: the prevalence ratio was 0.12 and the latter was assumed to be the average ratio for the whole region.

(e) Eastern Europe and Southern Europe

Information about contraceptive use by unmarried women was available for four Eastern European countries (table 16). In these countries, contraceptive use is lower among unmarried women than among their married counterparts: the prevalence ratio for the countries with data varies between 0.21 in the Republic of Moldova and 0.58

TABLE 16. PERCENTAGE OF WOMEN OF REPRODUCTIVE AGE WHO ARE USING CONTRACEPTION BY MARITAL STATUS, SELECTED COUNTRIES

Country	Year	Age group	Percentage using contraception among: married[a] women	Percentage using contraception among: unmarried[b] women	Percentage using contraception among: all women	Prevalence ratio[c]: unmarried vs. married
Less developed countries						
Sub-Saharan Africa						
Benin	2001	15-49	18.6	15.6	17.8	0.84
Botswana	1988	15-49	33.0	28.0	30.0	0.85
Burkina Faso	1999	15-49	11.9	12.5	12.0	1.05
Burundi	1987	15-49	8.7	1.6	6.4	0.18
Cameroon	1998	15-49	19.3	33.4	24.0	1.73
Central African Republic	1995	15-49	14.8	12.5	14.1	0.84
Chad	1997	15-49	4.1	3.1	3.9	0.76
Comoros	1996	15-49	21.0	5.6	13.8	0.27
Côte d'Ivoire	1999	15-49	15.0	29.7	20.7	1.98
Democratic Republic of the Congo	1991	15-49	7.7	5.0	7.0	0.65
Eritrea	1995	15-49	8.0	4.0	5.9	0.50
Ethiopia	2000	15-49	8.1	2.1	5.9	0.26
Gabon	2000	15-49	32.7	39.0	35.6	1.19
Ghana	1999	15-49	22.0	10.8	18.0	0.49
Guinea	1999	15-49	6.2	13.9	7.6	2.24
Kenya	1998	15-49	39.0	15.5	29.9	0.40
Liberia	1986	15-49	6.4	12.5	8.4	1.95
Madagascar	1997	15-49	19.4	10.2	16.0	0.53
Malawi	2000	15-49	30.6	10.7	25.0	0.35
Mali	2001	15-49	8.1	9.9	8.4	1.22
Mauritania	2001	15-49	8.0	0.2	4.8	0.03
Mauritius	1991	15-44	74.7	1.0	55.0	0.01
Mozambique	1997	15-49	5.6	7.3	6.0	1.30
Namibia	1992	15-49	28.9	19.2	23.3	0.66
Niger	1998	15-49	8.2	4.4	7.6	0.54
Nigeria	1999	15-49	15.3	16.4	15.7	1.07
Rwanda	2000	15-49	13.2	1.9	7.4	0.14
Senegal	1997	15-49	12.9	6.2	10.8	0.48
South Africa	1998	15-49	56.3	45.4	50.1	0.81
Swaziland	1988	15-49	19.9	7.0	17.0	0.35
Togo	1998	15-49	23.5	29.3	25.3	1.25
Uganda	2001	15-49	22.8	14.5	20.1	0.64
United Republic of Tanzania	1999	15-49	25.4	16.4	22.3	0.65
Zambia	1996	15-49	25.9	8.6	19.2	0.33
Zimbabwe	1999	15-49	53.5	12.8	37.7	0.24
Asia						
Armenia	2000	15-49	60.5	0.5	39.0	0.01
Cambodia	2000	15-49	23.8	0.3	14.2	0.01
Kazakhstan	1999	15-49	66.1	17.3	48.0	0.26
Kyrgyzstan	1997	15-49	59.5	4.5	42.8	0.08
Mongolia	1998	15-49	59.9	14.3	44.2	0.24
Philippines	1998	15-49	46.5	1.1	28.2	0.02

TABLE 16 *(continued)*

Country	Year	Age group	Percentage using contraception among: married[a] women	unmarried[b] women	all women	Prevalence ratio[c]: unmarried vs. married
Turkey	1998	15-49	63.9	0.2	44.2	0.00
Turkmenistan	2000	15-49	61.8	2.8	39.2	0.05
Uzbekistan	1996	15-49	55.6	1.7	39.6	0.03
Latin America and the Caribbean						
Bolivia	1998	15-49	48.3	6.6	31.4	0.14
Brazil	1996	15-49	76.7	23.2	55.4	0.30
Colombia	2000	15-49	76.9	27.5	52.8	0.36
Costa Rica	1993	15-49	75.0	21.0	53.0	0.28
Dominican Republic	1999	15-49	69.2	22.0	48.8	0.32
Ecuador	1999	15-49	65.8	8.5	41.9	0.13
El Salvador	1998	15-44	59.7	13.1	38.2	0.22
Guatemala	1999	15-49	38.2	4.2	26.6	0.11
Haiti	2000	15-49	27.4	7.1	19.4	0.26
Honduras	1996	15-44	50.0	2.0	32.0	0.04
Jamaica	1997	15-49	65.9	19.0	50.0	0.29
Mexico	1995	15-49	66.5	8.2	43.4	0.12
Nicaragua	1998	15-49	60.3	12.8	40.8	0.21
Paraguay	1998	15-44	57.4	15.5	41.1	0.27
Peru	2000	15-49	68.9	12.1	44.0	0.18
Trinidad and Tobago	1987	15-49	54.6	16.8	37.4	0.31
Melanesia/Micronesia/Polynesia						
Papua New Guinea	1996	15-49	25.9	3.0	20.0	0.12
More developed countries						
Eastern Europe						
Czech Republic	1993	15-44	68.9	39.7	59.1	0.58
Republic of Moldova	2000	15-49	62.4	13.4	54.3	0.21
Romania	1999	15-44	63.8	19.7	48.2	0.31
Ukraine	1999	15-44	67.5	26.2	53.5	0.39
Northern Europe, Western Europe, Northern America, Australia/New Zealand						
Australia	1986	20-49	76.1	56.0	72.0	0.74
Belgium	1992	21-39	79.0	75.0	79.0	0.95
France	1994	20-49	74.6	52.0	69.0	0.70
Germany	1992	20-39	74.7	68.0	72.0	0.91
Netherlands	1993	18-42	78.5	55.0	74.0	0.70
United Kingdom	1993	16-49	82.0	52.0	72.0	0.63
United States of America	1995	15-44	76.4	52.4	64.2	0.69

Sources: Various survey reports (Demographic and Health Surveys, Fertility and Family Surveys, Reproductive Health Surveys).
[a] Women of reproductive age who are currently in a marital or consensual union.
[b] Women of reproductive age who are not currently in a union.
[c] Percentage of women not currently in a union using contraception divided by percentage of married or in-union women using contraception.

in the Czech Republic. The average and median prevalence ratios for countries with data were 0.37 and 0.35, respectively. The median ratio of 0.35 was assumed for the countries lacking data, including the Southern European countries, and as a result, the average prevalence ratio for Eastern and Southern Europe was 0.36.

(f) Northern Europe, Western Europe, Northern America and Australia/New Zealand

Information about contraceptive use by unmarried women was available for five countries of Northern Europe, Western Europe and Northern America and for Australia and New Zealand (table 16). In these countries, too, contraceptive use is lower among unmarried women than among their married counterparts: the prevalence ratios varied from 0.63 in the United Kingdom to 0.95 in Belgium. The average and median prevalence ratios for countries with data were 0.76 and 0.70, respectively. The median ratio of 0.70 was assumed for the countries lacking data and as a result, the average prevalence ratio for these four regions was 0.72.

These regional average prevalence ratios were weighted by the number of women aged 15-49 in each region in 2000 to get the estimates of prevalence ratio for the development groups shown in table 17. These ratios, which were kept constant from 1998 to 2025, were then multiplied by the contraceptive prevalence among married women to get the percentage of unmarried women who are using contraception. Adding the corresponding number of unmarried contraceptive users to the number of married contraceptive users gave the number of all female contraceptive users. Finally, dividing this number by the number of all women aged 15-49 yielded the contraceptive use level among all women (table 18).

TABLE 17. RATIO OF CONTRACEPTIVE PREVALENCE AMONG UNMARRIED WOMEN TO CONTRACEPTIVE PREVALENCE AMONG MARRIED WOMEN

Major area or region	*Prevalence ratio[a] unmarried vs. married*
Less developed regions	0.33
Sub-Saharan Africa	0.75
Asia and Northern Africa	0.06
Latin America and the Caribbean	0.22
Melanesia/Micronesia/Polynesia	0.12
More developed regions	0.54
Eastern Europe and Southern Europe	0.36
Northern Europe, Western Europe, Northern America, Australia/New Zealand	0.72

Sources: Table 1 and table 16.
[a] Percentage of women not currently in a union using contraception divided by percentage of women who are married or in union using contraception.

TABLE 18. ESTIMATED AND PROJECTED PERCENTAGES OF WOMEN OF REPRODUCTIVE AGE USING CONTRACEPTION, BY MARITAL STATUS

	Year					
Major area and region	*2000*	*2005*	*2010*	*2015*	*2020*	*2025*
A. Percentage using contraception among all women[a]						
World	50.2	51.0	51.8	52.6	53.1	53.4
More Developed Regions	56.2	54.8	55.3	56.0	56.8	57.7
Less Developed Regions	48.8	50.2	51.1	51.9	52.5	52.7
Africa	23.2	26.9	31.1	35.2	38.9	41.9
Eastern Africa	20.7	25.4	30.3	35.1	39.5	43.5
Middle Africa	21.0	22.6	26.1	30.3	34.2	38.1
Northern Africa	31.0	32.8	35.0	37.2	38.6	39.3
Southern Africa	45.4	48.0	49.9	51.5	53.0	54.4
Western Africa	14.2	20.3	26.8	33.1	38.2	41.9
Asia	48.2	48.8	49.6	50.1	50.0	49.4
Eastern Asia	62.5	60.9	60.6	60.4	59.4	57.9
South-central Asia	37.9	41.1	43.6	45.5	46.8	47.2
South-eastern Asia	39.5	41.6	43.0	43.9	44.4	44.4
Western Asia	32.4	33.9	35.2	36.1	36.4	36.2
Europe	55.2	56.8	58.3	59.8	60.5	60.4
Eastern Europe	48.1	50.7	53.2	56.0	57.8	57.6
Northern Europe	68.3	67.6	67.1	66.9	66.9	67.1
Southern Europe	50.7	53.7	55.7	57.1	56.7	56.2
Western Europe	65.0	64.7	64.5	64.4	64.3	64.5
Latin America and the Caribbean	50.6	51.7	52.6	53.2	53.7	54.0
Caribbean	40.8	41.7	42.0	42.7	43.4	44.5
Central America	48.7	50.5	51.8	52.8	53.6	54.1
South America	52.4	53.2	54.0	54.4	54.7	54.8
Northern America	70.4	70.2	69.9	69.9	70.1	70.3
Oceania	56.6	56.5	56.1	56.0	56.1	56.2
Australia/New Zealand	68.5	67.9	67.3	67.0	67.0	67.2
Melanesia/Micronesia/Polynesia	21.4	25.7	28.9	31.6	33.9	35.6
B. Percentage using contraception among married women[b]						
World	62.6	63.8	64.6	65.3	66.0	66.6
More Developed Regions	70.1	71.0	72.0	73.0	74.0	75.0
Less Developed Regions	61.3	63.1	64.5	65.8	67.0	68.0
Africa	27.9	32.4	37.1	41.8	45.9	49.3
Eastern Africa	22.8	28.0	33.4	38.8	43.7	48.1
Middle Africa	22.8	24.7	28.8	33.4	37.9	42.4
Northern Africa	52.0	55.7	59.1	62.2	64.3	65.8
Southern Africa	54.0	58.0	61.1	63.5	65.2	66.6
Western Africa	15.4	22.1	29.3	36.2	41.9	46.0

TABLE 18 *(continued)*

Major area and region	*Year*					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Asia	65.2	66.9	68.2	69.2	70.0	70.7
Eastern Asia	83.6	84.0	84.0	84.0	84.0	84.0
South-central Asia	49.0	54.0	57.8	60.8	63.2	65.0
South-eastern Asia	59.7	62.6	64.4	65.5	66.3	66.7
Western Asia	49.1	52.2	54.6	56.4	57.4	57.6
Europe	68.2	71.0	73.0	75.0	75.0	75.0
Eastern Europe	62.7	67.0	70.0	73.0	75.0	75.0
Northern Europe	79.1	79.1	79.1	79.1	79.1	79.1
Southern Europe	68.0	71.0	73.0	75.0	75.0	75.0
Western Europe	74.4	74.6	74.8	75.0	75.0	75.0
Latin America and the Caribbean	74.1	75.4	76.3	76.9	77.3	77.5
Caribbean	61.3	62.2	62.9	63.5	64.1	64.8
Central America	70.5	72.6	74.2	75.4	76.3	76.9
South America	77.8	78.8	79.4	79.7	79.8	79.7
Northern America	81.4	81.5	81.5	81.5	81.5	81.5
Oceania	62.4	63.8	64.8	65.2	65.4	65.6
Australia/New Zealand	79.4	79.5	79.5	79.5	79.5	79.5
Melanesia/Micronesia/Polynesia	30.6	37.2	42.8	47.3	50.6	53.0
C. Percentage using contraception among unmarried women[c]						
World	24.7	25.4	25.6	25.7	25.9	25.9
More Developed Regions	37.9	38.3	38.9	39.4	40.0	40.5
Less Developed Regions	20.2	20.8	21.3	21.7	22.1	22.4
Africa	14.9	17.7	20.7	23.8	26.6	29.1
Eastern Africa	17.1	21.0	25.1	29.1	32.8	36.1
Middle Africa	17.1	18.5	21.6	25.1	28.5	31.8
Northern Africa	3.1	3.3	3.5	3.7	3.9	3.9
Southern Africa	40.5	43.5	45.8	47.6	48.9	49.9
Western Africa	11.5	16.6	22.0	27.1	31.4	34.5
Asia	3.9	4.0	4.1	4.2	4.2	4.2
Eastern Asia	5.0	5.0	5.0	5.0	5.0	5.0
South-central Asia	2.9	3.2	3.5	3.6	3.8	3.9
South-eastern Asia	3.6	3.8	3.9	3.9	4.0	4.0
Western Asia	2.9	3.1	3.3	3.4	3.4	3.5
Europe	36.3	37.5	38.7	39.8	40.3	40.5
Eastern Europe	22.6	24.1	25.2	26.3	27.0	27.0
Northern Europe	57.0	57.0	57.0	57.0	57.0	57.0
Southern Europe	24.5	25.6	26.3	27.0	27.0	27.0
Western Europe	53.6	53.7	53.9	54.0	54.0	54.0

TABLE 18 *(continued)*

Major area and region	Year					
	2000	*2005*	*2010*	*2015*	*2020*	*2025*
Latin America and the Caribbean	16.3	16.6	16.8	16.9	17.0	17.0
Caribbean	13.5	13.7	13.8	14.0	14.1	14.3
Central America	15.5	16.0	16.3	16.6	16.8	16.9
South America	17.1	17.3	17.5	17.5	17.6	17.5
Northern America	58.6	58.7	58.7	58.7	58.7	58.7
Oceania	46.9	46.8	46.0	45.2	44.6	43.8
Australia/New Zealand	57.2	57.2	57.2	57.2	57.2	57.2
Melanesia/Micronesia/Polynesia	3.8	4.5	5.2	5.8	6.1	6.4

Source: Table 15.
NOTE: The percentages using contraception among all women and unmarried women are projected as explained in the text.
[a] all women of reproductive age.
[b] women of reproductive age who are in a marital or consensual union.
[c] women of reproductive age who are not in a union.

2. Future trends in the number of unmarried contraceptive users

The extent to which the number of contraceptive users among unmarried women varies over time is, in general, greater than the changes in the number of contraceptive users among married women. At the world level, the number of unmarried contraceptive users in the world is projected to increase by 41 per cent, from 126 million to 178 million, between 2000 and 2025. This increase is the result of three factors: the projected increase in the proportion of unmarried women owing to the projected decrease in the proportion of married women (annex table A.3), the projected increase in the level of contraceptive use among unmarried women (table 18), and the projected increase in the number of unmarried women aged 15-49 (table 15). The number of unmarried contraceptive users is projected to grow in both the more developed and the less developed regions. However, the growth is expected to be much more important in the less developed regions where the number of contraceptive users is projected to almost double from 77 million to 124 million. This expected growth for the less developed regions owes mainly to the rapid forecasted increase in the number of unmarried women aged 15-49 (from 380 million to 553 million, that is, a 45 per cent increase) and to a lesser extent to the expected increase in contraceptive prevalence among these women (from 20 per cent to 22 per cent, see table 18). In the more developed regions, the number of unmarried contraceptive users is projected to increase only slightly from 49 million to 54 million (a 9 per cent increase). The latter increase is related to slight increases assumed in both the percentage of unmarried women who are using contraception in the more developed regions (from 38 to 41 per cent) and the number of unmarried women in these regions (from 130 to 133 million).

In Africa, the number of unmarried contraceptive users is projected to rise tremendously, almost quadrupling between 2000 and 2025 (table 15). In Asia, the number of contraceptive users among unmarried women is expected to increase at a much faster pace than that among married women. To a lesser extent, the same pattern applies to Northern America and Oceania. In Latin America and the Caribbean, by contrast, the pace of the increase in the number of unmarried contraceptive users is slower than that in the number of married contraceptive users. In Europe, the number of unmarried contraceptive users will decrease like the number of married users due to the overall decrease in the number of women of reproductive age. The difference, though, is that the pace of the decrease among the unmarried women will be smaller than that among the married women.

Not surprisingly, the regions where the number of unmarried contraceptive users is projected to increase the most, in relative terms, are located in Africa. These regions include Eastern Africa, Middle Africa and Western Africa. In the first region, the number of unmarried users is expected to quadruple between 2000 and 2025, rising from 3.7 million to 15 million. In the second region, the

Figure XI. Projected numbers of female contraceptive users, by major area

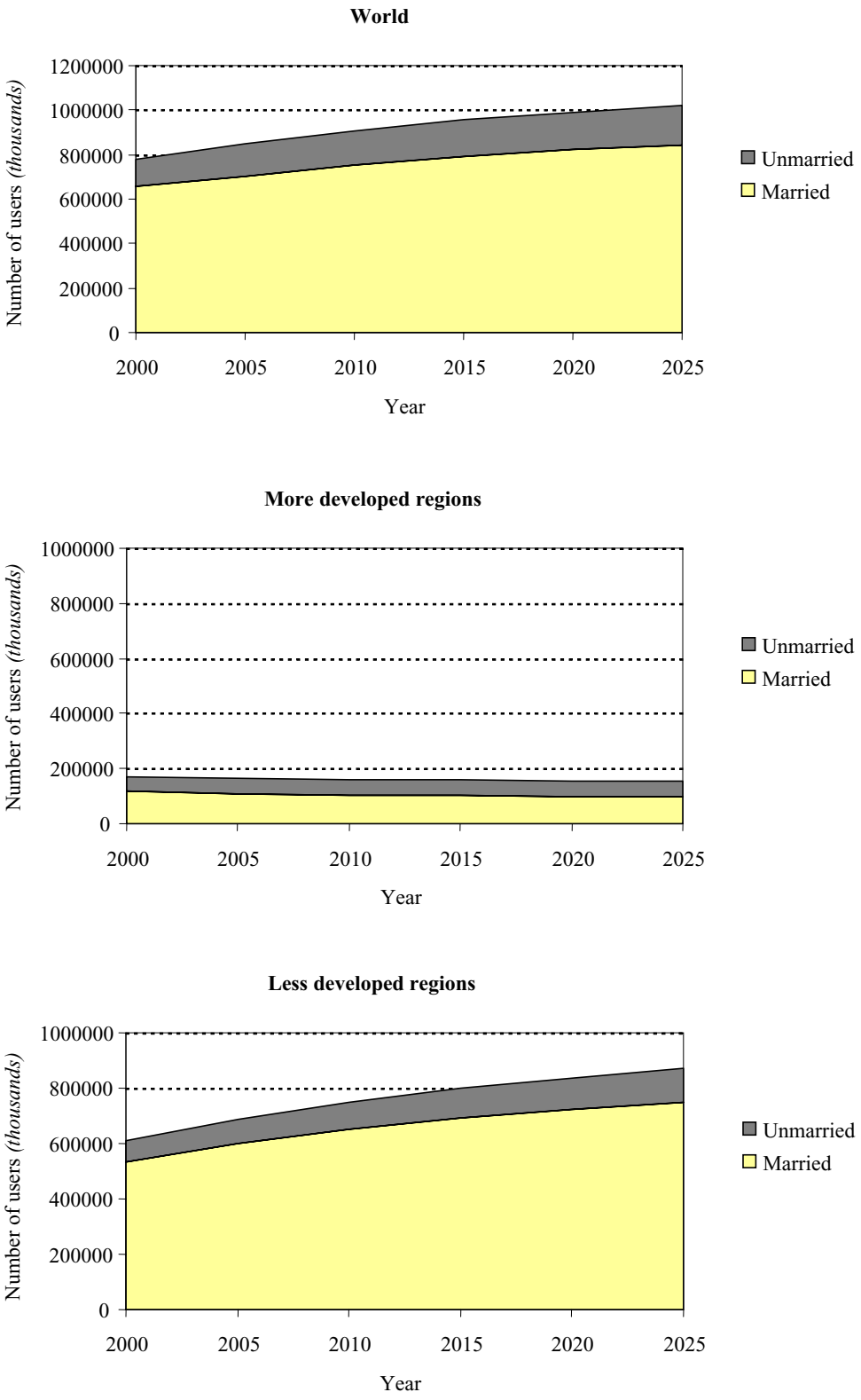


Figure XI *(continued)*

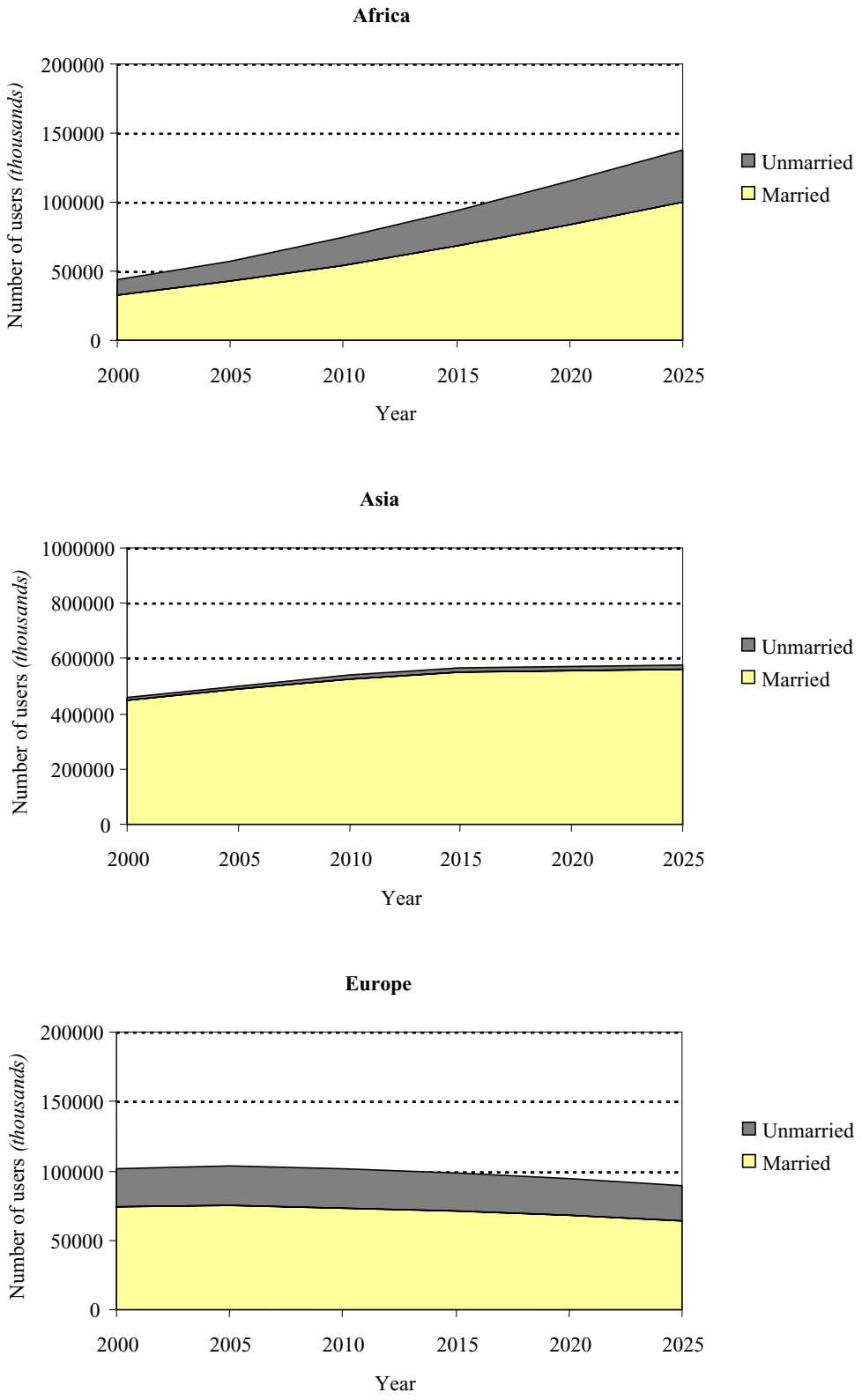
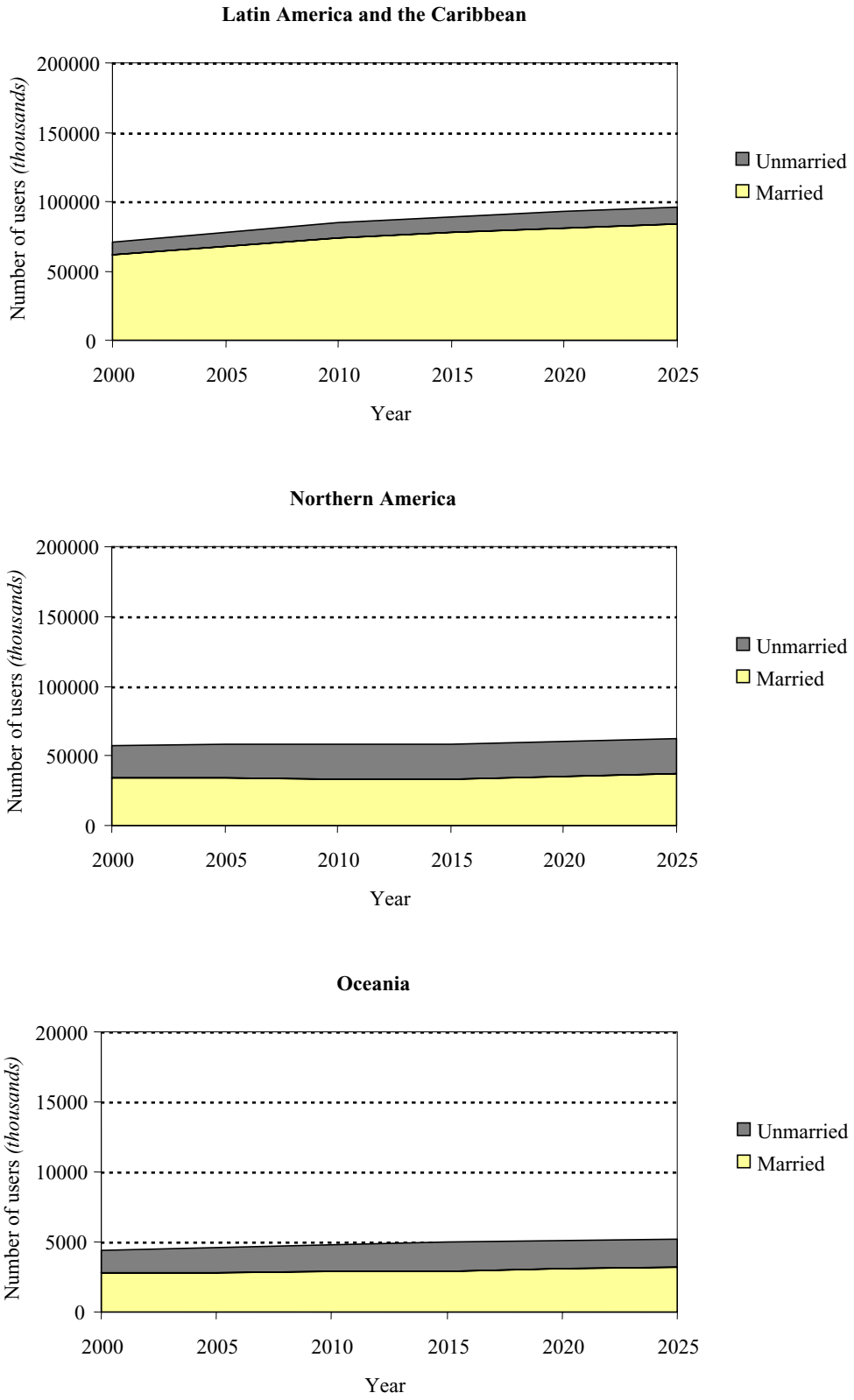


Figure XI *(continued)*



number of unmarried users is expected to grow five-fold, rising from 1.2 million to 5.3 million. In the third region, the number of unmarried contraceptive users is expected to grow seven-fold, rising from 1.9 million to 12 million. In Northern Africa and Southern Africa, the increase in the number of unmarried contraceptive users will be less spectacular. Nonetheless, the number of unmarried contraceptive users is expected to almost double in these two regions.

In Oceania, the less developed region of Melanesia/Micronesia/Polynesia is also expected to experience a large increase in the number of unmarried contraceptive users. This number is expected to triple from 26,000 to 78,000 between 2000 and 2025.

In Asia, the number of unmarried contraceptive users is expected to increase in all regions, owing mainly to the projected increase in the percentage of unmarried women. The number of unmarried contraceptive users is expected to increase the most in South-central Asia and Western Asia, doubling between 2000 and 2025. In all the regions of Latin America and the Caribbean, the number of unmarried contraceptive users will increase less rapidly than the number of married users. The number of contraceptive users will increase the most in Central America but it will increase by 44 per cent among unmarried women compared to 52 per cent among women who are married or in union. In Europe, the number of unmarried contraceptive users is expected to decrease slightly in Eastern and Southern Europe and remain practically the same in Northern Europe and Western Europe.

3. Conclusions

As shown in figure XI, female contraceptive users will be made up mostly of women who are married or in union between 2000 and 2025. The number of contraceptive users is expected to increase in all the less developed regions regardless of marital status, but the change is expected to be greater among unmarried than married users mainly as a consequence of the decrease in the proportions of women who are married or in union, which has been assumed for most regions of the world. In the more developed regions, the number of contraceptive users is expected to decrease between 2000 and 2025, due mainly to the important projected decrease in the number of women aged 15-49 in Europe. In Northern America by contrast, the number of all women aged 15-49 is expected to continue to increase, as well as the numbers of both married and unmarried contraceptive users.

NOTE

[1] Refer to United Nations (2000) for a thorough discussion on the plausibility of this assumption.

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V. DYNAMICS OF CONTRACEPTIVE USE

This chapter presents analyses of contraceptive behaviour over time, or use-dynamics. The term use-dynamics' refers to the temporal sequence in which couples may adopt a contraceptive method, discontinue use for a variety of reasons and subsequently re-start the same method, switch to another method, or abandon use altogether. While documentation of trends in current use of contraceptives among all couples of reproductive age (or among the sub-set who wish to avoid all future childbearing or delay the next pregnancy) continues to be the main way of monitoring progress in family planning in developing countries, the study of use-dynamics also has a long pedigree. New methods of contraception have always been assessed by carefully designed prospective studies with a clinical focus on failure rates and health-effects. Innumerable follow-up studies of acceptors, both facility- and community-based, have been conducted and a variety of cross-sectional approaches, involving retrospective questioning about recent past contraceptive behaviour, have been developed and applied. Several useful syntheses of results have been published (e.g. Kreager, 1977; United Nations, 1991; Curtis and Blanc, 1997).

As contraceptive practice in a society becomes more widespread, the avoidance of unintended pregnancies becomes less dependent on rates of initial adoption and more dependent on the ability and willingness of couples to use methods with maximum effectiveness, to use them persistently and to switch quickly to alternative methods as and when the need arises. In populations where most couples have never tried any method of contraception, the vast majority of unintended pregnancies inevitably stem from avoidance, or never-use of contraception. Conversely, in populations where most adults have tried one or more methods, the majority of unintended pregnancies are the result of the use of less effective methods, incorrect use of effective methods and abandonment of use. Thus the study of use-dynamics, and its relevance to an understanding of the ability of couples to achieve their reproductive intentions, has steadily grown in importance over the past 50 years, in line with the spread of contraceptive practice in developing regions.

Successful use of contraceptives depends on many factors. Important influences no doubt include the degree of commitment to control of reproduction, inter-partner discussion and agreement on reproductive goals and means to achieve them, attitudes about the moral or social acceptability of contraception and socio-cultural factors that condition beliefs about particular methods. A growing body of evidence also supports the commonsense expectation that the quality of family planning services affects the ability of couples to use contraceptives successfully. An analysis of data from 15 countries suggested that continuity of use is higher in settings with strong family planning programmes (Blanc, Curtis and Croft, 2002). Another multi-country study showed that couples who received their preferred method rather than an alternative one were more likely to continue using it (Huezo and others, 1993). Country-specific studies have found that the quality of community-based workers in Bangladesh, the adequacy of counselling in Gambia and the availability of female doctors in Egypt had significant effects on the willingness and ability of contraceptive adopters to persist with use (Koenig, Hossain and Whittaker, 1997; Cotten and others, 1992; Ali, 2001).

These links between quality of services and use-dynamics provide an additional justification for the study of contraceptive continuation, failure and switching. Results should provide guidance for improvement to services. High failure rates, for instance, suggest that efforts to improve information on correct use of methods are required. Discontinuation of use that is not followed by prompt recourse to an alternative method carries the possible implication that the range of readily accessible methods may need to be widened.

In this chapter, key indicators of the dynamics of contraceptive use are presented for developing countries with appropriate nationally representative data. These indicators include the probability of: (a) discontinuing use for any reason; (b) discontinuation because of accidental pregnancy while using a method (i.e. failure); and (c) discontinuation for reasons that imply dissat-isfaction or problems with the method. Method-

Method-switching is examined in terms of the probability of resumption of use within three months of discontinuing an earlier method because of dissatisfaction or problems. The reproductive consequences of contraceptive failure and discontinuation are assessed by measuring the occurrence of unwanted or mistimed births and abortions following the cessation of use.

A. THE NATURE OF THE DATA, THEIR QUALITY AND AVAILABILITY

The sources of data for the analysis of use-dynamics are the Demographic and Health Surveys (DHS). Building upon earlier methods associated with Gaslonde and Carrasco (1982) and Laing (1985), the DHS programme in 1990 added a contraceptive calendar to its core data collection instrument for countries with relatively high levels of contraceptive use. The contraceptive calendar takes the form of a grid in which contraceptive status is recorded for each calendar month over a five-year period preceding the survey. Specifically, interviewers are trained to enter on the monthly grid all live births (and current pregnancy if any), ascertained earlier in the interview. These reproductive events are used as anchor-points in the determination of dates of starting and stopping the use of specific contraceptive methods over the five-year retrospective period. Any abortions detected at this stage of detailed questioning are entered into the calendar but no attempt is made to distinguish induced from spontaneous abortions. Reasons for stopping method-use are entered into the calendar. In some surveys, the calendar is also used to record residential mobility and changes in marital or cohabitation status.

Information on the intention status of recent live-births (and current pregnancy, if any) is also used in the analysis. In Section 5 of the interview schedule respondents are asked the following question about each birth "At the time y ou became pregnant with (NAME OF CHILD) did you want to become pregnant **then**, did you want to wait until **later**, or did you want **no more children** at all? Respondents giving the response "later" are subsequently asked how long they would have preferred to wait before having another child. The responses permit a three-way classification of births into those **wanted** at that time, those that were **unwanted** at any future time and those that occurred at least two years earlier than desired (**mistimed**). This information on intention status was linked to the calendar data in order to investigate the reproductive consequences of contraceptive failure and discontinuation.

The quality of both the calendar information on episodes of contraceptive use and intention status of births is a key consideration. Experimental studies in the Dominican Republic and Peru indicated that the calendar approach yielded more complete and coherent information on past contraceptive use than the methods used in Phase 1 of DHS (Goldman, Moreno and Westoff, 1989; Westoff, Goldman and Moreno, 1990). Curtis and Blanc (1997) found that estimates of contraceptive use derived from the calendar corresponded closely with current use estimates from previous surveys. Similarly Ali, Cleland and Shah (2002) found a high level of consistency in contraceptive use trends when data from three successive calendar DHS were linked. In the aggregate, the quality of contraceptive use data thus appears to be high. Only one study has examined individual reliability of responses by re-interviewing women. In Morocco, a large sample was re-interviewed three years after the first interview and monthly contraceptive histories compared for the overlapping period of 1990-92 (Strickler and others, 1997). While aggregate consistency was high, individual consistency was inevitably less impressive: monthly histories matched exactly for only 28 per cent of relevant cases. However, in view of the very detailed month-by-month nature of the information, high reliability in individual reports is an unrealistic expectation and the results from Morocco do not undermine the general verdict that the calendar yields information on episodes of past contraceptive use of surprisingly high quality.

Stated reasons for discontinuation comprise one of the less reliable outputs of the calendar. The DHS allow for the recording of only one reason and, as argued by Curtis and Blanc (1997), this restriction may give oversimplified results because of the likely existence of several reasons acting in concert. Moreover the Moroccan re-interview study showed that one-third of respondents gave a different reason for stopping at re-interview from that given at first interview. Thus analysis of cause-specific discontinuation needs to be undertaken with considerable interpretative caution.

Undoubtedly the greatest defect of the DHS calendars is the poor quality of information on abortions—whether induced or spontaneous. Biological evidence indicates that about 15 per cent of recognisable conceptions end in spontaneous

miscarriage or still birth (Bongaarts and Potter, 1983). To this proportion should be added an unknown and widely varying number of induced abortions. As will be shown later, the ratio of abortions to live births in DHS calendars is much lower than biological expectations, indicating severe underreporting of spontaneous foetal loss. It is also probable that induced abortions have been under-reported. In most countries that have used DHS calendars, induced abortion is illegal, or highly restricted, and heavily stigmatised. It is thus not surprising that women in such countries are reluctant to report termination of pregnancy.

It is not possible to ascertain the effect of under-reporting of spontaneous and induced abortion on estimates of contraceptive failure and discontinuation. The concern is that omission of abortions that result from contraceptive failure or discontinuation may result in exaggerated reports of durations of uninterrupted use and a corresponding underestimation of failure and discontinuation probabilities. One analysis of calendar data indicated that a large majority of reported abortions arose from non-use of contraception rather than failure or discontinuation (Ali, Cleland and Shah, 2001). If this observation holds true for unreported foetal losses, the effect of omission on estimates of failure and discontinuation will be minor. While the magnitude of bias remains uncertain it is unlikely to be sufficiently great to jeopardise robustness of the main findings.

