Universal Access to Reproductive Health

PROGRESS AND CHALLENGES

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UNFPA

Acronyms

ABR: Adolescent birth rate

CPR: Contraceptive prevalence rate

CRVS: Civil registration and vital statistics

DHS: Demographic and Health Surveys

GPRHCS: Global Programme to Enhance Reproductive Health Commodity Security

IUD: Intrauterine device

LAM: Lactational amenorrhea method

mCPR: Modern contraceptive prevalence rate

MDGs: Millennium Development Goals

MICS: Multiple Indicators Cluster Surveys

mPDS: PDS satisfied by modern methods

NHFA: National Health Facility Assessment

PDS: Proportion of demand for contraception satisfied

RHCS: Reproductive health commodity security

SDP: Service delivery point

SDGs: Sustainable Development Goals

TD: Total demand

TFR: Total fertility rate

UNFPA: United Nations Population Fund

UNR: Unmet need for family planning

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Executive Summary

The importance of reproductive health and access to family planning in particular are now well recognized, to not only improve women's chances of surviving pregnancy and childbirth, but also to contribute to related issues such as gender equality, better child health, an improved response to HIV, greater education outcomes and poverty reduction. This report profiles existing data around the main MDG5b indicators to identify progress achieved, and old and new challenges that could be addressed under the SDGs, particularly the nine targets under SDG3. The report highlights the most vulnerable and disadvantaged population groups, and their access to and use of reproductive health services.

In 2015, two out of three women of reproductive age who are married or in a union, use some form of contraception, either modern or traditional, and another 12 per cent have an unmet need for contraception. The most common methods, female sterilization and the IUD, account for more than 60 per cent of modern method use. One out of four users is using either pill or male condom.

Combining contraceptive use and unmet need shows that over eight out of ten women aged 15-49 who were married or in a union had their family planning demand satisfied, but with substantial variation across regions and countries. However, in Africa, less than half of women who are married or in a union who need contraception have their family planning demand satisfied.

While the MDGs are close to an end, through the SDGs, it is critical for the international community to reaffirm the promise of universal access to reproductive health and family planning, and increase investment in this area. Special attention needs to go to those regions and countries lagging behind and making little or slower progress.

Worldwide, some 1.2 billion adolescents, aged 10-19, comprise more than 16 per cent of the total population. An estimated 250 million adolescent girls live in developing countries, accounting for about one-sixth of all women of reproductive age. More than one in five of these adolescent girls are currently married or in a union, and 3 per cent are unmarried but sexually active. In 2015, 15.3 million adolescent girls will give birth, a figure rising to 19.2 million by 2035 if current patterns remain unchanged. Demand and use of contraception among adolescent girls have increased, but current levels are still remarkably lower than for other age groups. Expanding access to family planning services to adolescents will require political and financial commitments from governments and civil society to use existing evidence to develop policies and interventions that focus particularly on the most vulnerable groups of adolescents—those who live in rural areas, are out of school, have little or no education and/or reside in the poorest households. About 15 per cent of adolescent girls who are married or in a union are using modern contraception. Single methods seem to dominate, such as injectable in East and Southern Africa, the pill in the Arab States, and male condoms in Latin America and the Caribbean. In 2015, 12.7 million adolescent girls have an unmet need for family planning. This number will increase to 15.1 million by 2035 if current trends continue.

Births rates among adolescents and contraceptive dynamics are significantly affected by place of residence, level of education and household wealth. Adolescent fertility rates are considerably higher in rural areas, among those without or with low levels of education, and in the poorest households.

In all developing regions, women in rural areas, in poor households and with no or low levels of education have lower levels of contraceptive use. This report shows that women from the wealthiest households, living in urban areas and with higher levels of education experience lower levels of unmet need for contraception.

There are many determinants of contraceptive use in developing countries, including access and availability to modern methods. For Ethiopia and Nigeria, a comparison of survey results contrasted changes in contraceptive use with method availability at service delivery points (SDPs). This revealed a possible contradiction between the high availability of modern methods in all SDPs, and Nigeria's low levels of CPR, and Ethiopia's high concentration on injections. In trying to understand these differences, this paper documented the main reasons for not using contraception among women with an unmet need as well as levels of informed choice. Important percentages of women with an unmet need in both countries were in the postpartum period and/or breastfeeding, while fertility-related reasons were of greater relevance among younger mothers. Since postpartum or breastfeeding periods carry the potential for pregnancy, counselling needs to target women in this group.

Guaranteeing informed choice to current and future users of contraception fulfils basic reproductive rights and indicates quality of care. In the long run, it contributors to the relevance, effectiveness, efficiency and sustainability of family planning programmes.

Introduction

2015 marks the end of the Millennium Development Goals (MDGs) and the beginning of the Sustainable Development Goals (SDGs), looking towards 2030. The international community is identifying new challenges and alternative solutions, and assessing progress, including on the fifth MDG on improving maternal health, with its targets for reducing maternal mortality (MDG5a) and achieving universal access to reproductive health (MDG5b).

Reproductive health[1] is critical to advancing development. Its importance, particularly in terms of access to rights-based family planning, is now well recognized in not only improving women's chances of surviving pregnancy and childbirth, but also in contributing to gender equality, better child health, preventing and responding to HIV transmission, better education outcomes and poverty reduction.

This report highlights existing data around the main indicators under MDG5b. It considers progress achieved as well as old and new challenges that could be addressed under the SDGs, particularly the nine targets under SDG3.

Universal access to reproductive health affects and is affected by many aspects of life. It involves individuals' most intimate relationships, including negotiation and decision-making within sexual relationships, and interactions with health providers regarding contraceptive methods and options.[2] This report seeks to identify areas where reproductive health has advanced or not according to four main indicators:

- Adolescent birth rate (ABR)
- Contraceptive prevalence rate (CPR)
- Unmet need for family planning rate (UNR)
- Proportion of demand for contraception satisfied (PDS)

The report is organized to present levels, trends and differentials, and to assess progress at the country, regional and global levels. Chapter 2 presents estimates of global and regional levels and trends from 1990 to 2015. It describes different family planning methods used across regions, and explores relationships between methods and improved availability of good quality, human rights-based family planning services.

Chapter 3 assesses progress on the reproductive health of adolescents, starting with a mapping of these populations by region, according to marital status and sexual activity. Since many developing countries are experiencing large cohorts of adolescents, the chapter includes numerical estimates and relevance to public policies and strategies. The chapter describes adolescents' existing access to contraception, their unmet need for it and the proportion of demand currently satisfied. The absolute number of adolescents in need of contraception is presented, as is the mix of methods they are currently using.

Chapter 4 looks at demographic disparities (age, place of residence), and social and economic inequalities (education, household wealth) observed across the indicators, towards identifying priorities for policies, programmes and interventions for 2016 to 2030, under the SDGs. Measuring progress based on such factors is important to determine whether the most

[1] "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process." UNFPA. 2014. Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, p. 45.

[2] UNFPA. 2010. "How Universal is Access to Reproductive Health? A review of the evidence," p. 9. Access to reproductive health is ultimately determined by social, cultural, religious, financial and legal issues.statement." 1997, reiterated in 2008. Geneva: World Health Organization (WHO).

vulnerable and disadvantaged groups have equal access to reproductive health services.

Chapter 5 features country case studies as examples of progress in using reproductive health indicators, highlighting interventions in place as well as remaining challenges. Chapter 6 concludes the report with a summary of findings intended to inform coming efforts under the sustainable development agenda, and geared towards finishing the agenda of universal access to reproductive health.

The analysis, tables, graphs and maps are produced from data compiled by UNFPA from vital statistics, population censuses, the Demographic and Health Surveys (DHS), and the Multiple Indicators Cluster Surveys (MICS).[3] Other data, such as projections and population estimates, were obtained from the United Nations Population Division. Fortunately, the quality of data around the four indicators is good enough to provide the desired analysis for this report, particularly data produced by the DHS and MICS, which have substantially contributed to filling data gaps in many developing countries during the last 10-15 years.

Family planning global and regional trend data and analysis came from model estimates by the United Nations Population Division.[4] Country trends and analysis were developed from two or more data points from DHS or MICS studies. The two most recent data points from these surveys correspond approximately to two periods: 2000-2008 and 2007-2014.

[3] For more information about the DHS and MICS, see www.dhsprogram.com and www.childinfo.org/mics.html.

[4] Using a multilevel regression model that incorporates available data points and key development indicators. See United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015*. New York: United Nations.

1.1. Indicator definitions

This paper attempts to measure progress towards universal access to reproductive health using the MDG5b indicators (ABR, CPR and UNR) plus a more recent indicator under the SDGs (PDS). See Table 1.1. These are linked to other indicators of health, gender equity and other factors that in one way or another shape reproductive health.

PDS "reflects the extent to which partners, communities and the health system support women [and girls] in acting on their choices, and monitors whether women's stated desires regarding contraception are being fulfilled. It calls attention to inequities in service access and is therefore used to promote a human rights-based approach to reproductive health."[5]

[5] UNFPA. 2010. "How Universal is Access to Reproductive Health? A review of the evidence." p. 11.

Table 1.1. Details of four indicators Indicator definitions

INDICATOR	DEFINITION	NUMERATOR	DENOMINATOR	DATA SOURCES
Adolescent birth rate	Number of births per 1,000 girls aged 15-19	Total number of births among girls aged 15-19	Total number of girls aged 15-19	CRVS, DHS, MICS, censuses
Contraceptive prevalence rate	Percentage of women who are married or in union and of reproductive age (15-49 years old) using any method of contraception (modern or traditional)	Number of women married or union aged 15-49 who are using (with her husband/partner) any method of contraception (modern or traditional)	Number of women who are married or in union and of reproductive age (15-49 years old)	DHS and MICS
Unmet need for family planning	Proportion of women not using contraception among women of reproductive age (15-49 years old), who are either married or in a union, and who are fecund and sexually active, but do not want any more children, or would like to delay the birth of their next child for at least two years	Number of women not using contraception among women of reproductive age (15-49 years old), who are either married or in a union, and who are fecund and sexually active, but do not want any more children or would like to delay the birth of their next child for at least two years	Number of women who are married or in a union and of reproductive age (15-49 years old)	DHS and MICS
Proportion of demand for contraception satisfied[6]	Percentage of the total demand (TD) for contraception that is satisfied	CPR	Total demand for contraception = CPR+UNR	PDS = CPR / (CPR+UNR) as a percentage

[6] mPDS, or proportion of the demand satisfied by modern methods, is commonly used for programmatic purposes expressing the percentage of the total demand for contraception (CPR+UNR) that is satisfied by the use of modern contraceptives (mCPR). mPDS is expressed as: mPDS = (mCPR/TD)x100.

Reproductive Health at the Global and Regional Levels

This chapter briefly describes progress towards universal access to reproductive health at the global and regional levels. It considers four main sexual and reproductive health indicators: ABR, CPR, UNR and PDS.

2.1. Global and regional levels and trends in adolescent birth rates

Worldwide in 2012, 1 out of 20 adolescents aged 15-19 had a live birth. During the last 25 years, significant progress has been made in reducing adolescent childbearing, especially between 1990 and 2000. The decline in the ABR, measured by the annual number of live births per 1,000 women aged 15-19, has been almost universal across regions and countries. Between 1990 and 2012, globally, the rate dropped from 59 to 51 births per 1,000 girls. During the same period, South Asia experienced the largest decline, from 88 to 50 births per 1,000 girls,[7] a reduction that occurred amid an increase in school participation, an increase in the demand for contraception and a decrease in the proportion of adolescents who were ever married.

Challenges remain, however. By 2012, the ABR was still as high as 75 live births or more per 1,000 girls in sub-Saharan Africa, Latin America and South Asia, excluding India. Sub-Saharan Africa has made the least progress, and in 2012 the region continued to show the highest ABR, of 118 births per 1,000 girls, just slightly lower than the rate in 1990, of 123 births per 1,000 girls.

[7] Inter-agency and Expert Group on Millennium Development Goal Indicators and Millennium Development Goal Indicators website (http://mdgs.un.org).

2.2. Levels and trends in contraceptive prevalence rate, unmet need for family planning and proportion of demand satisfied

In 2015, two out of three women or about 64 per cent of women of reproductive age (15-49), married or in a union, are using some form of contraception, either modern or traditional (Table 2.1 and Figure 2.1). Latin America and the Caribbean has the highest level of contraceptive use, with a CPR of 73 per cent, followed by Asia and the Pacific at 69 per cent, and Eastern Europe and Central Asia at 65 per cent.

During 2000-2015, two of six regions have had a significantly higher annual rate of increase of 1 per cent or more in the CPR, compared to the global average of 0.2 per cent: East and Southern Africa at 3.2 per cent and West and Central Africa at 1.7 per cent.

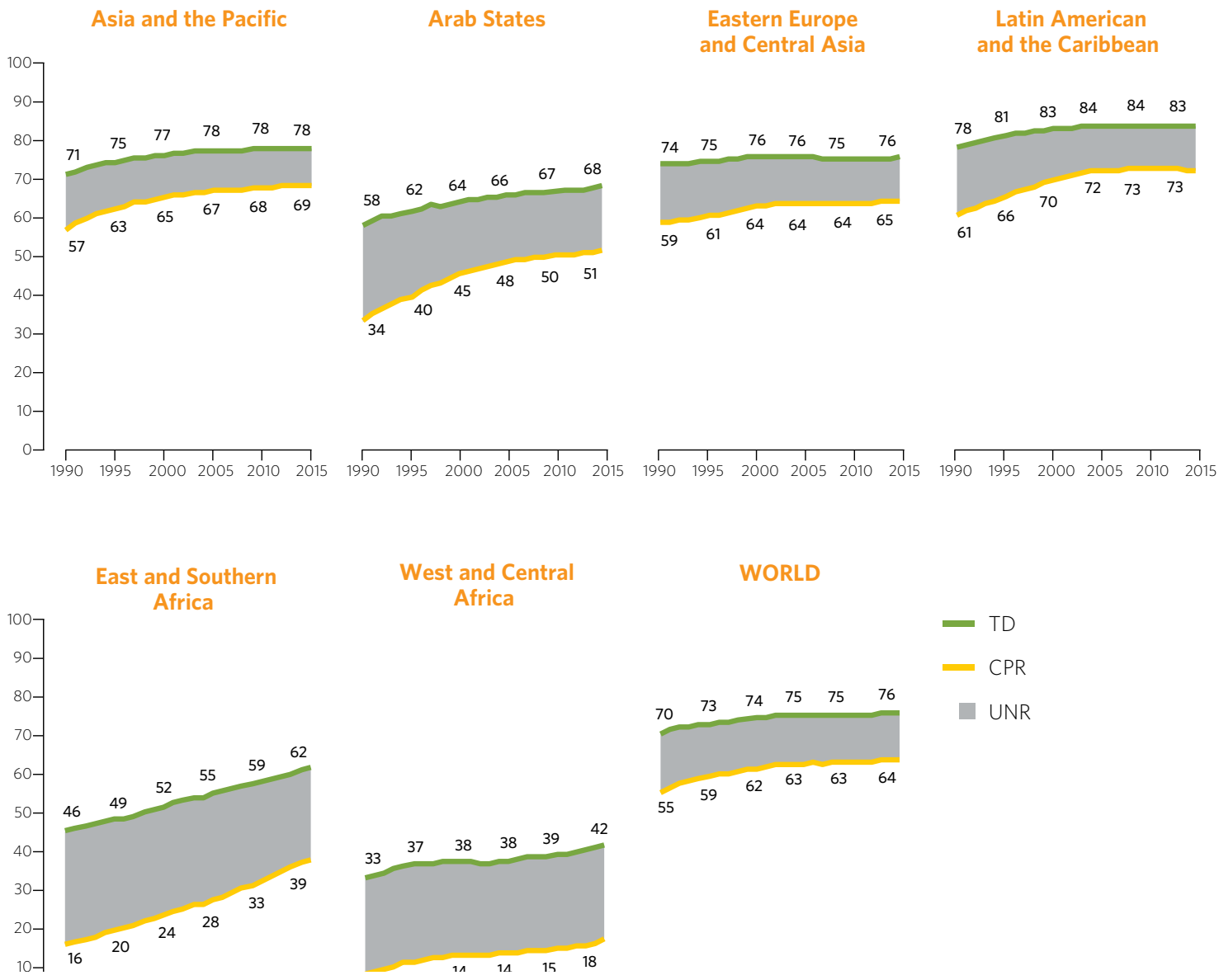
Increase in contraceptive use among women who are married or in a union has been slower since 2000. Between 2000 and 2015, globally, the prevalence of contraception use only increased 3.4 per cent, compared to an increase of 11.2 per cent between 1990 and 2000. Faster increases occurred in regions with relatively low levels of use, such as East and Southern Africa, with an increase of 61.4 per cent, West and Central Africa, up 28.5 per cent, and the Arab States, rising 13.8 per cent.

Table 2.1. Trends in contraceptive prevalence rate (CPR), among women aged 15-49, married or in a union, by region, 2015

REGION	CPR AMONG WOMEN AGED 15-49, MARRIED OR IN A UNION (PERCENTAGE)				INCREASE IN CPR (PERCENTAGE)			ANNUAL RATE OF INCREASE IN CPR (PERCENTAGE)		
	1990	2000	2010	2015	1990-2015	1990-2000	2000-2015	1990-2015	1990-2000	2000-2015
Asia and the Pacific	57.1	65.3	67.8	68.5	20.1	14.5	4.9	0.7	1.4	0.3
Arab States	33.7	45.2	49.8	51.5	52.6	34	13.8	1.7	2.9	0.9
Eastern Europe and Central Asia	59.5	63.6	64.4	65.0	9.2	6.9	2.2	0.4	0.7	0.1
Latin America and the Caribbean	61.2	69.9	72.9	72.7	18.8	14.3	3.9	0.7	1.3	0.3
East and Southern Africa	16.2	23.9	33.0	38.6	138.4	47.7	61.4	3.5	3.9	3.2
West and Central Africa	8.7	13.7	15.3	17.6	102.3	57.5	28.5	2.8	4.5	1.7
World	**55.3**	**61.5**	**63.1**	**63.6**	**15.0**	**11.2**	**3.4**	**0.6**	**1.1**	**0.2**

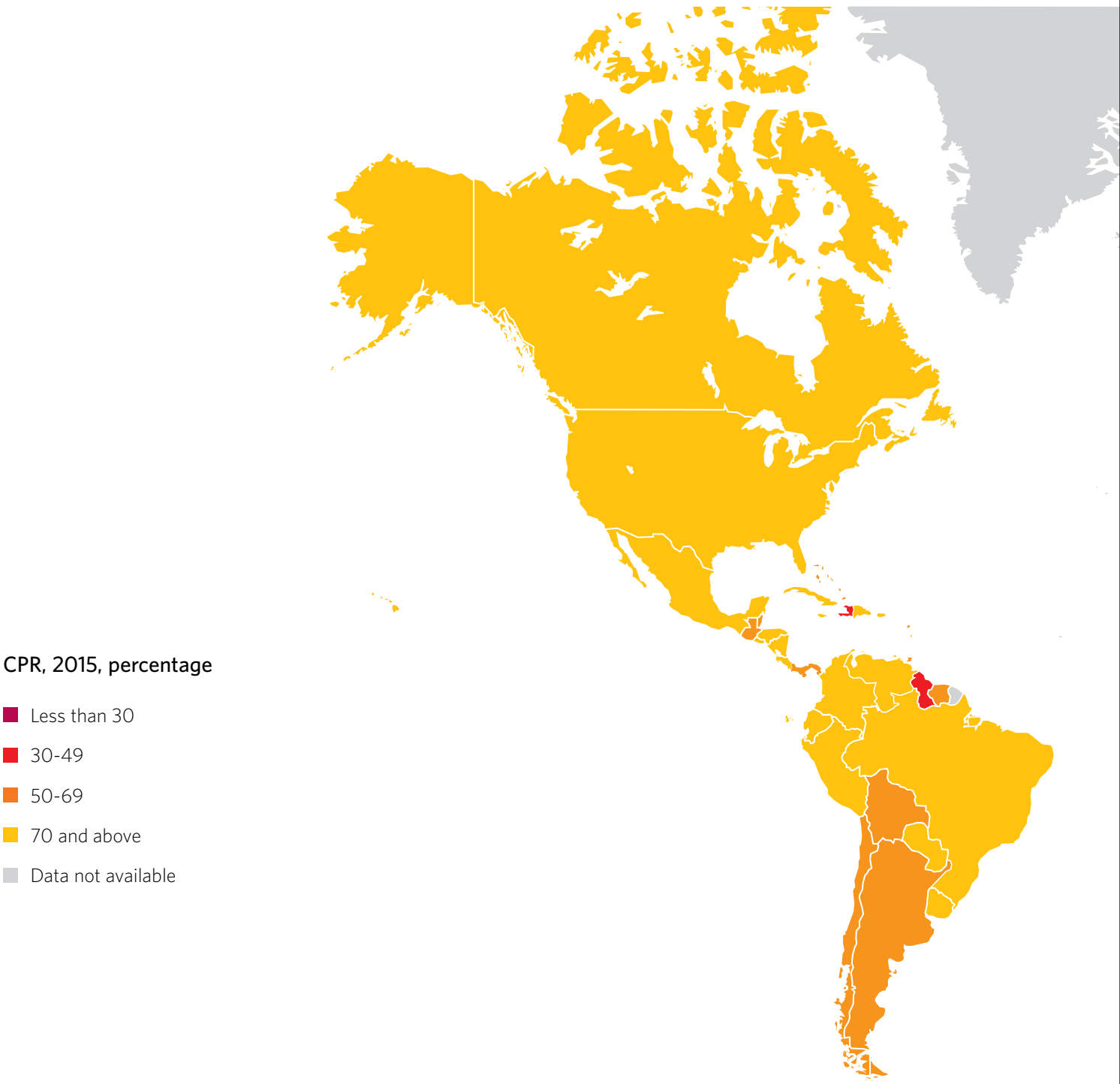
Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

Figure 2.1. Proportion of women aged 15-49, married or in a union, with a demand for family planning (TD), using any method of contraception (CPR), and having an unmet need (UNR), by region, 1990-2015

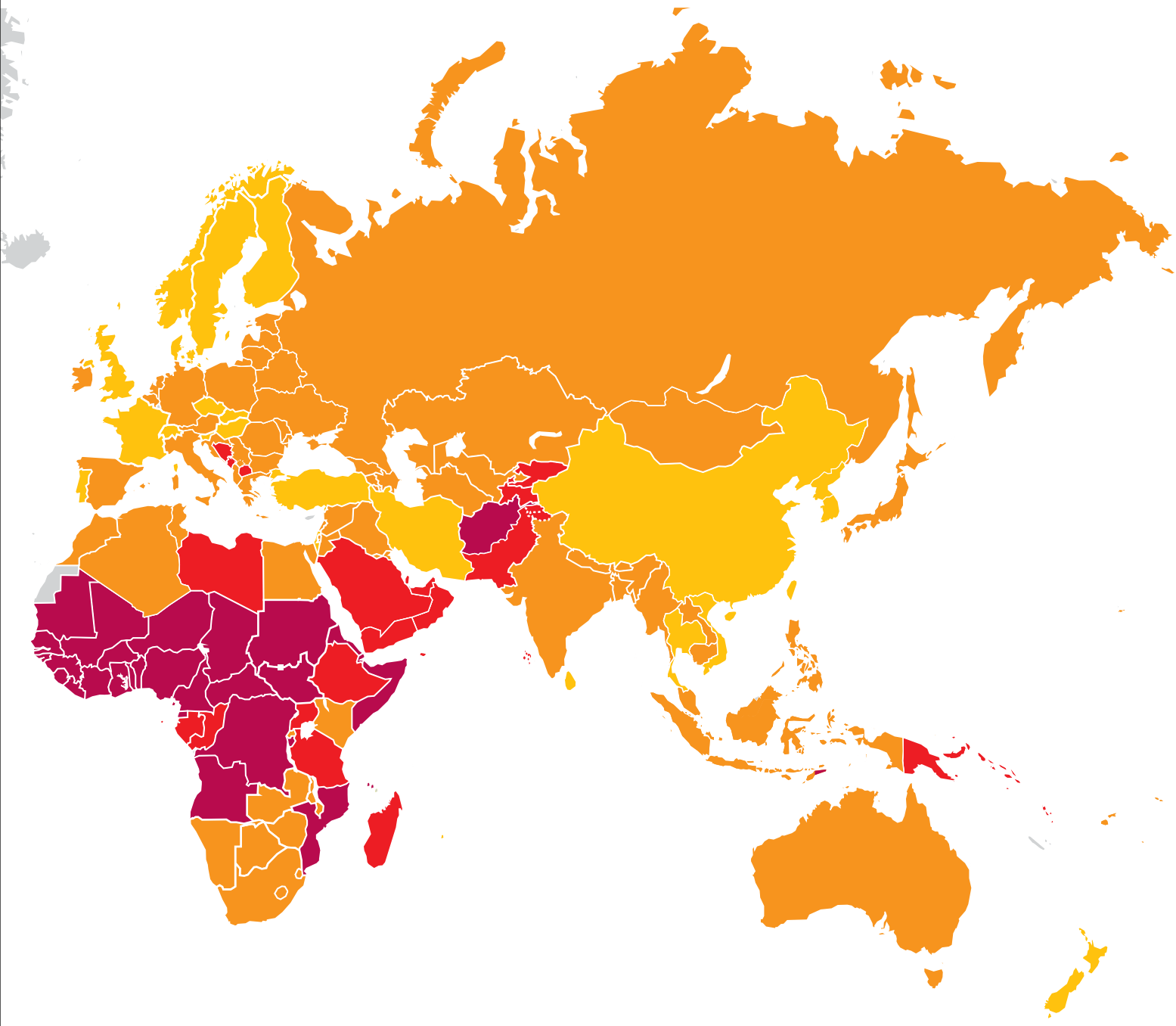


Source: United Nations Department of Economic and Social Affairs, Population *Division. 2015. Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

Map 2.1. Percentage of women aged 15-49, married or in a union, using any contraceptive method (CPR), by country, 2015



Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.