The reliability of reports on the intention status of live births is also relevant to the results presented in this chapter. As with reported reasons for stopping use, a simple pair of question is likely to oversimplify the motivational complexities of pregnancy planning and reactions to conception. The existence of post facto rationalisation whereby unintended and unwelcome pregnancies are subsequently declared as wanted is a particular concern. The panel study in Morocco provides evidence of such a bias: births were more likely to be classified as wanted in the second interview than in the first (Strickler and others, 1997, Bankole and Westoff, 1998). However, a multi-country analysis by Montgomery and others (1997) found only modest correlations between age of children and reported intention status, suggesting that the passage of time does not inevitably lead to pronounced shifts in stated attitudes from unwanted/mistimed to wanted. Moreover, strong and extremely plausible relationships exist between birth order, birth spacing and reported intention status. The percentage of births declared as unwanted rises steeply with birth order, and the percentage declared as mistimed falls steeply as length of the preceding birth interval increases (Adetunji, 1998). Despite measurement problems these data have sufficient face validity to warrant serious analysis.

As mentioned earlier, the DHS started collecting calendar data in 1990 for countries with relatively high (typically 40 per cent or more) contraceptive prevalence. By the time of this analysis, 34 data sets from 18 countries were available. For countries with repeated surveys, the most recent one has been selected. In table 19, these 18 countries are listed together with the number of method-specific episodes included in the analysis. An episode is defined as a duration in months of uninterrupted use that may or may not have ended by the time of the interview. Eight of the surveys were conducted in Latin America and the Caribbean, four in Northern Africa and Western Asia, four in South-central and South-eastern Asia, and two in sub-Saharan Africa. The small number of surveys in sub-Saharan Africa reflects the generally low levels of contraceptive practice in that region, but it is also clear that the Asian countries are underrepresented relative to those in the Americas. While it is unjustifiable to claim that the 18 countries are representative of all developing countries where contraceptive prevalence is high, nevertheless they encompass a sufficiently wide diversity of socio-economic, demographic and cultural circumstances, to permit cautious generalisation of results.

The set of reversible methods used in the 18 countries is certainly diverse (table 20). In Latin America and the Caribbean, the pill tends to be the dominant reversible method. The main exceptions are Bolivia where nearly half of all current users are practising periodic abstinence (rhythm) and Peru where injectables and periodic abstinence are commonly used.

In the four countries of Northern Africa and Western Asia, the IUD is widely used, the exception being Morocco where two-thirds of couples relying on reversible methods use the pill. Turkey is also distinguished by the popularity of withdrawal that accounts for almost half of overall use of reversible methods. In the four countries of South-central and South-eastern Asia, around half of users of reversible methods rely on the pill in Bangladesh, on injectables in Indonesia, and on the

TABLE 19. NUMBER OF EPISODES OF USE, IN MONTHS, BY COUNTRY, DATE OF SURVEY AND METHOD (MOST RECENT SURVEY)

Major area and region	*Pill*	*IUD*	*Injectables*	*Condom*	*Periodic abstinence*	*With-drawal*	*Vaginal barrier*	*Norplant*	*LAM*[a]	*Other*	*Total*
Latin America and the Caribbean											
Bolivia (1993)	464	425	161	155	1 818	214	45	1	0	437	**3 720**
Brazil (1996)	2 615	89	257	589	437	453	16	0	0	57	**4 513**
Colombia (2000)	1 490	670	654	696	662	754	131	16	297	259	**5 629**
Dominican Republic (1996)	1 938	181	85	266	305	338	36	56	108	119	**3 432**
Guatemala (1999)	378	75	294	115	290	82	18	0	0	9	**1 261**
Nicaragua (1998)	2 570	932	833	493	220	140	11	2	0	126	**5 327**
Paraguay (1990)	1 235	211	580	241	423	145	57	0	0	604	**3 496**
Peru (2000)	2 829	1 339	4 827	1 410	3 577	648	298	45	616	256	**15 845**
Northern Africa/Western Asia											
Egypt (2000)	2 597	5 236	1 453	216	90	63	0	27	0	698	**10 380**
Jordan (1997)	1 323	1 727	67	389	846	1 116	128	5	0	677	**6 278**
Morocco (1992)	3 123	268	34	114	408	286	49	0	0	33	**4 315**
Turkey (1998)	696	1 056	42	759	90	2 092	101	0	0	34	**4 870**
South-central/South-eastern Asia											
Bangladesh (1996)	3 265	272	1 030	798	617	324	0	10	0	71	**6 387**
Indonesia (1997)	5 610	1 289	7 096	264	407	313	26	1 241	0	312	**16 558**
Kazakhstan (1999)	273	1 002	50	358	233	177	32	0	279	181	**2 585**
Philippines (1998)	1 546	401	473	316	1 033	1 257	0	0	6	703	**5 735**
Sub-Saharan Africa											
Kenya (1998)	691	98	667	141	448	47	1	30	0	49	**2 172**
Zimbabwe (1999)	1 854	20	531	97	19	148	0	13	89	31	**2 802**
Total	34 497	15 291	19 134	7 417	11 923	8 597	949	1 446	1 395	4 656	**105 305**

Source: Demographic and Health Surveys.
NOTE: [a] LAM = Lactational amenorrhoea method.

TABLE 20. PERCENTAGE DISTRIBUTION OF MARRIED WOMEN CURRENTLY USING REVERSIBLE CONTRACEPTIVES, BY METHOD AND COUNTRY

Major area and region	*Pill*	*IUD*	*Injec-tables*	*Con-dom*	*Periodic abstinence*	*With-drawal*	*Vaginal barrier*	*Norplant*	*LAM*[a]	*Other*	*Total*
Latin America and the Caribbean											
Bolivia	12.5	11.4	4.3	4.2	48.9	5.8	1.2	0.0	0.0	11.7	3 720
Brazil	58.0	2.0	5.7	13.0	9.7	10.1	0.4	0.0	0.0	1.3	4 500
Colombia	26.5	11.9	11.6	12.4	11.8	13.4	2.3	0.3	5.3	4.6	5 616
Dominican	56.9	5.1	2.6	7.8	8.8	9.8	0.9	1.7	3.1	3.3	3 252
Guatemala	30.0	5.7	23.5	9.4	22.9	6.4	1.3	0.0	0.0	0.8	1 189
Nicaragua	48.2	17.5	15.7	9.3	4.1	2.6	0.2	0.0	0.0	2.4	5 316
Paraguay	35.0	6.1	16.6	6.9	12.2	4.1	1.6	0.0	0.0	17.4	3 404
Peru	17.9	8.2	30.7	9.0	22.6	4.1	1.9	0.3	3.8	1.6	15 306
Northern Africa/ Western Asia											
Egypt	25.0	50.4	14.0	2.1	0.9	0.6	0.0	0.3	0.0	6.7	10 380
Jordan	21.0	27.6	1.1	6.2	13.5	17.8	2.1	0.1	0.0	10.6	6 139
Morocco	72.1	6.3	0.8	2.8	9.3	6.9	1.1	0.0	0.0	0.7	3 875
Turkey	14.3	21.7	0.9	15.7	1.8	42.9	2.1	0.0	0.0	0.7	4 651
South-central/South-eastern Asia											
Bangladesh	51.0	4.3	16.4	12.5	9.5	5.1	0.0	0.1	0.0	1.1	6 183
Indonesia	34.0	7.4	43.0	1.6	2.5	1.9	0.2	7.5	0.0	1.9	15 712
Kazakhstan	10.7	38.2	2.0	14.2	9.0	7.0	1.2	0.0	10.7	6.9	2 457
Philippines	27.0	7.0	8.2	5.5	18.0	21.9	0.0	0.0	0.1	12.3	5 735
Sub-Saharan Africa											
Kenya	31.8	4.5	30.8	6.5	20.5	2.1	0.0	1.4	0.0	2.3	2 163
Zimbabwe	66.0	0.7	19.4	3.6	0.7	5.2	0.0	0.5	3.0	1.0	2 670

Source: Demographic and Health Surveys.

NOTE: Method started within five years period to the survey date.
[a] LAM = Lactational amenorrhoea method.

pill or withdrawal in the Philippines. Kazakhstan differs from the other countries by having the IUD as the most relied upon reversible method.

In the two sub-Saharan African countries, hormonal methods dominate. In Zimbabwe two-thirds of contracepting couples are using the pill and an additional 19 per cent injectables. In Kenya, injectables and the pill are the most commonly used reversible methods.

The number of method-specific episodes of contraceptive use (both completed and continuing) recorded in the calendars of each survey depends on several factors: the size of the sample of women, the overall level of use, the relative popularity of particular methods and the mean lengths of episodes. At least 100 episodes of use are needed to warrant statistical analysis of method-specific discontinuation. As shown in table 19, this condition is fulfilled in all 18 surveys only for oral contraceptives. It is also fulfilled for the majority of surveys for the following methods: IUD, injectable, condom, periodic abstinence and withdrawal. The analysis will therefore focus exclusively on these six major reversible methods. Sterilization, globally the most common method of contraception, is excluded because failure rates or discontinuation due to surgical reversal are negligible. Also excluded are implants (commonly used only in Indonesia among the 18 study countries), vaginal barrier methods (diaphragm, foam and jellies) and LAM (lactational amenorrhoea method).

B. Analytical Methods

The analysis is episode- not woman-based. An episode is defined as a duration in months of uninterrupted use that may or may not have ended by the time of the interview. One limitation of the calendar is that regularity of use within an episode is not measured. This limitation has potentially more severe consequences for coitus-related methods such as the condom and withdrawal, than for other methods. Interpretation of failure rates is complicated because it is not possible to distinguish pregnancies that result from irregular use, from incorrect use or from method-failure.

For analysis, the calendar data were truncated at a point three months before the interview date. Data from most recent three months of the calendar were not used to avoid the problem of severe underreporting of first trimester pregnancies (Goldman and Westoff, 1980). Their inclusion would have led to an underestimate of failure rates. The omission of the last three months has a related important implication that all current pregnancies retained in the analysis are in the second or third trimester. Nearly all will continue to term as live births. In the analysis of the reproductive consequences of failure and discontinuation, current pregnancies therefore can be classified as impending live births with only negligible loss of accuracy.

The analysis is restricted to the contraceptive experience of couples who are married or in a union. All episodes that started before marriage or cohabitation are excluded. The analysis of failure and discontinuation is based on all episodes recorded in the calendar with the exception of the exclusions specified above. Single-decrement life table methods were applied to estimate 12-month probabilities of discontinuation for all reasons and for specified reasons. The single-decrement approach yields hypothetical cause-specific probabilities in the absence of competing reasons for stopping. In the literature these are sometimes called gross rates, in distinction to net rates which are obtained from multiple-decrement life table analysis and measure the 'real life' or observed probabilities of cause-specific discontinuation in the presence of competing reasons (Ali, Babiker and Cleland, 2001; Farley, Ali and Slaymaker, 2001).

A wide range of reasons for stopping use is given by DHS respondents. For the analysis, these were grouped into three categories. The first category represents accidental pregnancy while the method was being used, or failure. It is not possible to distinguish between failure of the method and user-failure resulting from incorrect use. However most modern methods have very low failure rates if used correctly and consistently and it is therefore reasonable to attribute the majority of failures to some defect in the ways in which they are used. The second category - method-related reasons - comprises all reasons that imply some form of dissatisfaction with the method or associated services. For hormonal methods and IUDs, the dominant specific reasons in this category are health concerns and side-effects. Inconvenience, desire to switch to a better or more effective method and husbands dislike of the method are also included here and constitute particularly important reasons for stopping condom use. The cost of the method and its lack of availability are rarely stated by DHS respondents as reasons for stopping but, when mentioned, are also included in this category.

The third category consists of reasons that imply no further immediate need for contraception, predominantly because of the desire for another child, together with sexual abstinence because of illness or spouse's absence. Because this group of reasons implies no dissatisfaction or concern with the method or associated services, it is of less substantive interest than the other two categories.

Three correlates of discontinuation are examined: urban-rural residence, education of the wife and motive for use. Residence is selected as a proxy for access to services. It can be assumed with reasonable confidence that couples living in towns and cities have better access to a range of family planning services than most couples living in rural areas. Education of the wife is included because this characteristic has proved to be one of the most powerful influences on uptake of contraception and reproduction in general. The measurement of these factors is straightforward. The third factor, motive for use, is derived from a comparison of total desired family size and number of living children at the start of an episode. If the total desired size is equal to or less than actual family size, the motive for use is classified as family size limitation. All other episodes are classified as having a spacing motive: these include cases where desired family size is less than actual size or where a non-numerical response is given to the question on desired size. Motive is included on the expectation that couples who desire to limit family size will be more effective users of contraception than spacers.

The relationship between these three factors and contraceptive-use dynamics is summarised by box and whisker plots. The upper and lower ends of boxes show the values of the interquartile range and the mid-line indicates the median. Whiskers show the predicted values within which 95 per cent of the observations lie. Outliers are indicated by dots.

Method-switching is analysed following episodes of use that were stopped for a method-related reason. Multiple-decrement life table analysis was used to determine whether or not the couple had switched to another method (or had re-adopted the same method) within three months. The three-month criterion - rather than, say, one month or six months — was chosen on the basis of exploratory analysis showing that a large majority of those who adopt another method do so in the first three months following abandonment of the earlier method.

The reproductive consequences of method- or user-failure were established by simple tabulation of the four possible outcomes of the pregnancy: live birth/current pregnancy reported as (1) wanted; (2) mistimed; (3) or unwanted or (4) pregnancy ended in spontaneous or induced abortion. It should be re-emphasised that intention status of recent live-births was ascertained prior to and independently of the collection of contraceptive calendars. Partly for this reason, some births that occur because of failure are declared as wanted. While this combination may appear inconsistent, research from the United States has shown that not all contraceptive failures result in pregnancies that are classified as unintended (Trussell, Vaughan and Stanford, 1999).

Estimation of the reproductive consequences of method-related discontinuation is slightly more complicated than that for failure. In addition to the four pregnancy-related outcomes following failure, two further ones have to be considered for discontinuation; switched to another method and no conception despite non-use. The procedure used to estimate outcomes following discontinuation was multiple-decrement life table analysis for the 12-month period following discontinuation.

In some surveys, intention status was ascertained only for births in the preceding three years. Accordingly, the analyses of reproductive consequences is restricted to the period 4 to 39 months prior to interview. All life table analysis were carried out in Stata 7 (StataCorp, 2001) using programs developed by the authors, and the reported results are weighted by the inverse of the probability of selection.

C. Results

1. All-cause discontinuation

Table 21 shows the overall probability per 100 episodes of discontinuing use of methods for any reason within 12 months of starting use. These probabilities thus include accidental pregnancy while using the method, stopping the method because of dissatisfaction with it and stopping in order to have a planned pregnancy. One method — the IUD — stands out from all the other methods in having low discontinuation. Typically, between 10 and 20 per cent of IUD users stop within the first 12 months, with a median value of 15.5 per cent. The two main exceptions are Bangladesh and the

TABLE 21. TWELVE-MONTH CUMULATIVE PROBABILITIES OF OVERALL DISCONTINUATION PER 100 EPISODES

Major area and region	*Pill*	*IUD*	*Injectables*	*Condom*	*Periodic Abstinence*	*Withdrawal*
Latin America and the Caribbean						
Bolivia	57.6	11.8	76.6	67.1	36.7	51.5
Brazil	44.2		61.9	59.6	55.1	60.1
Colombia	45.7	17.7	59.6	56.6	54.2	56.5
Dominican Republic	57.7	35.0		82.1	68.8	66.5
Guatemala	45.5		54.9	62.7	29.5	
Nicaragua	47.2	24.6	58.0	60.6	45.0	59.9
Paraguay	56.9	14.9	71.5	73.3	51.2	33.8
Peru	54.4	16.1	37.8	49.0	33.7	37.7
Northern Africa/ Western Asia						
Egypt	48.2	13.9	48.2	52.7		
Jordan	66.3	17.7		67.7	61.5	55.8
Morocco	36.2	17.7		58.5	47.7	44.9
Turkey	56.5	9.0		43.0		37.9
South-central/South-eastern Asia						
Bangladesh	44.1	40.8	50.3	64.5	41.1	59.6
Indonesia	33.4	11.8	22.9	35.9	28.5	30.9
Kazakhstan	66.1	10.8		57.9	48.1	57.8
Philippines	43.3	14.3	50.7	59.5	35.0	45.2
Sub-Saharan Africa						
Kenya	33.9		22.0	60.6	31.6	
Zimbabwe	13.9		24.3			19.9
Median	**46.5**	**15.5**	**50.7**	**59.6**	**45.0**	**51.5**

Source: Demographic and Health Surveys.
NOTE: Estimates based on less than 100 episodes are not shown.

Dominican Republic where discontinuation is much higher at 41 and 35 per cent respectively. This difference between IUD users and users of other methods has been noted before (Ali and Cleland, 1999). It cannot be attributed to the socio-demographic characteristics of couples who choose IUDs, nor to the nature of their motivation for using (i.e. spacing versus limitation). It remains possible that IUD users are more strongly motivated to avoid pregnancy but this hypothesis cannot be assessed with DHS data because intensity of motivation is not assessed. Factors that probably contribute to the low discontinuation of IUD users include its low failure rate and the fact that it requires a determined resolve to stop, typically involving a visit to a medical facility for removal of the device. By comparison, all other commonly used methods included in this analysis can be terminated in a more passive manner, for instance by failing to obtain more supplies.

At the other end of the discontinuation spectrum is the condom. In these 18 countries, typically about 60 per cent of couples who adopt condoms as a contraceptive method stop use within 12 months. The main outliers here are the Dominican Republic where discontinuation is exceptionally high (82 per cent) and Indonesia (36 per cent) and Turkey (43 per cent) where it is relatively low. It may be noted that Turkey is the only one of the 18 countries where condom use is common within marriage. The fact that the condom is a familiar method of family planning in Turkey may be linked to the relatively low rate of discontinuation. Four countries included in the analysis (Dominican Republic, Guatemala, Kenya and Zimbabwe) are

classified by UNAIDS as having generalised HIV epidemics (i.e. HIV infection levels exceed one per cent in the general population). However, condom continuation rates in these countries is no better than elsewhere. In view of the great public health priority in countries with generalised HIV epidemics to promote condoms as a means of contraception that also offer protection against infection, this result is a matter of concern. Not only are condoms rarely used within marriage but they are used for short periods of time.

Two hormonal methods, the pill and the injectable, are included in the analysis. With notable exceptions such as China and India, the pill is the most commonly used modern reversible method in many developing countries. The injectable, a more recently introduced method, is much less widely used but is growing in popularity. A wide dispersion of discontinuation probabilities across countries is evident for both methods: from 33 to 66 per cent for the pill with one outlier (Zimbabwe) and from 22 to 62 per cent for injectables with two outliers (Bolivia and Paraguay). For those 13 countries with sufficient numbers of injectable episodes, discontinuation of both methods may be directly compared. In nine countries, couples are more likely to stop using injectables than pills within 12 months; in three the reverse is true and in the remaining country the probability of discontinuation is identical. It thus appears that delivery of hormonal contraception in the form of two or three monthly injection offers no advantages over daily pills in terms of encouraging persistent use. Indeed, the evidence points in the opposite direction.

Estimates for two traditional or less effective methods, periodic abstinence and coitus interruptus, or withdrawal, could be made for 15 countries. As for hormonal methods, the spread of discontinuation estimates is considerable, ranging from about 30 to 60 per cent (with one or two outliers) for both methods. In broad terms, users of less effective methods are no more likely to cease use within 12 months than users of highly effective pills and condoms. Discontinuation of withdrawal tends to be slightly higher than that of periodic abstinence. In nine out of 13 countries where a direct comparison can be made, probabilities of discontinuation are higher for withdrawal than for periodic abstinence. The median estimate is also higher for withdrawal than for periodic abstinence: 51.5 versus 45 per cent.

Variations in overall discontinuation by urban-rural residence, education of the wife and motive for use are summarised by box and whisker plots (figures XIIa-c). These plots provide a clear visual representation of the variability of estimates across surveys. Once again the IUD stands out from other methods, in that most estimates lie within a much narrower range than for all other methods. The probable reason, mentioned above, is that the IUD is less vulnerable than other methods to incorrect use and problems of re-supply than other methods and discontinuation requires positive action.

For the modern or more effective methods, estimates for the urban and rural populations are very similar. For the traditional or less effective methods, however, probabilities of discontinuation in urban areas tend to be higher than those for the rural population. The wife's education has little association with discontinuation of the pill, IUD or condom. For the other three methods (injectables, periodic abstinence and withdrawal), better educated wives tend to report higher probabilities of stopping than less educated ones.

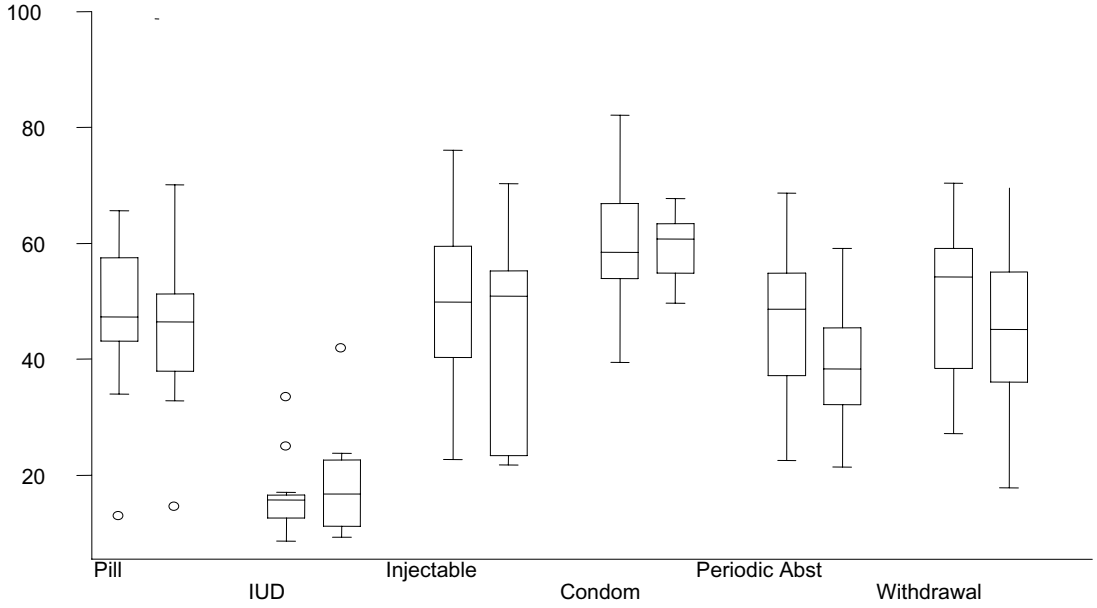
The links between motive for use and discontinuation are much more pronounced than for those for residence or education. For all methods, couples defined as wanting no more children are far less likely to cease use than those motivated by spacing. This contrast is particularly large for users of condoms and is also pronounced for users of periodic abstinence and withdrawal.

2. Failure and its reproductive consequences

Single-decrement life table estimates of user- or method-failure are shown in table 22. These estimates represent the hypothetical percentage of couples who would experience an accidental pregnancy while using the method for 12 months, in the absence of other reasons for stopping. Wide differences between countries and between methods are evident. As expected, failure rates are much higher for methods that require understanding, spousal cooperation, skill and/or memory (pill, condom, periodic abstinence, withdrawal) than for the two methods whose efficacy is less dependent on inputs from the user (injectable, IUD).

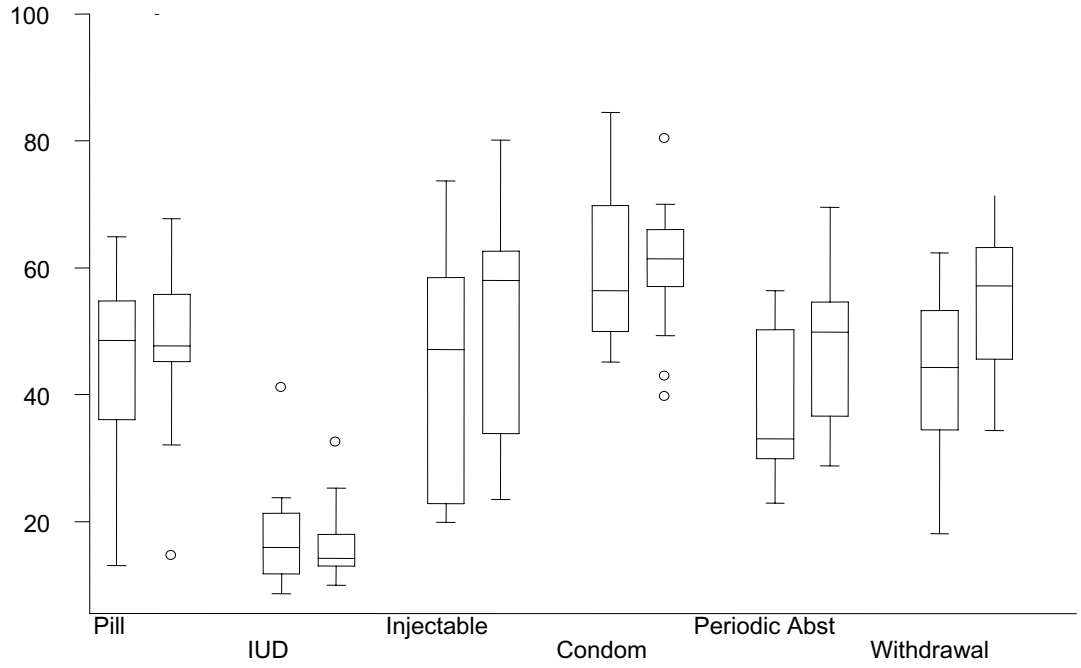
IUD users report much lower failure rates than users of other methods. In 11 of the 13 countries for which estimates are possible, the probability of experiencing an accidental pregnancy falls in the

Figure XIIa. Twelve-month cumulative probabilities of overall discontinuation per 100 episodes. Place of residence: urban (left box) vs. rural (right box)



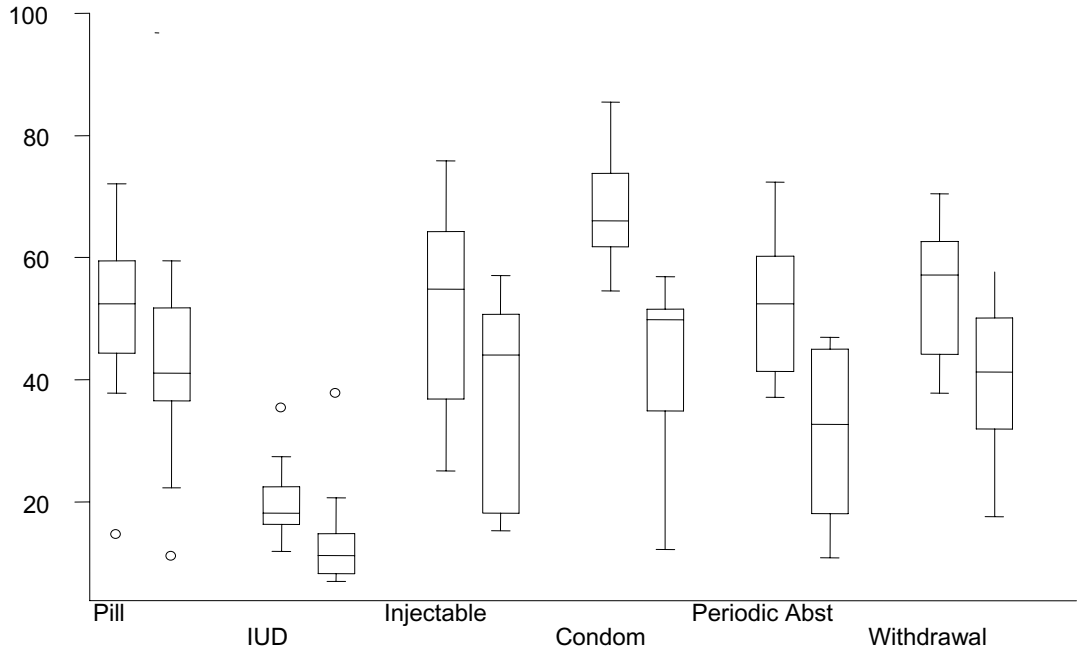
Source: Demographic and Health Surveys.

Figure XIIb. Twelve-month cumulative probabilities of overall discontinuation per 100 episodes. Women's education: primary or no education (left box) vs. secondary or higher (right box)



Source: Demographic and Health Surveys.

Figure XIIc. Twelve-month cumulative probabilities of overall discontinuation per 100 episodes. Motivation for use: spacers (left box) vs. limiters (right box)



Source: Demographic and Health Surveys.

range of 0.6 to 3.1 per cent. In Bangladesh no instances of failure in the first 12 months of use were reported. Two countries, both in Latin America, record higher failure rates: Dominican Republic, 6.1 per cent, and Colombia, 4.6 per cent. As under conditions of perfect use the efficacy of all IUDs commonly used in the 1990s is much higher than implied by the figures for Dominican Republic and Colombia, there must be some particular problem either with the quality of data or with the quality of IUD services in these two countries. The main direct cause of IUD failure under conditions of real rather than perfect use is spontaneous expulsion of the device without the woman's knowledge and thus one possible contributory cause of the high failure rates in Dominican Republic and Colombia is that women are not taught to check each month that the device is still in situ.

Reported failure rates for injectables are higher than those for the IUD, ranging from about one to ten per cent in all but one country (Paraguay, 15 per cent). The median failure rate is 2.9 per cent compared with 1.6 per cent for the IUD. When used correctly the most commonly available form of injectable, depo-provera which requires three-monthly injections, has a failure rate of only 0.3 per cent (Trussell, 1998). The fact that estimates from this analysis are much higher for six of the seven Latin American countries with available data is of interest and concern. The most plausible reason for high reported failure rates of this method is lack of correct knowledge among adopters on the required frequency of re-injections or forgetfulness, leading to pregnancies that occur after expiry of the method being attributed to failure of the method. Certainly the matter merits further investigation particularly in Paraguay where injectables are commonly need.

TABLE 22. TWELVE-MONTH CUMULATIVE PROBABILITIES OF FAILURE PER 100 EPISODES

Major area and region	*Pill*	*IUD*	*Injectables*	*Condom*	*Periodic Abstinence*	*Withdrawal*
Latin America and the Caribbean						
Bolivia	7.0	1.8	8.8	9.8	21.6	19.9
Brazil	6.4		9.0	8.2	22.6	24.1
Colombia	9.6	4.6	7.5	7.8	27.0	23.8
Dominican Republic	10.3	6.1		21.4	33.7	27.8
Guatemala	3.3		5.1	4.3	18.2	
Nicaragua	7.9	1.4	7.1	8.5	12.1	11.8
Paraguay	4.4	1.9	15.9	8.7	25.6	11.0
Peru	6.0	0.6	1.2	9.9	19.6	15.1
Northern Africa/ Western Asia						
Egypt	8.0	1.0	1.0	17.6		
Jordan	16.3	2.4		32.2	38.2	29.2
Morocco	7.0	2.2		12.0	26.2	13.8
Turkey	9.5	1.0		8.0		14.3
South-central/South-eastern Asia						
Bangladesh	3.8	0.0	1.6	10.1	12.1	8.0
Indonesia	4.9	1.4	1.7	6.4	12.0	12.9
Kazakhstan	18.3	3.1		18.6	26.8	26.0
Philippines	6.8	1.2	2.9	13.2	19.7	25.6
Sub-Saharan Africa						
Kenya	2.7		0.8	6.9	17.0	
Zimbabwe	1.9		1.1			1.7
Median	**6.9**	**1.6**	**2.9**	**9.8**	**21.6**	**15.1**

Source: Demographic and Health Surveys.
NOTE: Estimates based on less than 100 episodes are not shown.

Oral contraceptives, both the combined and progestin only pill, have 12-month failures rates that are well below one per cent under conditions of perfect use. Under conditions of typical use, failure rates in the United States are about five per cent (Trussell, 1998). In 16 of the 18 study countries, reported failure rates lie in the range of two to ten per cent and are thus broadly consistent with North American evidence. Countries where there is heavy reliance on the pill (Bangladesh, Brazil, Morocco, Zimbabwe) record failure rates in the range of two and seven recent and are thus fairly typical of the entire group of countries.

Exceptionally high pill failure rates are reported in two countries: Kazakhstan, 18 per cent and Jordan, 16 per cent. In the past decade, radical changes in fertility regulation in Kazakhstan have occurred. Prior to independence in 1991, withdrawal and induced abortion were the dominant methods of regulation but since then the use of modern methods of contraception has risen and abortion rates have fallen (Westoff, 2000). However the pill remains little used. In 1999 only 2.4 per cent of married women were using the pill compared with 42 per cent IUD use and 4.5 per cent condom use. The majority of pill users obtain supplies from pharmacies. The high failure rates for this country may reflect poor knowledge of correct use of the method, itself perhaps linked to lack of counselling.

In Jordan, despite its much longer history of organised family planning services, the explanation for high failure rates may be similar. The pill is not commonly used and has declined in popularity over time. As in Kazakhstan, pharmacies are the main source of supply and thus women may receive little or no advice on correct use of the method.

Condom failure rates can be derived from all but one survey (Zimbabwe). Rates range from 4 per

cent in Guatemala to 32 per cent in Jordan. The median failure rate is 9.8 per cent, below the estimate of 14 per cent for typical use in the United States (Trussell, 1998). Several possible reasons may contribute to this difference. Coital frequency, a major determinant of failure with a coitus-related method such as the condom, may be higher in the United States than in many developing countries. The mean days elapsed since last intercourse reported by wives of condom users imply an annual coital frequency of about 70 acts, appreciably lower than estimates from the United States (Rao and Demaris, 1995). Condom use in these 18 developing countries is less common than in the United States and thus users may be an atypical minority who are committed to effective use. As will be discussed below, motive for use acts as a powerful determinant of failure rates.

The reasons for the wide variation of estimates of condom failure within the 17 study countries must remain speculative. However, it is probably no coincidence that Kazakhstan and Jordan (along with the Dominican Republic) record very high condom failure rates, in addition to high pill failure rates. Indeed for all methods except IUD, couples in Jordan and Kazakhstan report very high probabilities of failure, a finding that may reflect a low commitment to pregnancy planning or a pervasive lack of detailed information about contraception. In Kazakhstan, though not in Jordan, the legacy of widespread and legal abortion may have engendered a casual attitude to correct use of contraceptives.

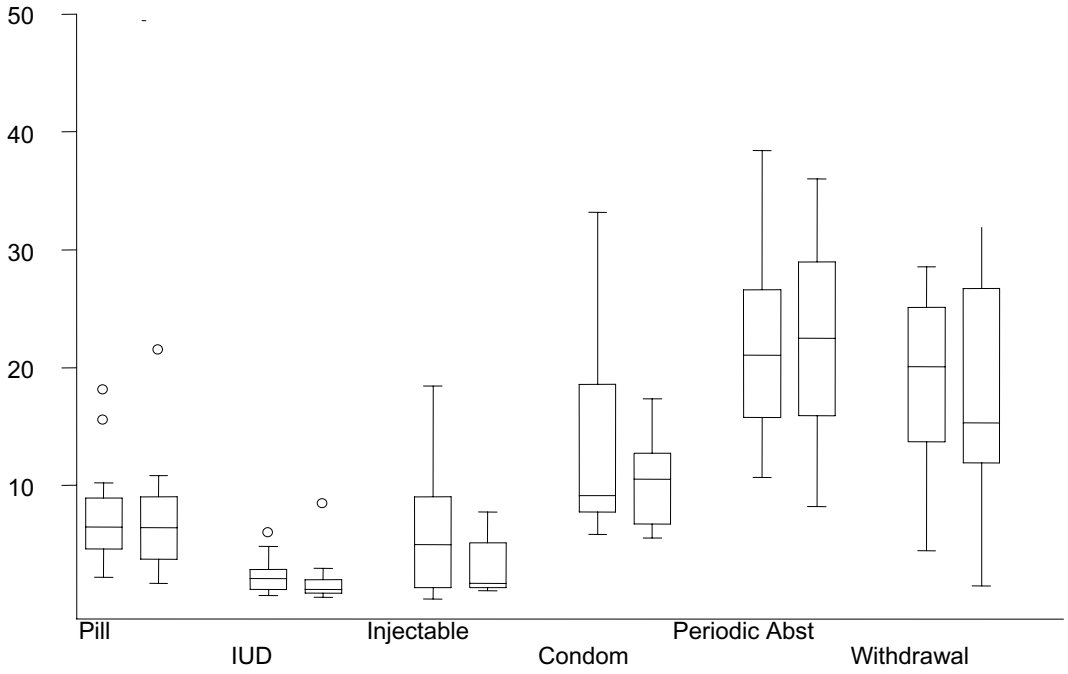
Failure rates for periodic abstinence are difficult to interpret because no information is available on which variant of this method is being used. However, it is reasonable to assume that a simple calendar method predominates. Many, though not all, DHS enquiries assess the knowledge of women about the time in the menstrual cycle when a woman is most likely to conceive, a prerequisite for optimal use of the calendar method. Typically four precoded answers are provided: before menses, during menses, just after menses and midway between menses. A tabulation of data from 12 DHS showed that, on average, only 52 per cent of women who had ever tried periodic abstinence were able to identify correctly the mid-cycle phase (Che, Cleland and Ali, 2003). For the countries analysed here, the proportion giving a correct answer ranges from about 20 per cent in Zimbabwe and Philippines to 81 per cent in Kazakhstan. Taking into account that many correct answers may arise by chance, or uninformed guesses, it is clear that knowledge of elementary reproductive physiology is low in many developing countries and that many users of periodic abstinence are practicing the method in a largely ineffective manner.

Under conditions of typical use in the United States, the 12-month failure rate for periodic abstinence is estimated to be 25 per cent (Trussell, 1998). In the 15 countries for which relevant estimates can be derived, the failure rate ranges from about 12 per cent in Nicaragua, Bangladesh and Indonesia to over 30 per cent in Dominican Republic and Jordan. The median value, 21.6 per cent, is close to the estimate for the United States. No straightforward correlation exists between the level of correct knowledge of the most fertile phase of the cycle among all ever-users and reported failure rates. For instance the high level of correct knowledge in Kazakhstan translates into a failure rate that is higher than the median for all 15 surveys. Nor is correct knowledge high in Nicaragua and Indonesia, both of which record low failure rates. The absence of any obvious strong correlation may reflect in part the fact that the husband's ability and willingness to abstain from sex may exert a stronger impact on failure than correct knowledge on when to abstain.

Withdrawal under conditions of typical use has higher efficacy than periodic abstinence, with a 19 per cent failure rate in the United States (Trussell, 1998). The median value for the 15 surveys containing sufficient episodes of withdrawal is 15.1 per cent, close to the North American value. There is one conspicuous outlier, Zimbabwe, where an implausibly low estimate of 1.7 per cent was obtained. This country also has an exceptionally low pill failure rate, which raises suspicions about the quality of information in the Zimbabwe DHS.