Globally in 2015, about 12 per cent of women aged 15-49, married or in a union, have an unmet need for contraception (Table 2.2 and Map 2.2). Data suggest significant differences among countries and across regions. West and Central Africa has the highest level of unmet need at 24 per cent, about 2.5 times higher than in Asia and the Pacific, the region with the lowest unmet need at 10 per cent.

Since 2000, the unmet need for family planning has declined in all regions except West and Central Africa, where the rate remains relatively stable.[8] The fastest decline has been in East and Southern Africa, dropping 16 per cent from 28.2 per cent to 23.6 per cent, followed by Latin America and the Caribbean, decreasing 16 per cent from 12.8 per cent to 10.7 per cent. East and Southern Africa has doubled its annual rate of reduction from 0.5 per cent over 1990-2000 to 1.2 per cent over 2000-2015, making it the only region with a faster decline in the past decade compared to 1990-2000.

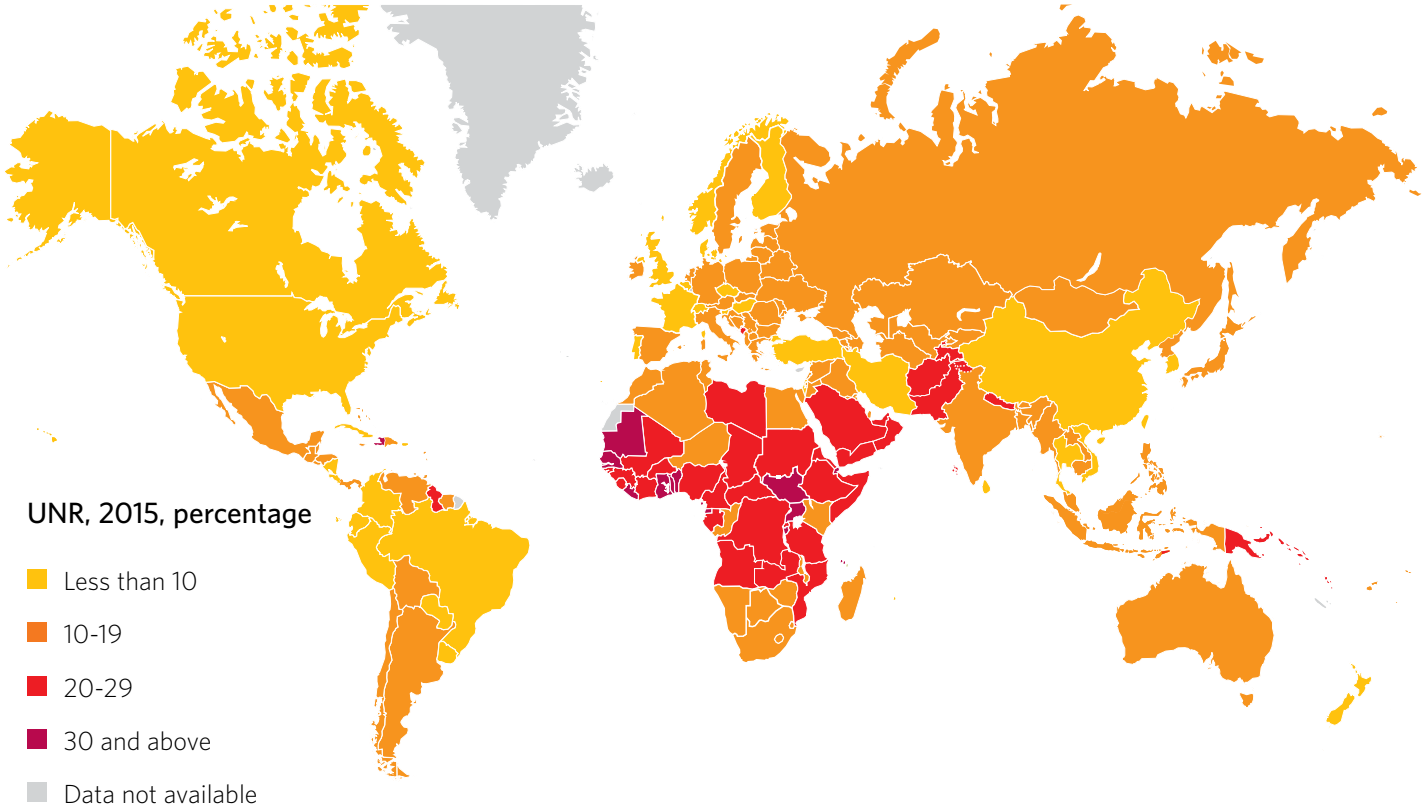
Table 2.2. Trends in the unmet need for family planning (UNR), any method, among women aged 15-49, married or in a union, by region, 2015

REGION	UNR AMONG WOMEN AGED 15-49, MARRIED OR IN A UNION (PERCENTAGE)				DECLINE IN UNR (PERCENTAGE)			ANNUAL RATE OF REDUCTION IN UNR (PERCENTAGE)		
	1990	2000	2010	2015	1990-2015	1990-2000	2000-2015	1990-2015	1990-2000	2000-2015
Asia and the Pacific	14.3	11.2	10.3	9.9	30.8	21.7	11.7	1.5	2.4	0.8
Arab States	24.7	19.0	17.0	16.6	32.7	23	12.6	1.6	2.6	0.9
Eastern Europe and Central Asia	14.4	12.4	11.0	10.7	25.7	14	13.6	1.2	1.5	1.0
Latin America and the Caribbean	17.3	12.8	10.6	10.7	38	26	16.2	1.9	3.0	1.2
East and Southern Africa	29.7	28.2	25.6	23.6	20.5	4.9	16.4	0.9	0.5	1.2
West and Central Africa	24.7	23.9	23.8	24.2	1.9	3.3	-1.5	0.1	0.3	-0.1
World	**15.1**	**12.7**	**12.0**	**11.9**	**21.2**	**15.9**	**6.3**	**1.0**	**1.7**	**0.4**

Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

[8] The UNR may remain stable or even increase where significant increases in the CPR occur.

Map 2.2. Percentage of women aged 15-49, married or in a union, with an unmet need for family planning (UNR), any method, by country, 2015



Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

In 2015, about 84 per cent of women aged 15-49, married or in a union, had their family planning demand satisfied. Similar to the CPR and UNR, levels vary significantly across regions. The highest CPR and the lowest UNR result in the highest PDS in Asia and the Pacific, and Latin America and the Caribbean, both with a PDS of 87 per cent. In contrast, the lowest CPR and the highest UNR lead to the lowest PDS in West and Central Africa, with a PDS of 42 per cent, less than half the rate in Latin America and the Caribbean or Asia and the Pacific.

Consistent with findings mentioned earlier, the PDS increased significantly for all regions during 1990 to 2000. Since 2000, however, the increase has slowed. At the global level, the PDS increased 5.5 per cent between 1990-2000, compared to only 1.6 per cent between 2000-2015. In West and Central Africa, the annual rate of increase was 3.4 per cent over 1990-2000, the fastest growth among all regions, compared to only 1 per cent during 2000- 2015.

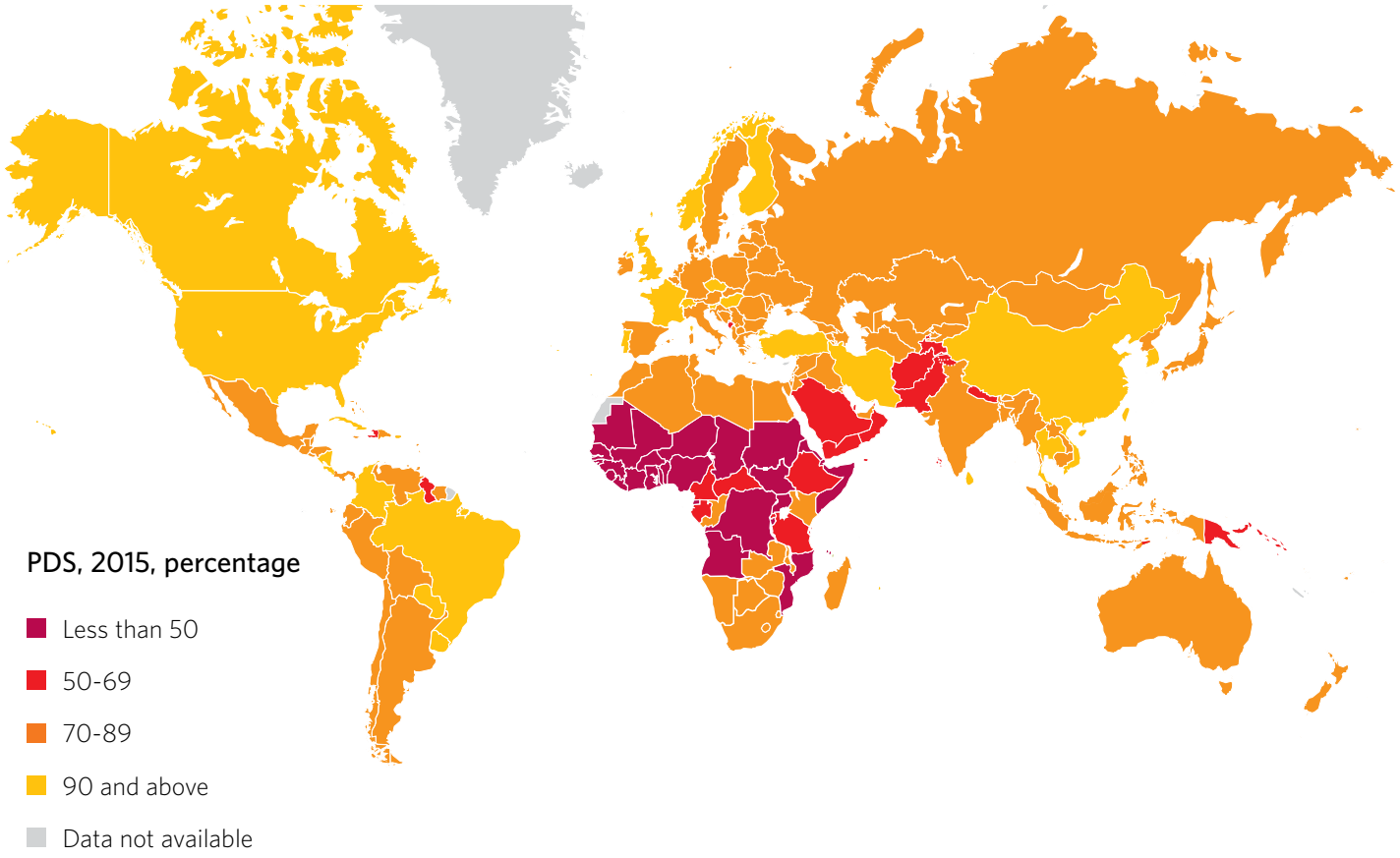
Table 2.3. Trends in percentage of total demand for family planning satisfied (PDS) among women aged 15-49, married or in a union, by region, 2015

REGION	PDS AMONG WOMEN AGED 15-49, MARRIED OR IN A UNION (PERCENTAGE)				INCREASE IN PDS (PERCENTAGE)			ANNUAL RATE OF INCREASE IN PDS (PERCENTAGE)		
	1990	2000	2010	2015	1990-2015	1990-2000	2000-2015	1990-2015	1990-2000	2000-2015
Asia and the Pacific	80.0	85.4	86.9	87.4	9.3	6.8	2.4	0.4	0.7	0.2
Arab States	57.8	70.4	74.6	75.6	30.9	21.9	7.4	1.1	2.0	0.5
Eastern Europe and Central Asia	80.5	83.7	85.4	85.8	6.7	4	2.6	0.3	0.4	0.2
Latin America and the Caribbean	78.0	84.5	87.3	87.2	11.8	8.4	3.1	0.4	0.8	0.2
East and Southern Africa	35.3	45.8	56.3	62.0	75.9	30	35.3	2.3	2.6	2.0
West and Central Africa	26.0	36.4	39.0	42.0	61.5	40	15.4	1.9	3.4	1.0
World	**78.6**	**82.9**	**84.0**	**84.2**	**7.2**	**5.5**	**1.6**	**0.3**	**0.5**	**0.1**

Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

Map 2.3 shows that low PDS countries, with a rate less than 50 per cent, are concentrated in West and Central Africa, and East and Southern Africa. While the MDGs are close to their end, in the new SDG era, it will be critical for the international community to reaffirm the promise of universal access to reproductive health and family planning, and increase investment in this area. Special attention needs to go to regions and countries lagging behind.

Map 2.3. Percentage of total demand for family planning satisfied (PDS) among women aged 15-49, married or in a union, by country, 2015



Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. *Model-based Estimates and Projections of Family Planning Indicators 2015.* New York: United Nations.

2.3. Contraceptive method mix

Contraceptive method mix refers to the distribution of the percentages of women using different types. This indicator is useful for policy and programme decisions related to commodities, for example, as well as for the measurement of the relevance, effectiveness, efficiency, sustainability and impact of a family planning programme.

There is no optimal method mix that could fit all needs across and within countries. But in general, a more diverse mix demonstrates that women have a choice. This allows them to select the method that best meets their needs in achieving their family planning goals. Other issues associated with and determining contraceptive use include stages of the reproductive health cycle and issues associated with culture, gender inequality, provider bias and users' perceived barriers.

Contraceptive methods are classified in 12 categories: 9 modern methods and 3 traditional methods:[9]

Modern methods: Female and male sterilization, the pill, injectables, intrauterine devices (IUDs), male and female condoms, vaginal barrier methods,[10] implants and other modern methods[11]

Traditional methods: Rhythm,[12] withdrawal, other traditional methods[13]

Figure 2.2 presents the shares of women using modern contraceptive methods and traditional methods in the developing and developed worlds. Among women in the developing world aged 15-49 years, married or in a union, 55 per cent are using modern contraception. The most common methods, female sterilization and IUDs, combined account for more than 60 per cent of modern contraceptive use. The pill and male condom are together responsible for 24 per cent, 13 per cent for the pill and 11 per cent for condoms. By contrast, developed regions not only have greater use of modern contraception at 62 per cent, but also a more diverse method mix: condoms, pills and sterilization (female and male) account for more than 80 percent of total modern contraceptive use, at 29 per cent, 29 per cent and 24 per cent, respectively.

[9] United Nations Department of Economic and Social Affairs, Population Division. 2015. World Contraceptive Use 2015.

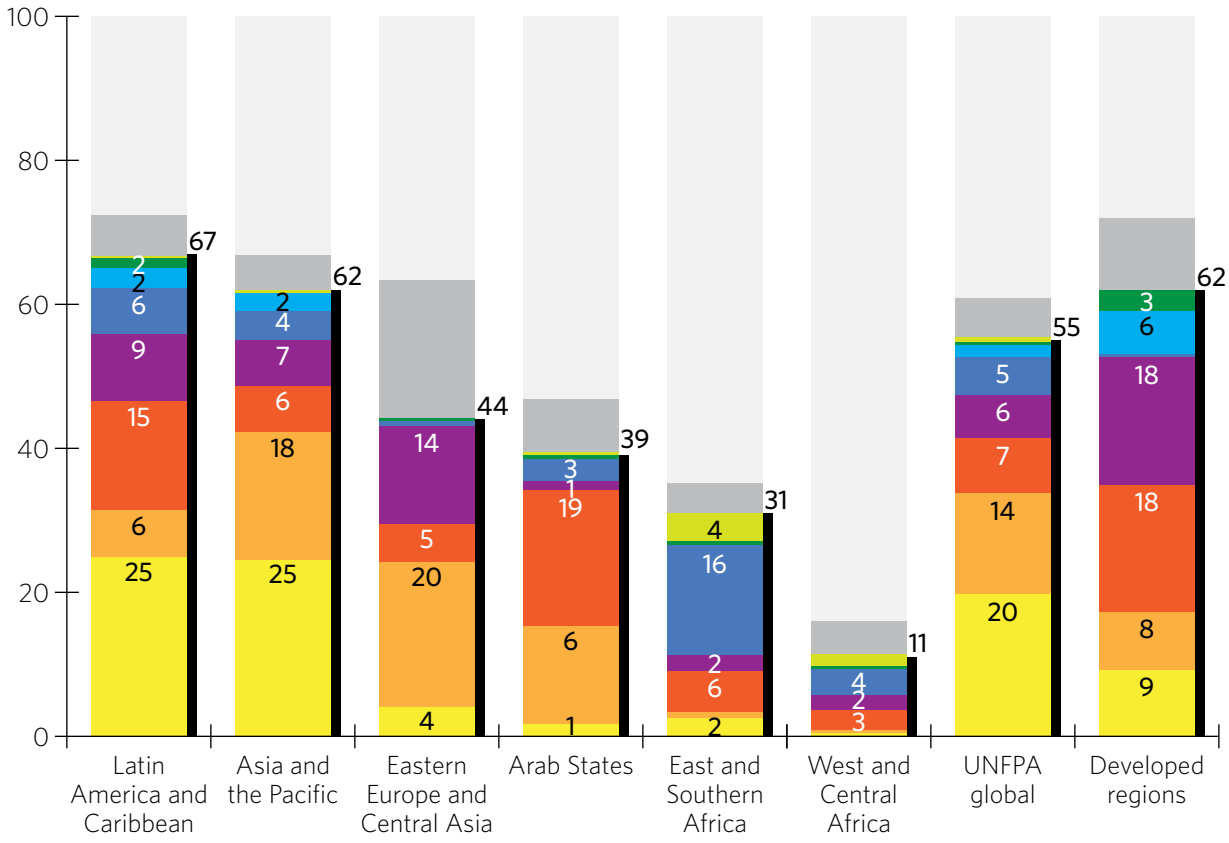
[10] Including diaphragms, cervical caps and spermicidal foams, jelly, cream and sponges.

[11] Including emergency contraception, female condoms and modern methods not reported separately.

[12] It is also called periodic abstinence or the calendar method.

[13] Including prolonged abstinence, breastfeeding, lactational amenorrhea method or LAM, douching, various folk methods and traditional methods not reported separately.

Figure 2.2. Percentage of women aged 15-49, married or in a union, using modern contraceptives, by method and region, latest data, 1970-2014



- Not using any method
- Any traditional method
- Implant
- Other modern methods
- Sterilization, male
- Injectable
- Male condom
- Pill
- IUD
- Sterilization, female
- mCPR

Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. Data for many developed countries may not reflect the most recent situation and therefore should be interpreted with caution.

Source: UNFPA analysis based on data from United Nations Department of Economic and Social Affairs, Population Division. 2015. *World Contraceptive Use 2015*.

Similar to the pattern of CPR by region, Latin America and the Caribbean has the highest level of modern CPR (mCPR), and more balanced distribution of methods used, even as three methods alone account for 73 per cent of the mCPR: female sterilization at 37 per cent, the pill at 22 per cent and male condoms at 13 per cent.

In other regions, one or two methods seem to dominate. For example, in the Arab States, the pill and IUD together account for 85 per cent of the mCPR. In East and Southern Africa, injectables account for more than half, and in Eastern Europe and Central Asia, IUDs account for close to half.

To quantify the degree to which women use a range of methods at the country level, a method mix index was calculated for each country using this formula:

$$\left(\text{percentage for most prevalent method} - \text{percentage for third highest}\right) / \text{total modern method prevalence} * 100$$ [14]

This index took the ratio of the difference in prevalence rates between the most prevalent modern method and the third most prevalent method and the total modern method prevalence in a given country. An index of higher value means use is concentrated in a small range of methods, while an index of lower value is associated with more diverse usage. In the most extreme scenario, if all girls in one country use one method, the index would be 100, and if exactly the same number of girls used all modern methods, the index would be 0.

Countries with a method mix index at 60 or higher are classified as low method mix countries with high dominance of one method. Those with an index between 30 and 60 are middle method mix countries. An index of less than 30 denotes high method mix index countries with low dominance of one method.

Map 2.4 indicates that a total of 20 countries are considered low method mix countries with high dominance of one method. These include Algeria, Azerbaijan, Botswana, the Czech Republic, the Democratic People's Republic of Korea, Ethiopia, Greece, India, Japan, Kyrgyzstan, Morocco, Niger, Portugal, Reunion, Saudi Arabia, Sudan, Tajikistan, Timor-Leste, Turkmenistan and Uzbekistan. The Democratic People's Republic of Korea has the highest index, at 94, where 62 percent of women are using IUDs, and only 3 percent of women are using all other modern methods combined.

These findings raise questions regarding options available to women when seeking to satisfy their demand for contraception, and strategies used to accelerate delivery of universal access to rights-based family planning. More specifically, are these method mixes a good representation of the availability of good quality, human rights-based, family planning services?

The response to this last question can be partially examined with data in Table 2.4, on the percentage of women aged 15-49 using contraception who were informed about possible side effects of their selected method, and how to deal with them, and were informed about other family planning methods that could be used.[15] At the global level, only 41 per cent indicated they were informed about side effects

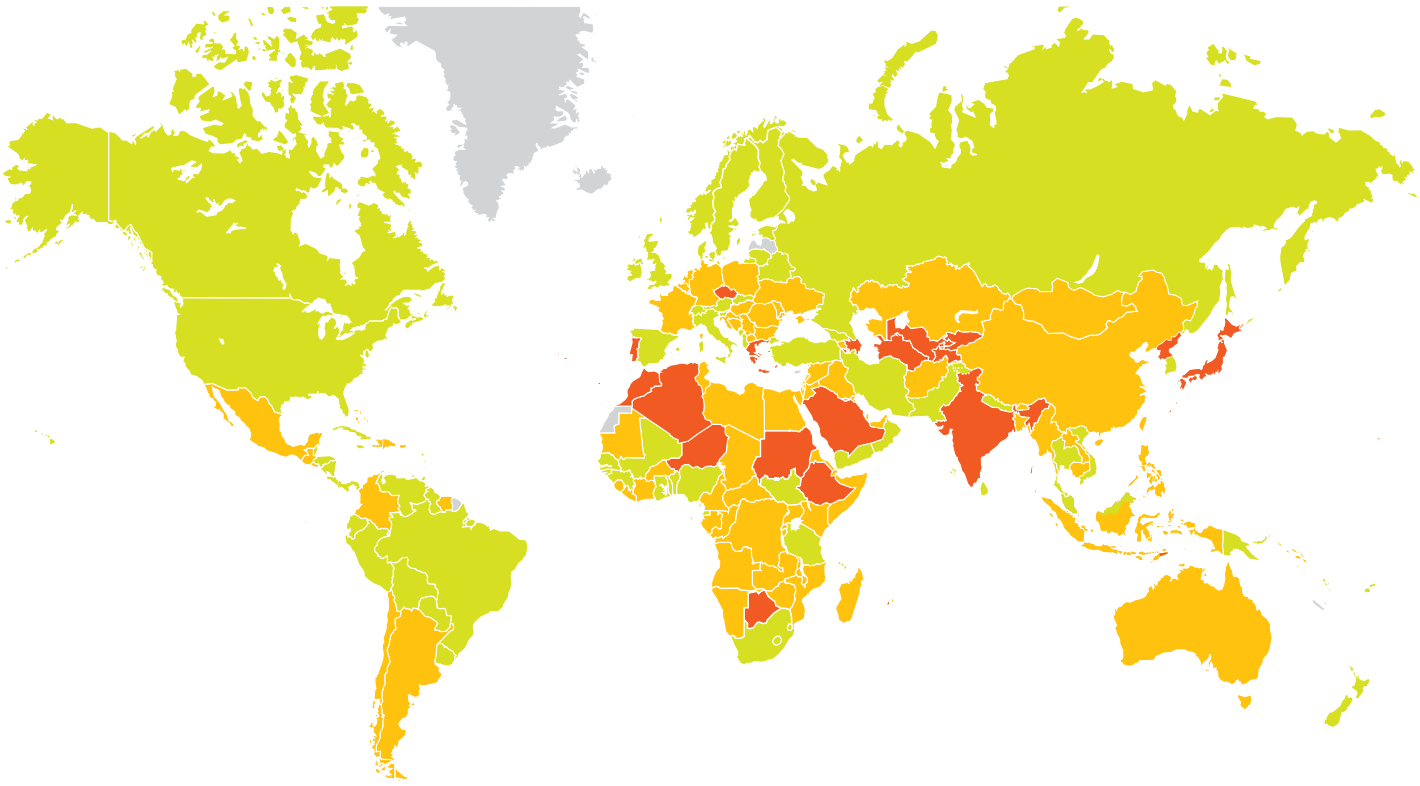
[14] USAID | DELIVER PROJECT, Task Order 1. 2010. "Contraceptive Security Index Technical Manual." Arlington, Virginia.