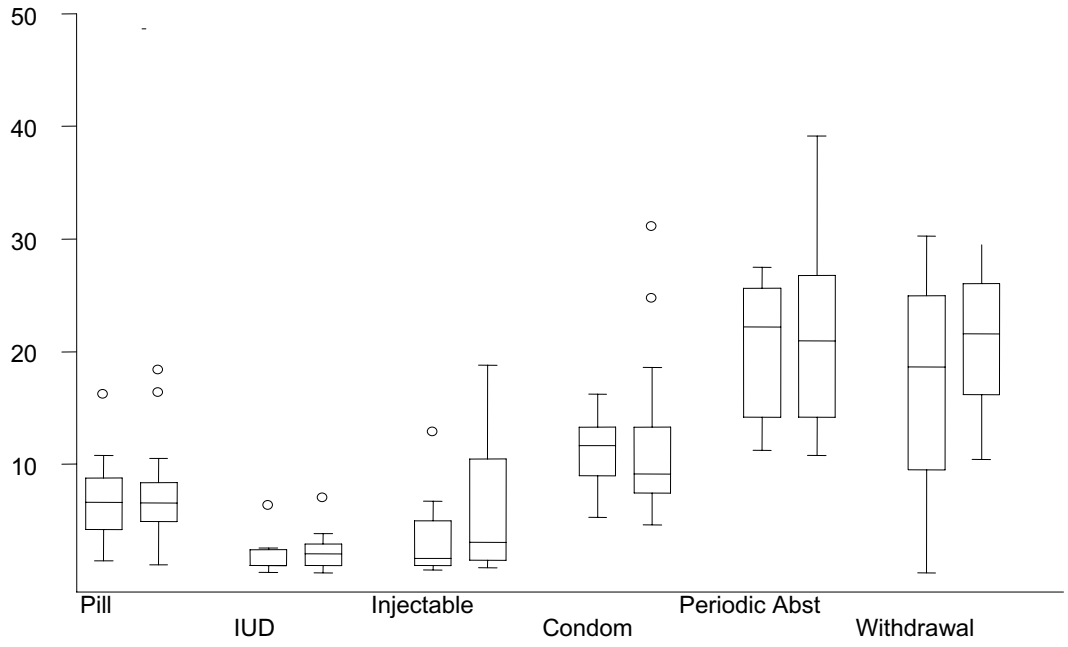
Rural-urban, educational and motivational differences in failure rates are summarised in figures XIIIa-c**.** Rural-urban estimates are broadly similar, as are, more surprisingly, estimates for different educational categories. The length of schooling of the wife does not appear to have much influence on ability to use methods of contraception correctly. Reproductive motivation, however, exerts a powerful influence on failure probabilities for some methods. Couples who want no more children are much less likely than spacers to experience condom-failure, failure while practicing periodic abstinence and, to a lesser extent, failure with coitus interruptus.

Figure XIIIa. Twelve-month cumulative probabilities of failure per 100 episodes. Place of residence: urban (left box) vs. rural (right box)



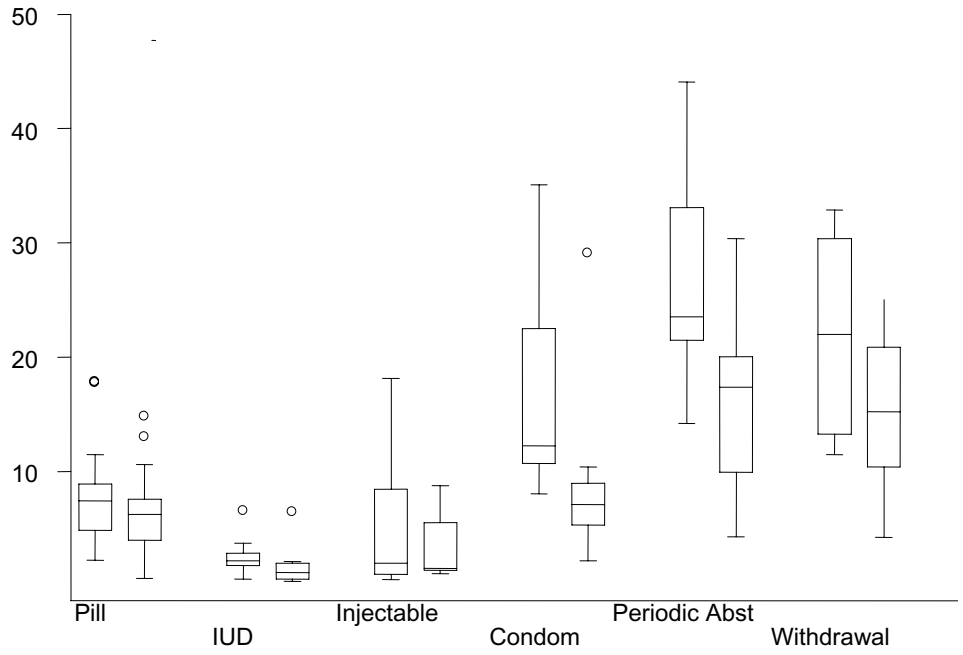
Source: Demographic and Health Surveys.

Figure XIIIb. Twelve-month cumulative probabilities of failure per 100 episodes. Women's education: primary or no education (left box) vs. secondary or higher (right box)



Source: Demographic and Health Surveys.

Figure XIIIc. Twelve-month cumulative probabilities of failure per 100 episodes. Motivation for use: spacers (left box) vs. limiters (right box)



Source: Demographic and Health Surveys.

The occurrence of an accidental pregnancy while a method is being used leads to one of four reproductive outcomes: an abortion or a live birth (current pregnancy) classified as unwanted, mistimed or wanted by the mother. On average in these 18 countries, the outcome of contraceptive failure was abortion in 16.8 per cent of instances (table 23). As noted earlier, it is impossible to distinguish in DHS calendars between induced abortion and spontaneous abortion. Nevertheless it is reasonable to assume that most are induced.

Estimates of abortion from the calendar depend on the true probability of abortion and the willingness of women to report such an event. In most of the 18 countries abortion is legally allowed only under extreme circumstances, such as to save the life of the woman or rape. The three main exceptions are Kazakhstan and Turkey where legal abortion is available on request and Bangladesh where menstrual regulation is also available on request up to eight weeks following the last menstrual period. It is obviously no coincidence that the prevalence of abortion following contraceptive failure is particularly high in these three countries: Kazakhstan 80 per cent; Turkey 44 per cent; and Bangladesh 23 per cent. Other countries with a high prevalence of abortion include Dominican Republic and Egypt. In the former, it is reported that abortion is common and ÞperformedÞ with impunity in private hospitals and clinics" (United Nations, 2001, p. 131). In Egypt abortion is permitted only to save the life of the woman and the United Nations Global Review of Abortion Policies provides no indication that the law is widely flouted. Nevertheless the evidence here suggests that abortion is a common recourse following contraceptive failure in Egypt.

In the majority of cases, contraceptive failure results in a live birth. Averaging across all countries, four out of five of these live births are reported by the mother to be unwanted or mistimed while the remaining 20 per cent are declared as wanted. A high prevalence of wanted births suggests measurement problems or ambivalence in reproductive motivations. This characterisation applies particularly in Paraguay and Nicaragua.

TABLE 23. REPRODUCTIVE CONSEQUENCES OF FAILURE PER 100 FAILURES

Major area and region	Abortion	Birth/current pregnancy: unwanted	mistimed	wanted	Total
Latin America and the Caribbean					
Bolivia	9.7	40.8	30.2	19.4	100.0
Brazil	11.4	30.2	38.7	19.7	100.0
Colombia	13.8	33.1	46.8	6.3	100.0
Dominican Republic	23.1	11.1	40.4	25.4	100.0
Guatemala	4.6	25.6	48.4	21.4	100.0
Nicaragua	12.8	20.1	36.9	30.2	100.0
Paraguay	17.2	10.5	31.8	40.6	100.0
Peru	11.2	42.0	40.2	6.6	100.0
Northern Africa/ Western Asia					
Egypt	21.6	36.1	15.6	26.7	100.0
Jordan	17.6	26.4	40.0	16.0	100.0
Kazakhstan	80.0	3.7	5.5	10.8	100.0
Morocco	10.7	42.2	36.3	10.7	100.0
Turkey	44.2	21.7	23.0	11.2	100.0
South-central/South-eastern Asia					
Bangladesh	22.7	24.9	46.6	5.8	100.0
Indonesia	8.9	24.7	45.2	21.3	100.0
Kazakhstan	80.0	3.7	5.5	10.8	100.0
Philippines	8.8	24.6	43.2	23.4	100.0
Sub-Saharan Africa					
Kenya	3.4	15.9	60.4	20.3	100.0
Zimbabwe	3.6	20.1	61.9	14.3	100.0
Total	**16.8**	**28.6**	**37.7**	**16.8**	**100.0**

Source: Demographic and Health Surveys.

As contraceptive use rises, the contribution of user- or method-failure to unwanted and mistimed births also rises, though this contribution is sensitive to the method-mix, specifically the balance between effective and less effective methods. A recent analysis of 15 DHS with calendar data showed that the total fertility rate would have been reduced by an average of 14 per cent if births resulting from contraceptive failure had never occurred (Blanc, Curtis and Croft, 2002). This estimates is biased upwards, as the authors realise, by the deduction of mistimed as well as unwanted births. The avoidance of mistimed births, it could be argued, makes little difference to the fertility rate in the medium term because they will occur sooner or later.

3. Method-related discontinuation and its reproductive consequences

Method-related discontinuation applies to all episodes that were stopped for reasons that imply dissatisfaction with the method or associated services. The dominant specific reasons are side-effects, health concerns, inconvenience, desire to switch to another method and objections by the husband. Probabilities of discontinuation for any one of those reasons provide the best available measure of how well particular methods meet the physiological, psychological and other needs of couples.

Of all six methods included in the analysis, the IUD is the least likely to be discontinued for method-related reasons (table 24). The median probability is 12 per cent for the 14 surveys with estimates. The main exceptions are Bangladesh, Dominican Republic and Nicaragua where probabilities are much higher. It will be recalled that the Dominican Republic also recorded an exceptionally high failure rate for IUDs, and this conjunction of results suggests that, for some reason, IUD-use is particularly problematic in this country. In Bangladesh and Nicaragua, however, IUD failure rates were low.

TABLE 24. TWELVE-MONTH CUMULATIVE PROBABILITIES OF METHOD-RELATED DISCONTINUATION PER 100 EPISODES

Major area and region	*Pill*	*IUD*	*Injectables*	*Condom*	*Periodic Abstinence*	*Withdrawal*
Latin America and the Caribbean						
Bolivia	50.3	9.5	68.0	55.6	11.5	33.0
Brazil	34.6		52.6	51.4	38.2	41.9
Colombia	30.5	12.0	51.2	47.9	28.5	33.0
Dominican Republic	37.2	26.3		67.4	30.0	40.3
Guatemala	36.1		48.3	48.0	4.3	
Nicaragua	32.9	21.0	49.7	49.3	23.5	48.2
Paraguay	48.0	12.4	57.2	66.7	27.3	22.0
Peru	46.9	14.4	33.6	36.4	11.9	20.1
Northern Africa/ Western Asia						
Egypt	30.0	9.4	41.2	29.4		
Jordan	47.2	12.0		42.8	18.0	22.4
Morocco	16.3	14.1		44.3	17.7	25.1
Turkey	43.6	7.6		29.9		19.0
South-central/South-eastern Asia						
Bangladesh	33.3	38.5	44.3	49.0	21.0	45.9
Indonesia	18.6	9.4	17.0	22.7	8.0	15.6
Kazakhstan	50.4	6.5		44.5	25.6	38.1
Philippines	29.2	12.4	46.2	47.3	11.8	19.0
Sub-Saharan Africa						
Kenya	27.1		16.6	45.9	8.0	
Zimbabwe	8.4		19.7			9.4
Median	**34.0**	**12.2**	**46.2**	**47.3**	**18**	**25.1**

Source: Demographic and Health Surveys.
NOTE: Estimates based on less than 100 episodes are not shown.

Users of periodic abstinence also tend to have low discontinuation probabilities, though the range across countries is wide, from less than 10 per cent in Guatemala, Indonesia and Kenya to 30 per cent or higher in Brazil and Dominican Republic. Indeed, this method is the only one of the six where failure probabilities are greater than probabilities of abandoning the method because of dissatisfaction or dislike.

In comparison with periodic abstinence, withdrawal is more likely to be discontinued for method-related reasons: the median probability is 25 per cent compared with 18 per cent for periodic abstinence. This difference holds true for all but one of the 13 countries where estimates for both methods can be derived.

Injectables are more likely to be stopped than pills within the first 12 months. The median probability is 46 per cent for injectables and 34 per cent for pills. This difference is maintained for 10 of 13 countries where a direct comparison can be made. All but one of the Latin American countries record probabilities of injectable discontinuation that are above the median. In Bolivia, over two-thirds stop within the first year. The exception is Peru where a low failure rate was also observed. In the other six countries of this region, high failure rates coexist with high probabilities of stopping for reasons that imply dissatisfaction with method or services.

In contrast to these six Latin American countries, discontinuation of injectables is low in Kenya and Zimbabwe. Doubts about the quality of the data from Zimbabwe preclude the possibility of drawing general inferences about the acceptability of this method in Africa. Discontinuation of injectables is also low in Indonesia but couples in this country are

distinguished by low discontinuation of all methods.

The results for the pill are of particular importance because of the widespread use of this method in many developing countries. Discontinuation lies in the range of 25 to 50 per 100 episodes, with three exceptions where it is lower: Zimbabwe, Indonesia and Morocco. The estimate for Indonesia reflects a general tendency for prolonged use of all types of method. In Kazakhstan and Jordan, where pill failure rates are exceptionally high, it may be noted that discontinuation rates are also very high.

The likelihood of stopping condom use is high in most countries, with a median value of 47 per cent. Two Latin American countries, Dominican Republic and Paraguay, record very high values of 67 per cent, and three countries, Egypt, Turkey and Indonesia low values of 30 per cent or less. As mentioned earlier Turkey is the only one of the 18 countries where condoms are widely used within marriage.

Socio-economic and motivational differentials in method-related discontinuation are summarised in figures XIVa-c. Neither urban-rural residence nor the wife's education are related to discontinuation of the more effective methods. However, for periodic abstinence and withdrawal, urban residence and a higher education are associated with elevated probabilities of stopping. Motive for use exerts a more pervasive influence on the probability of discontinuation because of dissatisfaction with the method or related services. For all six methods, couples who are contracepting to avoid all future childbearing are less likely to stop than spacers. This difference is relatively small for the pill, injectable and withdrawal but pronounced for IUD, condom and periodic abstinence.

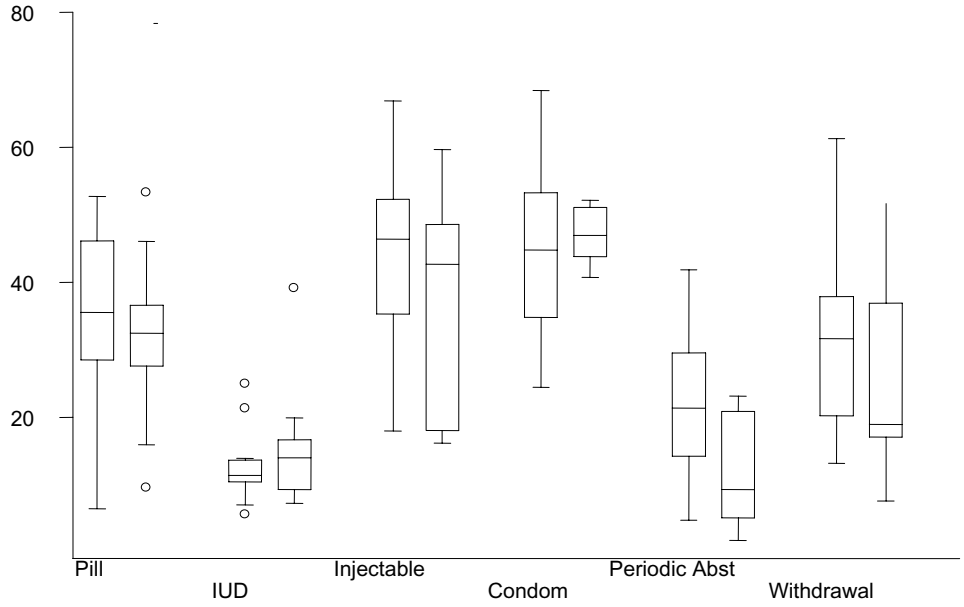
The reproductive consequences of method-related discontinuation were examined by multiple-decrement life table analysis of the 12-month period following discontinuation (table 25). On average (across all 18 countries), the majority of couples (67.9 per cent) switched to another method. An additional 10.1 per cent did not re-adopt any method in the following 12 months but nevertheless did not conceive. In table 25, this group is labelled "still at risk." The remaining 20 per cent became pregnant: 2.6 per cent experienced an induced or spontaneous abortion and 17.3 per cent a live birth (or current pregnancy). The latter sub-divide in approximately equal proportions into wanted, mistimed and unwanted births. Thus a mistimed or unwanted birth occurs as the result of method-related discontinuation in about 10 per cent of cases. The prevalence of these unintended births ranges from 5 per cent in Kenya to over 20 per cent in Morocco, Turkey and Zimbabwe. The main determinant of the probability of an unintended birth is the extent to which couples are willing and able to switch quickly to another method of contraception. Method-switching is exceptionally low in Turkey and Zimbabwe and below average in Morocco.

4. Method-switching

It was evident from the discussion of table 25 that the extent of re-adoption or method-switching is the dominant influence on the reproductive consequences of discontinuation. In this section, the analysis of switching is extended by examining the proportion of couples who re-start contraception within three months of stopping use of a prior method and by distinguishing the subsequent behaviour of couples who stopped a modern or more effective method and those who stopped a traditional, or less effective, method. Multiple-decrement life table methods were used to estimate the status of couples at the end of the third month following discontinuation. Four outcomes, or end points, may be identified. The couple may have become pregnant; they may have adopted no new method but have not yet conceived (labelled "still at risk" in table 26); they may have switched to a modern method; or they may have switched to a traditional method.

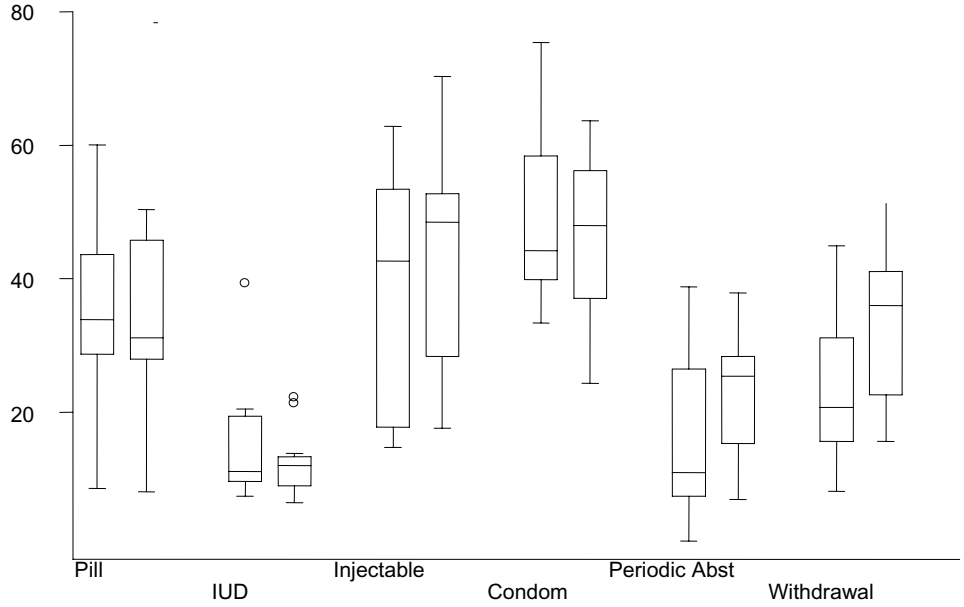
Disregarding for the moment the types of method involved, the bottom row of the left hand panel of table 26 shows that, on average, 59.3 per cent of couples switched to another method within three months, 12.8 per cent conceived and the remaining 29.4 per cent did not re-adopt any method but had not become pregnant. Behaviour following discontinuation varies widely between countries (figure XV). The probability of switching is highest in Paraguay and Colombia. Prompt switching is particularly low in Kenya and Zimbabwe, where less than 40 per cent re-adopt any method of contraception within three months. It is also low in Morocco (49 per cent switching) and Dominican Republic (46 per cent). Morocco, Dominican Republic and Zimbabwe share one characteristic that may partially explain their low

Figure XIVa. Twelve-month cumulative probabilities of method-related discontinuation per 100 episodes. Place of residence: urban (left box) vs. rural (right box)



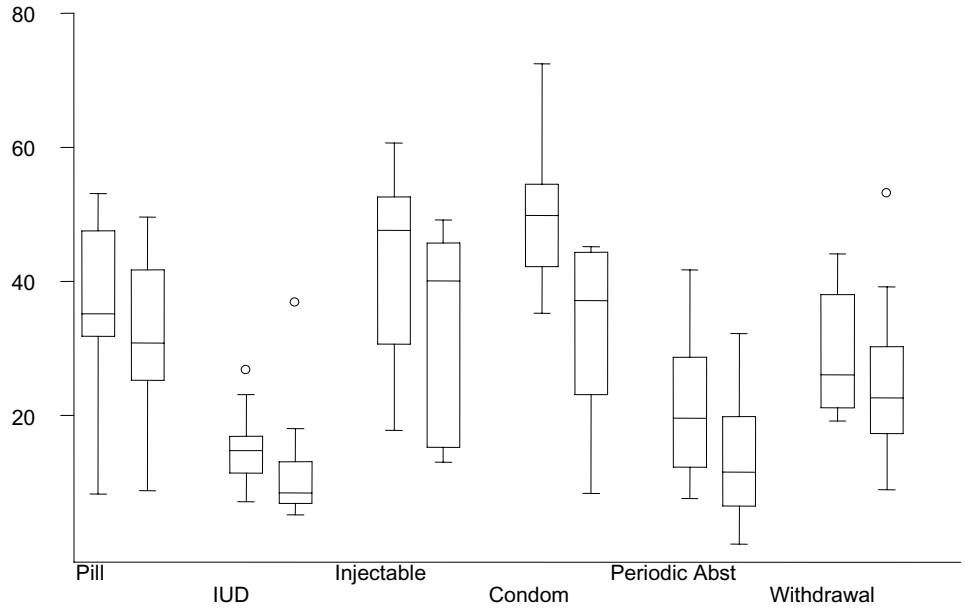
Source: Demographic and Health Surveys.

Figure XIVb. Twelve-month cumulative probabilities of method-related discontinuation per 100 episodes. Women's education: primary or no education (left box) vs. secondary or higher (right box)



Source: Demographic and Health Surveys.

Figure XIVc. Twelve-month cumulative probabilities of method-related discontinuation per 100 episodes. Motivation for use: spacers (left box) vs. limiters (right box)



Source: Demographic and Health Surveys.

switching probabilities. Contraceptive practice in all three countries is dominated by a single method. In Dominican Republic, nearly two-thirds of all current users are sterilised and in the other two countries a similar proportion uses oral contraceptives. Such a heavy reliance on a single method suggests a limited choice of alternatives when the dominant method is discontinued because of dissatisfaction. The limitation may stem from physical lack of access but it is equally likely to be a consequence of lack of familiarity with alternatives. Much evidence suggests that women are more ready to adopt methods that relatives and friends have tried than to try rarely used ones (Rogers and Kincaird, 1981; Entwistle and others, 1996). Only in one other country, Egypt, is current use dominated by one method (the IUD) to the same extent as in Dominican Republic, Morocco, and Zimbabwe. And in Egypt, the probability of switching is also low, 52 per cent.

The middle and right hand panels of table 26 provide more detail on the nature of switching, by distinguishing the type of method stopped (modern/effective versus traditional/less effective) and the type of method re-adopted. The median estimates for all 18 surveys indicate that couples who stop an effective method are less likely to switch within three months than those who discontinue a less effective method (55.5 per cent versus 67.7 per cent). This contrast is particularly large in four countries where the difference in switching probabilities between those discontinuing effective and less effective methods amounts to over 20 per cent. Three of these four are Dominican Republic, Morocco and Zimbabwe where, as already discussed, use is dominated by a single effective method, thus in effect limiting the options for couples who stop using an effective method. The fourth country is Nicaragua. Because use of less effective methods is rare in this country, little interpretative weight can be attached to the contrast in Nicaragua.

TABLE 25. REPRODUCTIVE CONSEQUENCES OF METHOD-RELATED DISCONTINUATIONS PER 100 DISCONTINUATIONS

Major area and region	Switched to another method	Current pregnancy/live birth			Abortion	Still at Risk
		wanted	mistimed	unwanted		
Latin America and the Caribbean						
Bolivia	72.1	6.2	6.6	5.7	2.7	6.7
Brazil	74.7	5.4	7.3	5.1	2.7	4.9
Colombia	49.8	13.6	13.0	4.6	4.8	14.1
Dominican Republic	49.5	13.0	11.4	7.3	3.3	15.5
Guatemala	80.8	7.2	5.3	1.4	1.9	3.4
Nicaragua	70.2	5.9	4.0	4.6	7.6	7.6
Paraguay	64.6	5.0	6.9	5.0	3.4	15.0
Peru	64.2	8.1	5.5	2.6	1.5	18.2
Northern Africa/ Western Asia						
Egypt	59.4	11.2	8.2	4.3	3.4	13.5
Jordan	53.0	11.4	6.2	10.2	4.2	15.1
Morocco	51.3	11.2	11.2	11.4	1.9	13.1
Turkey	36.8	12.4	19.5	7.9	4.3	19.0
South-central/South-eastern Asia						
Bangladesh	68.4	6.7	5.0	8.9	2.6	8.3
Indonesia	75.8	4.0	4.7	5.7	2.3	7.6
Kazakhstan	61.1	9.9	8.9	8.3	3.9	7.9
Philippines	52.5	9.2	11.9	5.6	3.8	17.0
Sub-Saharan Africa						
Kenya	67.9	4.7	3.0	1.6	12.8	10.1
Zimbabwe	37.5	8.2	23.5	3.8	2.5	24.5
Median	**67.9**	**6.7**	**5.0**	**5.6**	**2.6**	**10.1**

Source: Demographic and Health Surveys.

In the 18 countries, as in most developing countries, use of more effective (or modern) methods tends to be much higher than the use of less effective (or traditional) methods. It is to be expected therefore that method-switching will usually take the form of re-adoption of a more effective method. In half of the countries, among couples who stopped an effective method, 38.8 per cent switched to the same or another modern method within three months compared to only 16.7 per cent who switched to a traditional method. The two main exceptions in this regard are Bolivia and Philippines where more couples switched to a less effective method. Both countries record exceptionally high reliance on less effective methods. In Bolivia, about half of all current users are practicing periodic abstinence while in the Philippines use of both periodic abstinence and withdrawal is common and together these two methods comprise 37 per cent of current use.

Following discontinuation of a less effective method switching to a more effective method is also the common pattern. In half of the countries, among couples who stopped a traditional method, 57.0 per cent switched to a modern method within three months compared to only 10.7 per cent who switched to the same or another traditional method.

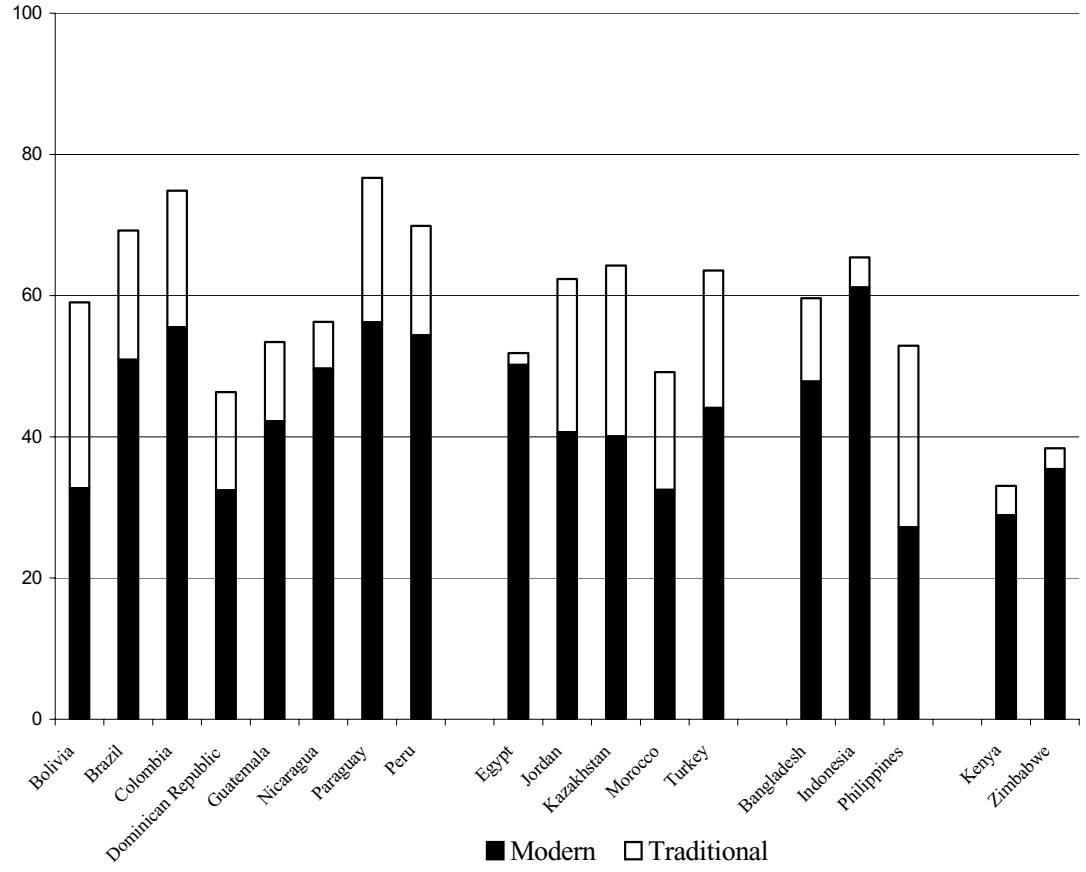
The ability of couples to switch to a modern method following abandonment of the earlier method because of dissatisfaction depends to some extent on the accessibility of a range of methods. Measures of method availability and accessibility are available for most developing countries in 1989, 1994 and 1999 from the work of Ross, Mauldin and colleagues (Mauldin and Ross, 1991; Ross and Mauldin, 1996; Ross and Stover, 2001). The availability scores were estimated for the mid-point of the five year calendar period for each of the 18 surveys by interpolation and plotted against the

TABLE 26. METHOD-SWITCHING: STATUS AT THREE MONTHS AFTER DISCONTINUATION FOR METHOD-RELATED REASON PER 100 DISCONTINUATIONS

	Discontinued Any Method					*Discontinued Modern Method*					*Discontinued Traditional Method*				
	Still at	*Switched to:*		*Became*		*Still at*	*Switched to:*		*Became*		*Still at*	*Switched to:*		*Became*	
Major area and region	*risk*	*Modern*	*Traditional*	*Pregnant*	*Total*	*risk*	*Modern*	*Traditional*	*Pregnant*	*Total*	*risk*	*Modern*	*Traditional*	*Pregnant*	*Total*
Latin America and the Caribbean															
Bolivia	27.9	32.7	26.3	13.1	100.0	31.4	25.1	30.5	13.0	100.0	18.9	52.2	15.6	13.4	100.0
Brazil	21.0	50.9	18.3	9.8	100.0	23.5	44.4	21.7	10.4	100.0	10.1	79.7	3.2	7.0	100.0
Colombia	15.4	55.5	19.4	9.7	100.0	16.7	51.0	20.8	11.5	100.0	12.1	67.3	15.6	5.0	100.0
Dominican Republic	32.9	32.4	13.9	20.8	100.0	35.3	27.8	13.2	23.8	100.0	23.6	49.8	16.8	9.8	100.0
Guatemala	35.0	42.2	11.2	11.6	100.0	36.0	41.3	11.6	11.1	100.0	27.1	49.3	8.1	15.4	100.0
Nicaragua	29.7	49.7	6.6	14.0	100.0	30.9	48.4	6.6	14.1	100.0	10.5	69.1	7.0	13.4	100.0
Paraguay	16.5	56.2	20.4	6.8	100.0	16.9	54.1	21.6	7.4	100.0	13.2	75.5	10.1	1.3	100.0
Peru	23.6	54.4	15.5	6.5	100.0	25.4	52.1	15.6	6.9	100.0	16.4	63.6	15.2	4.9	100.0
Northern Africa/ Western Asia															
Egypt	34.3	50.2	1.7	13.9	100.0	34.9	49.3	1.5	14.4	100.0	30.2	56.1	2.9	10.9	100.0
Jordan	22.3	40.7	21.7	15.4	100.0	23.3	35.9	23.2	17.6	100.0	20.1	50.9	18.6	10.5	100.0
Kazakhstan	25.6	40.1	24.2	10.1	100.0	25.4	36.3	24.4	13.9	100.0	25.9	46.3	23.9	3.9	100.0
Morocco	32.5	32.5	16.7	18.4	100.0	35.7	27.1	17.8	19.4	100.0	11.8	67.1	9.2	11.8	100.0
Turkey	17.3	44.1	19.4	19.1	100.0	19.5	36.3	29.6	14.7	100.0	13.5	57.9	1.6	27.0	100.0
South-central/South-eastern Asia															
Bangladesh	29.1	47.8	11.8	11.3	100.0	31.1	45.2	11.9	11.8	100.0	13.3	68.2	11.3	7.2	100.0
Indonesia	30.7	61.2	4.3	3.9	100.0	30.8	61.3	4.1	3.9	100.0	24.2	58.0	12.6	5.2	100.0
Philippines	34.7	27.2	25.7	12.4	100.0	39.0	23.3	25.6	12.1	100.0	28.8	32.6	25.9	12.7	100.0
Sub-Saharan Africa															
Kenya	47.9	28.9	4.2	19.1	100.0	50.8	28.3	3.8	17.1	100.0	24.8	33.5	6.9	34.8	100.0
Zimbabwe	43.5	35.4	3.0	18.1	100.0	46.6	33.1	2.3	17.9	100.0	21.7	51.6	7.3	19.4	100.0
Median	**29.4**	**43.2**	**16.1**	**12.8**	**100.0**	**31.0**	**38.8**	**16.7**	**13.5**	**100.0**	**19.5**	**57.0**	**10.7**	**10.7**	**100.0**

Source: Demographic and Health Surveys.

Figure XV. The probability of switching to a modern or a traditional method within three months of discontinuing any prior method, per 100 discontinuations



Source: Demographic and Health Surveys.

probability of switching to a modern method within three months of stopping a prior method for reasons that implied dissatisfaction. Surprisingly no relationship between method availability and switching was observed (results not shown). This negative result suggests either that the availability score, which is based on the judgement of experts, is a poor measure of availability or that other factors are more important determinants of the willingness of couples to switch to a modern method.

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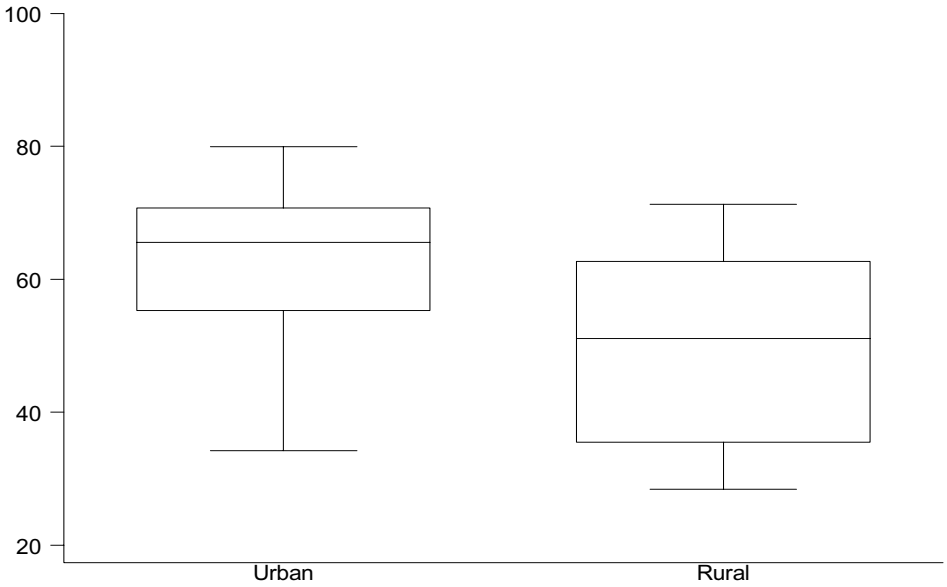
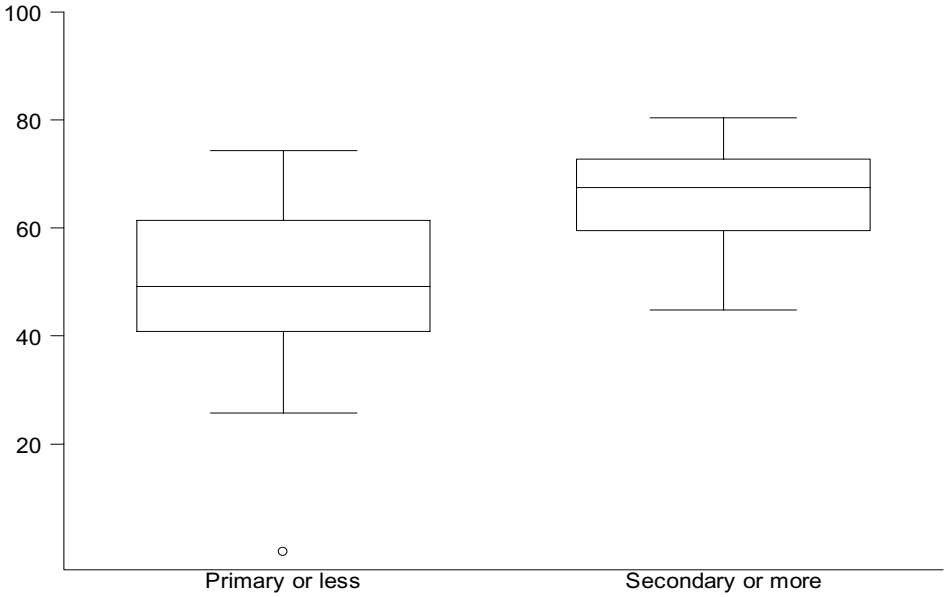
The relationships between switching probabilities and place of residence, wifes education and motive for use are summarised in figures XVIa-c. Clear differences are apparent for both urban-rural residence and education. Urban and educated couples are more likely to switch to any other method within three months of stopping a prior method than their rural, less educated counterparts. The effect of education is more pronounced than that of residence. By comparison motive for use appears to have rather little influence on the propensity of couples to re-adopt another method.

Figure XVIa. Percentage of women who switched to any reversible modern method within three months of discontinuation.
Place of residence: urban (left box) vs. rural (right box)



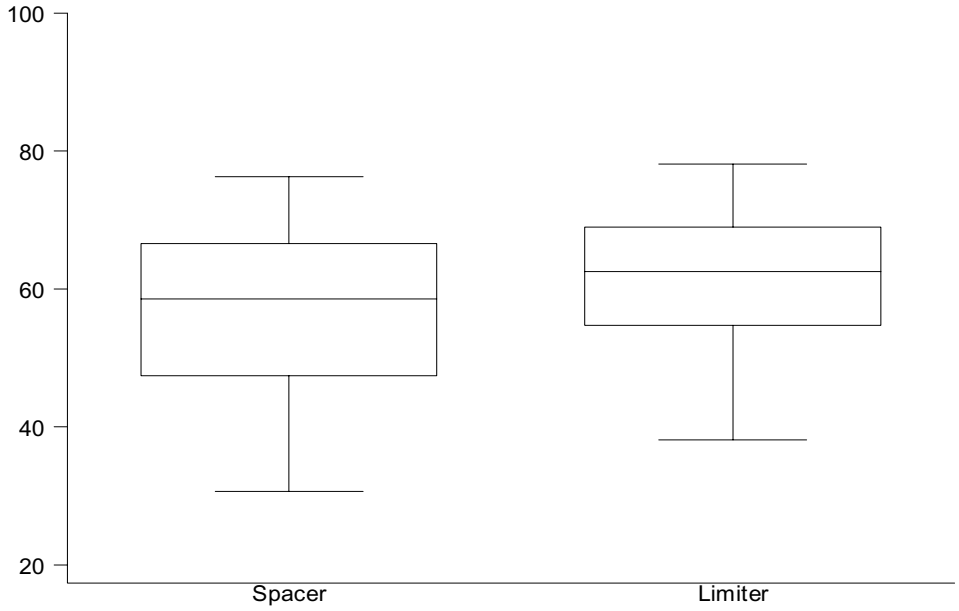
Source: Demographic and Health Surveys.

Figure XVIb. Percentage of women who switched to any reversible modern method within three months of discontinuation.
Women's education: primary or no schooling (left box) vs. secondary or higher (right box)



Source: Demographic and Health Surveys.

Figure XVIc. Percentage of women who switched to any reversible modern method within three months of discontinuation.
Motivation for use: spacers (left box) vs. limiters (right box)



Source: Demographic and Health Surveys.

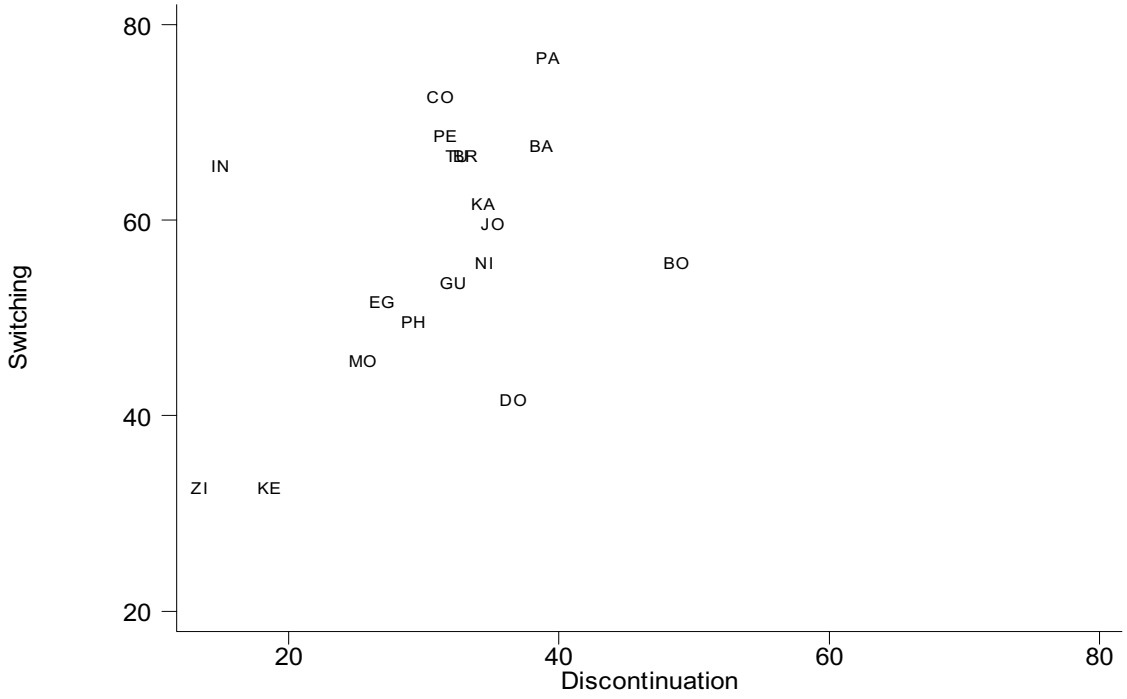
5. Relationship between discontinuation and switching

In a further attempt to analyse national patterns of contraceptive use dynamics, the probability of discontinuation for method-related reasons was plotted against the probability of switching to any other method within three months. A crude overall measure of method-related discontinuation was derived from table 24 by taking the unweighted average of discontinuation probabilities for the three most commonly used methods: pill, IUD and injectables. For countries where one of these three method-specific estimates was unavailable because of sample size considerations, the median value for all 18 surveys was imputed. The switching probabilities were obtained by simple addition of the middle two columns in the left hand panel of table 26.

No theoretical reason exists for expecting a relationship between discontinuation and switching probabilities at country-level. Rather the combination of these two key measures of contraceptive behaviour provides a useful overview of how well the family planning needs of couples are being met. The ideal combination is low discontinuation together with a high degree of switching, implying that the risk of unintended pregnancies is low. Conversely, high discontinuation and low switching implies a high exposure to unintended pregnancies. Intermediate combinations are low discontinuation plus low switching and high discontinuation accompanied by a high level of switching.

The plot of 18 countries is shown in figure XVII. Many occupy an intermediate position on both axes, with method-related discontinuation in the range of 30 to 35 per cent and switching probabilities of 50 to 65 per cent. The outliers can also be clearly identified. Indonesia approximates most closely to the ideal scenario with low discontinuation and high switching. Two other countries, Kenya and Zimbabwe, also record very low probabilities of stopping modern methods because of dissatisfaction but this positive feature is offset by exceptionally low switching. It should also be recalled that serious doubts surround the estimates for Zimbabwe.

Figure XVII. Scatter plot of switching and method-related discontinuation



Source: Demographic and Health Surveys.
NOTE: Countries identifed by first two letters of their name.

Another extreme outlier is Bolivia where very high levels of discontinuation coexist with below-average switching probabilities. A similar but far less extreme case is the Dominican Republic where higher than average discontinuation is accompanied by a lower than average propensity to switch to another method.

The two Northern African countries, Morocco and Egypt, possess a common distinct pattern of contraceptive behaviour where low discontinuation coexists with low probabilities of re-adopting another method. Bangladesh and Paraguay present the opposite situation: high discontinuation offset by high levels of switching.

D. SUMMARY AND CONCLUSIONS

The DHS contraceptive calendars permit much more detailed examination of contraceptive behaviour than has hitherto been possible. In particular they permit analysts to assess the turbulence that lies beneath the time honoured measures of ever use' and ćurrent use' of contraception. These data sets have the huge advantage that they are derived from large nationally representative surveys, executed with high standards of supervision and quality control. This chapter defines and presents simple but important indicators of contraceptive behaviour for 18 countries with available information. The approach was essentially descriptive. Little attempt was made to understand the factors that determine variations in contraceptive-use dynamics that were observed in the 18 countries.

The key results concern method-specific differences, couple-specific differences, the reproductive consequences of method-failure and discontinuation and country-level variations.

1. Method-specific results

A large body of knowledge concerning the failure of contraceptive methods; both under ideal and ŧeal life' conditions, has accumulated over the

past 40 years. In general terms, estimates of failure derived from DHS calendars are consistent with estimates assembled by Trussell (1998), largely on the basis of studies conducted in the United States. The major lesson is that couples in low and middle income countries with far lower levels of schooling on average than those in the United States are capable of achieving the same efficacy of use as North American couples. This generalisation certainly applies to methods that demand knowledge, skill and memory from one or both spouses: pill, condoms, periodic abstinence and withdrawal. Surprisingly the two methods that are least dependent on user non-compliance, IUDs and injectables, were the ones that yielded unexpectedly high failure rates. This was particularly true of injectables with a median 12-month failure rate of 2.9 per 100 episodes. Though the reason for the high reported failure in many of the 18 countries cannot be ascertained with DHS data, the matter is of concern and importance as the injectable is growing in popularity in many developing countries.

The results concerning abandonment or discontinuation of methods represent an important addition to previous knowledge. The most striking feature was the very large proportion of couples who stopped using particular methods because of side-effects, health concerns or other reasons that imply dissatisfaction. The probability of stopping use within 12 months for such a reason was nearly 50 per cent for injectables and condoms and 34 per cent for pills. Discontinuation of periodic abstinence and withdrawal was lower. Thus the very high failure rates associated with these two methods are somewhat balanced by the willingness of those users who do not experience accidental pregnancy to persist with use. Indeed, as shown in table 20, the overall probability of continued use for 12 months or more was just as high for the two traditional methods as it was for pills and injectables.

The large number of couples who try a hormonal method but abandon it underscores the need for family planning services to make readily available a range of alternatives, including different hormonal formulations. For many couples, contraception is clearly a matter of trial and error' until a method is found that is reasonably compatible with physiological and other criteria.

IUDs are the notable exception to the general rule that methods will be tried and abandoned by many couples. In 14 countries with estimates, the median per cent discontinuing IUDs was only 12 per cent, much lower than for the other five methods. Possible reasons have been mentioned earlier but remain speculative.

2. Couple-specific results

Rural-urban residence, educational and motivational differences were summarised by box and whisker plots which provide a succinct way of examining overall patterns of variation. Nearly all analyses of current use show residence and education to be major determinants of current use of contraceptives. It was to be expected, therefore, that these two factors would also be strongly associated with failure and discontinuation. However, little difference was found between urban and rural couples or between less and better educated couples. The ability and willingness of couples to use methods correctly and persistently does not appear to be related to these two factors. However, the urban and the better educated are distinguished from their counterparts by much higher probabilities of adopting another method when the earlier one is abandoned. This feature is thus one key consideration in accounting for the generally high levels of current use observed in urban areas and among better educated couples. Both physical access and greater knowledge of alternative methods and the social confidence to obtain them are probably implicated.

The effect of motive for use - the distinction between couples who want no more children or those who wish to postpone the next child - was the mirror opposite of the effects of residence and education. Limiters were less likely to experience failure and also less likely to abandon a method because of dissatisfaction. The clear implication is that spacers who have less at stake than limiters are less diligent in the way methods are used and more inclined to abandon use because of side effects, health concerns and other forms of dissatisfaction and concern. Surprisingly, however, limiters differ little from spacers in their propensity to switch quickly to another method when the earlier one is abandoned.

3. Reproductive consequences of failure and discontinuation

In most of the 18 countries, abortion is illegal and stigmatised. As expected therefore, contraceptive failure typically results in the birth of an unintended child. Averaged across all countries, two-thirds of failures led to an unwanted or mistimed birth. A smaller proportion (17 per cent)

resulted in a birth declared as wanted by the mother and an equal proportion ended in abortion. Some of these abortions were undoubtedly spontaneous but it is likely that the majority were induced. As contraceptive use rises further, the potential demand for abortion-usually illegal and often unsafe - as a result of contraceptive failure will also rise. The proportion of all unintended births that are the consequence of contraceptive failure will also increase.

The reproductive consequences of method-related discontinuation are strongly conditioned by the ability and willingness of couples to switch to another method (or possibly back to the same method) before they become pregnant. Averaged across all countries, about 60 per cent did switch within three months of stopping the earlier method and this proportion rose to 68 per cent within 12 months. Nevertheless the reproductive consequences of discontinuation are probably more serious than those of failure, because failure is much less common than discontinuation. After abandoning a method, the summary results for all 18 countries indicated that about 20 per cent of couples will become pregnant in the subsequent 12 months. And of these pregnancies, about 11 per cent will end as unintended births and about 3 per cent as induced or spontaneous abortions. The remainder (7 per cent) are births classified as wanted by the mother.

4. Country-specific differences

Country-specific difference in contraceptive use dynamics are difficult to summarise because preliminary attempts to explain them in terms of the quality of family planning services were not successful. Indonesia stands out as the only country where all the indicators of contraceptive behaviour are favourable to effective control of unintended pregnancies. Failure rates are low, discontinuation because of method-related problems or dissatisfaction is relatively uncommon and most couples who do discontinue for this reason switch promptly to another method.

No other country presents the opposite constellation of behaviours: high failure and discontinuation together with low switching. The nearest approximation is Bolivia, a country where nearly half of all current users rely on periodic abstinence. In Bolivia, failure rates are average (though high for injectables), but discontinuation of modern methods is exceptionally common and not offset by high switching. Clearly serious problems with modern methods exist in Bolivia, though it is not possible to ascertain with existing data whether they stem from poor quality services or from the attitude and beliefs of married couples.

Between these two extremes - Indonesia and Bolivia - lie the majority of countries with a mixture of ‘positive’ and ‘negative’ features. In the two sub-Saharan countries, Kenya and Zimbabwe, both failure and discontinuation rates appear to be very low but the propensity of couples to switch to another method after discontinuation is also exceptionally low. Two of the three Arab States in the sample, Egypt and Morocco, are similar to these two African countries though in a less extreme way. Bangladesh and Paraguay, on the other had, record high discontinuation probabilities which are offset by high switching probabilities.

A host of other country-specific results of considerable policy relevance, have emerged from this analysis. Examples include the poor performance of injectable methods in most Latin American countries and the high failure rates for certain methods in Jordan and Kazakhstan. The exceptionally high reported failure rates for IUDs in Dominican Republic and Colombia might need further investigation. The very high probabilities of stopping condom use in several countries is of particular concern in view of the continuing spread of HIV and this topic is of high priority for future investigations. Indeed one of the main strengths of a comparative analysis like this one is to identify deviations from norms, that may stimulate localised research in an attempt to discern the underlying reasons.

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VI. FERTILITY, CONTRACEPTION AND POPULATION POLICIES

Governments' views and policies with regard to the use of contraceptives have changed considerably during the second half of the 20th century. At the same time, many developing countries have experienced a transition from high to low fertility with a speed and magnitude that far exceeds the earlier fertility transition in European countries. Government policies on access to contraceptives have played an important role in the shift in reproductive behaviour. Low fertility now prevails in some developing countries, as well as in most developed countries. The use of contraception is currently widespread throughout the world. The highest prevalence rates at present are found in more developed countries and in China.

This chapter begins with a global overview of the current situation with regard to Governments' views and policies on contraception. It then briefly summarizes the five phases in the evolution of population policies, from the founding of the United Nations to the beginning of the 21st century. It examines the various policy recommendations concerning contraception adopted at the three United Nations international population conferences, and it discusses the role of regional population conferences in shaping the policies of developed and developing countries.

As part of its work programme, the Population Division of the United Nations Secretariat is responsible for the global monitoring of the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). To this end, the Population Division maintains a Population Policy Data Bank, which includes information from many sources. Among these sources are official Government responses to the United Nations Population Inquiries; Government and inter-governmental publications, documents and other sources; and non-governmental publications and related materials (United Nations, 2002a).

A. GLOBAL OVERVIEW OF CURRENT GOVERNMENT VIEWS AND POLICIES ON FERTILITY AND PROVIDING ACCESS TO CONTRACEPTIVE METHODS

At the beginning of the 21st century, the percentage of countries that reported that they were satisfied with their fertility level continued to decline, with the result that only 38 per cent of countries found the present level satisfactory (see table 27). Far more countries considered fertility to be too high rather than too low, but the percentage of countries that viewed fertility as too high, after rising from 1976 to 1996, levelled off after 1996 at about 45 per cent. Among countries in less developed regions, 58 per cent considered fertility too high, while more than three fourths (78 per cent) of the 49 least developed countries said fertility was too high in 2001. By contrast, the percentage of countries that considered fertility to be too low has been climbing over the last three decades. Of the more developed countries, fully half now consider fertility to be too low (up from 21 per cent in 1976), while 48 per cent are satisfied with the level of fertility. Seven per cent of countries in less developed regions considered fertility to be too low in 2001.

In the past, dissatisfaction with the level of fertility has not necessarily translated into a policy intervention. In 1976, more than one half of countries (52 per cent) did not intervene to modify the level of fertility. By 2001, the percentage of non-interventionist countries had fallen to one-third (table 28, figure XVIII). However, countries that view fertility as too high are more likely to intervene than countries that view fertility as too low. In 2001 practically the same percentage of countries that considered fertility too high (44 per cent) had adopted policies to lower fertility (45 per cent). In contrast, of the countries that considered fertility to be too low, eight of the 34 countries in this category did not have a policy in place to raise fertility.

An important determinant of reproductive behaviour, as well as of maternal and child health, has been Government policies on providing access to contraceptive methods. Direct support entails the provision of family planning services through Government-run facilities, such as hospitals, clinics, health posts and health centres and through Government fieldworkers. Government support for methods of contraception has been steadily increasing during the last quarter of the twentieth century. By 2001, 92 per cent of all countries supported family planning programmes and contraceptives, either directly (75 per cent), through government facilities, or indirectly (17 per cent),

TABLE 27. GOVERNMENT VIEWS ON THE LEVEL OF FERTILITY: 1976, 1986, 1996 AND 2001

A. By level of development

Year	(Number of countries)				(Percentage)			
	Too low	*Satisfactory*	*Too high*	*Total*	*Too low*	*Satisfactory*	*Too high*	*Total*
				World				
1976	16	79	55	150	11	53	37	100
1986	22	75	67	164	13	46	41	100
1996	28	78	87	193	15	40	45	100
2001	34	74	85	193	18	38	44	100
				More developed regions				
1976	7	27	0	34	21	79	0	100
1986	9	25	0	34	26	74	0	100
1996	19	28	1	48	40	58	2	100
2001	24	23	1	48	50	48	2	100
				Less developed regions				
1976	9	52	55	116	8	45	47	100
1986	13	50	67	130	10	38	52	100
1996	9	50	86	145	6	34	60	100
2001	10	51	84	145	7	35	58	100
				Least developed countries				
1976	3	26	13	42	7	62	31	100
1986	2	20	26	48	4	42	54	100
1996	0	11	38	49	0	22	78	100
2001	0	11	38	49	0	22	78	100

TABLE 27 (*continued*)

Year	*B. Major area*							
	(Number of countries)				*(Percentage)*			
	Too low	*Satisfactory*	*Too high*	*Total*	*Too low*	*Satisfactory*	*Too high*	*Total*
				Africa				
1976	5	25	18	48	10	52	38	100
1986	3	17	31	51	6	33	61	100
1996	1	11	41	53	2	21	77	100
2001	1	11	41	53	2	21	77	100
				Asia				
1976	2	18	17	37	5	49	46	100
1986	7	17	14	38	18	45	37	100
1996	7	20	19	46	15	43	41	100
2001	8	19	19	46	17	41	41	100
				Europe				
1976	7	22	0	29	24	76	0	100
1986	9	20	0	29	31	69	0	100
1996	18	24	1	43	42	56	2	100
2001	23	19	1	43	53	44	2	100
				Latin America and the Caribbean				
1976	2	9	16	27	7	33	59	100
1986	3	15	15	33	9	45	45	100
1996	1	14	18	33	3	42	55	100
2001	1	15	17	33	3	45	52	100
				Northern America				
1976	0	2	0	2	0	100	0	100
1986	0	2	0	2	0	100	0	100
1996	0	2	0	2	0	100	0	100
2001	0	2	0	2	0	100	0	100
				Oceania				
1976	0	3	4	7	0	43	57	100
1986	0	4	7	11	0	36	64	100
1996	1	7	8	16	6	44	50	100
2001	1	8	7	16	6	50	44	100

Source: *National Population Policies, 2001* (United Nations publication, Sales No. E.02.XIII.12).

through support of non-governmental activities, such as those operated by family planning associations (see annex table 4). Despite the pervasiveness of Government support for contraceptive methods, the demand for family planning services is believed to outstrip the supply. It has been estimated that as of 2000, some 123 million women did not have ready access to safe and effective means of contraception (Ross and Winfrey, 2002).

TABLE 28. GOVERNMENT POLICIES ON THE LEVEL OF FERTILITY: 1976, 1986, 1996 AND 2001

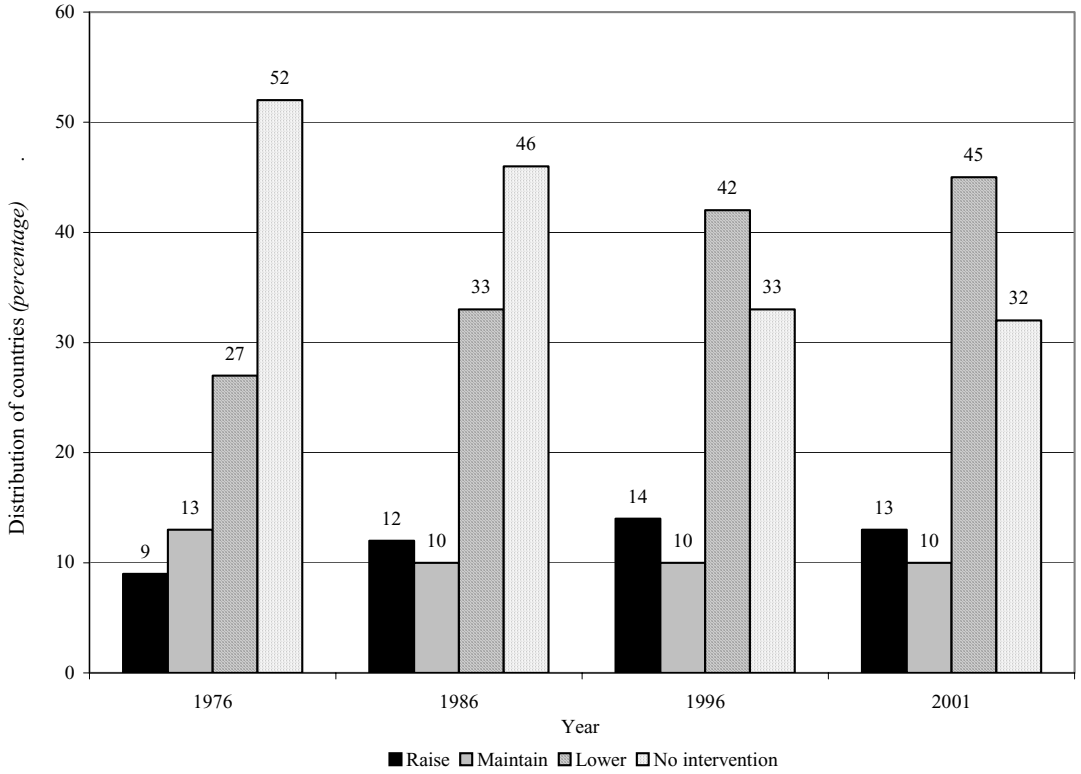
Year	Raise	Maintain	Lower	No intervention	Total	Raise	Maintain	Lower	No intervention	Total
	A. By level of development									
	(Number of countries)					*(Percentage)*				
					World					
1976	13	19	40	78	150	9	13	27	52	100
1986	19	16	54	75	164	12	10	33	46	100
1996	27	20	82	64	193	14	10	42	33	100
2001	26	19	86	62	193	13	10	45	32	100
					More developed regions					
1976	7	7	0	20	34	12	21	0	59	100
1986	8	6	0	20	34	24	18	0	59	100
1996	16	4	1	27	48	33	8	2	56	100
2001	15	4	1	28	48	31	10	2	56	100
					Less developed regions					
1976	6	12	40	58	116	5	10	34	50	100
1986	11	10	54	55	130	8	8	42	42	100
1996	11	16	81	37	145	8	11	56	24	100
2001	11	14	85	35	145	8	10	59	24	100
					Least developed countries					
1976	1	2	6	33	42	2	5	14	79	100
1986	2	4	15	27	48	4	8	31	56	100
1996	0	3	32	14	49	0	6	65	29	100
2001	0	4	34	11	49	0	8	69	22	100

TABLE 28 (*continued*)

Year	*B. Major area*									
	(Number of countries)					*(Percentage)*				
	Raise	*Maintain*	*Lower*	*No intervention*	*Total*	*Raise*	*Maintain*	*Lower*	*No intervention*	*Total*
					Africa					
1976	2	2	12	32	48	4	4	25	67	100
1986	3	3	21	24	51	6	6	41	47	100
1996	2	3	36	12	53	4	6	68	23	100
2001	1	3	38	11	53	2	6	72	21	100
					Asia					
1976	2	9	14	12	37	5	24	38	32	100
1986	8	6	13	11	38	21	16	34	29	100
1996	7	9	19	11	46	15	20	41	24	100
2001	8	7	20	11	46	17	15	43	24	100
					Europe					
1976	7	7	0	15	29	24	24	0	52	100
1986	8	6	0	15	29	28	21	0	52	100
1996	16	4	1	22	43	37	9	2	51	100
2001	15	5	1	22	43	35	12	2	51	100
					Latin America and the Caribbean					
1976	2	0	10	15	27	7	0	37	56	100
1986	0	0	15	18	33	0	0	45	55	100
1996	1	1	18	13	33	3	3	55	39	100
2001	1	1	19	12	33	3	3	58	36	100
					Northern America					
1976	0	0	0	2	2	0	0	0	100	100
1986	0	0	0	2	2	0	0	0	100	100
1996	0	0	0	2	2	0	0	0	100	100
2001	0	0	0	2	2	0	0	0	100	100
					Oceania					
1976	0	1	4	2	7	0	14	57	29	100
1986	0	1	5	5	11	0	9	45	45	100
1996	1	3	8	4	16	6	19	50	25	100
2001	1	3	8	4	16	6	19	50	25	100

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12).

Figure XVIII. Government policies on the level of fertility, 1976-2001: World



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

In many countries, Government support for contraception preceded the formulation of population policies. The responses to the first United Nations Population Inquiry in 1963 indicated that of the 53 countries that replied, none had formulated policies aimed at altering the reproductive behaviour of their respective populations. Nevertheless, many countries supported the distribution of contraceptive supplies. In Africa, particularly Northern Africa, many countries began providing direct support for contraceptive distribution as early as the mid 1970s. These Governments supported contraceptive methods as part of basic reproductive health services even in the absence of policies to reduce population growth or fertility levels. Moreover, many countries in Asia (excepting Western Asia) and Latin America and the Caribbean were also early supporters of family planning.

During the last 30 years, nearly all countries have shifted their policies in favour of increased direct or indirect support for contraceptive methods. Even previously pro-natalist Governments, which in the past had wanted to maintain or even increase the rate of population growth, have gradually changed their stance and now accept family planning and contraception as an integral part of maternal and child health programmes. At the same time, some countries, particularly in Europe (for example, Austria, Denmark, France, Italy and Switzerland) have reduced support for family planning programmes, possibly as a response to below-replacement fertility rates, or an acknowledgement that the private sector was meeting demands for contraception without Government subsidies (see annex table 4).

In Eastern Europe, profound economic and political changes have been accompanied by a sharp decline in fertility, resulting in some of the lowest fertility rates in the world. Several reasons have been suggested to explain the situation: political instability has led to a "fear of the future" and a reluctance to have children; the economic crisis has lowered per capita income and living standards; and new forms of the family, which favour low fertility, have been adopted (Economic Commission for Europe, 2002). Although most countries in Eastern Europe considered fertility to be too low in 2001, they continue to support access to contraceptive methods.

Policy formulation and implementation differ according to level of development. In developing countries, there is a clear trend towards increased Government support for methods of contraception (figure XIX). This trend is especially visible in the group of least developed countries, which have moved from having a low percentage of supportive Governments in the early 1970s to almost unanimous support at the present time. Data referring to 2001 show that the least developed countries have the highest percentage (96 per cent) of Governments with direct and indirect support policies in place. Only two least developed countries, Equatorial Guinea and Lao People's Democratic Republic, offer no official support for contraception. By contrast, in developed countries, there has been a shift away from direct support of contraception to indirect support. Among the more developed countries, 62 per cent had implemented direct support policies in 1976, whereas in 2001, fewer than half (46 per cent) had such policies in place (figure XX).

B. Five phases in the evolution of government policies

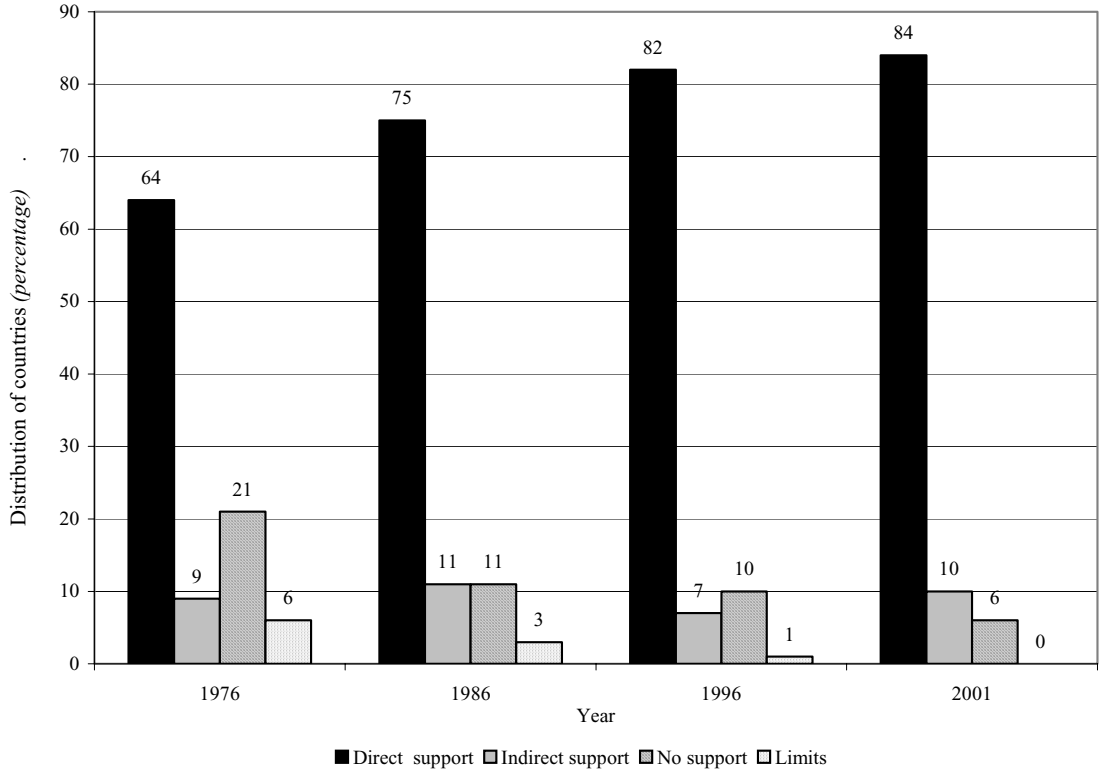
The evolution of population policies can be divided into five phases: (a) the 25-year period following the establishment of the United Nations (1945-1970); (b) the decade of the 1974 World Population Conference in Bucharest (1970-1980); (c) the decade of the 1984 International Conference on Population in Mexico City (1980-1990); (d) the decade of the 1994 International Conference on Population and Development in Cairo (1990-2000); and (e) the beginning of the 21st century.

1. Population policy development following the establishment of the United Nations, 1945-1970

During the first decades following the establishment of the United Nations, population and development were only beginning to emerge as concerns of the international community. Demographic data were generally lacking or deficient, as many countries had never conducted a census. Thus, knowledge of global population trends was limited, while the relationship between rapid population growth and economic development was only beginning to be explored. Moreover, fertility and family planning were not generally considered to be appropriate areas for government intervention. However, by the 1950s, the United Nations had established a programme of technical assistance in the field of population, focusing on demographic data collection and analytical studies rather than family planning activities (Gille, 1987). The earliest requests for technical assistance came from the Governments of Brazil, India, Indonesia and Thailand.

It was in this context that the United Nations organized the World Population Conference in Rome in September 1954. Unlike subsequent international population conferences, the Rome conference was a scientific exchange of information. Participants consisted of demographers and population specialists who did not represent governments. The Conference addressed the entire gamut of population issues and helped to establish the importance of demographic research for population policy. The inadequacy of statistics for much of the world's population was highlighted, as were ideological differences, particularly between Western countries and representatives of the USSR, who contended that rapid population growth was only a problem for capitalistic societies (Macura, 1987). An important outcome of the Conference was its focus on the need to study all populations in the context of their particular economic, social and cultural conditions. Although the main emphasis of the Rome Conference was on demographic research and gaps in knowledge, it also provided a platform for wider concerns, indicating that the importance of global population trends was beginning to be acknowledged.

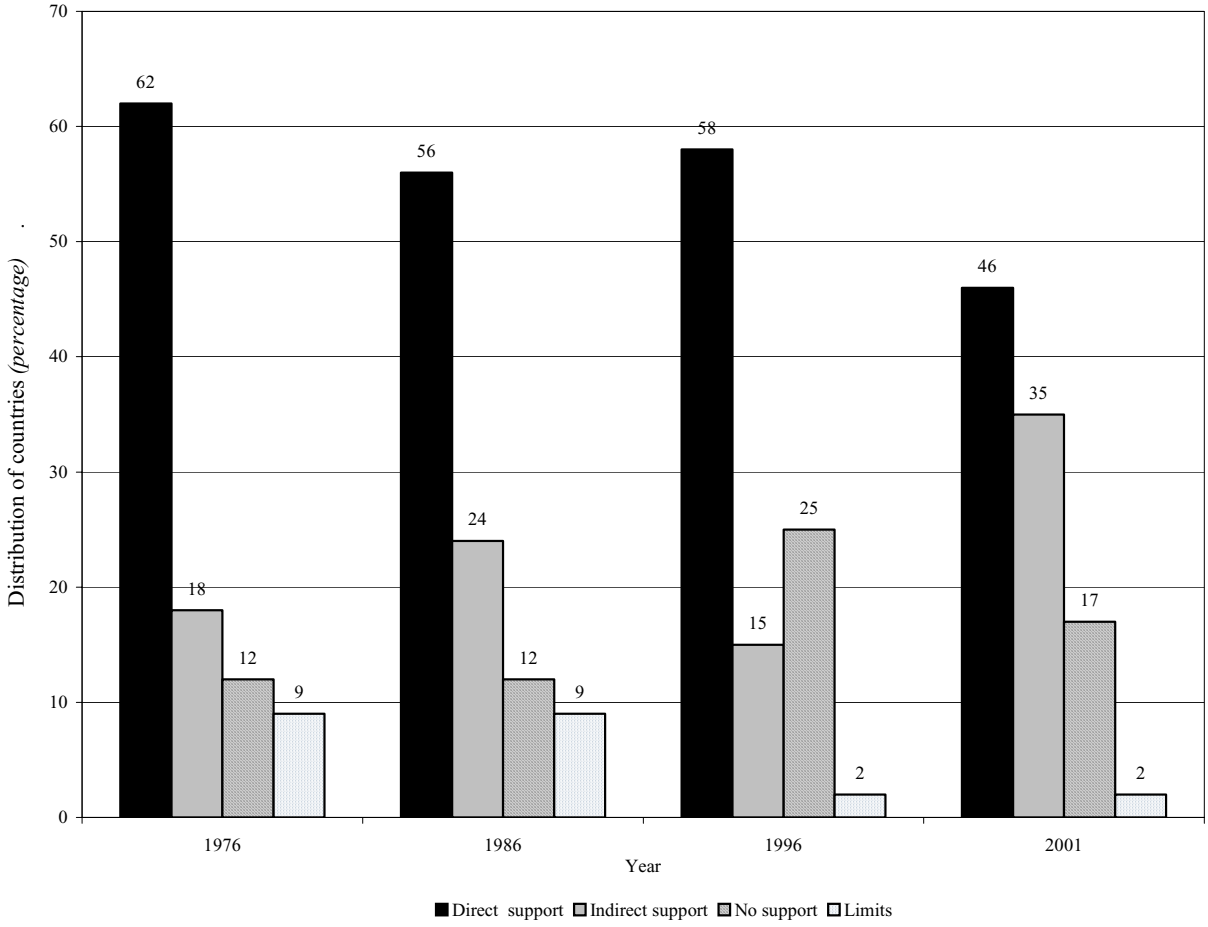
Figure XIX. Government policies on providing access to contraceptive methods, 1976-2001: Less developed regions



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

In 1959, a Presidential Committee on the United States foreign aid programme, chaired by General William Draper, Jr., recommended that the United States Government should assist countries that requested help in designing programmes to deal with rapid population growth and that it should support research on the topic. President Eisenhower rejected this recommendation, saying emphatically that it was not a proper function or responsibility of Government. Within a few years, however, attitudes began to change dramatically. The United Nations General Assembly had designated the 1960s as the United Nations Decade of Development, reflecting a growing international consensus that development should be an important objective of United Nations assistance. Evidence was accumulating that rapid population growth could wipe out the gains accruing to economic development by diverting resources from investment to consumption (Coale and Hoover, 1958; Notestein, 1964). Modernization, it was felt, required investment not only in capital equipment but also in human capital, such as health and education. High birth rates and a young population hampered the ability of developing countries to save and invest sufficiently in order to raise the country's per capita income and improve living standards. Coale and Hoover (1958) estimated that in India, reducing fertility by 50 per cent would in a generation induce a level of per capita income about 40 per cent higher than if fertility had not been reduced.

Figure XX. Government policies on providing access to contraceptive methods, 1976-2001: More developed regions



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

Several developing countries, without support from more developed countries, began to respond to rapid population growth by introducing family planning programmes. In 1959, the Government of India declared that it supported all methods of family limitation, including sterilization. In Pakistan, a group of citizens founded the Family Planning Association of Pakistan and opened family planning clinics in several cities, with no financial support from the Government. Similar activities to limit population growth occurred in Japan, Singapore, and some small island states of the Caribbean and the Pacific. The Government of Egypt, recognizing the problem of its rapidly growing population, established a national family planning programme in 1962 (Johnson, 1994).

These developments were crucial in persuading potential donor countries like the United States, as well as the United Nations, that international action on population concerns was both timely and appropriate. In 1961, the United Nations Population Commission made an important statement on population policy: it said that each Government had the responsibility to make its own policies and devise its own programmes for dealing with its population issues, and that the United Nations should encourage and assist Governments in obtaining basic population data and carrying out studies on the demographic aspects of their economic and social development problems. The statement also said that the United Nations should provide technical assistance to Governments who

requested it for national projects of research, experimentation and action for dealing with problems of population (United Nations, 1987).

In 1962, the United Nations General Assembly passed Resolution 1839 on population growth and economic development, which established the guidelines for United Nations activity in the population field for the next decade and more. Among other things, it called for increased research on the relationship between population growth and economic and social development; it recommended that the Second World Population Conference, to be held in Belgrade in 1965, pay special attention to this relationship; and it directed the Secretariat to conduct an inquiry among Governments concerning problems in the realm of population and development (GA Resolution 1839 (XVII) of 18 December 1962).