[15] DHS data obtained for 61 countries during 2006-2013 (35 countries in Africa, 8 in Eastern Europe and Central Asia, 9 in East Asia and the Pacific, and 8 in Latin America and the Caribbean).

or problems, and only 35 per cent were informed about what to do if they experienced side effects. Less than half of the same group of women (41 per cent) were told about other methods. All women who could not make informed choices experienced gaps in the quality of care and the fulfilment of their reproductive rights.[16]

Quality of care should be in the future agenda of any existing family planning programme. Reference points may come from countries with the highest level of informed choice, such as Zambia, where 80 per cent of users had received information about side effects and alternative methods.

Map 2.4. Modern contraceptive method mix index for women aged 15-49, married or in a union, by country, latest data, 1970-2014



- High dominated by one method (index>=60)
- Middle dominated by one method (index>=30&<60)
- Low dominated by one method (index<30)

Notes: Data not available for countries in grey. Data for many developed countries may not reflect the most recent situation and should be interpreted with caution.

Source: UNFPA analysis based on data from United Nations Department of Economic and Social Affairs, Population Division. 2015. *World Contraceptive Use 2015*

[16] Of the 61 countries with DHS data available on informed choice, 17 reported percentages less than 50 per cent and as low as 25 per cent (Bangladesh, Burundi, Côte d'Ivoire, Dominican Republic, Egypt, Ethiopia, Gabon, Gambia, Guinea, Honduras, India, Indonesia, Lesotho, Maldives, Morocco, Niger and Pakistan).

Table 2.4. Patterns of informed choices among current users of modern contraceptive methods in the five years preceding the survey, 2006-2014

COUNTRY/REGION	SURVEY	PERCENTAGE WHO WERE		
		Informed about side effects or problems of method used	Informed what to do if experiencing side effects	Informed about other methods that could be used
Albania	2008-09 DHS	62.3	59.1	59.7
Armenia	2010 DHS	68.6	62.3	42.2
Azerbaijan	2006 DHS	66.3	64.5	36.6
Bangladesh	2004 DHS	30.0	24.9	34.9
Benin	2011-12 DHS	53.0	51.1	49.3
Bolivia	2008 DHS	67.3	60.2	74.6
Burkina Faso	2010 DHS	72.2	68.5	85.0
Burundi	2010 DHS	35.3	34.9	67.7
Cambodia	2010 DHS	76.1	74.6	71.7
Cameroon	2011 DHS	63.6	52.3	62.7
Colombia	2010 DHS	58.3	47.6	61.8
Comoros	2012 DHS	54.1	45.8	58.1
Congo	2011-12 DHS	55.2	48.4	34.0
Congo Democratic Republic	2013-14 DHS	57.1	47.8	45.5
Cote d'Ivoire	2011-12 DHS	43.4	34.4	44.3
Dominican Republic	2013 DHS	44.7	36.2	54.4
Egypt	2014 DHS	44.3	34.0	56.8
Ethiopia	2011 DHS	28.1	24.4	37.1
Gabon	2012 DHS	47.5	38.9	25.4
Gambia	2013 DHS	43.8	38.5	54.3
Ghana	2008 DHS	55.7	52.6	53.2
Guinea	2012 DHS	46.5	41.0	34.2
Guyana	2009 DHS	50.2	39.0	60.9
Haiti	2012 DHS	70.2	63.2	63.0
Honduras	2011-12 DHS	44.5	35.7	62.2
India	2005-06 DHS	32.0	25.7	28.0
Indonesia	2012 DHS	36.5	29.4	51.2
Jordan	2012 DHS	69.7	60.5	70.9
Kenya	2008-09 DHS	57.2	51.9	60.9
Kyrgyz Republic	2012 DHS	71.6	68.5	64.5
Lesotho	2009 DHS	42.9	37.4	53.5
Liberia	2013 DHS	75.8	73.8	72.4
Madagascar	2008-09 DHS	50.7	47.8	62.0

COUNTRY/REGION	SURVEY	PERCENTAGE WHO WERE		
		Informed about side effects or problems of method used	Informed what to do if experiencing side effects	Informed about other methods that could be used
Malawi	2010 DHS	74.5	74.9	80.2
Maldives	2009 DHS	45.3	42.6	53.7
Mali	2012-13 DHS	51.9	45.1	56.2
Moldova	2005 DHS	70.2	67.9	55.3
Morocco	2003-04 DHS	24.6	20.1	35.0
Mozambique	2011 DHS	57.1	52.1	66.2
Namibia	2013 DHS	56.8	50.7	64.4
Nepal	2011 DHS	62.8	58.2	53.8
Nicaragua	2001 DHS	53.4	46.4	66.5
Niger	2012 DHS	39.0	35.1	37.0
Nigeria	2013 DHS	59.6	54.3	55.4
Pakistan	2012-13 DHS	33.9	28.1	23.9
Peru	2011 DHS	65.3	58.9	72.2
Philippines	2013 DHS	65.7	66.6	68.9
Rwanda	2010 DHS	63.8	67.7	75.8
Sao Tome and Principe	2008-09 DHS	79.9	76.1	79.2
Senegal	2010-11 DHS	55.6	51.8	75.1
Sierra Leone	2013 DHS	75.6	74.8	79.0
Swaziland	2006-07 DHS	58.0	54.5	66.7
Tajikistan	2012 DHS	78.5	73.0	69.3
Tanzania	2010 DHS	56.9	56.6	76.9
Timor-Leste	2009-10 DHS	61.3	55.3	51.9
Togo	2013-14 DHS	75.6	72.2	79.2
Turkmenistan	2000 DHS	77.7	65.3	35.8
Uganda	2011 DHS	55.9	53.2	58.9
Ukraine	2007 DHS	77.0	78.6	65.5
Zambia	2013-14 DHS	79.0	77.4	80.6
Zimbabwe	2010-11 DHS	52.8	47.2	60.7
Africa	---	**52.1**	**46.9**	**56.0**
Eastern Europe and Central Asia	---	**73.9**	**71.6**	**59.4**
Asia and the Pacific	---	**34.8**	**28.9**	**33.7**
Latin America and the Caribbean	---	**59.5**	**51.0**	**65.2**
Total	---	**41.0**	**35.3**	**41.1**

2.4. Reproductive health in humanitarian settings

In today's ever-changing world, more and more people are leaving their homes because of natural disasters, conflicts and wars, and other humanitarian conditions. The number of refugees, asylum seekers and internally displaced persons reached 50 million in 2013, for the first time since World War II.[17] Depending on the type of humanitarian crisis and the situation in a country, crisis affects women's reproductive health and access to family planning in different ways. Obtaining family planning data during humanitarian situations can be very challenging, but understanding levels of contraceptive use and meeting needs among women of reproductive age is possible. This section presents the CPR and UNR for 28 countries in humanitarian situations.[18]

In 2015, less than one out of three (30 per cent) of women aged 15-49 who are married or in a union and who live in countries affected by humanitarian crisis use contraception. This low level is similar to that of West and Central Africa (see Figure 2.3), and below other regions. Similarly, the unmet need for contraception in humanitarian crisis-affected countries is higher than that of most of the world (23 per cent).

As bad as the situation seems to be regarding access to sexual and reproductive health in crisis situations, the reality is likely even worst, since the numbers presented are estimated based on data that do not necessarily reflect the most recent situation or the real impact of the crisis. As such, these numbers mostly represent the poor social and economic conditions of these countries, which ultimately make them highly vulnerable to humanitarian crisis.

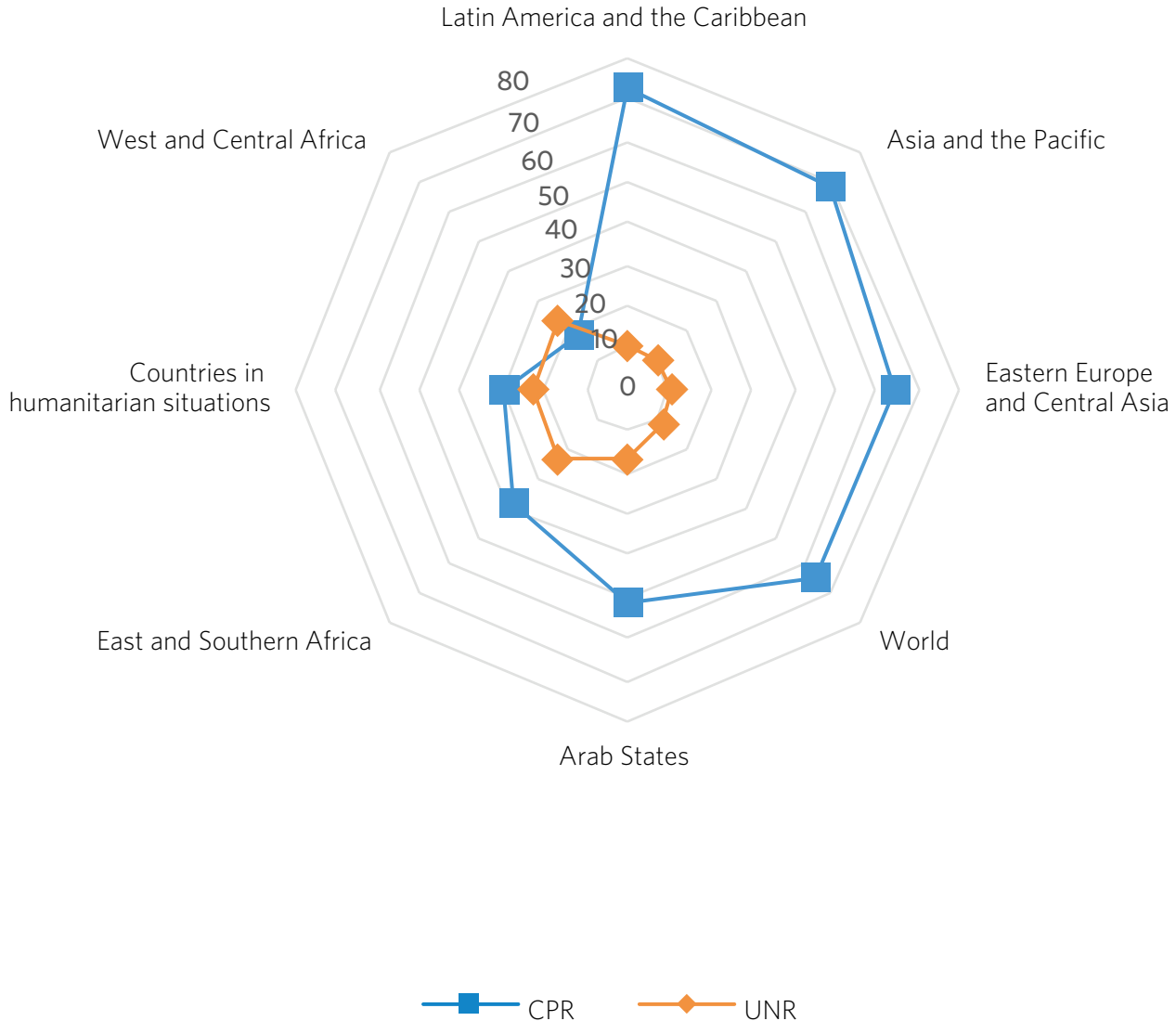
[17] Bond for International Development. 2015. State of the World's Emergencies. See www.bond.org.uk/sites/default/files/state_of_the_worlds_emergencies_0715.pdf.