The Belgrade conference in 1965, like the conference in Rome more than a decade earlier, was a scientific gathering, with experts participating in their individual capacities. It differed, however, in that it took a broader approach to the population problem and provided a forum where experts could examine population trends and assess their implications. Ideological differences continued: some countries objected to the involvement of the United Nations in population policy and family planning, as well as in research on methods of fertility control. A new tide of interest was spreading through the Organization. The United Nations Economic and Social Commission for Asia and the Pacific called upon the United Nations to expand the scope of technical assistance. In addition, the Economic Commission for Latin America and the Caribbean cited survey results demonstrating that people were more favourably disposed than political leaders to population limitation. Chile became the first country in Latin America to incorporate family planning services within the national health service, largely because of concerns with the increasing number of illegal abortions.

The papers presented at the Second World Population Conference in Belgrade discussed national family planning programmes in some 20 developing countries, and the question appeared to be not whether programmes were needed but whether they were effective. The right of parents to control the number of children had been established earlier as a basic human right; at the Belgrade conference, that principle was situated in its social and international context (Macura, 1987).

The right to family planning is not explicitly mentioned in the United Nations Universal Declaration of Human Rights, but some have argued that it may be inferred from the rights to privacy, conscience, health and well-being set forth in various United Nation's conventions and declarations. For example, the Secretary-General noted in 1967 that

> the Universal Declaration of Human Rights describes the family as the natural and fundamental unit of society. It follows that any choice and decision with regard to the size of the family must inevitably rest with the family itself, and cannot be made by anyone else. But this right of parents to free choice will remain illusory unless they are aware of the alternatives open to them. Hence, the right of every family to information and the availability of services in the field is increasingly considered as a basic human right and as an indispensable ingredient of human dignity (Statement on Population by UN Secretary-General U Thant, 10 December 1967).

Several months later, the International Conference on Human Rights, held in Teheran, moved towards a more explicit recognition of family planning as a human right. Its groundbreaking Proclamation of Teheran, adopted on 13 May 1968, provided a foundation for conferences and population activities that followed. The Conference proclaimed that "the protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of their children" (United Nations, 1968). It recognized that moderating population growth would enhance the opportunities for the enjoyment of human rights and the improvement of living conditions. It also urged Member States, as well as United Nations bodies and agencies to pay close attention to the implications of population increase for the exercise of human rights. This proclamation gave enormous encouragement and impetus to the family planning movement and to its supporters, who had argued that all children should not only be wanted children, but also, by implication, that Governments had an obligation to accept responsibility for the provision of family planning information and services to enable couples to plan the size of their families.

By the 1960s, significant progress had been made in developing new types of contraceptives. The introduction of the oral contraceptive pill and the intrauterine device (IUD) separated sexual activity from pregnancy and allowed women to exert some control over their reproductive lives. Both the pill and the IUD were suitable for large-scale family planning programmes. Research continued on making contraceptives safe, more effective, easier to use and less expensive.

2. Population policies, 1970-1980

By the end of the 1960s, concern was growing in the United States and Europe about population increases in developing countries and the strains placed on resources. For example, a bill was introduced in the United States Congress in 1967 to appropriate funds to support voluntary family planning programmes in "friendly" foreign nations. Later that year, the Secretary-General of the United Nations established a trust fund—the United Nations Trust Fund for Population Activities—to assist developing countries in addressing their population problems.

As the decade of the 1970s began, rapid population growth had come to be widely viewed by specialized agencies of the United Nations as a major obstacle to development in the area of maternal health (WHO), children's health (UNICEF), food security (FAO), education (UNESCO), the welfare of workers (ILO) and investment for development (World Bank). There was still reluctance on the part of the United Nations and others to move beyond demographic research and analysis and support population activities that would directly influence demographic variables, in particular, fertility (Gille, 1987)

However, in response to the request from developing countries for population assistance and the concerns about the consequences of rapid population growth, the United Nations Population Trust Fund was transformed into the United Nations Fund for Population Activities (UNFPA) in 1970. By 1972, more than 50 countries had made commitments to contribute to the Fund. The Fund's mandate from the United Nations Economic and Social Council required it

> to promote awareness, both in developed and developing countries, of the social, economic and environmental implications of national and international population problems, of the human rights aspects of family planning, and of possible strategies to deal with them in accordance with the plans and priorities of each country; [and] to extend systematic and sustained assistance to developing countries at their request in dealing with their population problems; such assistance to be afforded in forms and by means requested by the recipient countries and best suited to meet the individual country's needs (ECOSOC Resolution 1763 (LIV) of 18 May 1973).

A turning point in the consideration of population policy issues at the global level occurred at the sixteenth session of the United Nations Population Commission in 1971. At this session, population policy was no longer treated in a cautious and indirect manner but as an explicit major concern (United Nations, 1987). The Commission discussed the role of population in the International Development Strategy for the Second United Nations Development Decade, as well as activities to commemorate the World Population Year in 1974, so designated by the General Assembly (GA Resolution 2683 (XXV) of 11 December 1970). The Commission hoped to encourage the development of national population policies that were suited to specific country needs and conditions, within the framework of a "global population strategy", which would slow down and stabilize world population growth (United Nations, 1987). A complete review of policies intended to affect fertility—including such controversial methods as abortion and sterilization—was published by the Secretariat in 1972 (United Nations, 1987).

By 1974, international public opinion generally favoured measures to deal with rapid population growth. Moreover, Governments were more favourable towards adopting population policies, while opposition was diminishing (Macura, 1987). The World Population Conference, held in Bucharest in 1974, focused on policy issues rather than scientific questions. The participants were Government representatives and political leaders rather than technical experts and demographers, as was the case in the two earlier United Nations Population Conferences. In a number of countries, particularly in Asia, as well as in Latin America and some countries of Northern Africa, national policy makers were becoming increasingly aware of the consequences of rapid population growth. Moreover, by the 1970s, modern contraceptives had been further improved and were more widely

available, thus facilitating the promotion of their use (Finkle and McIntosh, 2002).

The negotiations in Bucharest were mainly focused on the rationale for family planning—that is, whether rapid population growth was the major reason for the slow pace of economic development. Representatives agreed that development and not population control was the overriding objective of the World Population Plan of Action (WPPA), the policy document produced by the Bucharest conference. The WPPA also stressed national sovereignty in domestic policy making. This was particularly important for the newly independent countries of Africa, which perceived the WPPA as a threat to their national sovereignty (Finkle and McIntosh, 2002). The WPPA recommended that all countries respect and ensure "the right of persons to determine, in a free, informed and responsible manner, the number and spacing of their children…" (paragraph 29a). The document encouraged further research to evaluate available family planning techniques (paragraph 78i), but it did not go so far as to provide any recommendation in favour of family planning and the provision of modern family planning methods.

The WPPA was a major international strategy; the final text did not emphasize population policies, but highlighted aspects of social and economic policy (Macura, 1987). This was due in part to the need to develop a consensus among mainly Western states, who believed that rapid population growth was a serious impediment to development, and a group of developing countries, led by Algeria and Argentina, who believed that the population problem was a consequence, not a cause, of underdevelopment, and that it could be solved by a new international economic order (Macura, 1987). Nevertheless, the WPPA had an enormous impact on world opinion, and modifying population growth was now considered a legitimate concern for Government policy. Moreover, international population assistance had become widespread in many developing countries.

3. Population policies, 1980-1990

By the early 1980s, world population growth had declined appreciably, despite the unfavourable economic conditions prevailing at that time. Ten years after the Bucharest conference, at the International Conference on Population in Mexico City in 1984, Government representatives again debated questions of population and family planning (United Nations, 1984). Four expert group meetings and five regional meetings preceded and prepared for the conference in Mexico City. The two main objectives of the conference were to review and appraise the WPPA and to make recommendations for the further implementation of the Plan (Macura, 1987).

The development of population policies and programmes and the expansion of international cooperation and assistance were at the top of the agenda. The final document went beyond the basic concepts of reproduction and family planning already set forth in the WPPA. In the Mexico City document, family planning programmes and the provision of modern contraception were now strongly advocated as the right of all couples and individuals (recommendations 25 and 30). As in the Bucharest document, further research in human reproduction and fertility regulation was encouraged (recommendation 69). The references to urgency and universality and the specific reference to the rights of individuals were introduced at Mexico City; they were not found in the WPPA. In the years following the adoption of the WPPA, some countries in Africa (for example, Burundi, Burkina Faso, Central African Republic and Niger) reversed their stance and adopted policies more favourable towards contraception. In addition, several countries in Latin America (Guyana, Suriname and Uruguay), which had maintained a rather conservative approach, also moved towards supporting contraceptive use.

4. Population policies, 1990-2000

The final major global United Nations population conference of the twentieth century, the International Conference on Population and Development held in Cairo in 1994, produced the Programme of Action (United Nations, 1994a). This Programme built upon and further extended the goals and recommendations of the previous intergovernmental conferences on population and development (United Nations, 1999). Two prominent aspects of the Programme of Action, the integration of population and development issues and the attention given to women, have their roots in both the earlier 1974 and 1984 United Nations population conferences (United Nations, 1999). However, its recommendations break new ground in several areas. Integrating family planning and women's health services and promoting the rights of women were key issues on the agenda discussed at the conference. The Programme of Action

strongly urged Governments to make reproductive health services available to "all individuals of appropriate ages" (paragraph 7.6). All Governments were encouraged to assess the unmet need for good-quality family-planning services (paragraph 7.16) and to take steps to meet this need. They were also encouraged to expand the provision of maternal and child health services in the context of primary health care (paragraph 8.22). Moreover, for the first time in such a document, the Programme of Action mentioned men's fertility, citing the need to assign high priority to the development of new methods for fertility regulation for men (paragraph 12.14).

The language of the Programme of Action is striking because of the openness and clarity with which it addresses numerous sensitive issues (United Nations, 1995). In particular, it denounces social ills such as infanticide, rape, incest, trafficking in persons, use of children in prostitution and pornography and sexual harassment of women. It also condemns harmful practices meant to control women's sexuality, such as female genital mutilation. The document emphasizes the value of open and active discussion of sensitive issues as a positive step in increasing knowledge and understanding of human reproductive behaviour. In this respect, it differs markedly from the World Population Plan of Action and the Mexico City recommendations, neither of which used the words "sexual" or "sexuality."

Several important new concepts were introduced in the Programme of Action. The empowerment of women as "a cornerstone of population and development-related programmes", along with gender equality and equity, provides the basis for addressing numerous themes related to women, including education for girls, the pressures on women's time, gender-based disparities in income and the safety of women in abusive relationships. In the area of reproduction and health, the new concepts of safe motherhood and unsafe abortion were introduced and elicited much discussion and negotiation. Women's issues are interwoven throughout the text, so that approximately one third of the 243 recommendations for action explicitly mention women or girls (United Nations, 1995).

The extensive and varied preparatory process for the International Conference on Population and Development at the national, regional and international levels gave a great impetus to Governments to review and to reformulate their population policies, especially their approach to fertility regulation. This was particularly true for several francophone countries in Africa and some countries in Western Asia, which removed legal barriers to the use of modern contraception.

5. Population policies at the beginning of the 21st century

Since the International Conference on Population and Development, considerable progress has been achieved in many countries in implementing the objectives of the Programme of Action. A review and appraisal of this progress undertaken by the United Nations five years after the International Conference on Population and Development found that reproductive health programmes had been established in many countries, with rising contraceptive use among couples indicating greater accessibility to family planning and more freedom to choose the number and spacing of the children they desired (United Nations, 1999). However, many births were still unwanted or mistimed, and modern family planning methods remained unavailable to large numbers of couples worldwide (United Nations, 1999). The threat of sexually transmitted infections (STIs), including HIV/AIDS, has increased in many countries, but access to information and services was still restricted for adolescents, in spite of their enhanced biological susceptibility to STIs.

More recently, regional conferences have addressed the progress made in Africa and in Asia and the Pacific. A meeting in January 2002 in Yaounde, Cameroon, reported increased awareness among policy makers of the concepts of reproductive health and reproductive rights and more political commitment at the highest level among African countries. Most countries in Africa have revised their population policies and have incorporated reproductive health programmes and strategies (United Nations Economic Commission for Africa, 2002b). For example, information and education campaigns have been undertaken in a number of countries, including Gabon, Nigeria, South Africa and the United Republic of Tanzania, to sensitize the population about reproductive health and HIV/AIDS. Côte d'Ivoire and Lesotho have established counseling centres for the most vulnerable segments of the population, especially young people. Mali has launched a new initiative to promote the status of women. Lesotho has also introduced training in contraceptive logistics management for family planning service providers; improved access to family planning services at the

community level; and developed a Parent Education Programme manual (United Nations Economic Commission for Africa, 2002b). However, despite efforts at all levels to improve reproductive health and eradicate HIV/AIDS, Africa still faces a number of challenges not found in many other regions, including the spreading HIV/AIDS pandemic, conflict, food insecurity, poverty and a substantial burden of debt.

In Asia and the Pacific, the Fifth Asian and Pacific Population Conference, held in Bangkok in December 2002, noted that since International Conference on Population and Development, some countries had successfully integrated family planning with other components of reproductive health services. For example, the Islamic Republic of Iran, the Republic of Korea, Sri Lanka and Thailand are providing integrated services, whereas in other countries—for example, Indonesia and Viet Nam—several Government organizations were responsible for different service components (United Nations Economic and Social Commission for Asia and the Pacific, 2002). Other countries, including Cambodia, Lao People's Democratic Republic and Mongolia, had incorporated quality-of-care issues in the training curricula of service providers. Bangladesh, Philippines, Thailand and Viet Nam had encouraged the involvement of communities and the private sector and introduced social-marketing mechanisms to provide non-clinical methods of contraception (United Nations Economic and Social Commission for Asia and the Pacific, 2002). A survey of countries in the region found that, although there was a clear desire to provide integrated reproductive health services, major obstacles—especially management arrangements, financial constraints, training of service providers and logistic systems—hindered progress. Many countries with high fertility and low contraceptive prevalence reported that their programmes were not ready for integration and considered that the move towards a reproductive health approach would dilute family planning efforts.

C. Government policies in developing countries

1. Africa

With the exception of Equatorial Guinea, Gabon and Libyan Arab Jamahiriya, all countries in Africa either directly or indirectly support the distribution of contraceptives. The large majority of these countries—48 out of 53—provide direct government support for the distribution of family planning methods, whereas several countries—Somalia in Eastern Africa, Cameroon, Central African Republic and Chad in Middle Africa and Sierra Leone in Western Africa—make contraception available by supporting the activities of non-governmental organisations.

In the early 1970s, the situation was quite different (United Nations Economic Commission for Africa, 2002a). Only 26 countries out of 48 provided direct or indirect support for contraception, while almost half the countries prohibited contraception. The earliest support for contraceptive methods was in the countries of Southern and Northern Africa. The countries of Middle and Western Africa have traditionally given little support. One reason for the lack of support was the perception in the 1970s that Africa was underpopulated, and that overpopulation was mainly a matter of uneven spatial distribution. Only a few countries in Africa had explicit population policies targeted towards curbing population growth. Several countries supported family planning programmes as part of basic reproductive health services, but most of this support was indirect and was channeled through NGOs. This approach was preferred even by countries that had no explicit policies in place to alter population growth or fertility.

By the mid 1970s, nine countries (Democratic Republic of the Congo, Ghana, Kenya, Madagascar, Mauritius, Seychelles, Uganda, the United Republic of Tanzania and Zambia) had adopted legislation that was supportive of family planning. In Southern Africa, all countries excepting Namibia, which only gained independence in 1990, were early supporters of contraception. Countries in Northern Africa, with the exception of the Libyan Arab Jamahiriya, were also early supporters of family planning. Most Governments, however, believed that problems related to population were due to a lack of economic growth and development. This was the essential message of the First African Population Conference held in Ghana in 1971. The conference also acknowledged the need for trained professionals in demography and demonstrated that African Governments were becoming increasingly more aware of population problems.

Some Governments, particularly in the francophone countries of Middle and Western Africa, had pronatalist policies inherited from their

colonial past. Family planning activities and contraceptives were not permitted in the former French colonies because of the existing 1920 French law forbidding both abortion and the promotion of contraception. This situation has changed over time. Countries have either repealed the law or no longer enforce it. A pioneer was Tunisia, which in 1961 repealed the former colonial law that prohibited the advertisement of contraception. Among the francophone countries to follow suit were Mali in 1972, Cameroon and Senegal in 1980, Côte d'Ivoire in 1982 and Burkina Faso in 1986. All these countries abrogated laws that had made contraceptives illegal.

In many African countries, family planning services and contraceptives first became available after the Alma Ata Conference in 1978 (World Health Organization, 1978), when many Governments, particularly in Africa, adopted a primary health-care strategy with integrated family planning services. This approach provided the framework for countries to re-orient official policies: contraception was made available as a way to assist couples to have the number and spacing of children they desired, and as a means to improve the quality of life for women and children in particular. Thus, Governments such as Benin, Cameroon and Mali, which while pro-natalist, began to provide indirect support for family planning services.

A major milestone in the history of contraceptive policies was the Second African Population Conference held in Arusha in early 1984 (United Nations Economic Commission for Africa, 1984). This conference was also an essential part of the preparatory process leading up to the international conference in Mexico City later that year. The Arusha Conference adopted the Kilimanjaro Programme of Action, which provided the framework for the formulation and implementation of population policies and programmes in Africa. The Programme of Action was still strongly linked to the socio-economic development of the region, but it increasingly recognized the importance of family planning services. Recommendations concerning family planning included the following:

- Governments should acknowledge that family planning and child spacing strengthen the stability of the family;

- Countries should incorporate family planning services into maternal and child health-care services;

- Governments should ensure the availability and accessibility of family planning services to all couples or individuals seeking them and should offer services free or at subsidized prices;

- Governmental national family planning programmes should make available a variety of methods to allow choice to all users.

The integration of family planning programmes into maternal and child health services during the late 1970s and early 1980s put new emphasis on allowing Governments to assist couples to plan the size of their families and the timing of childbirth. This provided an incentive for some Governments with restrictive policies to revise their policies. The clear endorsement of family planning programmes, both in the Kilimanjaro Programme of Action and the Mexico City recommendations, gave Governments a strong rationale to modify their stance. Some Governments moved from prohibiting the distribution of contraception towards official support. For example, in Eastern Africa, Burundi, Comoros, Malawi, Somalia and Zimbabwe began providing support, as did Cameroon, Central African Republic and Sâo Tome and Principe in Middle Africa. In Western Africa, Guinea and Niger also modified their policies in this direction. Some countries that had permitted the distribution of contraceptives through NGOs, established Government facilities to provide family planning services. These countries included Angola, Democratic Republic of the Congo, Ethiopia, Nigeria, Senegal, Sierra Leone and Togo.

Other francophone countries—Benin, Burkina Faso, Côte d'Ivoire and Chad—derived considerable impetus from the preparatory process and follow-up events surrounding the international population conference in 1984. The Governments of these countries began to support the work of non-governmental organizations in providing contraceptive services and eventually moved towards directly providing family planning services. Only Djibouti tightened policies in the 1980s and abandoned all governmental support until the late 1990s, when it adopted a more supportive position.

The increased availability of timely and accurate population data and demographic analysis afforded policy makers the possibility of understanding the relationships between population and development and the consequences of high fertility, young age structure, urbanization and the spread of the HIV/AIDS virus. These pressing demographic concerns were discussed at the Third African Population Conference held in Dakar in 1992 (United Nations, 1992). The outcome of the conference, the Dakar/Ngor Declaration, clearly reflected the growing commitment of African heads of state to finding solutions for the most urgent demographic concerns in order to enhance the quality of life. The Declaration recommended the establishment of a follow-up mechanism to accelerate the implementation of the Kilimanjaro programme, and, for the first time in the African context, it recommended quantitative population targets:

- Recommendation 1: Population policies and programmes should be integrated into development strategies. They should focus on strengthening social sectors with a view to influencing human development and they should work towards the solution of the population problem by setting quantified national objectives for the reduction of population growth. The aim is to bring down the regional natural growth rate from 3.0 to 2.5 per cent by the year 2000 and to 2.0 per cent by the year 2010.

The recommendations also established quantitative targets for contraceptive prevalence for the first time:

- Recommendation 9: Steps should be taken to make available and promote the use of all tested available contraceptive and fertility regulation methods, including traditional and natural family planning methods. A choice of methods should be available, and a goal should be set for doubling regional contraceptive prevalence, from about 10 to about 20 per cent by the year 2000 and 40 per cent by the year 2010.

2. Asia and Oceania

Asia and Oceania encompass a large variety of countries, including developed countries, less developed countries and least developed countries. They represent a wide variety of socio-economic situations and cultural diversity and are home to some of the most populous countries in the world—China, India, Japan and Indonesia—as well as countries with small populations, such as Brunei Darussalam, Maldives and the small island nations in Oceania. Western Asian countries, which held separate regional conference to address their population concerns, are discussed in the next section of this chapter.

Most countries in the regions supported access to contraceptive methods in 2001, and most Governments provided direct support. Of the 45 countries in the regions (not including Western Asia), 80 per cent directly supported access and 13 per cent provided indirect support. Only Brunei Darussalam, Lao People's Democratic Republic and Turkmenistan provided no support. All countries in Eastern Asia and Oceania provided either direct or indirect support for access to contraceptive methods, and all three of the most populous countries (China, India and Indonesia) provided direct support.

Countries in these regions were among the first to recognize the negative consequences of rapid population growth and to search for solutions. In general, there has been more emphasis in these regions than others on modifying fertility to reduce population growth. By the early 1960s, knowledge and understanding of the demographic situation was common in some of the most populous Asian countries. The impact of high population growth on socio-economic development was at the top of the agenda at the First Asian Population Conference in 1963. By the early 1970s, the majority of countries had initiated Government programmes to provide family planning services and contraceptives.

The declarations of the various regional population conferences reflect a strong commitment to support family planning. The recommendations of the Second Asian Population Conference held in Tokyo in 1972 emphasized the need for strong family planning programmes to curb high population growth (United Nations, 1972). At the Third Asian and Pacific Population Conference, held in Colombo in September 1982 (United Nations Economic and Social Commission for Asia and the Pacific, 1982), the approach widened from policies to reduce fertility to ones that integrated population and development. The Conference's recommendations again stressed the need to provide family planning information and to make available a variety of methods. Moreover, a broader approach that linked family planning efforts to

health programmes and other aspects of social development was considered crucial for improving the quality of life. This new focus was reflected in the change of policies in Maldives and Myanmar, which were among the last countries in the region to adopt supportive policies.

The Bali Declaration on Population and Sustainable Development, which was the final document adopted at the Fourth Asian and Pacific Population Conference in 1992, further stressed the fact that family planning and maternal and child health programmes have played an integral role in influencing population growth and improving the quality of life (United Nations, 1992). For the first time, special attention was given to the need to design information programmes and services for youth and adolescents (recommendation 23).

3. Western Asia

Western Asian countries supported access to contraception by a large majority (88 per cent) in 2001, even though there are as many countries in the region that want to raise fertility as want to lower it. (Two countries, Azerbaijan and Qatar, want to maintain fertility at the current level; both provide direct support for contraceptives.) Of the countries that provide support, two thirds provide direct support. Only Oman and United Arab Emirates provide no support for contraceptive access. Saudi Arabia, which had limited access to contraceptive methods from 1976 to 1996, was providing indirect support by 2001.

In the early 1970s, many countries of Western Asia considered their population growth to be too low and provided no support for contraception and family planning. But in the following years, awareness of the negative consequences of high population growth increased. Bahrain, Iraq, Jordan and the Syrian Arab Republic were early supporters of policies in favour of contraception. For many countries in the region, however, the most urgent population issues were spatial distribution, internal migration and refugees rather than fertility and family planning. This was the background for the First Regional Population Conference in Beirut in early 1974 (United Nations Economic Commission for Western Asia, 1974) and the Regional Consultation Meeting held in Damascus (United Nations, 1974b) that same year.

At these conferences there was much debate on the terminology of family planning. Up until that time, family planning had been based on a broad social welfare and health outlook. Only later in the 1970s were national policies formulated to reduce population growth. Under the topic "Population and Health," the conferences agreed to "give attention to family health and its relationship to the size of the family and spacing between pregnancies". Family planning as a separate issue and the use of modern contraception were not further discussed at these two meetings.

As a consequence of the preparatory process leading to the International Population Conference held in Mexico City in 1984, some countries increased support for family planning activities and the use of contraception. In the late 1980s, for example, Bahrain modified its policies and moved from providing indirect support to direct governmental support for the use of contraception.

The introduction to the Amman Declaration of Population in the Arab World, which was the outcome of the Second Regional Population Conference held in Amman in 1984, emphasized that "as a result of this rapid and continuous increase in the population, it was imperative to formulate appropriate plans and policies to meet their basic human needs…" (United Nations Economic Commission for Western Asia, 1984). The Preamble of the declaration states that "the Regional Population Conference in the Arab World is convinced that the new circumstances…make it necessary to consider the formulation of an Arab Plan of Action for population policies in the coming decade." The consensus reached by participating member states on the issue of birth control and family planning demonstrated a general shift towards support for birth control in the context of primary health care, particularly to improve the health conditions for women and children.

- Principle 8: "The practice of birth control by couples is a human right guaranteed by international covenants…The Arab countries should endeavor to safeguard this right by providing facilities for the dissemination of knowledge and effective means for the practice of family planning on the basis of free choice…"

The next round of regional and sub-regional meetings was held in the early 1990s in preparation for the International Conference on Population and Development held in Cairo in 1994. Rapid population growth and high infant and child

mortality in the region necessitated urgent action. The regional Arab Population Conference convened in Amman in 1994 adopted the Second Amman Declaration on Population and Development (United Nations, 1994b). In point 8 of the General Principles, the Declaration articulated the "right of couples to choose freely the number and spacing of their children. To enable them to exercise this right, they must have access to the necessary education, information and services. Present and future demand for family planning must be met. The Arab States should be called upon…to provide for family planning services as a basic human right of couples."

One objective of the Declaration was for countries to achieve appropriate population growth rates. In the case of countries wishing to reduce population growth, family planning services would need to be developed and enhanced. Several recommendations strongly supported the provision of information on and access to family planning within the maternal and child health-care framework, as well as the integration of family planning services into the primary health-care system (recommendations 36d, 40, 41). Cooperation with non-governmental organizations on these matters was recommended (recommendation 43).

These principles—particularly placing family planning and contraception services within the framework of primary health care—provided the impetus for some countries to begin supporting contraceptive services, at least indirectly. In the late 1990s, Kuwait and Qatar made family planning services and counseling available through public and private health facilities. The Government of Saudi Arabia moved from a rather restrictive approach to indirect support for activities conducted by non-governmental organizations. Iraq, after a decade of rather restrictive policies, moved to direct support of contraception.

4. Latin America and the Caribbean

Support for access to contraceptive methods was very strong in Latin America and the Caribbean in 2001. Of 33 countries in the region, 31 (94 per cent) provided direct support and 2 (6 per cent) provided indirect support. Support was nearly as strong in 1996, when 29 of 33 offered direct support and 3 provided indirect support. Only Argentina provided no support in 1996. This near unanimity with regard to access to contraceptives shows a dramatic change in the region in the last few decades.

Until the 1960s, many Latin American Governments were generally not supportive of family planning efforts and the use of contraception. However, rapid population growth and its socio-economic implications, particularly in urban areas, persuaded some Governments to consider the relationships between population and development. Consequently, contraception has been widely available in Government facilities in most of the countries in Latin America and the Caribbean since the early 1970s. Only the Bahamas had initially channelled support through non-governmental institutions. The region is noteworthy for Government recognition of the unmet demand for contraceptives and family planning services.

Several countries in Latin America and the Caribbean, however, did not provide access to contraceptive methods until the early or mid 1980s. Among them were Argentina, Belize, Bolivia, Guyana, Suriname and Uruguay. Nevertheless, by 2001, almost all countries in Central and South America, with the exception of Argentina and Belize, had policies in place to provide direct support for contraception.

The Economic Commission for Latin America and the Caribbean has played an important role in providing research and analysis on the interrelations between population and development. High population growth, high abortion rates and significant rural-urban migration flows were the background against which population issues and their social and economic implications were discussed at the Latin American Preparatory Meeting for the World Population Conference, held in Costa Rica in 1974 (United Nations Economic Commission for Latin America and the Caribbean, 1974). Most Governments acknowledged the need to support family planning programmes in general, but their strategies for implementation differed widely. However, the need for families to "decide freely on the number and spacing of the children" (paragraph 22) was recognized by all countries. In the decade following the conference, many countries gradually adopted policies in support of family planning and contraception.

In the early 1980s, during the preparatory process for the Third International Population Conference in Mexico City, some countries that

were not supportive of family planning moved towards providing access to contraception through Government facilities. These countries included Bolivia, Guyana and Uruguay. The recommendation referring to contraception adopted at the regional preparatory meeting strongly supported access to contraception as part of the basic human right to decide freely on the number and spacing of children (United Nations Economic Commission for Latin America and the Caribbean, 1984). By this time almost all countries had official maternal and child health/family planning programmes, whose common objectives were to provide family planning information and services and to improve coverage in rural areas and marginal urban areas. However, the severe economic crisis of the 1980s forced some Governments to cut back expenditures in this area, which seriously curtailed the availability of services.

In spite of budget constraints, Governments strongly recommended support for reproductive health care and family planning (recommendations 3, 6, 20 and 21) during the Latin American and Caribbean Regional Conference on Population and Development, held in Mexico City in 1993. The document further considered that "the opportunity to regulate fertility [is] a universally recognized human right" (recommendation 35). A major objective was to improve living conditions, particularly for marginalized segments of the population in rural and less developed urban areas.

D. Government policies in developed countries

1. Europe and Northern America

Nearly three fourths (73 per cent) of European countries provided either direct or indirect support for contraceptive methods by 1996. By 2001 the proportion rose to 88 per cent (see annex table 4). Ireland, the last country in Europe to permit the use of modern contraception, began providing direct support in the early 1990s. Several countries, however, provide no support for contraceptive methods, including Andorra, Germany, Greece, Italy, Slovakia and Switzerland. Others—for example, Bosnia and Herzegovina, Czech Republic, France, Luxembourg and the Netherlands—provide only indirect support. The majority of countries, however, provide direct Government support for contraceptives.

In Eastern European countries, liberal abortion laws were enacted during the 1950s, and by the mid-1970s, abortion ratios in Eastern Europe and the Union of Soviet Socialist Republics were among the highest in the world (United Nations, 1992). Abortion became a major means of birth regulation, partly because modern contraceptives (other than condoms) were essentially unavailable. Only, in the 1980s, did the situation begin to improve (United Nations, 1996). Prevalence rates for modern contraceptives, however, continue to be low in Eastern Europe compared with rates in other developed countries.

Following the dissolution of the former Union of Soviet Socialist Republics and Yugoslavia, and the division of Czechoslovakia, the number of countries that provided direct support for family planning through Government facilities increased significantly. A more recent development, in the second half of the 1990s, is the shift from direct to indirect support, as the State partially withdrew from health and welfare activities in former communist countries. Furthermore, in many countries of Europe, the widespread use of modern contraceptives and the increased involvement of non-governmental organizations and the private sector have contributed to a decline in Government support. Countries that shifted from direct to indirect support between 1996 and 2001 include Austria, Canada, Denmark, Kazakhstan, Latvia and Lithuania (see annex table 4).

The United Nations Economic Commission for Europe has convened a series of intergovernmental meetings on population-related issues and policies over the last three decades. The regional preparatory meeting for the Bucharest conference was held in Geneva in 1974 (United Nations, 1974b); the regional event for the Mexico City conference was conducted in Sofia in 1983; and consultations leading to the International Conference on Population and Development in Cairo were held in Geneva in 1993 (United Nations, 1994c).

The regional meeting in 1974 was one of the first among the member States of the ECE to address broad population questions from a policy point of view. Many delegations were concerned about declining population growth in some countries in the region, as well as high population growth in less developed countries. However, there was full

agreement that population policies should be integrated with development policies as a whole and that "nations have the sovereign right to determine their population policies" (Principle h). Reference to family planning and contraception was made in the framework of maternal and child health care: "good maternal and child health contribute to the well-being of the family and the nation and are facilitated by small numbers of births" (Principle f). It was also mentioned in the context of improving the status of women: status would be improved by giving women "the opportunity to plan births" (Principle g). An emphasis on curbing population growth rates in the countries where they were still high was included in the Recommendations for Action in the final document.

In the early 1980s many Governments realized that their countries were experiencing major demographic changes. Declining fertility resulted in low population growth and the ageing of their populations. These topics, as well as several others, such as the high number of unwanted pregnancies in some member States and questions of population distribution and internal and international migration, were priority areas dealt with at the Second Regional Meeting on Population in 1983 (United Nations Economic Commission for Europe, 1983). Family planning was also discussed at this meeting, and all participating Governments considered that it was "a fundamental right of all couples and individuals to decide freely and responsibly the number and spacing of their children" (recommendation 32). They further considered that access to relevant information as well as to effective means of birth control should be assured by the Governments (recommendation 37). With regard to the need for international cooperation, all heads of state supported the view that "the rate of population growth in many developing countries is still very high and continues to be an important obstacle to the improvement of life" (recommendation 66). Delegates strongly endorsed the call to increase international assistance for population activities.

The European Population Conference, held in Geneva in 1993 (United Nations, 1994c), continued to endorse reproductive health and family planning (recommendations 8 to 10), but it was now in the context of reproductive rights and reproductive health. The conference recommended that Governments adopt measures to make available efficient family planning methods to all in need and to provide access to appropriate information and services related to reproductive health through governmental and non-governmental channels. It was stressed that all services should be available only upon request and that no "coercive, discriminatory or prejudicial approaches" should be applied (recommendations 56 and 57). As was the case in 1983, all Governments strongly supported the continuation of international cooperation in the field of population services (recommendation 47) in developing countries.

There is no direct relationship between the level of governmental support and the use of contraceptive methods in Europe. Some countries with supportive policies do not necessarily have the highest prevalence rates. This is the case in Belarus, Poland, Portugal, Romania and Ukraine. Countries that have continuously supported family planning services, such as Canada, the United States and the Scandinavian countries, are more likely to have high prevalence rates.

2. Australia, New Zealand and Japan

The Governments of Australia and New Zealand have had similar views on their level of fertility. Both countries have considered the level of fertility to be satisfactory since 1976. In Japan, however, the Government changed its view in 1996 from satisfactory to too low. The three countries do not intervene to modify fertility, but all provide some support for access to contraceptive methods. Support in Australia has been indirect since 1976; Japan and New Zealand, which both provided direct support in 1996, changed to indirect support in 2001.

The low birth rate in Japan led the Government to propose legislation in 2002 that would review working conditions of both men and women with the aim of making careers more compatible with child rearing. All major companies would be asked to develop plans to improve child-care leave, provide shorter working hours for parents and offer work-share arrangements. The plan, known as the Plus One Proposal to End the Low Birth Rate, would encourage couples to have an additional child.

In Australia, a range of family-friendly measures aims to allow parents to choose between labour market activities or child-rearing, although options for part-time work and flexible working hours are not widely available. Social support is targeted on low-income families and especially single parents

(Organisation for Economic Co-operation and Development, 2002). Recent data indicating that Australia's total fertility rate had dropped to 1.73 children per woman have increased pressure on the Government to implement a scheme for paid maternity.

E. SUMMARY AND CONCLUSIONS

The second half of the twentieth century has been a period of unprecedented population change. During the past 50 years, the world experienced the highest rates of population growth and the largest annual population increases ever recorded in history. In response to these and other unparalleled demographic changes, Governments formulated a variety of policies and established a broad range of programmes. These policies and programmes were aimed at national development objectives as well as improving the well-being of the population. Reproductive behaviour, for example, while once viewed as a private matter outside the purview of Government action, became widely accepted as a major concern of Governments.

Virtually all countries have shifted their policies toward supporting family planning. By 2001, 91 per cent of Governments were providing support either directly or indirectly for contraceptive methods. The practice of limiting access to family planning methods has almost vanished.

At the beginning of the 21st century, the most significant demographic concern in the world is HIV/AIDS. The HIV/AIDS crisis has spawned renewed interest in barrier methods of contraception, such as the condom. A recent United Nations study found that despite the considerable efforts that have been devoted to promoting the use of condoms, as part of HIV/AIDS education and prevention campaigns, condom use among couples remains low in affected countries (United Nations, 2002b)[1]. While AIDS awareness is rising, behaviour, for the most part remains unchanged and risky.

The United Nations has been instrumental in promoting the international acceptance of family planning and the intervention of Governments to deal with a wide spectrum of their population issues. Through the convening of international and inter-governmental conferences, and the wide dissemination of research on demographic trends, population projections and the evolution of national population policies, the United Nations helped foster a mind-set on the issue of lowering high rates of population growth and fertility, as a means of facilitating socio-economic development, and also as a means of helping couples to achieve their desired family sizes. As a result, the international community, non-governmental organizations and civil society were mobilized to provide resources and marshall grass roots support for family planning efforts in developing countries based on the principle of human rights. This in turn led to the wide distribution and acceptance of effective, safe, low-cost and easy to use contraceptives. The United Nations also played a crucial role in situating family planning programmes within the wider framework of reproductive health and reproductive rights.

Adopting a supportive Government policy, however, is only the first step in ensuring the success of family planning programmes. Other necessary elements include implementing the programme and the commitment of sufficient resources over time. A variety of other factors also need to be considered, including the quality of care, traditional cultural attitudes towards family planning, ensuring client confidentiality, financial constraints, costs to users, the condition of the health care infrastructure, partnerships with non-governmental organizations and international donors, and civil conflicts that may disrupt the provision of supplies and services. Finally, measures for the monitoring and evaluation of programmes beyond their impact on fertility need to be elaborated.

First established at the World Population Conference, held at Bucharest in 1974, Principle 8 of the International Conference on Population and Development Programme of Action stressed that States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

More recently, the Secretary-General of the United Nations noted in his message to the Fifth Asian and Pacific Population Conference (Ministerial segment, Bangkok, Thailand, 11-17 December 2002), "the Millennium Development Goals,…cannot be achieved if questions of

population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights and greater investment in education and health, including reproductive health and family planning".

NOTE

[1] For a discussion on the linkages between reproductive health care and HIV/AIDS programmes, as well as on levels and trends of contraceptive use, see *World Population Monitoring 2002, Reproductive rights and reproductive health: selected aspects* (United Nations publication, ESA/P/WP.171).

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ANNEX I

Estimates and projections of the number of married women of reproductive age

Contraceptive prevalence is most often reported for the base population of married women of reproductive age (MWRA). In order to estimate the total number of contraceptive users or users of particular methods, such prevalence rates must be multiplied by the total number of MWRA. MWRA figures are also needed to calculate regional and world average prevalence estimates from country-specific survey results.

Estimates of the number of women of reproductive age (WRA), by five-year age groups, are provided as part of the estimates and projections of population produced by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat. For most countries marital status data are obtained through censuses and surveys. Such information, especially those from censuses, is collected, published and maintained by the Statistics Division of the Department of Economic Affairs of the United Nations Secretariat in its Demographic Database. In addition the Population Division has compiled marital status information from demographic surveys. Those data together with data from the Statistics Division make up the Population Division's database on marriage.

For purposes of estimating and projecting the number of contraceptive users the proportions of women aged 15-49 currently married or in union were updated from the Statistics Division Demographic Database and separate survey publications. Reasonably up-to-date marital status figures were available for about 99 per cent of the world population.[1] MWRA estimates and projections in this review were prepared for individual countries, not just for regions, on an age-specific basis, in order to take account of the substantial changes in age structure in the reproductive ages that will occur during the projection period. It also takes into account actual recent trends in the proportions married. These considerations imply that, at least for the near-term future, the projections for each country should be more or less in line with recent trends. For instance, in a country where the proportion married at young ages has been falling rapidly, the projections should not assume a sudden reversal of that trend. The projection procedures also made assumptions about changes in age-specific proportions married in countries for which no trend data were available. Given that age at marriage has in fact been rising in most developing countries (see United Nations, 2003), it seemed reasonable to assume that the proportions married would decline in the developing countries, on average.

It was decided to use a model pattern of age-specific proportions married towards which all countries would eventually converge. This model provides a basis for projecting changes in proportions married for those countries where direct information about trends was unavailable, and also provides a simple mechanism for moderating the projections in order to avoid the extreme results that might, in some countries, result from projecting the future situation from rapid changes in the past. However, the projections assume that the model pattern would not be reached until 2050, 25 years beyond the end of the projection period established in chapter IV. Consequently, the model used was the empirical average set of age-specific proportions married for countries in the more developed regions, based on recent data. Some of the implications of using this model are discussed briefly in the section below. It should be noted, however, that the projection procedures described below ensure that the near-term projection results are determined primarily by the trends observed in each country. The choice of alternative models has little effect until the later years of the projection period.

A. Assumptions and procedures for projecting proportions currently in union

The projection is based on actual age-specific proportions married (AS-PMARs) at two time points, if available, and a model pattern that is assumed to be reached in 2050, 25 years after the end of the period for which projection results are shown. The model pattern is the set of average AS-PMARs for the more developed regions around 2000.

An examination of the proportions married (or currently in union) in the more developed countries showed the existence of two patterns: first, where the proportion married or in union at young ages is

very low and second, where the proportion formally married at young ages is low but where the proportion of the young cohabiting is fairly high resulting in a high proportion in union at young ages. Thus, two variants of the model proportions to be reached were used. Model I where age at marriage is relatively low accompanied by a high prevalence of cohabitation and Model II where age at marriage is high accompanied by a low prevalence of cohabitation. Model I was applied to countries in Asia whereas Model II was applied to countries in Africa and Latin America and the Caribbean.

The model proportions to be reached in 2050 are:

	Percentage currently in union		
Age	*All developed countries*	*Model I*	*Model II*
15-19	6.4	3.1	7.7
20-24	35.6	21.7	40.2
25-29	65.7	55.9	68.8
30-34	78.1	76.6	78.5
35-39	80.3	81.8	79.8
40-44	79.7	82.3	78.9
45-49	78.4	83.9	76.6

The model proportions married are, on average, below those currently observed in the developing regions although many exceptions exist for individual countries.

1. Projection method

The projections for particular countries depend upon the extent of data availability: AS-PMARs for one time point (case I), for two or more time points (case II), or no data available for 1975 or later (case III).

Case I. Countries with AS-PMAR data at one time point only:

Let:

t_0 = year of observed AS-PMARs

t_T = year model pattern reached (= 2050)

p_{it} = proportion currently married, for age group i at time t

p_{iT} = proportion currently married, for age group i in the model population

For $t_0 \leq t \leq t_T$, the proportion of the interval $[t_0,2050]$ that has elapsed at time t is:

$$\tau = (t - t_0)/(t_T - t_0)$$

Assume that the country AS-PMARs approach the model pattern as follows:

$$logit(p_{it}) = logit(p_{i0}) + \tau(logit(p_{iT}) - logit(p_{i_0})) \quad (1)$$

where $logit(p) = ln(p/(1-p))$, by definition, and

$$p = exp(logit(p))/(1+exp(logit(p)))$$

Case II. Countries with trend data (two or more time points, 1975 or later):

Step 1. Choose a pair of time points as discussed below (the most recent and an earlier point).

Step 2. Calculate the projected proportion married as a weighted average of two preliminary projections: (*a*) assuming the observed trend were to continue into the indefinite future; and (*b*) assuming that the proportions would converge to the model pattern, beginning from the most recently observed AS-PMARs, according to the rule in case (I) above.

Projected proportion married at time *t,* p_t, is calculated as:

$$logit(p_t) = (1 - \tau)logit(p'_t) + \tau(logit(p\tau_t)) \quad (2)$$

where p'_t is the projected proportion married at time t, assuming the past trend were to continue into the future under the following rule:

$$logit(p'_t) = \frac{t - t_r}{tr - te}(logit(p_r) - logit(p_e)) + logit(p_r)$$

where t_e is the earlier and t_r the most recent time AS-PMARs were measured.

$p\tau_t$ is the projected proportion married at time *t*, following the rule for case (I) above.

Case III. Countries with no AS-PMAR data for 1975 or later,

Regional averages were attributed, after aggregating the results from the country-specific projections for those countries with AS-PMAR data:

Step 1. For case I and case II countries, the number of women and married women, by five-year age groups, were totalled within each region;

Step 2. AS-PMARS were then calculated for each region and year, and the resulting PMARs were applied to the regional total number of women, by 5-year age group, to derive the final estimated number of married women for the region, for each age group and year;

Step 3. Finally, the regional totals of AS-WRA and AS-MWRA were aggregated further to the larger regional groups shown in the summary tables.

2. Choice of data points to establish a trend

Trends were determined by two time-points at least five years apart. If more than two time points were available, the latest point and a time 10-20 years earlier were chosen, if possible. Some exceptions were made, particularly if comparability of data from particular sources was thought to be a problem. Countries with no acceptable AS-PMAR data for 1975 or later were excluded (case III above). Countries with a population of under 200,000 in 1990 were not included in the projections of AS-PMARs and MWRA, since projections of the numbers of women by five-year age group were not available for countries of that size.[2]

AS-PMARs were available for two or more time-points for countries, including 97 per cent of the population of the developing regions and 97 per cent of more developed regions. AS-PMARs for at least one year, 1975 or later, were available for 99 per cent of the world population.

NOTES

[1]Additional information on the marriage database is available upon request from the Director, Population Division, Department of Economic and Social Affairs, United Nations Secretariat, New York, NY 10017, United States of America.

[2]The projections are based on *World Population Prospects: The 2002 Revision* (United Nations, 2003a).

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ANNEX TABLES

TABLE A.1. TRENDS IN CONTRACEPTIVE PREVALENCE[a], BY COUNTRY

Country	Survey date	Contraceptive prevalence[a] (percentage)		Source[b]
		Any method	Modern methods	
Africa				
Eastern Africa				
Burundi	1987	8.7	1.2	DHS
Burundi	2000	15.7	10.0	MICS
Comoros	1996	21.0	11.4	DHS
Comoros	2000	25.7	19.3	MICS
Eritrea	1995	8.0	4.0	DHS
Eritrea	2002	8.0	5.1	DHS
Ethiopia	1990	4.8	2.9	FHS
Ethiopia	2000	8.1	6.3	DHS
Kenya	1977/1978	6.7	4.2	WFS
Kenya	1984	17.0	9.6	CPS
Kenya	1988/1989	26.9	17.8	DHS
Kenya	1993	32.7	27.3	DHS
Kenya	1998	39.0	31.5	DHS
Madagascar	1992	16.7	5.1	DHS
Madagascar	1997	19.4	9.7	DHS
Madagascar	2000	18.8	11.8	MICS
Malawi	1984	6.9	3.2	FHS
Malawi	1992	13.0	7.4	DHS
Malawi	1996	21.9	14.4	DHS
Malawi	2000	30.6	26.1	DHS
Mauritius	1985	75.3	44.3	CPS
Mauritius	1991	74.7	48.9	CPS
Mozambique	1997	5.6	5.1	DHS
Réunion	1990	66.6	61.7	RES
Rwanda	1983	10.1	0.8	WFS
Rwanda	1992	21.2	12.9	DHS
Rwanda	1996	13.7	7.1	SES
Rwanda	2000	13.2	4.3	DHS
Uganda	1988/1989	4.9	2.5	DHS
Uganda	1995	14.8	7.8	DHS
Uganda	2000/2001	22.8	18.2	DHS
United Republic of Tanzania	1991	10.4	6.6	DHS
United Republic of Tanzania	1996	18.4	13.3	DHS
United Republic of Tanzania	1999	25.4	16.9	DHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage)		Source[b]
		Any method	*Modern methods*	
Zambia	1992	15.2	8.9	DHS
Zambia	1996	25.9	14.4	DHS
Zambia	1999	22.0	17.6	MICS
Zambia	2001/2002	34.2	22.6	DHS
Zimbabwe	1984	38.4	26.6	FHS
Zimbabwe	1988/1989	43.1	36.1	DHS
Zimbabwe	1994	48.1	42.2	DHS
Zimbabwe	1999	53.5	50.4	DHS
Middle Africa				
Angola	1996	8.1	4.0	MICS
Angola	2001	6.2	4.5	MICS
Cameroon	1978	2.4	0.6	WFS
Cameroon	1991	16.1	4.3	DHS
Cameroon	1998	19.3	7.1	DHS
Central African Republic	1994/1995	14.8	3.3	DHS
Central African Republic	2000	27.9	6.9	MICS
Chad	1996/1997	4.1	1.2	DHS
Chad	2000	7.9	2.1	MICS
Democratic Republic of the Congo	1991	7.7	2.0	CDC
Democratic Republic of the Congo	2001	31.4	4.4	MICS
Gabon	2000	32.7	11.8	DHS
Sao Tome and Principe	2000	29.3	27.4	MICS
Northern Africa				
Algeria	1986/1987	35.5	31.3	WFS
Algeria	1992	50.9	43.2	AHS
Algeria	1995	56.9	49.4	RES
Algeria	2000	64.0	50.1	MICS
Egypt	1988/1989	36.7	35.4	DHS
Egypt	1991	47.6	44.3	AHS
Egypt	1992	46.2	44.8	DHS
Egypt	1995	47.9	45.5	DHS
Egypt	2000	56.1	53.9	DHS
Morocco	1987	35.9	28.9	DHS
Morocco	1992	41.5	35.5	DHS
Morocco	1995	50.3	42.4	DHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage)		Source[b]
		Any method	Modern methods	
Sudan	1989/1990	8.7	5.6	DHS
Sudan	1992/1993	9.9	6.9	AHS
Tunisia	1978	31.4	25.1	WFS
Tunisia	1988	49.8	40.4	DHS
Tunisia	1994	60.0	51.0	AHS
Southern Africa				
Botswana	1988	33.0	31.7	FHS
Botswana	2000	40.4	38.8	MICS
Lesotho	1991/1992	23.2	18.9	DHS
Lesotho	2000	30.4	29.5	MICS
South Africa	1988	49.7	48.4	RES
South Africa	1998	56.3	55.1	DHS
Swaziland	1988	19.9	17.2	DHS
Swaziland	2000	27.7	26.0	MICS
Western Africa				
Benin	1996	16.4	3.4	DHS
Benin	2001	18.6	7.2	DHS
Burkina Faso	1993	7.9	4.2	DHS
Burkina Faso	1998/1999	11.9	4.8	DHS
Côte d'Ivoire	1994	11.4	4.2	DHS
Côte d'Ivoire	1998/1999	15.0	7.3	DHS
Gambia	1990	11.8	6.7	FHS
Gambia	2000	9.6	8.9	MICS
Ghana	1988	12.9	5.2	DHS
Ghana	1993	20.3	10.1	DHS
Ghana	1998/1999	22.0	13.3	DHS
Guinea	1992/1993	1.7	1.0	DHS
Guinea	1999	6.2	4.2	DHS
Mali	1987	4.7	1.3	DHS
Mali	1995/1996	6.7	4.5	DHS
Mali	2001	8.1	5.7	DHS
Mauritania	1990/1991	4.1	1.2	AHS
Mauritania	2000/2001	8.0	5.1	DHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Niger	1992	4.4	2.3	DHS
Niger	1998	8.2	4.6	DHS
Niger	2000	14.0	4.3	MICS
Nigeria	1990	6.0	3.5	DHS
Nigeria	1999	15.3	8.6	DHS
Senegal	1986	11.3	2.4	DHS
Senegal	1992/1993	7.4	4.8	DHS
Senegal	1997	12.9	8.1	DHS
Togo	1988	12.1	3.0	DHS
Togo	1998	23.5	7.0	DHS
Togo	2000	25.7	9.3	MICS
Asia				
Eastern Asia				
China	1988	72.1	71.2	FHS
China	1992	83.4	83.2	RES
China	1997	83.8	83.3	FHS
Hong Kong, China SAR	1987	80.8	75.0	RES
Hong Kong, China SAR	1992	86.2	79.7	RES
Japan	1950	19.5	0.9	RES
Japan	1952	26.3		RES
Japan	1990	58.0	51.9	FHS
Japan	1992	64.0	56.7	FHS
Japan	1994	58.6	52.8	FHS
Japan	1998	54.1	48.2	FHS
Japan	2000	55.9	51.0	FHS
Mongolia	1994	64.6	27.0	FHS
Mongolia	1998	59.9	45.7	FHS
Mongolia	2000	67.4	54.3	MICS
Republic of Korea	1988	77.3	70.2	RES
Republic of Korea	1991	79.4	69.5	FHS
Republic of Korea	1994	77.4	66.8	RES
Republic of Korea	1997	80.5	66.9	RES
South-central Asia				
Afghanistan	1972/1973	1.6	1.6	FHS
Afghanistan	2000	4.8	3.6	MICS
Bangladesh	1989	30.8	23.2	WFS
Bangladesh	1991	39.9	31.2	CPS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Bangladesh	1993/1994	44.6	36.2	DHS
Bangladesh	1996/1997	49.2	41.6	DHS
Bangladesh	1999/2000	53.8	43.4	DHS
India	1988	43.0	38.0	FHS
India	1992	40.6	36.2	FHS
India	1998/1999	48.2	42.8	FHS
Iran (Islamic Republic of)	1989	49.0	27.7	RES
Iran (Islamic Republic of)	1992	64.6	44.6	RES
Iran (Islamic Republic of)	1997	72.9	56.0	RES
Kazakhstan	1995	59.1	46.1	DHS
Kazakhstan	1999	66.1	52.7	DHS
Kyrgyzstan	1997	59.5	48.9	DHS
Nepal	1986	13.9	13.9	FHS
Nepal	1991	22.7	21.8	FHS
Nepal	1996	28.5	26.0	DHS
Nepal	2001	39.3	35.4	DHS
Pakistan	1984/1985	7.6	6.4	CPS
Pakistan	1990/1991	11.8	9.0	DHS
Pakistan	1994/1995	17.8	12.6	CPS
Pakistan	1996/1997	23.9	16.9	FHS
Pakistan	2000/2001	27.6	20.2	FHS
Sri Lanka	1987	62.0	40.5	DHS
Sri Lanka	1993	66.1	43.6	DHS
Sri Lanka	2000	70.0	49.6	DHS
Uzbekistan	1996	55.6	51.3	DHS
Uzbekistan	2000	67.2	62.5	MICS
South-eastern Asia				
Cambodia	1995	12.5	6.8	DHS
Cambodia	2000	23.8	18.5	DHS
Indonesia	1987	47.7	44.0	CPS
Indonesia	1991	49.7	47.1	DHS
Indonesia	1994	54.7	52.1	DHS
Indonesia	1997	57.4	54.7	DHS
Lao People's Democratic Republic	1993	18.6	15.0	FHS
Lao People's Democratic Republic	2000	32.2	28.9	FHS
Malaysia	1988	48.3	31.4	FHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Malaysia	1994	54.5	29.8	SES
Myanmar	1992	16.8	13.6	FHS
Myanmar	1997	32.7	28.4	FHS
Philippines	1988	36.2	21.6	RES
Philippines	1993	40.0	24.9	DHS
Philippines	1998	46.5	28.2	DHS
Singapore	1987	67.0	51.0	FHS
Singapore	1992	65.0	51.0	FHS
Singapore	1997	62.0	53.0	FHS
Thailand	1987	67.5	65.5	DHS
Thailand	1993/1993	73.9	72.2	RES
Thailand	1996/1997	72.2	69.8	CPS
Viet Nam	1988	53.2	35.3	FHS
Viet Nam	1994	65.0	43.8	FHS
Viet Nam	1997	75.3	55.8	DHS
Viet Nam	2002	78.5	56.7	DHS
Western Asia				
Azerbaijan	2000	55.1	15.8	MICS
Azerbaijan	2001	55.4	11.9	CDC
Bahrain	1989	53.8	30.3	AHS
Bahrain	1995	61.8	30.6	AHS
Iraq	1974	14.5	12.9	FHS
Iraq	1989	13.7	10.4	AHS
Jordan	1990	40.0	26.9	DHS
Jordan	1997	52.6	37.7	DHS
Jordan	2002	55.8	41.2	DHS
Kuwait	1987	34.6	31.7	AHS
Kuwait	1994	49.8	47.3	RES
Kuwait	1996	50.2	40.9	AHS
Lebanon	1971	53.0	23.0	RES
Lebanon	1996	61.0	37.0	AHS
Oman	1988	8.6	7.5	AHS
Oman	1995	23.7	18.2	AHS
Qatar	1987	32.3	28.9	AHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Qatar	1998	43.2	32.3	AHS
Syrian Arab Republic	1978	19.8	15.0	WFS
Syrian Arab Republic	1993	39.6	28.3	AHS
Turkey	1988	63.3	31.1	FHS
Turkey	1993	62.6	34.5	DHS
Turkey	1998	63.9	37.7	DHS
Yemen	1979	1.1	1.1	WFS
Yemen	1991/1992	9.7	6.1	DHS
Yemen	1997	20.8	9.8	DHS
Europe				
Eastern Europe				
Bulgaria	1976	75.1	6.0	RES
Bulgaria	1995	85.9	45.6	RES
Bulgaria	1997	41.5	25.6	FFS
Czech Republic	1977	95.0	49.0	WFS
Czech Republic	1993	68.9	44.9	CDC
Czech Republic	1997	72.0	62.6	FFS
Hungary	1986	73.1	62.3	TPI
Hungary	1992/1993	77.4	68.4	FFS
Poland	1977	75.0	26.0	WFS
Poland	1991	49.4	19.0	FFS
Republic of Moldova	1997	73.7	50.0	CDC
Republic of Moldova	2000	62.4	42.8	MICS
Romania	1978	58.0	5.0	WFS
Romania	1993	57.3	14.5	CDC
Romania	1999	63.8	29.5	CDC
Northern Europe				
Denmark	1975	63.0	60.0	WFS
Denmark	1988	78.0	72.0	RES
Finland	1977	80.0	78.0	WFS
Finland	1989	77.4	75.4	FFS
Norway	1977	71.0	65.0	WFS
Norway	1988	73.8	69.2	FFS
United Kingdom	1986	81.0	78.0	FHS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage): Any method	Contraceptive prevalence[a] (percentage): Modern methods	Source[b]
United Kingdom	1993	82.0	82.0	TPI
United Kingdom	1998	82.0	82.0	FHS
United Kingdom	1999	76.0	76.0	FHS
United Kingdom	2000	80.0	80.0	FHS
United Kingdom	2001	83.0	82.0	FHS
United Kingdom	2002	84.0	81.0	FHS
Southern Europe				
Italy	1979	78.0	32.0	WFS
Italy	1995/1996	60.2	38.9	FFS
Serbia and Montenegro	1976	55.0	12.0	WFS
Serbia and Montenegro	2000	58.3	32.8	MICS
Spain	1985	59.4	38.0	FHS
Spain	1995	80.9	67.4	FFS
Western Europe				
Austria	1981/1982	71.4	56.3	RES
Austria	1995/1996	50.8	46.8	FFS
Belgium	1982/1983	80.0	65.0	TPI
Belgium	1991/1992	78.4	74.3	FFS
France	1988	81.2	66.6	RES
France	1994	74.6	69.3	FFS
Germany	1985	77.9	67.6	RES
Germany	1992	74.7	71.8	TPI
Netherlands	1988	76.0	71.0	RES
Netherlands	1993	78.5	75.6	FFS
Switzerland	1980	71.2	64.9	RES
Switzerland	1994/1995	82.0	77.5	FFS
Latin America and the Caribbean				
Caribbean				
Antigua and Barbuda	1981	38.9	37.1	RES
Antigua and Barbuda	1988	52.6	50.6	CPS
Barbados	1980	46.5	44.6	FHS
Barbados	1988	55.0	53.2	CPS
Cuba	1987	70.0	67.0	RES
Cuba	2000	73.3	72.1	MICS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Dominica	1981	49.0	47.2	RES
Dominica	1987	49.8	48.2	CPS
Dominican Republic	1986	50.0	46.7	DHS
Dominican Republic	1991	56.4	51.7	DHS
Dominican Republic	1996	63.7	59.2	DHS
Dominican Republic	2000	64.7	62.5	MICS
Dominican Republic	2002	69.8	65.8	DHS
Grenada	1985	31.0	27.3	CPS
Grenada	1990	54.3	..	RES
Haiti	1989	10.2	9.8	CPS
Haiti	1994/1995	18.0	13.2	FHS
Haiti	2000	27.4	21.4	DHS
Jamaica	1989	54.6	51.3	CPS
Jamaica	1993	62.0	58.3	CPS
Jamaica	1997	65.9	62.6	CDC
Puerto Rico	1982	70.4	62.1	RES
Puerto Rico	1995/1996	77.7	67.6	CDC
Saint Lucia	1981	42.7	40.2	RES
Saint Lucia	1988	47.3	46.1	CPS
Saint Vincent and the Grenadines	1981	41.5	39.5	RES
Saint Vincent and the Grenadines	1988	58.3	54.6	CPS
Trinidad and Tobago	1987	52.7	44.4	DHS
Trinidad and Tobago	2000	38.2	33.2	MICS
Central America				
Costa Rica	1986	69.3	58.5	CDC
Costa Rica	1992/1993	75.0	64.6	FHS
El Salvador	1988	47.1	43.5	CDC
El Salvador	1993	53.3	48.4	CDC
El Salvador	1998	59.7	54.1	CDC
Guatemala	1987	23.2	19.1	DHS
Guatemala	1995	31.4	26.9	DHS
Guatemala	1998/1999	38.2	30.9	DHS
Honduras	1987	40.6	32.9	FHS
Honduras	1991/1992	46.7	34.7	FHS
Honduras	1996	50.0	41.0	CDC

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage) Any method	Modern methods	Source[b]
Honduras	2001	61.8	50.8	CDC
Mexico	1987	52.7	44.6	DHS
Mexico	1995	66.5	57.5	FHS
Mexico	1997	68.4	59.5	FHS
Nicaragua	1981	27.0	22.8	FHS
Nicaragua	1992	48.7	44.9	CDC
Nicaragua	1998	60.3	57.4	DHS
Nicaragua	2001	68.6	66.1	DHS
Panama	1976	54.1	46.2	WFS
Panama	1979	60.6	56.3	CDC
Panama	1984	58.2	54.2	CDC
South America				
Bolivia	1989	30.3	12.2	DHS
Bolivia	1994	45.4	17.8	DHS
Bolivia	1998	48.3	25.2	DHS
Bolivia	2000	53.4	27.3	MICS
Brazil	1986	65.8	56.7	DHS
Brazil	1996	76.7	70.3	DHS
Colombia	1990	66.1	54.7	DHS
Colombia	1995	72.2	59.3	DHS
Colombia	2000	76.9	64.0	DHS
Ecuador	1989	52.9	41.5	CDC
Ecuador	1994	56.8	45.7	CDC
Ecuador	1999	65.8	50.1	CDC
Guyana	1975	31.4	28.3	WFS
Guyana	2000	37.3	36.0	MICS
Paraguay	1990	44.1	35.2	DHS
Paraguay	1995	50.7	41.3	CDC
Paraguay	1998	57.4	47.7	CDC
Peru	1986	45.8	23.0	DHS
Peru	1991	59.0	32.8	DHS
Peru	1996	64.2	41.3	DHS
Peru	2000	68.9	50.4	DHS
Northern America				
Canada	1984	73.1	69.7	RES
Canada	1995	74.7	73.3	FFS

TABLE A.1 *(continued)*

Country	Survey date	Contraceptive prevalence[a] (percentage)		Source[b]
		Any method	*Modern methods*	
United States of America	1990	70.7	67.0	RES
United States of America	1995	76.4	70.5	RES
New Zealand	1976	69.5	61.5	RES
New Zealand	1995	74.9	72.0	TPI

Sources: World Contraceptive Use 2003 and *World Population Prospects 2002,* databases maintained by the Population Division of the United Nations.

NOTES: Two dots (..) indicate that the information is not available.

[a] Contraceptive prevalence is the percentage of women of reproductive age in a marital or consensual union who are using contraception. The prevalence of modern methods is the percentage of women of reproductive age in a marital or consensual union who are using a modern contraceptive method.

[b] The data were compiled from nationally representative surveys of women of reproductive age, including the Gulf Family Health Surveys and Pan-Arab Child Health Surveys (AHS), surveys carried out with the assistance of the US Centers for Disease Control and Prevention (CDC) such as the Reproductive Health Surveys, the Contraceptive Prevalence Surveys (CPS), the Demographic and Health Surveys (DHS), the Fertility and Family Surveys (FFS), national fertility and/or family planning surveys (FHS), the Multiple Indicator Cluster Surveys (MICS), national socioeconomic and/or demographic surveys (SES) and the World Fertility Surveys (WFS). Other sources of data are research papers or publications, including United Nations publications (RES) and tabulations provided by individuals or institutions (TPI).

TABLE A.2. USE OF SPECIFIC CONTRACEPTIVE METHODS, BY COUNTRY

Country or area	Year	Age range	Any method	Modern methods									Traditional methods		
				Any modern method	Female sterilization	Male sterilization	Pill	IUD	Male condom	Injectables and implants	Vaginal barrier methods	Other modern methods	Rhythm	Withdrawal	Other traditional methods
				A. Contraceptive prevalence (percentage)											
Africa															
Eastern Africa															
Burundi	2000	15-49	**15.7**	**10.0**	0.2	0.1	3.9	0.8	0.2	4.7	0.0	0.0	3.4	0.0	2.3
Comoros	2000	15-49	**25.7**	**19.3**	0.7	0.0	8.3	0.4	0.7	9.2	0.0	0.0	2.9	1.2	2.3
Eritrea	2002	15-49	**8.0**	**5.1**	0.2	0.0	1.4	0.4	0.6	2.6	0.0	0.0	0.7	0.1	2.1
Ethiopia	2000	15-49	**8.1**	**6.3**	0.3	0.0	2.5	0.1	0.3	3.1	0.0	0.0	1.5	0.2	0.1
Kenya	1998	15-49	**39.0**	**31.5**	6.2	0.0	8.5	2.7	1.3	12.6	0.0	0.0	6.1	0.6	0.8
Madagascar	2000	15-49	**18.8**	**11.8**	0.6	0.0	3.3	0.3	0.4	7.1	0.0	0.0	6.0	0.3	0.8
Malawi	2000	15-49	**30.6**	**26.1**	4.7	0.1	2.7	0.1	1.6	16.5	0.0	0.4	0.9	1.5	2.1
Mauritius	1991	15-44	**74.7**	**48.9**	7.2	0.2	20.9	2.8	13.3	4.1	0.4	0.0	9.2	16.1	0.4
Mozambique	1997	15-49	**5.6**	**5.1**	0.7	0.0	1.5	0.3	0.3	2.3	0.0	0.0	0.1	0.0	0.4
Réunion [1]	1990	15-49	**66.6**	**61.7**	3.3	0.0	40.1	14.2	2.7	1.2	0.2	0.0	1.1	2.5	1.2
Rwanda	2000	15-49	**13.2**	**4.3**	0.8	0.0	1.0	--	0.4	1.9	--	0.3	4.7	2.9	1.4
Uganda	2000/01	15-49	**22.8**	**18.2**	2.0	0.0	3.2	0.2	1.9	6.7	0.0	4.2	2.5	1.1	1.0
United Republic of Tanzania	1999	15-49	**25.4**	**16.9**	2.0	0.0	5.3	0.4	2.7	6.3	0.0	0.0	2.2	3.5	2.9
Zambia	2001/02	15-49	**34.2**	**22.6**	2.0	0.0	11.9	0.1	3.8	4.8	0.1	0.0	1.1	5.1	5.4
Zimbabwe	1999	15-49	**53.5**	**50.4**	2.6	0.1	35.5	0.9	1.8	8.6	0.0	0.9	0.2	2.6	0.4
Middle Africa															
Angola	2001	15-49	**6.2**	**4.5**	0.1	0.0	2.2	0.4	0.3	1.4	0.1	0.1	1.2	0.1	0.4
Cameroon	1998	15-49	**19.3**	**7.1**	1.5	--	2.0	0.6	2.1	0.7	--	0.2	9.6	1.6	1.0
Central African Republic	2000	15-49	**27.9**	**6.9**	0.3	0.0	4.8	0.2	0.9	0.6	0.0	0.0	14.7	0.8	5.5
Chad	2000	15-49	**7.9**	**2.1**	0.6	0.0	1.1	0.1	0.0	0.2	0.1	0.0	1.5	0.0	4.4
Democratic Republic of the Congo	2001	15-49	**31.4**	**4.4**	0.4	0.1	1.0	0.1	2.3	0.3	0.1	0.0	17.2	3.1	6.8
Gabon	2000	15-49	**32.7**	**11.8**	1.0	--	4.8	--	5.1	0.5	--	0.3	15.8	1.8	3.4
Sao Tome and Principe	2000	15-49	**29.3**	**27.4**	0.4	0.1	16.7	1.4	0.1	8.6	0.1	0.1	0.6	0.1	1.3
Northern Africa															
Algeria	2000	15-49	**64.0**	**50.1**	0.0	0.0	44.3	4.3	1.5	0.0	0.0	0.0	4.9	3.5	4.9
Egypt	2000	15-49	**56.1**	**53.9**	1.4	0.0	9.5	35.5	1.0	6.3	0.2	0.0	0.6	0.2	1.3
Libyan Arab Jamahiriya	1995	15-49	**39.7**	**25.6**	4.8	0.0	9.6	11.2	0.0	0.0	0.0	0.0	11.0	2.4	0.7

TABLE A.2 *(continued)*

Country or area	Year	Age range	Any method	Modern methods									Traditional methods		
				Any modern method	Female sterilization	Male sterilization	Pill	IUD	Male condom	Injectables and implants	Vaginal barrier methods	Other modern methods	Rhythm	Withdrawal	Other traditional methods
Morocco	1995	15-49	**50.3**	**42.4**	4.3	0.0	32.2	4.3	1.4	0.1	0.1	0.0	4.6	2.8	0.4
Sudan [a]	1992/93	15-49	**8.3**	**6.9**	0.9	0.0	5.1	0.6	0.0	0.2	0.0	0.0	1.2	0.1	0.2
Tunisia	1994	15-49	**60.0**	**51.0**	14.5	0.0	11.1	21.5	1.6	1.0	1.3	0.0	6.0	2.3	0.7
Southern Africa															
Botswana	2000	15-49	**40.4**	**38.8**	1.3	0.1	14.7	1.3	11.2	10.0	0.1	0.0	0.1	--	1.5
Lesotho	2000	15-49	**30.4**	**29.5**	1.3	0.1	9.4	2.6	1.8	14.0	0.2	0.0	0.0	0.4	0.5
Namibia	1992	15-49	**28.9**	**26.0**	7.4	0.2	8.3	2.1	0.3	7.7	0.1	0.0	0.7	0.3	1.9
South Africa	1998	15-49	**56.3**	**55.1**	15.8	2.1	10.6	1.8	1.7	23.2	0.0	0.0	0.3	0.6	0.3
Swaziland	2000	15-49	**27.7**	**26.0**	6.0	0.0	5.4	1.2	1.8	11.6	0.0	0.0	0.4	0.8	0.5
Western Africa															
Benin	2001	15-49	**18.6**	**7.2**	0.3	0.0	1.8	0.8	1.3	2.4	0.2	0.4	6.9	4.3	0.2
Burkina Faso	1998/99	15-49	**11.9**	**4.8**	--	--	1.8	0.4	1.2	1.1	--	0.4	4.6	0.2	2.2
Cape Verde	1998	15-49	**52.9**	**46.0**	12.8	0.0	18.2	4.3	3.0	7.7	0.1	0.0	4.9	2.0	0.1
Côte d'Ivoire	1998/99	15-49	**15.0**	**7.3**	0.1	0.0	3.5	0.4	1.8	1.4	0.0	0.0	6.2	0.4	0.0
Gambia	2000	15-49	**9.6**	**8.9**	0.2	0.0	3.9	0.8	0.1	3.9	0.0	0.0	0.1	0.2	0.4
Ghana	1998/99	15-49	**22.0**	**13.3**	1.3	0.0	3.9	0.7	2.7	3.2	0.9	0.5	6.6	1.5	0.6
Guinea	1999	15-49	**6.2**	**4.2**	--	--	2.1	0.2	0.6	1.0	--	0.3	1.6	0.2	0.2
Guinea-Bissau	2000	15-49	**7.6**	**3.6**	0.3	0.0	0.3	2.3	0.1	0.5	0.0	0.0	2.5	0.3	1.3
Liberia	1986	15-49	**6.4**	**5.5**	1.1	0.0	3.3	0.6	0.0	0.3	0.2	0.0	0.6	0.1	0.2
Mali	2001	15-49	**8.1**	**5.7**	0.3	0.0	2.8	0.2	0.3	2.2	0.0	0.0	0.6	0.0	1.7
Mauritania	2000/01	15-49	**8.0**	**5.1**	--	--	2.6	0.8	0.8	0.9	--	0.1	0.3	2.2	0.3
Niger	2000	15-49	**14.0**	**4.3**	0.2	0.0	3.4	0.1	0.0	0.6	0.0	0.0	0.0	0.0	9.7
Nigeria	1999	15-49	**15.3**	**8.6**	0.3	0.0	2.4	2.0	1.2	2.5	0.2	0.0	4.6	1.2	0.9
Senegal	1997	15-49	**12.9**	**8.1**	0.5	0.0	3.3	1.6	0.6	1.7	0.2	--	1.1	0.2	3.6
Sierra Leone	2000	15-49	**4.3**	**3.9**	0.2	0.0	2.5	0.2	0.1	0.9	0.1	0.0	0.1	--	0.4
Togo	2000	15-49	**25.7**	**9.3**	0.7	0.0	2.5	0.2	1.6	4.0	0.2	0.1	5.6	0.4	10.4
Asia															
Eastern Asia															
China	1997	15-49	**83.8**	**83.3**	33.5	7.7	1.7	36.4	3.4	0.4	0.2	0.0	--	--	0.5
China, Hong Kong SAR [b]	1992	15-49	**86.2**	**79.7**	18.9	0.9	17.1	5.1	34.5	1.7	1.5	0.0	5.1	<------1.5------>	
Democratic People's Republic of Korea	1990/92	15-49	**61.8**	**53.0**	4.1	0.3	0.1	48.5	0.0	0.0	0.0	0.0	8.9	0.0	0.0
Japan	2000	15-49	**55.9**[p]	**51.0**	<------3.6------>		<-----2.3--->		42.1	--	15.4	--	3.6	--	1.3

TABLE A.2 *(continued)*

				Modern methods									*Traditional methods*		
Country or area	*Year*	*Age range*	*Any method*	*Any modern method*	*Female sterili-zation*	*Male sterili-zation*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*With-drawal*	*Other traditional methods*
Mongolia	2000	15-49	**67.4**	**54.3**	1.3	0.2	8.3	0.3	4.3	39.3	0.1	0.6	8.0	0.1	5.0
Republic of Korea	1997	15-44	**80.5**	**66.9**	24.1	12.7	1.8	13.2	15.1	0.0	0.0	0.0	<----------13.6---------->		
South-central Asia															
Afghanistan [c]	2000	15-49	**4.8**	**3.6**	0.8	0.1	1.2	0.3	0.0	1.3	0.0	0.0	0.4	0.5	0.3
Bangladesh	1999/00	10-49	**53.8**	**43.4**	6.7	0.5	23.0	1.2	4.3	7.7	0.0	0.0	5.4	4.0	0.9
Bhutan [k]	1994	15-49	**18.8**	**18.8**	3.1	8.0	2.4	1.0	0.3	4.0	0.0	0.0	0.0	0.0	0.0
India [d]	1998/99	15-49	**48.2**	**42.8**	34.2	1.9	2.1	1.6	3.1	0.0	0.0	0.0	3.0	2.0	0.4
Iran (Islamic Republic of)	1997	15-49	**72.9**	**56.0**	15.5	1.9	20.9	8.3	5.4	2.9	--	1.1	<---------16.9---------->		
Kazakhstan	1999	15-49	**66.1**	**52.7**	2.8	0.0	2.4	42.0	4.5	0.6	0.4	0.0	4.7	2.9	5.9
Kyrgyzstan	1997	15-49	**59.5**	**48.9**	1.8	--	1.7	38.2	5.7	1.3	--	0.1	3.2	6.0	1.5
Nepal	2001	15-49	**39.3**	**35.4**	15.0	6.3	1.6	0.4	2.9	9.0	0.0	0.0	1.1	2.6	0.3
Pakistan	2000/01	15-49	**27.6**	**20.2**	6.9	0.0	1.9	3.5	5.5	2.6	0.0	0.0	1.6	5.3	0.5
Sri Lanka	1993	15-49	**66.1**	**43.6**	23.5	3.7	5.5	3.0	3.3	4.6	0.0	0.0	15.2	5.0	2.3
Tajikistan	2000	15-49	**33.9**	**27.3**	0.2	0.1	0.6	25.1	0.4	0.9	0.0	0.0	2.5	3.0	1.1
Turkmenistan	2000	15-49	**61.8**	**53.1**	1.8	0.0	1.2	39.0	2.0	1.0	0.0	7.9	2.1	5.3	1.3
Uzbekistan	2000	15-49	**67.2**[p]	**62.5**	1.4	0.1	2.6	56.3	0.8	1.3	0.0	1.1	1.5	1.3	1.9
South-eastern Asia															
Cambodia	2000	15-49	**23.8**	**18.5**	1.5	--	7.2	1.3	0.9	7.4	--	0.2	2.7	2.3	0.4
Indonesia	1997	15-49	**57.4**	**54.7**	3.0	0.4	15.4	8.1	0.7	27.1	0.0	0.0	1.1	0.8	0.8
Lao People's Democratic Republic	2000	15-49	**32.2**	**28.9**	4.7	0.0	12.9	3.0	0.5	7.7	0.0	0.0	2.2	0.7	0.3
Malaysia [e]	1994	15-49	**54.5**	**29.8**	<-----6.4----->		13.4	3.9	5.3	--	--	0.8	8.8	6.9	8.9
Myanmar	1997	15-49	**32.7**	**28.4**	5.5	2.2	7.4	1.3	0.1	11.7	--	--	--	--	4.3
Philippines	1998	15-49	**46.5**	**28.2**	10.3	0.1	9.9	3.7	1.6	2.4	0.2	0.0	8.9	8.9	0.8
Singapore	1997	15-44	**62.0**	**53.0**	<-----16.0----->		10.0	5.0	22.0	0.0	0.0	0.0	<-----7.0------>		2.0
Thailand	1996/97	15-44	**72.2**	**69.8**	22.0	2.0	23.1	3.2	1.8	17.7	0.0	0.0	--	--	2.4
Viet Nam	2002	15-49	**78.5**	**56.7**	5.9	0.5	6.3	37.7	5.8	0.4	0.0	0.0	7.5	14.3	0.1
Western Asia															
Armenia	2000	15-49	**60.5**	**22.3**	2.7	0.0	1.1	9.4	6.9	0.1	0.2	1.9	4.8	31.9	1.5
Azerbaijan	2001	15-44	**55.4**[q]	**11.9**	1.2	0.0	1.0	6.1	3.2	0.0	0.3	0.1	3.0	40.5	0.0
Bahrain [j]	1995	15-49	**61.8**	**30.6**	6.2	--	10.9	2.9	9.6	0.0	0.0	1.1	3.2	26.3	1.7
Georgia	1999/00	15-44	**40.5**	**19.8**	1.6	--	1.0	9.7	6.3	--	--	1.1	10.2	10.5	0.0
Iraq [j]	1989	15-49	**13.7**	**10.4**	1.4	--	4.7	2.8	1.0	0.5	0.0	0.0	2.1	1.1	0.2