[18] UNFPA list of countries in humanitarian settings.

Table 2.5. Contraceptive prevalence rate and unmet need for contraception rate in countries affected by humanitarian crisis in 2015

COUNTRY	2015 CPR	2015 UNR
Afghanistan	29.3	27.1
Burkina Faso	18.8	26.6
Burundi	27.5	29.8
Central African Republic	23.6	23.2
Chad	6.2	23.1
Cote d'Ivoire	20.4	23.8
Democratic Republic of the Congo	22.5	27.2
Ethiopia	36.2	25.0
Guinea	7.5	24.6
Guinea-Bissau	16.9	22.1
Haiti	37.8	32.9
Iraq	54.8	14.2
Liberia	20.1	31.6
Madagascar	46.0	18.8
Mali	12.2	26.9
Mauritania	14.1	30.9
Myanmar	52.0	16.3
Nepal	52.4	23.9
Niger	15.4	17.6
Nigeria	16.0	21.9
Pakistan	38.5	20.4
Sierra Leone	16.5	26.2
Somalia	23.7	29.2
South Sudan	6.8	29.8
Sudan	15.9	28.5
Syrian Arab Republic	57.7	15.1
Tajikistan	33.1	21.9
Uganda	29.9	33.4

Figure 2.3. Proportions of women aged 15-49, married or in a union, using any method of contraception or having an unmet need, globally, by region and for countries in humanitarian situations, 2015



< Table 2.5

Notes: Bangladesh, Colombia, Guatemala, Kenya, State of Palestine, Philippines and Turkey excluded.

Source: United Nations Department of Economic and Social Affairs, Population Division. 2015. Model-based Estimates and Projections of Family Planning Indicators 2015. New York: United Nations.

^ Figure 2.3

Source: UNFPA analysis based on UNPD model-based estimates and projections of family planning indicators

Family Planning and Adolescent Sexual and Reproductive Health

This chapter describes adolescents as a population group, and their levels of sexual activity and marital status, followed by an analysis of reproductive behaviours and contraceptive dynamics. It presents estimates of the absolute number of adolescents in need of contraception to guide the development of appropriate policies and programmes to respond to their immediate needs.

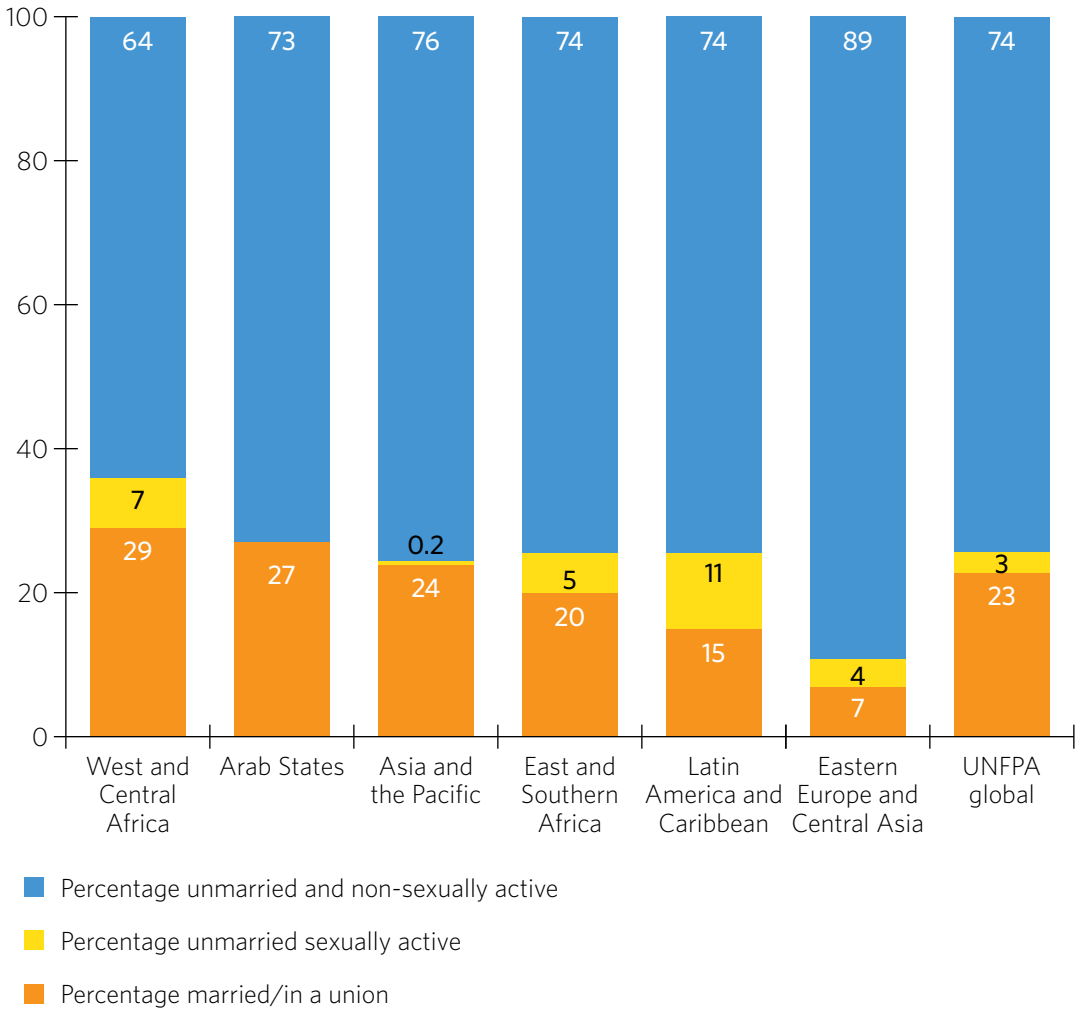
3.1. Sexual activity and marital status among adolescent girls

Worldwide, more than 16 per cent of people are adolescents—numbering 1.2 billion aged 10-19.[19] An estimated 250 million adolescent girls aged 15-19 live in developing countries, and account for about one-sixth of all women of reproductive age (15-49). Adolescent girls have special sexual and reproductive health needs compared to adults, and they are often more vulnerable, have less sexual and reproductive health knowledge, and face more obstacles to accessing sexual and reproductive health services, including family planning.

This section focuses on adolescent girls, their marital status (single or married/in a union), sexual activity (active or not active), and different sexual and reproductive behaviours. Of particular importance is the analysis of adolescents currently married or in a union, and those never married but sexually active.

[19] United Nations Department of Economic and Social Affairs, Population Division. 2015. *World Population Prospects: The 2015 Revision.*

Figure 3.1. Distribution of adolescent girls aged 15-19, by marital status and sexual activity, by region, latest data, 2005-2014



Notes: Distributions by marital status and sexual activity were calculated based on data from household surveys. Percentages of adolescent girls who are unmarried and sexually active were not available for the Arab States because there are not sufficient data in household surveys, so a value of 0 was assigned to this region. "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA analysis based on DHS and MICS data.

In the developing world, 23 per cent of adolescent girls are currently married or in a union, and 3 per cent are unmarried but sexually active. Latin American and the Caribbean has the highest percentage of girls who are unmarried but sexually active, at 11 per cent, compared to 0.2 per cent in Asia and the Pacific.

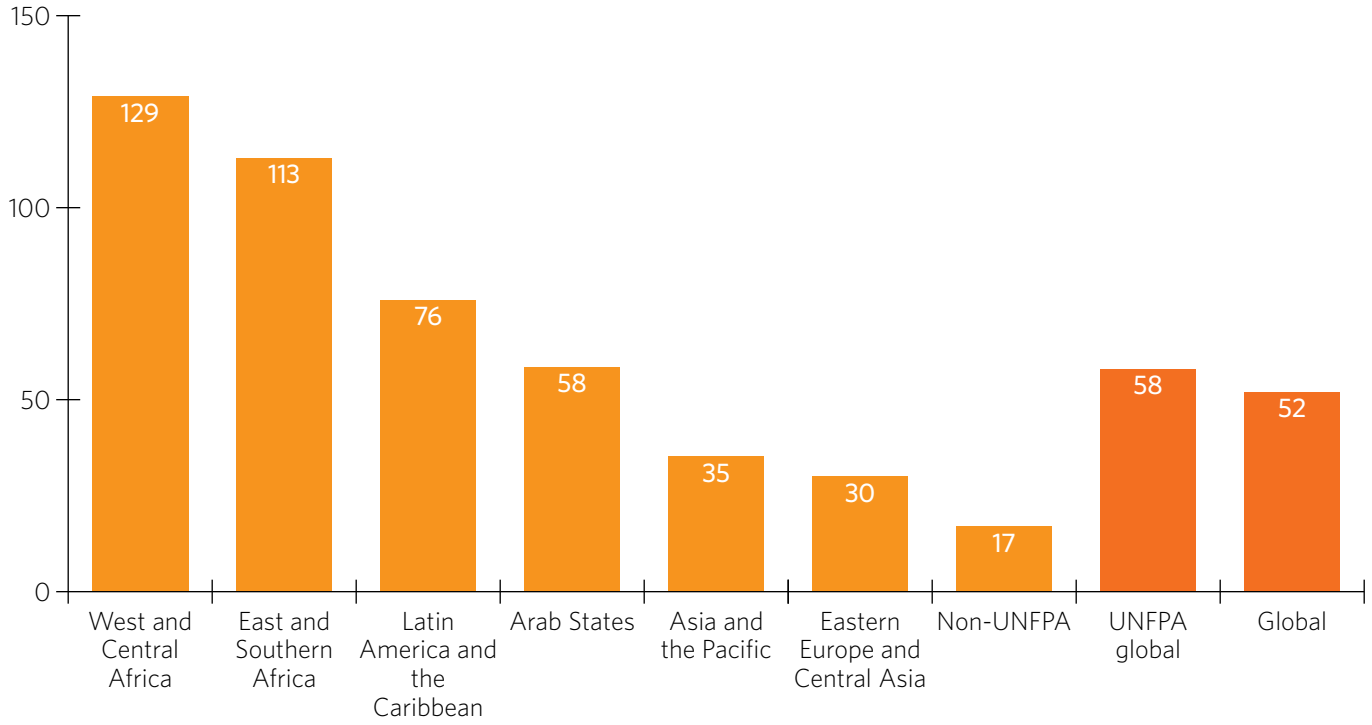
West and Central Africa has the highest percentage of girls who are sexually active, at 36 per cent, including 29 per cent who are married or in a union, and 7 per cent who are unmarried and sexually active. Currently, the proportion of adolescents who are not married or in a union but are sexually active is relatively low across all developing regions. Even in West and Central Africa, where sexual activities among never married adolescents are more common than in regions such as Asia and the Pacific, the proportion is much lower compared to that of adolescents who are currently married or in a union. If the proportion of the first group increases, so will total demand for family planning.

3.2. Adolescent birth rate at the country level

Analysis based on data from household surveys and vital registration systems indicated an ABR for 1991-2014 of 52 live births for every 1,000 adolescent girls. This number was significantly higher in some regions, such as West and Central Africa, with an estimated 129 live births per 1,000 adolescents, and East and Southern Africa, at 113 live births per 1,000 adolescents. Developed countries, Eastern Europe and Central Asia, and Asia and the Pacific had the lowest rates, at 17, 30 and 35 per 1,000 adolescents, respectively (Figure 3.2).

Figure 3.2. Adolescent birth rates by region, latest data, 1991-2014

Number of live births per 1,000 adolescents aged 15-19



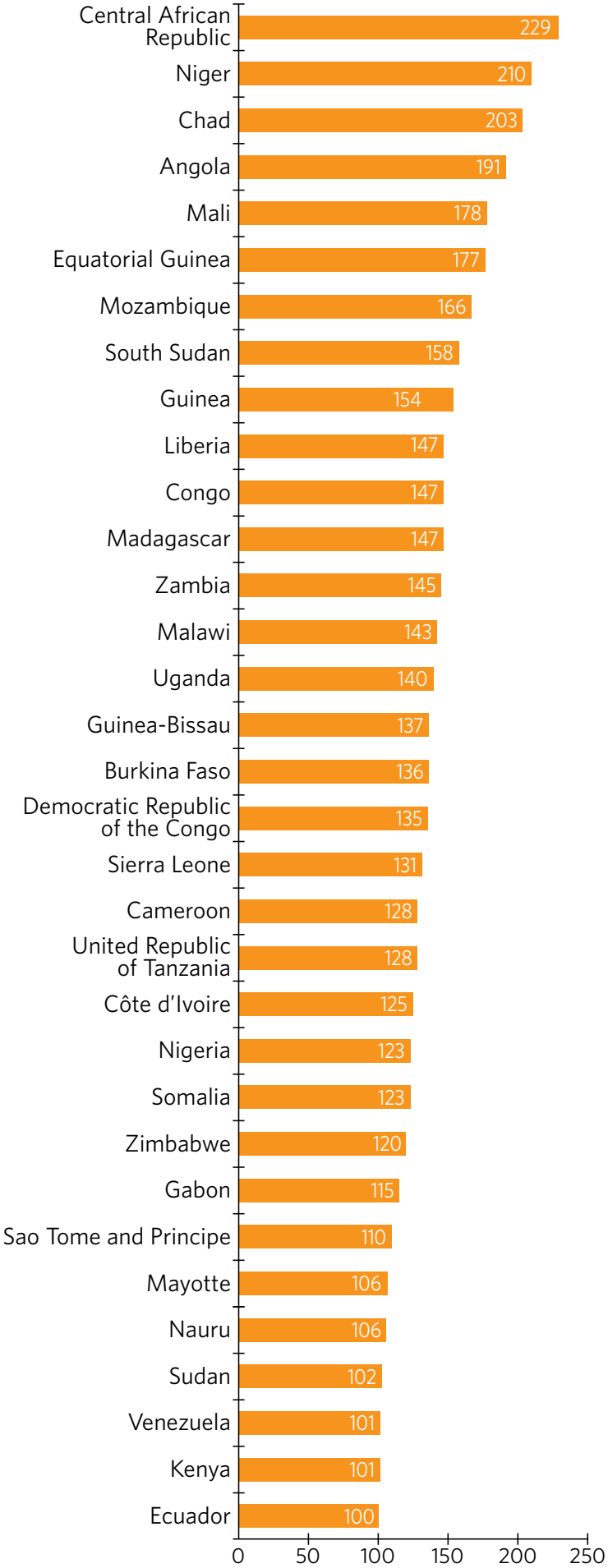
Notes: UNFPA analysis based on data for 255 countries. "Non-UNFPA" refers to countries in which UNFPA does not have a programme (mostly developed countries). "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. "Global" refers to the weighted average of all countries with data available, including both developing countries and developed countries.

Source: UNFPA analysis based on data from the United Nations Population Division.

Countries with an ABR of 100 or higher are considered high ABR countries. Figure 3.3 and Map 3.1 indicate that there are 33 high ABR countries. Of them, the Central African Republic had the highest rate at 229. Niger and Chad have rates higher than 200. Countries above 100 are concentrated in West and Central Africa, and East and Southern Africa; close to 90 per cent are African countries.

Figure 3.3. Adolescent birth rates, by country, latest data, 2004-2014

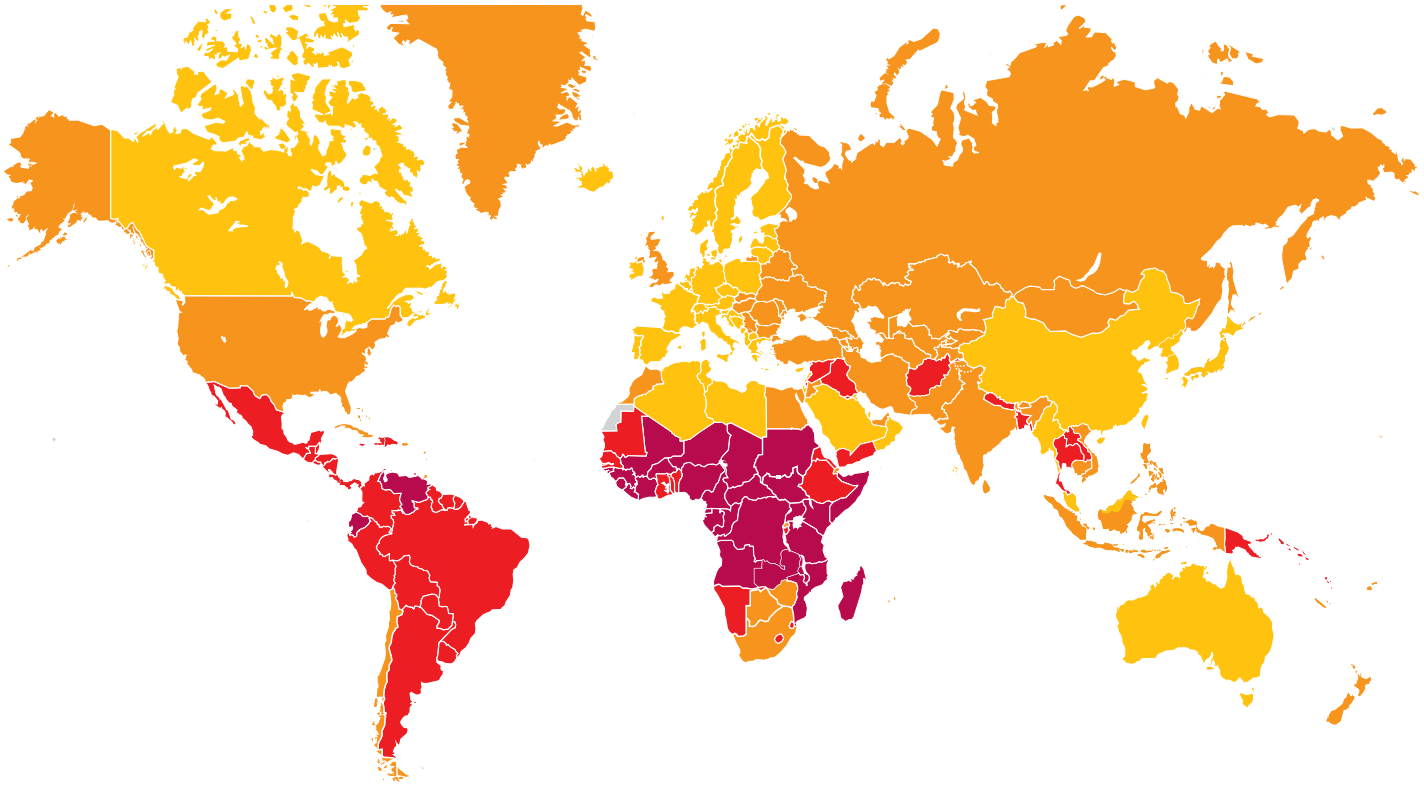
Number of births per 1,000 women aged 15-19



Source: UNFPA global open database (unfpaopendata.org) based on data from the United Nations Population Division.

Map 3.1. Adolescent birth rates, latest data, 1991-2014

Number of births per 1,000 women aged 15-19



ABR, most recent data

- Less than 20
- 20-59
- 60-99
- 100 and above
- Data not available

Notes: Map was created using data for 255 countries.

Source: UNFPA global open database (unfpaopendata.org) based on data from the United Nations Population Division.

Map 3.1 presents ABR data for each country. It shows that despite the concentration of high ABR countries in Africa, five are in other regions: Ecuador and Venezuela in Latin America and the Caribbean, Somalia and Sudan in the Arab States, and Nauru in Asia and the Pacific.

3.3. Absolute number of adolescent births: global and UNFPA regions

Women giving birth under age 20 face higher risks of maternal mortality, obstructed labour and obstetric fistula, and have lower chances of receiving an education and obtaining employment. Children born to adolescent mothers face higher risks of mortality, undernourishment and school dropout compared to their peers. To better serve this extremely vulnerable group of mothers, programme managers and policymakers need to understand future challenges under the SDGs.

This section presents a projection analysis of the number of children to be born to adolescent girls, married and unmarried, if current trends persist. Globally in 2015, 15.2 million births took place among adolescent girls, with an estimated 19.6 million in 2035.

Table 3.1. Projections for the number of live births among adolescents aged 15-19, by region, 2015-2035

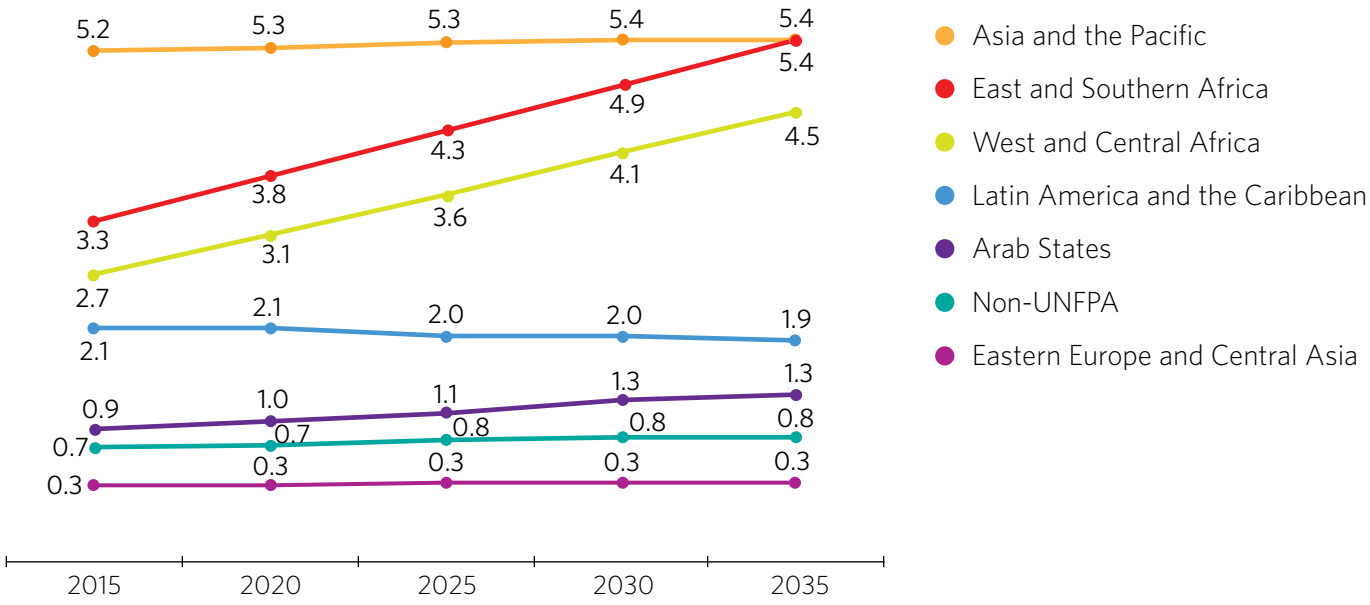
REGION	NUMBER OF ADOLESCENT BIRTHS (MILLIONS)				
	2015	2020	2025	2030	2035
Asia and the Pacific	5.2	5.3	5.4	5.4	5.4
Arab States	0.9	1.0	1.1	1.3	1.3
East and Southern Africa	3.3	3.8	4.3	4.9	5.4
Eastern Europe and Central Asia	0.3	0.3	0.3	0.3	0.3
Latin America and the Caribbean	2.1	2.1	2.0	2.0	1.9
West and Central Africa	2.7	3.1	3.6	4.1	4.5
Non-UNFPA	0.7	0.7	0.8	0.8	0.8
UNFPA Global	**14.5**	**15.5**	**16.7**	**17.9**	**18.8**
Global	**15.2**	**16.3**	**17.4**	**18.7**	**19.6**

Notes: UNFPA analysis based on data for 255 countries. "Non-UNFPA" refers to countries in which UNFPA does not have a programme (mostly developed countries). "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. "Global" refers to the weighted average of all countries with data available, including both developing countries and developed countries.

Source: UNFPA analysis based on data from the United Nations Population Division.

In 2015, Africa and Asia and the Pacific account for almost 80 per cent of total live births among adolescent girls in the developing world—5.2 million in Asia and the Pacific, 3.3 million in East and Southern Africa, and 2.7 million in West and Central Africa. Between 2015 and 2035, East and Southern Africa, West and Central Africa, and the Arab States could be the three regions with the highest increases in the number of live births among adolescent girls, from 3.3 million to 5.4 million, 2.7 million to 4.5 million, and 0.9 million to 1.3 million, respectively (Figure 3.4). The rapid increase in the African regions is mainly due to high levels of fertility, consistent reductions in mortality rates (especially among children) and the resulting very young age structure.