TABLE A.2 *(continued)*

Country or area	Year	Age range	Any method	Modern methods: Any modern method	Female sterilization	Male sterilization	Pill	IUD	Male condom	Injectables and implants	Vaginal barrier methods	Other modern methods	Traditional methods: Rhythm	Withdrawal	Other traditional methods
Israel [f]	1987/88	18-39	**68.0**	**51.9**	<-------0.9------>		13.0	30.0	4.0	0.0	4.0	0.0	4.0	11.0	1.0
Jordan	2002	15-49	**55.8**	**41.2**	2.9	--	7.5	23.6	3.4	0.9	--	2.9	5.2	9.3	0.1
Kuwait [j]	1996	15-49	**50.2**	**40.9**	2.1	--	28.8	6.8	2.9	--	--	0.3	4.3	3.4	1.6
Lebanon	1996	15-49	**61.0**	**37.0**	--	--	10.0	17.0	--	--	--	10.0	--	--	24.0
Oman [j]	1995	15-49	**23.7**	**18.2**	4.5	0.0	6.1	2.2	1.5	3.8	0.0	0.0	1.0	2.3	2.3
Qatar [j]	1998	15-49	**43.2**	**32.3**	4.1	--	15.8	9.0	2.9	--	--	0.5	2.3	6.8	1.8
Saudi Arabia [j]	1996	15-49	**31.8**	**28.5**	1.0	--	19.6	6.6	0.9	0.2	--	0.2	1.2	0.8	1.3
Syrian Arab Republic	1993	15-49	**36.1**	**28.3**	2.2	0.0	9.9	15.7	0.3	0.0	0.2	0.0	6.7	1.0	0.1
Turkey	1998	15-49	**63.9**	**37.7**	4.2	0.0	4.4	19.8	8.2	0.5	0.6	0.0	1.1	24.4	0.6
United Arab Emirates [j]	1995	15-49	**27.5**	**23.6**	4.2	--	11.9	3.7	2.0	1.5	0.2	0.1	1.6	1.4	0.9
Yemen	1997	15-49	**20.8**	**9.8**	1.4	0.1	3.8	3.0	0.3	1.2	0.1	0.0	1.1	1.7	8.2
Europe															
Eastern Europe															
Belarus	1995	18-34	**50.4**	**42.1**	0.8	0.0	6.7	29.0	4.8	0.0	0.8	0.0	3.0	5.2	0.1
Bulgaria	1997	18-45	**41.5**	**25.4**	<------0.1------>		6.9	6.8	10.7	0.0	0.9	0.0	2.5	12.7	0.4
Czech Republic	1997	15-44	**72.0**	**62.6**	7.2	5.1	23.1	13.9	12.7	0.0	0.7	0.0	1.7	7.3	0.5
Hungary	1992/93	18-41	**77.4**	**68.4**	4.8	--	37.7	17.4	7.8	0.0	0.6	0.0	2.5	6.3	0.2
Poland	1991	20-49	**49.4**	**19.0**	0.0	0.0	2.3	5.7	9.1	0.0	1.9	0.0	19.3	11.1	0.0
Republic of Moldova	2000	15-49	**62.4**	**42.8**	1.1	0.0	3.3	34.5	3.5	0.0	0.3	0.0	4.3	13.9	1.4
Romania	1999	15-44	**63.8**	**29.5**	2.5	--	7.9	7.3	8.5	--	2.8	0.5	5.6	28.7	0.0
Slovakia [m]	1991	15-44	**74.0**	**41.0**	4.0	0.0	5.0	11.0	21.0	0.0	0.0	0.0	<-------32.0------->		1.0
Ukraine	1999	15-44	**67.5**[s]	**37.6**	1.4	--	3.0	18.6	13.5	--	0.8	0.3	10.4	19.5	0.0
Northern Europe															
Denmark [m]	1988	15-44	**78.0**[p]	**72.0**	5.0	5.0	26.0	11.0	22.0	0.0	3.0	0.0	2.0	5.0	0.0
Estonia [n]	1994	20-49	**70.3**[p]	**56.4**	--	--	3.9	35.9	16.1	0.0	0.6	--	8.1	4.5	1.2
Finland	1989	25-49	**77.4**	**75.4**	14.9	1.1	11.3	25.8	20.1	1.9	0.3	0.0	0.7	0.6	0.8
Latvia	1995	18-49	**48.0**	**39.3**	<------1.5------>		8.0	19.8	9.6	0.1	0.3	0.0	5.0	3.2	0.5
Lithuania	1994/95	18-49	**46.6**	**30.5**	0.0	0.0	3.2	13.9	13.1	0.2	0.0	0.0	9.3	6.0	0.7
Norway [o]	1988/89	--	**73.8**[p]	**69.2**	10.4	4.1	17.8	24.1	12.5	0.0	0.4	0.0	2.3	1.8	0.5
Sweden	1981	20-44	**78.0**	**72.0**	<------3.0------->		23.0	20.0	25.0[t]	0.0	--	--	<----------7.0---------->		
United Kingdom [g]	2002	16-49	**84.0**[p]	**81.0**	13.0	17.0	22.0	6.0	18.0	3.0	1.0	1.0	1.0	4.0	0.0

TABLE A.2 *(continued)*

				Modern methods									*Traditional methods*		
Country or area	*Year*	*Age range*	*Any method*	*Any modern method*	*Female sterilization*	*Male sterilization*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*th-drawal*	*Other traditional methods*
Southern Europe															
Albania	2000	15-49	**57.5**	**15.3**	0.9	0.2	5.6	0.0	7.9	0.7	0.0	0.0	7.5	31.8	0.2
Bosnia and Herzegovina	2000	15-49	**47.5**	**15.7**	0.1	0.0	4.5	7.9	3.1	0.0	0.1	0.0	4.1	26.9	0.7
Italy	1995/96	20-49	**60.2**[r]	**38.9**	5.8	0.1	13.6	5.5	13.7	0.0	0.2	0.0	3.6	17.5	0.3
Portugal	1979/80	15-49	**66.3**	**32.8**	0.9	0.1	19.1	3.6	5.6	1.5	2.0	0.0	4.0	25.6	4.0
Serbia and Montenegro [h]	2000	15-49	**58.3**[p]	**32.8**	0.0	0.0	4.7	7.7	17.4	0.0	1.8	1.2	14.2	11.3	0.6
Slovenia	1994	15-44	**73.8**	**59.1**	5.6	0.1	21.7	21.5	7.6	0.2	2.4	0.0	7.0	7.5	0.2
Spain	1995	18-49	**80.9**	**67.4**	12.1	8.1	14.6	7.6	24.3	0.2	0.6	0.0	1.9	11.4	0.3
Western Europe															
Austria	1995/96	20-49	**50.8**	**46.8**	0.0	0.5	30.8	7.3	7.2	0.3	0.7	0.0	2.5	0.7	0.9
Belgium [i]	1991/92	21-39	**78.4**[r]	**74.3**	10.9	7.0	46.7	5.0	4.7	0.0	0.1	0.0	2.1	2.0	0.0
France	1994	20-49	**74.6**	**69.3**	<-------8.0------>		35.6	19.9	5.0	0.0	0.8	0.0	1.6	3.2	0.5
Germany	1992	20-39	**74.7**	**71.8**	0.9	0.0	58.6	6.0	4.4	0.7	1.2	0.0	0.6	0.3	1.9
Netherlands	1993	18-42	**78.5**	**75.6**	4.8	10.5	49.0	3.6	7.7	0.0	0.0	0.0	<----------2.9---------->		
Switzerland	1994/95	20-49	**82.0**[r]	**77.5**	13.8	8.3	34.1	6.0	14.2	0.3	0.9	0.0	2.3	2.2	0.0
Latin America and the Caribbean															
Caribbean															
Antigua and Barbuda [l]	1988	15-44	**52.6**	**50.6**	11.4	0.0	26.2	1.1	5.5	3.2	3.2	0.0	0.5	1.1	0.4
Bahamas [l]	1988	15-44	**61.7**	**60.1**	16.4	0.0	31.5	3.7	2.3	4.8	1.4	0.0	<--------1.6----->		--
Barbados [l]	1988	15-44	**55.0**	**53.2**	10.4	0.3	26.2	5.3	7.2	1.0	2.8	0.0	0.8	1.0	0.0
Cuba	2000	15-49	**73.3**	**72.1**	19.0	0.0	3.6	43.5	5.0	1.0	0.1	0.0	0.6	0.4	0.3
Dominica [l]	1987	15-44	**49.8**	**48.2**	12.6	0.0	16.5	1.7	5.6	11.8	0.0	0.0	<----------1.7---------->		
Dominican Republic	2000	15-49	**64.7**	**62.5**	42.9	0.0	14.2	2.5	0.9	2.0	0.0	0.0	1.4	0.1	0.7
Grenada [l]	1990	15-44	**54.3**	--	5.1[u]	--	15.2	3.0	21.9	9.0	--	--	--	--	--
Haiti	2000	15-49	**27.4**	21.4	3.0	--	2.3	--	2.2	13.6	--	0.6	1.8	3.3	0.6
Jamaica [l]	1997	15-49	**65.9**	62.6	12.3	0.0	21.2	1.1	17.0	11.0	0.0	0.0	--	2.8	0.2
Montserrat [l]	1984	15-44	**52.6**	52.2	<-------1.6------>		30.6	11.0	3.4	3.2	2.4	0.0	<-------0.3------>		0.0
Puerto Rico	1995/96	15-49	**77.7**	67.6	45.5	3.5	9.7	1.0	6.4	1.3	0.4	0.0	6.1	4.0	0.0
Saint Kitts and Nevis	1984	15-44	**40.6**	37.0	<-------2.6------>		19.7	3.8	5.6	2.3	3.0	0.0	<--------3.6----->		0.0
Saint Lucia	1988	15-44	**47.3**	46.1	8.6	0.0	18.4	4.3	5.8	7.4	1.6	0.0	<--------1.3----->		0.0
Saint Vincent and the Grenadines	1988	15-44	**58.3**	54.6	13.1	0.0	24.3	2.7	7.4	7.1	0.0	0.0	<----------3.7---------->		
Trinidad and Tobago	2000	15-49	**38.2**	33.2	7.2	0.2	10.2	2.2	11.7	1.3	0.5	0.0	0.8	1.1	3.1

TABLE A.2 *(continued)*

Country or area	Year	Age range	Any method	Modern methods									Traditional methods		
				Any modern method	*Female sterilization*	*Male sterilization*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*Withdrawal*	*Other traditional methods*
Central America															
Belize [1]	1991	15-44	**46.7**	41.8	18.7	0.0	14.9	1.9	1.9	4.3	0.0	0.0	2.5	0.0	2.4
Costa Rica	1992/93	15-49	**75.0**	64.6	19.7	1.3	18.0	8.7	15.7	1.0	0.2	0.0	7.0	3.3	0.1
El Salvador	1998	15-44	**59.7**	54.1	32.4	0.7[v]	8.1	1.5	2.5	8.9[w]	--	--	3.1	2.6	0.0
Guatemala	1998/99	15-49	**38.2**	30.9	16.7	0.8	5.0	2.2	2.3	3.9	0.0	0.0	5.7	1.5	0.1
Honduras	2001	15-44	**61.8**	50.8	18.0	0.0	10.4	9.6	3.2	9.6	0.0	0.0	4.4	6.4	0.2
Mexico	1997	15-49	**68.4**	59.5	30.0	1.3	7.1	14.1	3.7	3.1	0.1	0.1	5.4	3.6	0.1
Nicaragua	2001	15-49	**68.6**	66.1	25.3	0.5	14.6	6.4	3.3	14.3	0.0	1.8	1.5	1.0	0.0
Panama	1984	15-44	**58.2**	54.2	32.4	0.4	11.8	6.0	1.6	0.8	1.2	0.0	2.3	1.4	0.3
South America															
Bolivia	2000	15-49	**53.4**	27.3	4.3	0.0	3.8	12.6	3.3	3.2	0.0	0.0	21.3	0.5	4.3
Brazil	1996	15-49	**76.7**	70.3	40.1	2.6	20.7	1.1	4.4	1.2	0.1	0.0	3.0	3.1	0.3
Colombia	2000	15-49	**76.9**	64.0	27.1	1.0	11.8	12.4	6.1	4.2	0.8	0.7	6.0	6.3	0.7
Ecuador	1999	15-49	**65.8**	50.1	22.5	0.0	11.1	10.1	2.7	3.5	0.2	0.0	7.9	6.5	1.4
Guyana	2000	15-49	**37.3**	36.0	4.5	0.1	11.2	6.3	8.8	4.7	0.4	0.1	0.5	0.4	0.5
Paraguay	1998	15-44	**57.4**	47.7	8.0	0.0	13.1	11.1	7.3	7.5	0.5	0.0	4.3	5.4	0.0
Peru	2000	15-49	**68.9**	50.4	12.3	0.5	6.7	9.1	5.6	15.0	0.6	0.7	14.4	3.2	0.9
Suriname	2000	15-49	**42.1**	40.6	9.3	0.1	24.5	1.7	2.5	2.6	0.0	0.0	0.5	0.4	0.5
Northern America															
Canada	1995	15-49	**74.7**	73.3	30.6	15.2	14.4	2.9	9.4	0.0	0.8	0.0	0.6	0.7	0.2
United States of America	1995	15-44	**76.4**	70.5	23.8	13.2	15.6	0.7	13.3	2.1	1.8	0.0	2.3	2.3	1.3
Oceania															
Australia/New Zealand															
Australia	1986	20-49	**76.1**	72.2	27.7	10.4	24.0	4.9	4.4	0.0	0.8	0.0	2.0	1.6	0.3
New Zealand	1995	20-49	**74.9**	72.0	15.0	18.0	20.1	3.4	12.4	2.0	1.0	0.0	1.9	1.0	0.0
Melanesia/Micronesia/Polynesia															
Cook Islands	1996	15-49	**63.2**[p]	60.4	11.3	0.0	22.6	3.3	2.4	20.8	0.0	0.0	1.4	2.8	2.8
Papua New Guinea	1996	15-49	**25.9**	19.6	7.6	0.2	4.4	0.1	0.5	6.8	0.0	0.0	2.9	0.6	2.8

TABLE A.2 *(continued)*

Country or area	Year	Age range	Any method	Modern methods: Any modern method	Female sterilization	Male sterilization	Pill	IUD	Male condom	Injectables and implants	Vaginal barrier methods	Other modern methods	Traditional methods: Rhythm	Withdrawal	Other traditional methods
B. Method mix (percentage)															
Africa															
Eastern Africa															
Burundi	2000	15-49	**100.0**	**63.7**	1.3	0.6	24.8	5.1	1.3	29.9	0.0	0.0	21.7	0.0	14.6
Comoros	2000	15-49	**100.0**	**75.1**	2.7	0.0	32.3	1.6	2.7	35.8	0.0	0.0	11.3	4.7	8.9
Eritrea	2002	15-49	**100.0**	**63.8**	2.5	0.0	17.5	5.0	7.5	32.5	0.0	0.0	8.8	1.3	26.3
Ethiopia	2000	15-49	**100.0**	**77.8**	3.7	0.0	30.9	1.2	3.7	38.3	0.0	0.0	18.5	2.5	1.2
Kenya	1998	15-49	**100.0**	**80.8**	15.9	0.0	21.8	6.9	3.3	32.3	0.0	0.0	15.6	1.5	2.1
Madagascar	2000	15-49	**100.0**	**62.8**	3.2	0.0	17.6	1.6	2.1	37.8	0.0	0.0	31.9	1.6	4.3
Malawi	2000	15-49	**100.0**	**85.3**	15.4	0.3	8.8	0.3	5.2	53.9	0.0	1.3	2.9	4.9	6.9
Mauritius	1991	15-44	**100.0**	**65.5**	9.6	0.3	28.0	3.7	17.8	5.5	0.5	0.0	12.3	21.6	0.5
Mozambique	1997	15-49	**100.0**	**91.1**	12.5	0.0	26.8	5.4	5.4	41.1	0.0	0.0	1.8	0.0	7.1
Réunion	1990	15-49	**100.0**	**92.6**	5.0	0.0	60.2	21.3	4.1	1.8	0.3	0.0	1.7	3.8	1.8
Rwanda	2000	15-49	**100.0**	**32.6**	6.1	0.0	7.6	--	3.0	14.4	--	2.3	35.6	22.0	10.6
Uganda	2000/01	15-49	**100.0**	**79.8**	8.8	0.0	14.0	0.9	8.3	29.4	0.0	18.4	11.0	4.8	4.4
United Republic of Tanzania	1999	15-49	**100.0**	**66.5**	7.9	0.0	20.9	1.6	10.6	24.8	0.0	0.0	8.7	13.8	11.4
Zambia	2001/02	15-49	**100.0**	**66.1**	5.8	0.0	34.8	0.3	11.1	14.0	0.3	0.0	3.2	14.9	15.8
Zimbabwe	1999	15-49	**100.0**	**94.2**	4.9	0.2	66.4	1.7	3.4	16.1	0.0	1.7	0.4	4.9	0.7
Middle Africa															
Angola	2001	15-49	**100.0**	**72.6**	1.6	0.0	35.5	6.5	4.8	22.6	1.6	1.6	19.4	1.6	6.5
Cameroon	1998	15-49	**100.0**	**36.8**	7.8	--	10.4	3.1	10.9	3.6	--	1.0	49.7	8.3	5.2
Central African Republic	2000	15-49	**100.0**	**24.7**	1.1	0.0	17.2	0.7	3.2	2.2	0.0	0.0	52.7	2.9	19.7
Chad	2000	15-49	**100.0**	**26.6**	7.6	0.0	13.9	1.3	0.0	2.5	1.3	0.0	19.0	0.0	55.7
Democratic Republic of the Congo	2001	15-49	**100.0**	**14.0**	1.3	0.3	3.2	0.3	7.3	1.0	0.3	0.0	54.8	9.9	21.7
Gabon	2000	15-49	**100.0**	**36.1**	3.1	--	14.7	--	15.6	1.5	--	0.9	48.3	5.5	10.4
Sao Tome and Principe	2000	15-49	**100.0**	**93.5**	1.4	0.3	57.0	4.8	0.3	29.4	0.3	0.3	2.0	0.3	4.4
Northern Africa															
Algeria	2000	15-49	**100.0**	**78.3**	0.0	0.0	69.2	6.7	2.3	0.0	0.0	0.0	7.7	5.5	7.7
Egypt	2000	15-49	**100.0**	**96.1**	2.5	0.0	16.9	63.3	1.8	11.2	0.4	0.0	1.1	0.4	2.3
Libyan Arab Jamahiriya	1995	15-49	**100.0**	**64.5**	12.1	0.0	24.2	28.2	0.0	0.0	0.0	0.0	27.7	6.0	1.8
Morocco	1995	15-49	**100.0**	**84.3**	8.5	0.0	64.0	8.5	2.8	0.2	0.2	0.0	9.1	5.6	0.8

TABLE A.2 *(continued)*

Country or area	*Year*	*Age range*	*Any method*	*Modern methods*									*Traditional methods*		
				Any modern method	*Female sterilization*	*Male sterilization*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*Withdrawal*	*Other traditional methods*
Sudan	1992/93	15-49	**100.0**	**83.1**	10.8	0.0	61.4	7.2	0.0	2.4	0.0	0.0	14.5	1.2	2.4
Tunisia	1994	15-49	**100.0**	**85.0**	24.2	0.0	18.5	35.8	2.7	1.7	2.2	0.0	10.0	3.8	1.2
Southern Africa															
Botswana	2000	15-49	**100.0**	**96.0**	3.2	0.2	36.4	3.2	27.7	24.8	0.2	0.0	0.2	--	3.7
Lesotho	2000	15-49	**100.0**	**97.0**	4.3	0.3	30.9	8.6	5.9	46.1	0.7	0.0	0.0	1.3	1.6
Namibia	1992	15-49	**100.0**	**90.0**	25.6	0.7	28.7	7.3	1.0	26.6	0.3	0.0	2.4	1.0	6.6
South Africa	1998	15-49	**100.0**	**97.9**	28.1	3.7	18.8	3.2	3.0	41.2	0.0	0.0	0.5	1.1	0.5
Swaziland	2000	15-49	**100.0**	**93.9**	21.7	0.0	19.5	4.3	6.5	41.9	0.0	0.0	1.4	2.9	1.8
Western Africa															
Benin	2001	15-49	**100.0**	**38.7**	1.6	0.0	9.7	4.3	7.0	12.9	1.1	2.2	37.1	23.1	1.1
Burkina Faso	1998/99	15-49	**100.0**	**40.3**	--	--	15.1	3.4	10.1	9.2	--	3.4	38.7	1.7	18.5
Cape Verde	1998	15-49	**100.0**	**87.0**	24.2	0.0	34.4	8.1	5.7	14.6	0.2	0.0	9.3	3.8	0.2
Côte d'Ivoire	1998/99	15-49	**100.0**	**48.7**	0.7	0.0	23.3	2.7	12.0	9.3	0.0	0.0	41.3	2.7	0.0
Gambia	2000	15-49	**100.0**	**92.7**	2.1	0.0	40.6	8.3	1.0	40.6	0.0	0.0	1.0	2.1	4.2
Ghana	1998/99	15-49	**100.0**	**60.5**	5.9	0.0	17.7	3.2	12.3	14.5	4.1	2.3	30.0	6.8	2.7
Guinea	1999	15-49	**100.0**	**67.7**	--	--	33.9	3.2	9.7	16.1	--	4.8	25.8	3.2	3.2
Guinea-Bissau	2000	15-49	**100.0**	**47.4**	3.9	0.0	3.9	30.3	1.3	6.6	0.0	0.0	32.9	3.9	17.1
Liberia	1986	15-49	**100.0**	**85.9**	17.2	0.0	51.6	9.4	0.0	4.7	3.1	0.0	9.4	1.6	3.1
Mali	2001	15-49	**100.0**	**70.4**	3.7	0.0	34.6	2.5	3.7	27.2	0.0	0.0	7.4	0.0	21.0
Mauritania	2000/01	15-49	**100.0**	**63.8**	--	--	32.5	10.0	10.0	11.3	--	1.3	3.8	27.5	3.8
Niger	2000	15-49	**100.0**	**30.7**	1.4	0.0	24.3	0.7	0.0	4.3	0.0	0.0	0.0	0.0	69.3
Nigeria	1999	15-49	**100.0**	**56.2**	2.0	0.0	15.7	13.1	7.8	16.3	1.3	0.0	30.1	7.8	5.9
Senegal	1997	15-49	**100.0**	**62.8**	3.9	0.0	25.6	12.4	4.7	13.2	1.6	--	8.5	1.6	27.9
Sierra Leone	2000	15-49	**100.0**	**90.7**	4.7	0.0	58.1	4.7	2.3	20.9	2.3	0.0	2.3	--	9.3
Togo	2000	15-49	**100.0**	**36.2**	2.7	0.0	9.7	0.8	6.2	15.6	0.8	0.4	21.8	1.6	40.5
Asia															
Eastern Asia															
China	1997	15-49	**100.0**	**99.4**	40.0	9.2	2.0	43.4	4.1	0.5	0.2	0.0	--	--	0.6
China, Hong Kong SAR	1992	15-49	**100.0**	**92.5**	21.9	1.0	19.8	5.9	40.0	2.0	1.7	0.0	5.9	<----1.7---->	
Democratic People's Republic of Korea	1990/92	15-49	**100.0**	**85.8**	6.6	0.5	0.2	78.5	0.0	0.0	0.0	0.0	14.4	0.0	0.0
Japan	2000	15-49	**100.0**	**91.2**	<-------6.4---->		<----4.1---->		75.3	--	27.5	--	6.4	--	2.3

TABLE A.2 *(continued)*

				Modern methods									*Traditional methods*		
Country or area	*Year*	*Age range*	*Any method*	*Any modern method*	*Female sterili-zation*	*Male sterili-zation*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*With-drawal*	*Other traditional methods*
Mongolia	2000	15-49	**100.0**	**80.6**	1.9	0.3	12.3	0.4	6.4	58.3	0.1	0.9	11.9	0.1	7.4
Republic of Korea	1997	15-44	**100.0**	**83.1**	29.9	15.8	2.2	16.4	18.8	0.0	0.0	0.0	<----------16.9---------->		
South-central Asia															
Afghanistan	2000	15-49	**100.0**	**75.0**	16.7	2.1	25.0	6.3	0.0	27.1	0.0	0.0	8.3	10.4	6.3
Bangladesh	1999/00	10-49	**100.0**	**80.7**	12.5	0.9	42.8	2.2	8.0	14.3	0.0	0.0	10.0	7.4	1.7
Bhutan	1994	15-49	**100.0**	**100.0**	16.5	42.6	12.8	5.3	1.6	21.3	0.0	0.0	0.0	0.0	0.0
India	1998/99	15-49	**100.0**	**88.8**	71.0	3.9	4.4	3.3	6.4	0.0	0.0	0.0	6.2	4.1	0.8
Iran (Islamic Republic of)	1997	15-49	**100.0**	**76.8**	21.3	2.6	28.7	11.4	7.4	4.0	--	1.5	<----------23.2---------->		
Kazakhstan	1999	15-49	**100.0**	**79.7**	4.2	0.0	3.6	63.5	6.8	0.9	0.6	0.0	7.1	4.4	8.9
Kyrgyzstan	1997	15-49	**100.0**	**82.2**	3.0	--	2.9	64.2	9.6	2.2	--	0.2	5.4	10.1	2.5
Nepal	2001	15-49	**100.0**	**90.1**	38.2	16.0	4.1	1.0	7.4	22.9	0.0	0.0	2.8	6.6	0.8
Pakistan	2000/01	15-49	**100.0**	**73.2**	25.0	0.0	6.9	12.7	19.9	9.4	0.0	0.0	5.8	19.2	1.8
Sri Lanka	1993	15-49	**100.0**	**66.0**	35.6	5.6	8.3	4.5	5.0	7.0	0.0	0.0	23.0	7.6	3.5
Tajikistan	2000	15-49	**100.0**	**80.5**	0.6	0.3	1.8	74.0	1.2	2.7	0.0	0.0	7.4	8.8	3.2
Turkmenistan	2000	15-49	**100.0**	**85.9**	2.9	0.0	1.9	63.1	3.2	1.6	0.0	12.8	3.4	8.6	2.1
Uzbekistan	2000	15-49	**100.0**	**93.0**	2.1	0.1	3.9	83.8	1.2	1.9	0.0	1.6	2.2	1.9	2.8
South-eastern Asia															
Cambodia	2000	15-49	**100.0**	**77.7**	6.3	--	30.3	5.5	3.8	31.1	--	0.8	11.3	9.7	1.7
Indonesia	1997	15-49	**100.0**	**95.3**	5.2	0.7	26.8	14.1	1.2	47.2	0.0	0.0	1.9	1.4	1.4
Lao People's Democratic Republic	2000	15-49	**100.0**	**89.8**	14.6	0.0	40.1	9.3	1.6	23.9	0.0	0.0	6.8	2.2	0.9
Malaysia	1994	15-49	**100.0**	**88.1**	<------11.7------>		24.6	7.2	9.7	--	--	1.5	16.1	12.7	16.3
Myanmar	1997	15-49	**100.0**	**86.9**	16.8	6.7	22.6	4.0	0.3	35.8	--	--	--	--	13.1
Philippines	1998	15-49	**100.0**	**60.6**	22.2	0.2	21.3	8.0	3.4	5.2	0.4	0.0	19.1	19.1	1.7
Singapore	1997	15-44	**100.0**	**85.5**	<------25.8------>		16.1	8.1	35.5	0.0	0.0	0.0	<------11.3----->		3.2
Thailand	1996/97	15-44	**100.0**	**96.7**	30.5	2.8	32.0	4.4	2.5	24.5	0.0	0.0	--	--	3.3
Viet Nam	2002	15-49	**100.0**	**72.2**	7.5	0.6	8.0	48.0	7.4	0.5	0.0	0.0	9.6	18.2	0.1
Western Asia															
Armenia	2000	15-49	**100.0**	**36.9**	4.5	0.0	1.8	15.5	11.4	0.2	0.3	3.1	7.9	52.7	2.5
Azerbaijan	2001	15-44	**100.0**	**21.5**	2.2	0.0	1.8	11.0	5.8	0.0	0.5	0.2	5.4	73.1	0.0
Bahrain	1995	15-49	**100.0**	**49.5**	10.0	--	17.6	4.7	15.5	0.0	0.0	1.8	5.2	42.6	2.8
Georgia	1999/00	15-44	**100.0**	**48.9**	4.0	--	2.5	24.0	15.6	--	--	2.7	25.2	25.9	0.0

TABLE A.2 *(continued)*

Country or area	Year	Age range	Any method	Modern methods: Any modern method	Female sterilization	Male sterilization	Pill	IUD	Male condom	Injectables and implants	Vaginal barrier methods	Other modern methods	Traditional methods: Rhythm	Withdrawal	Other traditional methods
Iraq	1989	15-49	**100.0**	**75.9**	10.2	--	34.3	20.4	7.3	3.6	0.0	0.0	15.3	8.0	1.5
Israel	1987/88	18-39	**100.0**	**76.3**	<------1.3---->		19.1	44.1	5.9	0.0	5.9	0.0	5.9	16.2	1.5
Jordan	2002	15-49	**100.0**	**73.8**	5.2	--	13.4	42.3	6.1	1.6	--	5.2	9.3	16.7	0.2
Kuwait	1996	15-49	**100.0**	**81.5**	4.2	--	57.4	13.5	5.8	--	--	0.6	8.6	6.8	3.2
Lebanon	1996	15-49	**100.0**	**60.7**	--	--	16.4	27.9	--	--	--	16.4	--	--	39.3
Oman	1995	15-49	**100.0**	**76.8**	19.0	0.0	25.7	9.3	6.3	16.0	0.0	0.0	4.2	9.7	9.7
Qatar	1998	15-49	**100.0**	**74.8**	9.5	--	36.6	20.8	6.7	--	--	1.2	5.3	15.7	4.2
Saudi Arabia	1996	15-49	**100.0**	**89.6**	3.1	--	61.6	20.8	2.8	0.6	--	0.6	3.8	2.5	4.1
Syrian Arab Republic	1993	15-49	**100.0**	**78.4**	6.1	0.0	27.4	43.5	0.8	0.0	0.6	0.0	18.6	2.8	0.3
Turkey	1998	15-49	**100.0**	**59.0**	6.6	0.0	6.9	31.0	12.8	0.8	0.9	0.0	1.7	38.2	0.9
United Arab Emirates	1995	15-49	**100.0**	**85.8**	15.3	--	43.3	13.5	7.3	5.5	0.7	0.4	5.8	5.1	3.3
Yemen	1997	15-49	**100.0**	**47.1**	6.7	0.5	18.3	14.4	1.4	5.8	0.5	0.0	5.3	8.2	39.4
Europe															
Eastern Europe															
Belarus	1995	18-34	**100.0**	**83.5**	1.6	0.0	13.3	57.5	9.5	0.0	1.6	0.0	6.0	10.3	0.2
Bulgaria	1997	18-45	**100.0**	**61.2**	<------0.2---->		16.6	16.4	25.8	0.0	2.2	0.0	6.0	30.6	1.0
Czech Republic	1997	15-44	**100.0**	**86.9**	10.0	7.1	32.1	19.3	17.6	0.0	1.0	0.0	2.4	10.1	0.7
Hungary	1992/93	18-41	**100.0**	**88.4**	6.2	--	48.7	22.5	10.1	0.0	0.8	0.0	3.2	8.1	0.3
Poland	1991	20-49	**100.0**	**38.5**	0.0	0.0	4.7	11.5	18.4	0.0	3.8	0.0	39.1	22.5	0.0
Republic of Moldova	2000	15-49	**100.0**	**68.6**	1.8	0.0	5.3	55.3	5.6	0.0	0.5	0.0	6.9	22.3	2.2
Romania	1999	15-44	**100.0**	**46.2**	3.9	--	12.4	11.4	13.3	--	4.4	0.8	8.8	45.0	0.0
Slovakia	1991	15-44	**100.0**	**55.4**	5.4	0.0	6.8	14.9	28.4	0.0	0.0	0.0	<-------43.2------->		1.4
Ukraine	1999	15-44	**100.0**	**55.7**	2.1	--	4.4	27.6	20.0	--	1.2	0.4	15.4	28.9	0.0
Northern Europe															
Denmark	1988	15-44	**100.0**	**92.3**	6.4	6.4	33.3	14.1	28.2	0.0	3.8	0.0	2.6	6.4	0.0
Estonia	1994	20-49	**100.0**	**80.2**	--	--	5.5	51.1	22.9	0.0	0.9	--	11.5	6.4	1.7
Finland	1989	25-49	**100.0**	**97.4**	19.3	1.4	14.6	33.3	26.0	2.5	0.4	0.0	0.9	0.8	1.0
Latvia	1995	18-49	**100.0**	**81.9**	<------3.1---->		16.7	41.3	20.0	0.2	0.6	0.0	10.4	6.7	1.0
Lithuania	1994/95	18-49	**100.0**	**65.5**	0.0	0.0	6.9	29.8	28.1	0.4	0.0	0.0	20.0	12.9	1.5
Norway	1988/89	--	**100.0**	**93.8**	14.1	5.6	24.1	32.7	16.9	0.0	0.5	0.0	3.1	2.4	0.7
Sweden	1981	20-44	**100.0**	**92.3**	<------3.8---->		29.5	25.6	32.1	0.0	--	--	<----------9.0---------->		
United Kingdom	2002	16-49	**100.0**	**96.4**	15.5	20.2	26.2	7.1	21.4	3.6	1.2	1.2	1.2	4.8	0.0

TABLE A.2 *(continued)*

				Modern methods									Traditional methods		
Country or area	*Year*	*Age range*	*Any method*	*Any modern method*	*Female sterilization*	*Male sterilization*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*Withdrawal*	*Other traditional methods*
Southern Europe															
Albania	2000	15-49	**100.0**	**26.6**	1.6	0.3	9.7	0.0	13.7	1.2	0.0	0.0	13.0	55.3	0.3
Bosnia and Herzegovina	2000	15-49	**100.0**	**33.1**	0.2	0.0	9.5	16.6	6.5	0.0	0.2	0.0	8.6	56.6	1.5
Italy	1995/96	20-49	**100.0**	**64.6**	9.6	0.2	22.6	9.1	22.8	0.0	0.3	0.0	6.0	29.1	0.5
Portugal	1979/80	15-49	**100.0**	**49.5**	1.4	0.2	28.8	5.4	8.4	2.3	3.0	0.0	6.0	38.6	6.0
Serbia and Montenegro	2000	15-49	**100.0**	**56.3**	0.0	0.0	8.1	13.2	29.8	0.0	3.1	2.1	24.4	19.4	1.0
Slovenia	1994	15-44	**100.0**	**80.1**	7.6	0.1	29.4	29.1	10.3	0.3	3.3	0.0	9.5	10.2	0.3
Spain	1995	18-49	**100.0**	**83.3**	15.0	10.0	18.0	9.4	30.0	0.2	0.7	0.0	2.3	14.1	0.4
Western Europe															
Austria	1995/96	20-49	**100.0**	**92.1**	0.0	1.0	60.6	14.4	14.2	0.6	1.4	0.0	4.9	1.4	1.8
Belgium	1991/92	21-39	**100.0**	**94.8**	13.9	8.9	59.6	6.4	6.0	0.0	0.1	0.0	2.7	2.6	0.0
France	1994	20-49	**100.0**	**92.9**	<----10.7----->		47.7	26.7	6.7	0.0	1.1	0.0	2.1	4.3	0.7
Germany	1992	20-39	**100.0**	**96.1**	1.2	0.0	78.4	8.0	5.9	0.9	1.6	0.0	0.8	0.4	2.5
Netherlands	1993	18-42	**100.0**	**96.3**	6.1	13.4	62.4	4.6	9.8	0.0	0.0	0.0	<-------3.7------->		0.0
Switzerland	1994/95	20-49	**100.0**	**94.5**	16.8	10.1	41.6	7.3	17.3	0.4	1.1	0.0	2.8	2.7	0.0
Latin America and the Caribbean															
Caribbean															
Antigua and Barbuda	1988	15-44	**100.0**	**96.2**	21.7	0.0	49.8	2.1	10.5	6.1	6.1	0.0	1.0	2.1	0.8
Bahamas	1988	15-44	**100.0**	**97.4**	26.6	0.0	51.1	6.0	3.7	7.8	2.3	0.0	<-------2.6------->		--
Barbados	1988	15-44	**100.0**	**96.7**	18.9	0.5	47.6	9.6	13.1	1.8	5.1	0.0	1.5	1.8	0.0
Cuba	2000	15-49	**100.0**	**98.4**	25.9	0.0	4.9	59.3	6.8	1.4	0.1	0.0	0.8	0.5	0.4
Dominica	1987	15-44	**100.0**	**96.8**	25.3	0.0	33.1	3.4	11.2	23.7	0.0	0.0	<----------3.4---------->		
Dominican Republic	2000	15-49	**100.0**	**96.6**	66.3	0.0	21.9	3.9	1.4	3.1	0.0	0.0	2.2	0.2	1.1
Grenada	1990	15-44	**100.0**	**--**	9.4	--	28.0	5.5	40.3	16.6	--	--	--	--	--
Haiti	2000	15-49	**100.0**	**78.1**	10.9	--	8.4	--	8.0	49.6	--	2.2	6.6	12.0	2.2
Jamaica	1997	15-49	**100.0**	**95.0**	18.7	0.0	32.2	1.7	25.8	16.7	0.0	0.0	--	4.2	0.3
Montserrat	1984	15-44	**100.0**	**99.2**	<-----3.0----->		58.2	20.9	6.5	6.1	4.6	0.0	<-------0.6------->		0.0
Puerto Rico	1995/96	15-49	**100.0**	**87.0**	58.6	4.5	12.5	1.3	8.2	1.7	0.5	0.0	7.9	5.1	0.0
Saint Kitts and Nevis	1984	15-44	**100.0**	**91.1**	<-----6.4----->		48.5	9.4	13.8	5.7	7.4	0.0	<-------8.9------->		0.0
Saint Lucia	1988	15-44	**100.0**	**97.5**	18.2	0.0	38.9	9.1	12.3	15.6	3.4	0.0	<-------2.7------->		0.0

TABLE A.2 *(continued)*

				Modern methods									Traditional methods		
Country or area	*Year*	*Age range*	*Any method*	*Any modern method*	*Female sterilization*	*Male sterilization*	*Pill*	*IUD*	*Male condom*	*Injectables and implants*	*Vaginal barrier methods*	*Other modern methods*	*Rhythm*	*Withdrawal*	*Other traditional methods*
Saint Vincent and the Grenadines	1988	15-44	**100.0**	**93.7**	22.5	0.0	41.7	4.6	12.7	12.2	0.0	0.0	<----------6.3---------->		
Trinidad and Tobago	2000	15-49	**100.0**	**86.9**	18.8	0.5	26.7	5.8	30.6	3.4	1.3	0.0	2.1	2.9	8.1
Central America															
Belize	1991	15-44	**100.0**	**89.5**	40.0	0.0	31.9	4.1	4.1	9.2	0.0	0.0	5.4	0.0	5.1
Costa Rica	1992/93	15-49	**100.0**	**86.1**	26.3	1.7	24.0	11.6	20.9	1.3	0.3	0.0	9.3	4.4	0.1
El Salvador	1998	15-44	**100.0**	**90.6**	54.3	1.2	13.6	2.5	4.2	14.9	--	--	5.2	4.4	0.0
Guatemala	1998/99	15-49	**100.0**	**80.9**	43.7	2.1	13.1	5.8	6.0	10.2	0.0	0.0	14.9	3.9	0.3
Honduras	2001	15-44	**100.0**	**82.2**	29.1	0.0	16.8	15.5	5.2	15.5	0.0	0.0	7.1	10.4	0.3
Mexico	1997	15-49	**100.0**	**87.0**	43.9	1.9	10.4	20.6	5.4	4.5	0.1	0.1	7.9	5.3	0.1
Nicaragua	2001	15-49	**100.0**	**96.4**	36.9	0.7	21.3	9.3	4.8	20.8	0.0	2.6	2.2	1.5	0.0
Panama	1984	15-44	**100.0**	**93.1**	55.7	0.7	20.3	10.3	2.7	1.4	2.1	0.0	4.0	2.4	0.5
South America															
Bolivia	2000	15-49	**100.0**	**51.1**	8.1	0.0	7.1	23.6	6.2	6.0	0.0	0.0	39.9	0.9	8.1
Brazil	1996	15-49	**100.0**	**91.7**	52.3	3.4	27.0	1.4	5.7	1.6	0.1	0.0	3.9	4.0	0.4
Colombia	2000	15-49	**100.0**	**83.2**	35.2	1.3	15.3	16.1	7.9	5.5	1.0	0.9	7.8	8.2	0.9
Ecuador	1999	15-49	**100.0**	**76.1**	34.2	0.0	16.9	15.3	4.1	5.3	0.3	0.0	12.0	9.9	2.1
Guyana	2000	15-49	**100.0**	**96.5**	12.1	0.3	30.0	16.9	23.6	12.6	1.1	0.3	1.3	1.1	1.3
Paraguay	1998	15-44	**100.0**	**83.1**	13.9	0.0	22.8	19.3	12.7	13.1	0.9	0.0	7.5	9.4	0.0
Peru	2000	15-49	**100.0**	**73.1**	17.9	0.7	9.7	13.2	8.1	21.8	0.9	1.0	20.9	4.6	1.3
Suriname	2000	15-49	**100.0**	**96.4**	22.1	0.2	58.2	4.0	5.9	6.2	0.0	0.0	1.2	1.0	1.2
Northern America															
Canada	1995	15-49	**100.0**	**98.1**	41.0	20.3	19.3	3.9	12.6	0.0	1.1	0.0	0.8	0.9	0.3
United States of America	1995	15-44	**100.0**	**92.3**	31.2	17.3	20.4	0.9	17.4	2.7	2.4	0.0	3.0	3.0	1.7
Oceania															
Australia/New Zealand															
Australia	1986	20-49	**100.0**	**94.9**	36.4	13.7	31.5	6.4	5.8	0.0	1.1	0.0	2.6	2.1	0.4
New Zealand	1995	20-49	**100.0**	**96.1**	20.0	24.0	26.8	4.5	16.6	2.7	1.3	0.0	2.5	1.3	0.0
Melanesia/Micronesia/Polynesia															
Cook Islands	1996	15-49	**100.0**	**95.6**	17.9	0.0	35.8	5.2	3.8	32.9	0.0	0.0	2.2	4.4	4.4
Papua New Guinea	1996	15-49	**100.0**	**75.7**	29.3	0.8	17.0	0.4	1.9	26.3	0.0	0.0	11.2	2.3	10.8

Source: *World Contraceptive Use 2003,* database maintained by the Population Division of the United Nations.

NOTES:

Data coverage: The file shows the most recent data pertaining to 1980 or later dates and available to the Population Division up to September 2003.

Sources of data: Data on contraceptive use were compiled primarily from surveys based on nationally representative samples of women of reproductive age (15 to 49 years unless otherwise specified).

Contraceptive prevalence is the percentage of women is of reproductive age, in a marital or consensual union, who are currently using contraception.

Method mix is the percentage distribution of contraceptive users by method of contraception.

Modern methods include female and male sterilization, the pill, the intrauterine device (IUD), the male condom, injectables and implants, vaginal barrier methods and other modern methods. **Vaginal barrier methods** include diaphragms, cervical caps, and spermicidal foams, jelly, cream and sponges.

Traditional methods include rhythm, withdrawal, and other traditional methods. **Rhythm** is also called periodic abstinence or calendar method. **Other traditional methods** include prolonged abstinence, the lactational amenorrhea method (LAM), douching, various folk methods and traditional methods not reported separately.

Two dashes (--) indicate that prevalence for the corresponding method or age range was not reported separately.

Missing countries: Countries or areas with no data available for 1980 or later years are not included in the file.

[a] The data refer only to Northern Sudan.

[b] As of 1 July 1997, Hong Kong became a Special Administrative Unit (SAR) of China.

[c] The data refer only to the Eastern Region, South-eastern Region and two provinces of the Central Region of Afghanistan.

[d] The data exclude the State of Tripura in India.

[e] The data refer only to Peninsular Malaysia.

[f] The data refer only to the Jewish population.

[g] The data exclude Northern Ireland.

[h] The data refer to the former Yugoslavia, excluding the Province of Kosovo and Metohija.

[i] The data refer only to the Flemish population.

[j] The data were drawn from a sample of women living in households of nationals of the country.

[k] The data were drawn from a sample of **all** women of reproductive age, irrespective of marital status.

[l] The data were drawn from a sample that included women in visiting unions.

[m] The data were drawn from a sample of all sexually active women, irrespective of marital status.

[n] The data were drawn from a sample of women who were sexually active within the month preceding interview.

[o] The data were drawn from a sample of women born in 1945, 1950, 1955, 1960, 1965 or 1968.

[p] Figures by method do not add to the total because some methods are used in combination.

[q] The figure for "any method" includes also emergency contraception.

[r] The figure for "any method" includes some cases of sterilization for non-contraceptive reasons.

[s] The figure for "any method" excludes abstinence, douche and folk methods.

[t] The figure for "male condom" includes the prevalence of vaginal barrier methods.

[u] The figure for "female sterilization" includes the prevalence of male sterilization, vaginal barrier methods and all traditional methods.

[v] The figure for "male sterilization" includes the prevalence of implants, vaginal barrier methods and other modern methods.

[w] The figure for "injectables and implants" includes the prevalence of injectables only.

TABLE A.3. PROJECTED PERCENTAGE OF WOMEN OF REPRODUCTIVE AGE WHO ARE CURRENTLY MARRIED OR IN UNION, BY FIVE-YEAR AGE GROUP AND REGION

		Number of women aged 15-49 (thousands)		*Percentage married or in union*							
Major area and region	*Year*	*All*	*Married*	*15 - 49*	*15 - 19*	*20 - 24*	*25 - 29*	*30 - 34*	*35 - 49*	*40 - 44*	*45 - 49*
World	2000	1 553 650	1 043 265	67.1	14.9	51.8	78.5	87.0	87.7	86.1	84.4
	2005	1 662 574	1 097 427	66.0	13.6	49.4	76.2	86.2	87.8	86.4	84.1
	2010	1 753 146	1 151 442	65.7	13.0	46.9	74.7	85.1	87.3	86.8	84.6
	2015	1 818 756	1 192 049	65.5	12.1	45.2	73.5	84.6	86.4	86.5	85.3
	2020	1 867 954	1 214 596	65.0	11.0	43.4	72.0	84.3	85.9	85.7	85.1
	2025	1 915 778	1 229 572	64.2	9.7	41.1	70.7	83.6	85.7	85.3	84.3
Africa	2000	189 134	117 120	61.9	21.5	56.9	74.7	82.1	84.1	82.9	78.2
	2005	213 705	129 763	60.7	20.0	54.7	73.3	81.6	83.4	82.8	78.2
	2010	238 621	143 785	60.3	18.8	53.2	72.1	81.4	83.4	83.0	78.5
	2015	265 726	159 930	60.2	17.6	52.0	71.5	80.9	83.3	83.5	78.9
	2020	296 452	178 125	60.1	16.2	51.0	71.2	80.8	82.8	83.6	79.3
	2025	329 189	197 336	59.9	14.6	49.6	71.3	80.9	82.6	83.3	79.6
Eastern Africa	2000	58 322	36 975	63.4	23.3	65.7	79.3	83.5	81.6	78.9	73.4
	2005	65 802	41 184	62.6	22.3	64.8	78.9	84.0	81.4	79.2	73.8
	2010	74 219	46 264	62.3	21.2	63.8	78.4	84.1	81.1	79.4	74.1
	2015	84 020	52 226	62.2	19.9	62.7	77.8	84.0	80.9	79.6	74.3
	2020	95 002	58 750	61.8	18.2	61.1	77.3	83.9	80.7	79.6	74.3
	2025	106 835	65 520	61.3	16.4	58.9	76.5	83.6	80.6	79.6	74.6
Middle Africa	2000	20 922	14 213	67.9	32.1	70.5	82.1	84.3	84.3	83.7	76.5
	2005	23 949	15 701	65.6	29.6	67.0	79.8	83.2	81.9	83.4	74.4
	2010	27 380	17 390	63.5	27.2	63.6	77.4	82.0	79.9	83.1	72.7
	2015	31 324	19 398	61.9	25.0	61.0	75.5	80.8	78.3	83.0	71.7
	2020	36 228	21 900	60.5	22.7	59.5	74.3	80.1	76.8	82.7	71.5
	2025	41 773	24 976	59.8	20.4	58.5	73.9	79.8	76.3	82.2	71.4
Northern Africa	2000	44 824	25 590	57.1	10.3	39.0	66.1	80.4	86.6	86.0	82.5
	2005	50 478	28 425	56.3	9.1	36.2	62.8	78.8	85.7	85.9	82.4
	2010	55 205	31 269	56.6	8.3	34.1	60.4	77.4	85.0	85.7	82.7
	2015	59 315	33 986	57.3	7.6	32.5	58.7	76.4	84.3	85.5	82.8
	2020	63 585	36 570	57.5	6.6	31.1	57.7	75.9	83.8	85.2	82.8
	2025	67489	38 604	57.2	5.6	28.9	57.3	75.7	83.4	84.9	82.9
Southern Africa	2000	13 567	4 923	36.3	2.8	17.9	38.5	53.3	59.2	61.1	62.2
	2005	14 108	4 400	31.2	2.2	13.6	31.2	46.9	52.6	54.8	56.7
	2010	13 872	3 712	26.8	1.8	11.4	27.0	42.8	48.1	50.0	52.3
	2015	13 472	3 328	24.7	1.8	10.3	24.9	40.8	45.7	47.2	49.4
	2020	13 247	3 312	25.0	1.7	10.2	24.5	40.7	45.4	46.6	48.5
	2025	13 132	3 558	27.1	1.8	10.7	26.1	42.5	47.0	47.9	49.5

TABLE A.3 *(continued)*

Major area and region	*Year*	*Number of women aged 15-49 (thousands)*		*Percentage married or in union*							
		All	*Married*	*15 - 49*	*15 - 19*	*20 - 24*	*25 - 29*	*30 - 34*	*35 - 49*	*40 - 44*	*45 - 49*
Western Africa	2000	51 499	35 419	68.8	27.9	65.2	83.5	89.6	91.6	90.2	84.6
	2005	59 367	40 053	67.5	24.8	62.0	82.8	89.5	92.2	91.0	86.1
	2010	67 945	45 149	66.4	22.2	59.1	82.0	89.2	92.3	91.2	87.0
	2015	77 595	50 992	65.7	20.0	56.4	81.2	88.8	92.2	91.0	87.3
	2020	88 392	57 593	65.2	18.0	54.1	80.5	88.3	91.8	90.5	87.2
	2025	999 60	64 678	64.7	16.1	51.9	79.5	87.8	91.5	90.0	86.8
Asia	2000	952 262	688 738	72.3	15.3	57.1	85.7	93.1	93.5	91.8	90.3
	2005	1 025 347	727 001	70.9	13.5	54.2	83.6	92.1	93.1	91.8	90.1
	2010	1 087 384	766 143	70.5	12.8	50.8	81.8	91.1	92.2	91.6	90.4
	2015	1 127 385	791 053	70.2	11.6	48.6	80.0	90.5	91.2	90.8	90.5
	2020	1 146 490	794 831	69.3	10.1	45.8	77.8	89.8	90.4	89.8	90.0
	2025	1 163 405	790 486	67.9	8.5	42.2	75.3	88.6	89.8	89.1	89.1
Eastern Asia	2000	401 246	293 294	73.1	0.9	40.4	85.6	95.1	95.7	95.3	94.2
	2005	412 593	291 883	70.7	0.4	34.9	81.9	93.4	94.8	95.0	94.3
	2010	417 826	293 863	70.3	0.3	30.6	78.9	91.7	93.3	94.7	94.6
	2015	408 809	286 663	70.1	0.3	26.7	76.3	90.7	91.9	93.8	94.6
	2020	385 784	265 546	68.8	0.3	23.8	72.2	90.0	90.9	92.9	94.1
	2025	365 286	244 453	66.9	0.3	21.8	68.4	88.2	90.2	92.3	93.5
South-central Asia	2000	363 439	275 510	75.8	27.3	74.5	91.0	93.9	93.6	91.2	89.1
	2005	405 716	302 864	74.6	24.2	71.5	89.8	93.7	93.3	91.2	89.8
	2010	445 861	329 248	73.8	21.5	68.5	88.4	93.2	92.7	91.0	90.2
	2015	481 603	352 635	73.2	18.8	65.0	86.8	92.5	91.9	90.6	90.5
	2020	512 709	371 099	72.4	15.8	61.1	85.0	91.6	91.1	89.9	90.3
	2025	540 974	383 417	70.9	12.9	55.5	82.8	90.6	90.2	89.2	89.9
South-eastern Asia	2000	139 990	89 587	64.0	12.5	52.3	75.6	86.2	87.5	84.4	80.0
	2005	152 905	98 335	64.3	11.7	49.5	74.9	86.5	88.5	84.4	79.3
	2010	163 559	105 607	64.6	10.8	47.6	74.0	86.6	88.8	84.5	78.9
	2015	171 311	111 201	64.9	10.1	45.0	72.9	86.5	89.0	84.5	78.6
	2020	176 703	114 568	64.8	9.0	42.5	71.4	86.3	88.9	84.5	78.6
	2025	180 426	116 166	64.4	7.9	39.6	69.8	85.6	88.8	84.2	79.0
Western Asia	2000	47 587	30 347	63.8	13.6	49.5	75.8	87.0	89.3	86.9	85.6
	2005	54 134	33 919	62.7	12.7	46.3	73.3	86.3	88.8	86.0	84.7
	2010	60 138	37 425	62.2	12.0	43.1	70.9	85.6	88.3	85.1	84.3
	2015	65 662	40 554	61.8	11.1	40.3	68.7	84.7	87.7	84.1	84.1
	2020	71 295	43 617	61.2	10.3	37.6	66.6	84.0	86.9	83.7	83.8
	2025	76 720	46 450	60.5	9.4	35.4	64.7	83.2	86.2	83.4	83.8
Europe	2000	184 198	109 277	59.3	6.8	33.2	60.5	73.7	78.1	78.2	77.4
	2005	181 919	105 526	58.0	7.0	30.2	57.3	72.6	76.9	77.0	77.0

TABLE A.3 *(continued)*

Major area and region	*Year*	*Number of women aged 15-49 (thousands)*		*Percentage married or in union*							
		All	*Married*	*15 - 49*	*15 - 19*	*20 - 24*	*25 - 29*	*30 - 34*	*35 - 49*	*40 - 44*	*45 - 49*
	2010	174 746	100 678	57.6	6.3	27.8	54.3	71.3	76.6	76.2	76.7
	2015	165 316	95 094	57.5	6.0	24.5	52.0	69.8	76.1	76.2	76.7
	2020	156 647	89 851	57.4	5.9	22.7	49.5	68.8	75.4	76.1	76.9
	2025	148 192	84 572	57.1	5.8	22.5	48.8	68.2	75.0	75.9	76.8
Eastern Europe	2000	80 517	51 321	63.7	11.7	47.8	73.1	80.5	80.4	79.3	76.1
	2005	79 337	49 245	62.1	12.4	43.2	68.9	78.9	79.7	78.9	75.9
	2010	74 775	46 718	62.5	12.3	39.8	65.3	77.3	78.9	78.9	75.7
	2015	69 774	44 422	63.7	12.4	36.5	63.0	76.0	78.3	78.7	75.8
	2020	65 777	42 266	64.3	12.2	34.1	61.2	75.3	77.8	78.6	75.9
	2025	61 185	38 963	63.7	11.6	33.0	60.0	75.0	77.7	78.5	76.0
Northern Europe	2000	22 589	11 529	51.0	3.1	18.0	44.7	62.8	69.9	73.4	73.9
	2005	22 725	10 917	48.0	2.9	15.5	39.0	58.6	66.7	71.1	72.4
	2010	22 696	10 416	45.9	2.2	14.6	35.8	55.2	64.5	69.4	71.3
	2015	22 147	9 926	44.8	1.9	13.5	34.7	53.7	63.0	68.3	70.7
	2020	21 463	9 592	44.7	1.8	12.0	34.1	53.7	62.9	67.9	70.1
	2025	21 021	9 588	45.6	1.8	12.4	34.2	54.5	63.7	68.4	70.1
Southern Europe	2000	36 689	22 077	60.2	3.2	19.0	54.8	78.2	85.7	84.0	86.2
	2005	35 965	22 275	61.9	3.6	16.4	52.4	77.9	86.1	83.6	87.1
	2010	34 571	21 762	62.9	4.1	14.6	50.0	78.0	86.6	83.3	87.7
	2015	32 607	20 468	62.8	4.8	13.4	47.6	77.2	87.0	83.1	88.1
	2020	30 429	18 831	61.9	5.1	13.1	46.2	76.1	86.6	82.8	88.4
	2025	28 003	17 059	60.9	5.1	13.2	46.5	75.7	86.0	82.6	88.3
Western Europe	2000	44 403	24 350	54.8	1.1	23.6	51.4	66.2	73.0	73.9	74.7
	2005	43 892	23 089	52.6	0.7	21.4	47.4	63.9	70.9	71.8	73.5
	2010	42 703	21 782	51.0	0.5	20.0	44.7	61.6	69.8	70.4	72.5
	2015	40 788	20 278	49.7	0.5	19.7	42.9	60.4	68.8	69.6	71.9
	2020	38 978	19 161	49.2	0.5	20.2	42.9	60.1	68.5	69.3	71.5
	2025	37 983	18 962	49.9	0.5	21.3	44.3	61.1	68.9	69.6	71.5
LatinAmerica and the Caribbean	2000	139 572	81 810	58.6	14.2	45.0	69.2	78.1	79.0	77.2	74.1
	2005	151 071	89 191	59.0	13.7	43.9	68.4	77.7	79.2	77.3	74.4
	2010	160 580	95 459	59.4	13.0	42.9	67.7	77.3	79.5	77.8	73.9
	2015	167 719	100 369	59.8	12.4	41.9	67.2	76.9	79.6	78.3	74.1
	2020	173 591	104 406	60.1	11.8	41.1	66.7	76.6	79.6	78.5	74.7
	2025	177 448	107 322	60.5	11.2	40.6	66.6	76.4	79.6	78.6	75.4
Caribbean	2000	9 879	5 648	57.2	25.2	51.5	67.8	72.9	71.7	71.5	45.9
	2005	10 421	6 004	57.6	26.7	51.7	66.8	73.0	72.0	71.8	49.0
	2010	10 742	6 174	57.5	26.9	52.6	66.0	73.2	72.5	72.6	44.4

TABLE A.3 *(continued)*

Major area and region	Year	Number of women aged 15-49 (thousands)		Percentage married or in union							
		All	Married	15 - 49	15 - 19	20 - 24	25 - 29	30 - 34	35 - 49	40 - 44	45 - 49
	2015	10 746	6 238	58.1	26.5	52.5	65.9	73.2	73.4	73.4	45.0
	2020	10 713	6 281	58.6	25.5	52.2	65.8	73.6	74.1	74.5	47.9
	2025	10 681	6 393	59.9	24.1	51.5	65.8	74.0	75.1	75.3	56.4
Central America	2000	35 960	21 747	60.5	15.0	47.8	72.3	79.0	83.9	82.6	80.8
	2005	39 732	24 241	61.0	13.9	45.5	71.1	78.1	84.3	83.1	81.4
	2010	43 165	26 435	61.2	12.9	43.5	70.0	77.3	84.6	83.5	81.6
	2015	46 090	28 373	61.6	12.0	41.9	69.2	76.6	84.6	83.7	81.8
	2020	48 275	29 857	61.8	11.3	40.7	68.4	76.3	84.3	83.4	81.8
	2025	49 437	30 625	61.9	10.7	39.9	67.9	76.0	84.0	82.9	81.4
South America	2000	93 733	54 415	58.1	12.7	43.3	68.0	78.3	78.2	75.9	75.0
	2005	100 919	58 946	58.4	12.2	42.4	67.4	78.0	78.0	76.0	74.7
	2010	106 673	62 849	58.9	11.7	41.6	67.0	77.6	78.1	76.2	74.4
	2015	110 883	65 757	59.3	11.2	40.8	66.5	77.4	78.1	76.6	74.3
	2020	114 604	68 268	59.6	10.7	40.3	66.1	77.0	78.2	76.9	74.3
	2025	117 330	70 304	59.9	10.2	39.9	66.1	76.8	78.2	77.2	74.5
Northern America	2000	80 631	42 029	52.1	3.9	19.6	51.1	66.1	70.4	72.5	70.4
	2005	82 315	41 645	50.6	3.6	16.0	48.8	66.2	70.8	73.4	70.3
	2010	83 227	41 049	49.3	3.4	13.9	47.5	66.5	71.3	74.2	70.3
	2015	83 738	41 204	49.2	3.4	12.8	47.1	67.2	72.0	74.9	70.5
	2020	85 645	42 824	50.0	3.5	12.7	47.6	68.1	72.8	75.6	70.9
	2025	88 248	45 128	51.1	3.6	13.4	49.0	69.3	73.7	76.3	71.4
Oceania	2000	7 853	4 292	54.6	6.2	29.1	54.8	70.2	75.6	76.7	76.9
	2005	8 217	4 301	52.3	5.9	26.0	50.1	67.1	73.6	74.9	75.1
	2010	8 588	4 328	50.4	6.2	24.7	46.8	65.0	72.1	73.7	73.8
	2015	8 872	4 399	49.6	6.1	25.3	45.3	63.7	71.3	72.9	73.0
	2020	9 128	4 559	49.9	5.9	25.3	46.4	63.6	70.9	72.7	72.5
	2025	9 296	4 729	50.9	5.5	25.1	47.6	65.1	71.3	72.8	72.5
Australia/New Zealand	2000	5 867	2 989	50.9	1.5	14.8	45.4	65.5	72.4	74.6	75.4
	2005	6 003	2 866	47.7	1.4	11.0	38.3	61.2	69.6	72.2	73.2
	2010	6 093	2 754	45.2	1.4	9.3	33.7	58.1	67.4	70.5	71.4
	2015	6 103	2 675	43.8	1.4	8.5	31.5	56.2	66.1	69.3	70.2
	2020	6 112	2 678	43.8	1.4	8.2	31.0	55.9	65.6	68.7	69.4
	2025	6 070	2 709	44.6	1.4	8.6	32.0	56.9	66.1	68.9	69.3
Melanesia/Micronesia/ Polynesia	2000	1 986	1 302	65.6	15.4	59.7	78.4	84.0	87.4	86.2	85.3
	2005	2 214	1 435	64.8	14.5	57.4	76.8	82.9	86.3	85.4	84.5
	2010	2 495	1 573	63.0	13.7	55.3	75.6	82.0	85.5	84.7	83.8

TABLE A.3 *(continued)*

Major area and region	*Year*	*Number of women aged 15-49 (thousands)*		*Percentage married or in union*							
		All	*Married*	*15 - 49*	*15 - 19*	*20 - 24*	*25 - 29*	*30 - 34*	*35 - 49*	*40 - 44*	*45 - 49*
	2015	2 769	1 723	62.2	12.9	53.3	74.5	81.3	84.7	84.0	83.0
	2020	3 016	1 879	62.3	12.1	51.2	73.4	80.8	83.9	83.3	82.2
	2025	3 226	2 019	62.6	11.2	49.1	72.4	80.2	83.2	82.6	81.4

Source: Calculated as described in annex I.

TABLE A.4. GOVERNMENT POLICIES ON PROVIDING ACCESS TO CONTRACEPTIVE METHODS, BY COUNTRY: 1976, 1986, 1996 AND 2001

Country	*1976*	*1986*	*1996*	*2001*
Africa				
Eastern Africa				
Burundi	No support	Direct support	Direct support	Direct support
Comoros	No support	Direct support	Direct support	Direct support
Djibouti	..	No support	No support	Direct support
Eritrea	..	..	..	Direct support
Ethiopia	Indirect support	Direct support	Direct support	Direct support
Kenya	Direct support	Direct support	Direct support	Direct support
Madagascar	Indirect support	Direct support	Direct support	Direct support
Malawi	Limits	Direct support	Direct support	Direct support
Mauritius	Direct support	Direct support	Direct support	Direct support
Mozambique	Direct support	Direct support	Direct support	Direct support
Rwanda	No support	Direct support	Direct support	Direct support
Seychelles	Direct support	Direct support	Direct support	Direct support
Somalia	No support	Indirect support	Indirect support	Indirect support
Uganda	Direct support	Direct support	Direct support	Direct support
United Republic of Tanzania	Direct support	Direct support	Direct support	Direct support
Zambia	Direct support	Direct support	Direct support	Direct support
Zimbabwe	..	Direct support	Direct support	Direct support
Middle Africa				
Angola	..	Direct support	Direct support	Direct support
Cameroon	Indirect support	Direct support	Indirect support	Indirect support
Central African Republic	No support	Direct support	Direct support	Indirect support
Chad	Limits	No support	Indirect support	Indirect support
Congo	Direct support	Direct support	Direct support	Direct support
Dem. Rep. of the Congo	Direct support	Indirect support	Direct support	Direct support
Equatorial Guinea	No support	No support	No support	No support
Gabon	Limits	No support	No support	No support
Sao Tome and Principe	No support	Direct support	Direct support	Direct support
Northern Africa				
Algeria	Direct support	Direct support	Direct support	Direct support
Egypt	Direct support	Direct support	Direct support	Direct support
Libyan Arab Jamahiriya	No support	No support	No support	No support
Morocco	Direct support	Direct support	Direct support	Direct support
Sudan	Direct support	Direct support	Direct support	Direct support
Tunisia	Direct support	Direct support	Direct support	Direct support
Southern Africa				
Botswana	Direct support	Direct support	Direct support	Direct support
Lesotho	Direct support	Direct support	Direct support	Direct support
Namibia	..	..	Direct support	Direct support
South Africa	Direct support	Direct support	Direct support	Direct support
Swaziland	Direct support	Direct support	Direct support	Direct support

TABLE A.4 *(continued)*

Country	*1976*	*1986*	*1996*	*2001*
Western Africa				
Benin	Indirect support	Indirect support	Direct support	Direct support
Burkina Faso	No support	Indirect support	Direct support	Direct support
Cape Verde	Direct support	Direct support	Direct support	Direct support
Côte d'Ivoire	No support	No support	Indirect support	Direct support
Gambia	Indirect support	Direct support	Direct support	Direct support
Ghana	Direct support	Direct support	Direct support	Direct support
Guinea	No support	Direct support	Direct support	Direct support
Guinea-Bissau	Indirect support	Direct support	Direct support	Direct support
Liberia	Direct support	Indirect support	Direct support	Direct support
Mali	Direct support	Direct support	Direct support	Direct support
Mauritania	No support	No support	Direct support	Direct support
Niger	No support	Direct support	Direct support	Direct support
Nigeria	Direct support	Direct support	Direct support	Direct support
Senegal	No support	Direct support	Direct support	Direct support
Sierra Leone	Direct support	Indirect support	Indirect support	Indirect support
Togo	Indirect support	Direct support	Direct support	Direct support
Asia				
Eastern Asia				
China	Direct support	Direct support	Direct support	Direct support
Dem. People's Rep. of Korea	Direct support	Direct support	Direct support	Direct support
Japan	Direct support	Direct support	Direct support	Indirect support
Mongolia	Direct support	Direct support	Direct support	Direct support
Republic of Korea	Direct support	Direct support	Direct support	Direct support
South-central Asia				
Afghanistan	Direct support	Direct support	Direct support	Direct support
Bangladesh	Direct support	Direct support	Direct support	Direct support
Bhutan	Direct support	Direct support	Direct support	Direct support
India	Direct support	Direct support	Direct support	Direct support
Iran (Islamic Republic of)	Direct support	Indirect support	Direct support	Direct support
Kazakhstan	..	..	Direct support	Indirect support
Kyrgyzstan	..	..	..	Direct support
Maldives	No support	Direct support	Direct support	Direct support
Nepal	Direct support	Direct support	Direct support	Direct support
Pakistan	Direct support	Direct support	Direct support	Direct support
Sri Lanka	Direct support	Direct support	Direct support	Direct support
Tajikistan	..	..	Direct support	Direct support
Turkmenistan	..	..	No support	No support
Uzbekistan	..	..	Direct support	Direct support
South-eastern Asia				
Brunei Darussalam	..	No support	No support	No support
Cambodia	Limits	Limits	Direct support	Direct support
Dem. Rep. of Timor-Leste	..	..	..	..
Indonesia	Direct support	Direct support	Direct support	Direct support
Lao People's Dem. Republic	Limits	Limits	No support	No support

TABLE A.4 *(continued)*

Country	*1976*	*1986*	*1996*	*2001*
Malaysia	Direct support	Direct support	Direct support	Direct support
Philippines	Direct support	Direct support	Direct support	Direct support
Singapore	Direct support	Direct support	Direct support	Direct support
Thailand	Direct support	Direct support	Direct support	Direct support
Viet Nam	Direct support	Direct support	Direct support	Direct support
Western Asia				
Armenia	..	..	Direct support	Direct support
Azerbaijan	..	..	Indirect support	Direct support
Bahrain	Indirect support	Direct support	Direct support	Direct support
Cyprus	No support	Direct support	Indirect support	Indirect support
Georgia	..	..	No support	Direct support
Iraq	Direct support	Limits	No support	Direct support
Israel	Direct support	Direct support	Direct support	Indirect support
Jordan	Direct support	Indirect support	Direct support	Direct support
Kuwait	No support	No support	No support	Indirect support
Lebanon	Indirect support	Indirect support	Indirect support	Indirect support
Oman	No support	No support	No support	No support
Qatar	No support	No support	No support	Direct support
Saudi Arabia	Limits	Limits	Limits	Indirect support
Syrian Arab Republic	Direct support	Direct support	Direct support	Direct support
Turkey	Direct support	Direct support	Direct support	Direct support
United Arab Emirates	No support	No support	No support	No support
Yemen	Direct support	Direct support	Direct support	Direct support
Europe				
Eastern Europe				
Belarus	Direct support	Direct support	Direct support	Direct support
Bulgaria	Direct support	Direct support	No support	Indirect support
Czech Republic	..	..	Indirect support	Indirect support
Hungary	Direct support	Direct support	Direct support	Direct support
Poland	Direct support	Direct support	Direct support	Direct support
Republic of Moldova	..	..	Direct support	Direct support
Romania	Direct support	Limits	Direct support	Direct support
Russian Federation	..	..	Direct support	Direct support
Slovakia	..	..	No support	No support
Ukraine	Direct support	Direct support	Direct support	Direct support
Northern Europe				
Denmark	Direct support	Direct support	Direct support	Indirect support
Estonia	..	..	No support	Indirect support
Finland	Direct support	Direct support	Direct support	Direct support
Iceland	Direct support	Direct support	Direct support	Direct support
Ireland	No support	Limits	Direct support	Direct support
Latvia	..	..	Direct support	Indirect support
Lithuania	..	..	Direct support	Indirect support
Norway	Direct support	Direct support	Direct support	Direct support

TABLE A.4 *(continued)*

Country	*1976*	*1986*	*1996*	*2001*
Sweden	Direct support	Direct support	Direct support	Direct support
United Kingdom	Direct support	Indirect support	Direct support	Direct support
Southern Europe				
Albania	Direct support	Direct support	Direct support	Direct support
Andorra	..	..	No support	No support
Bosnia and Herzegovina	..	..	Indirect support	Indirect support
Croatia	..	..	Direct support	Direct support
Greece	Limits	No support	No support	No support
Holy See	Limits	Limits	Limits	Limits
Italy	Indirect support	Direct support	Direct support	No support
Malta	No support	No support	No support	Indirect support
Portugal	Direct support	Direct support	Direct support	Direct support
San Marino	No support	No support	No support	No support
Serbia and Montenegro	..	..	Indirect support	Indirect support
Slovenia	..	..	Direct support	Direct support
Spain	Limits	Direct support	Direct support	Direct support
TFYR Macedonia [a]	..	..	Direct support	Direct support
Western Europe				
Austria	Direct support	Direct support	Direct support	Indirect support
Belgium	Indirect support	Indirect support	Indirect support	Direct support
France	Direct support	Indirect support	No support	Indirect support
Germany	..	..	No support	No support
Liechtenstein	No support	No support	No support	Direct support
Luxembourg	Indirect support	Indirect support	Indirect support	Indirect support
Monaco	Direct support	Direct support	No support	No support
Netherlands	Indirect support	Indirect support	Indirect support	Indirect support
Switzerland	Indirect support	Indirect support	No support	No support
Latin America and the Caribbean				
Caribbean				
Antigua and Barbuda	..	Direct support	Direct support	Direct support
Bahamas	Indirect support	Indirect support	Indirect support	Direct support
Barbados	Direct support	Direct support	Direct support	Direct support
Cuba	Direct support	Direct support	Direct support	Direct support
Dominica	..	Direct support	Direct support	Direct support
Dominican Republic	Direct support	Direct support	Direct support	Direct support
Grenada	Direct support	Direct support	Direct support	Direct support
Haiti	Direct support	Direct support	Direct support	Direct support
Jamaica	Direct support	Direct support	Direct support	Direct support
Saint Kitts and Nevis	..	Direct support	Direct support	Direct support
Saint Lucia	..	Direct support	Direct support	Direct support
Saint Vincent and Grenadines	..	Direct support	Direct support	Direct support
Trinidad and Tobago	Direct support	Direct support	Direct support	Direct support

TABLE A.4 *(continued)*

Country	*1976*	*1986*	*1996*	*2001*
Central America				
Belize	..	No support	Indirect support	Indirect support
Costa Rica	Direct support	Direct support	Direct support	Direct support
El Salvador	Direct support	Direct support	Direct support	Direct support
Guatemala	Direct support	Direct support	Direct support	Direct support
Honduras	Direct support	Direct support	Direct support	Direct support
Mexico	Direct support	Direct support	Direct support	Direct support
Nicaragua	Direct support	Indirect support	Direct support	Direct support
Panama	Direct support	Direct support	Direct support	Direct support
South America				
Argentina	Limits	No support	No support	Indirect support
Bolivia	Direct support	Indirect support	Direct support	Direct support
Brazil	Indirect support	Direct support	Direct support	Direct support
Chile	Direct support	Direct support	Direct support	Direct support
Colombia	Direct support	Direct support	Indirect support	Direct support
Ecuador	Direct support	Direct support	Direct support	Direct support
Guyana	No support	Direct support	Direct support	Direct support
Paraguay	Direct support	Indirect support	Direct support	Direct support
Peru	Direct support	Direct support	Direct support	Direct support
Suriname	No support	Direct support	Direct support	Direct support
Uruguay	No support	Direct support	Direct support	Direct support
Venezuela	Direct support	Direct support	Direct support	Direct support
Northern America				
Canada	Direct support	Direct support	Direct support	Indirect support
United States of America	Direct support	Direct support	Direct support	Direct support
Oceania				
Australia/New Zealand				
Australia	Indirect support	Indirect support	Indirect support	Indirect support
New Zealand	Direct support	Indirect support	Direct support	Indirect support
Melanesia				
Fiji	Direct support	Direct support	Direct support	Direct support
Papua New Guinea	Direct support	Direct support	Direct support	Direct support
Solomon Islands	..	Direct support	Direct support	Direct support
Vanuatu	..	Direct support	Direct support	Direct support
Micronesia				
Kiribati	..	Direct support	Direct support	Direct support
Marshall Islands	..	..	Direct support	Direct support
Micronesia (Federated States of)	..	..	Direct support	Direct support
Nauru	Direct support	Direct support	Direct support	Direct support
Palau	..	..	..	Indirect support

TABLE A.4 *(continued)*

Country	*1976*	*1986*	*1996*	*2001*
Polynesia				
Cook Islands	..	..	Direct support	Direct support
Niue	..	..	..	Indirect support
Samoa	Direct support	Direct support	Direct support	Direct support
Tonga	Direct support	Direct support	Direct support	Direct support
Tuvalu	..	Direct support	Direct support	Direct support

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12).
NOTES: Two dots (..) indicate that data are not available.
[a] The Former Yugoslav Republic of Macedonia.

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