Figure 3.4. Projections for the number of live births to adolescents aged 15-19, selected regions, 2015-2035



Notes: "Non-UNFPA" refers to countries in which UNFPA does not have a programme (mostly developed countries).

Source: UNFPA analysis based on data from the United Nations Population Division.

3.4. Expanding access to family planning services to adolescents

Adolescents face many sexual and reproductive health risks, often related to early and unprotected sexual activity. The developing world requires many more programmes to help adolescents meet their family planning needs. Statistics show that adolescent girls are more vulnerable than older women to shortfalls in family planning.

Adolescents face more obstacles than adults to obtaining contraceptives. Even where contraceptive services are available, adolescents, especially those who are unmarried, may not be able to obtain them due to restrictive laws and policies. They may also fear that their confidentiality will not be respected as well as the stigma associated with early sex.[20] Adolescent girls in particular may not feel comfortable visiting clinics for contraception even if they are youth friendly. In many regions, adolescent girls marry much older men, which can leave them with less power in negotiating contraceptive use and family planning with their husbands.

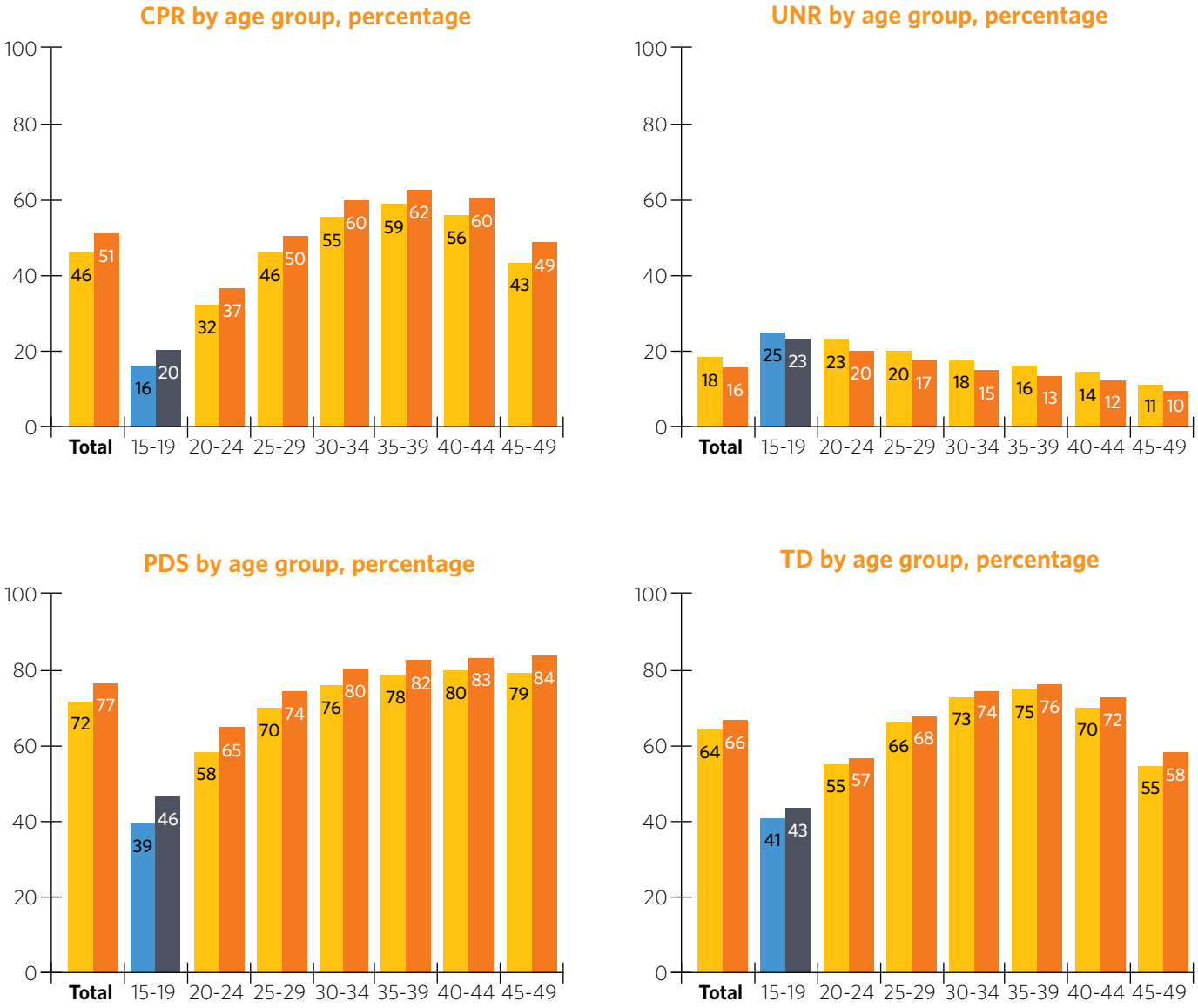
Figure 3.5 shows trends in the CPR, UNR, TD and PDS among women currently married or in a union by age group.

According to two surveys, both PDS and TD have increased among adolescents, with PDS rising from 39 per cent to 46 per cent. Levels of PDS and TD among adolescents are markedly lower than among other age groups. A CPR of 20 per cent for adolescents compares to 60 per cent among women aged 30-34. In contrast, the UNR is highest among adolescents, at 23 per cent, compared to 15 per cent among women aged 30-34. Adolescents have a PDS of 46 per cent, the lowest among all age groups, compared to 65 per cent among women aged 20-24, 74 per cent among women aged 25-29, 80 per cent among women aged 30-34, 82 per cent among women aged 35-49, and 83 per cent among women aged 40-44.

Expanding access to family planning services to adolescents is of critical importance given great demand. It will require political and financial commitments from governments and civil society, particularly to developing policies and interventions to reach the most vulnerable groups of adolescents, such as those who are out of school, have little or no education and/or are poor.

[20] World Health Organization. 2012. "From Evidence to Policy: Expanding access to contraceptive services for adolescents."

Figure 3.5. Levels and trends in family planning indicators (CPR, UNR, PDS and TD), by age group, 1997-2008 and 2003-2014



Source: UNFPA global open database (unfpaopendata.org).

3.5. Family planning among unmarried but sexually active adolescents

While most statistical analysis in family planning focuses on women who are currently married or in a union, a special and important group, adolescent girls aged 15-19 who are unmarried but sexually active, is often neglected. There are many reasons for this. In developing countries, most sexually active adolescent girls are married, and the majority of births to adolescent mothers occur within marriage. In fact, in many countries, it is claimed that sexual activity only happens within marriage, and that sex outside of marriage does not exist. As a result, when planning a household survey, these countries often decide to have an ever-married sample; data on unmarried women, including adolescent girls, are not collected.

Although unmarried adolescent girls account for a smaller proportion of those who are sexually active than those who are currently married or in a union, and there is a lack of data on unmarried sexually active adolescent girls in many countries, this group should be considered in the international family planning agenda, and their family planning demand should be fulfilled.

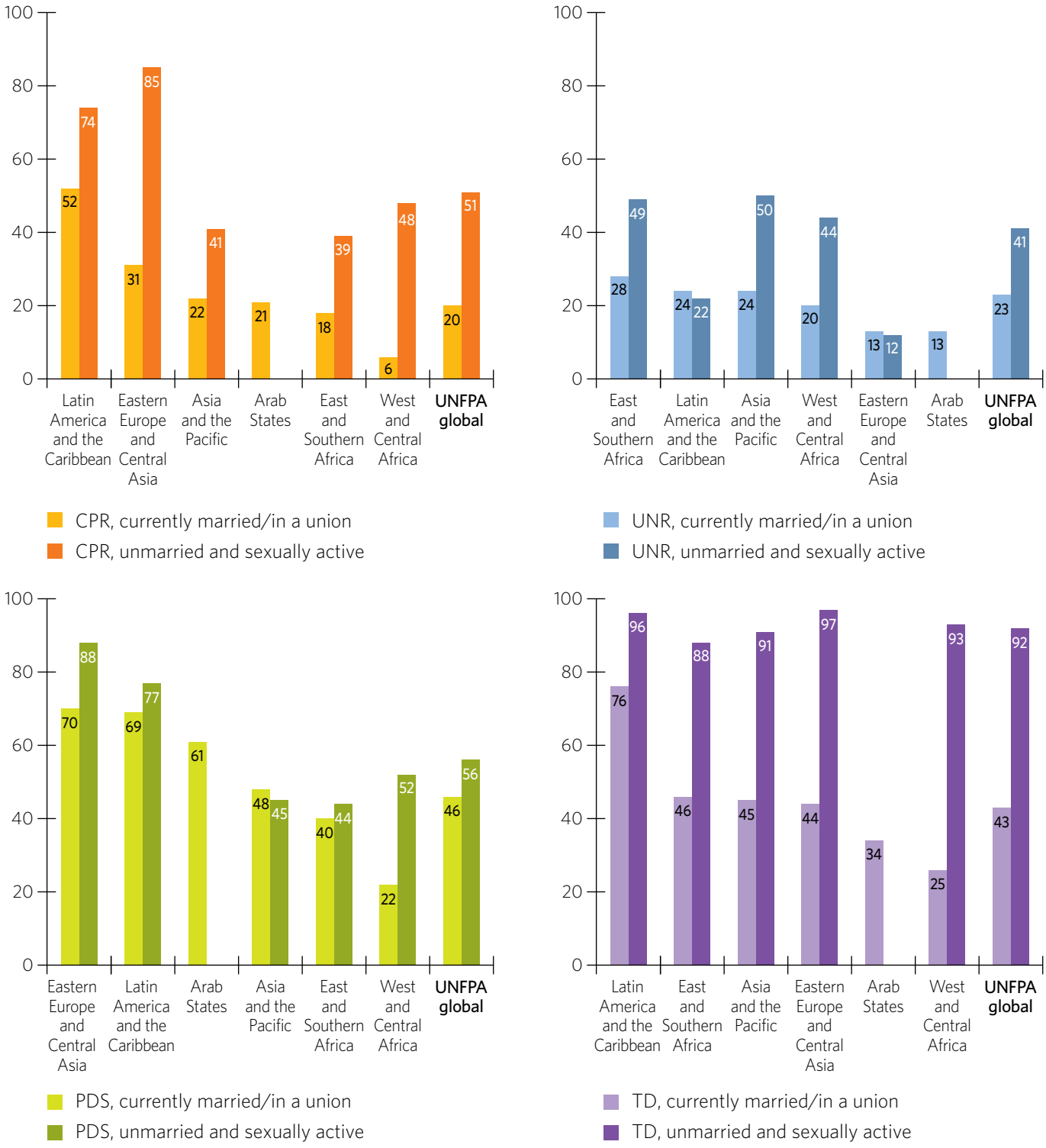
Figure 3.6 compares levels of family planning use among adolescent girls currently married or in a union, with those among adolescent girls who are unmarried and sexually active. Total demand among the latter, at 92 per cent, is more than double the 43 per cent among the former.

While the use of contraceptives is much higher among unmarried and sexually active adolescent girls, so is the unmet need for family planning. In developing countries, 41 per cent of unmarried and sexually active adolescent girls have an unmet need for contraception, compared to only 23 per cent of their peers who are married or in a union. In three out of five developing regions, the UNR is about double in unmarried and sexually active adolescent girls: in Asia and the Pacific, the rate is 50 per cent among unmarried adolescents compared to 24 per cent among those who are married or in a union; in East and Southern Africa, the figures are 49 per cent and 28 per cent, respectively, and in West and Central Africa, 44 per cent and 20 per cent, respectively.

Sexually active adolescents, especially those who are unmarried, may feel stigma related to needing family planning services.[21] In some countries and areas, laws and regulations prevent adolescents from accessing services. Consequences of unintended pregnancies, especially for girls who are not married, can be far-reaching, comprising school dropout, poor sexual and reproductive health, cultural stigmas and social pressures, as well as lost opportunities for employment and income in the long term.

[21] E. Presler-Marshall and N. Jones. 2012. *Charting the future: Empowering girls to prevent early pregnancy.* London: Overseas Development Institute.

Figure 3.6. Contraceptive prevalence rate, unmet need for family planning rate, proportion of demand satisfied and total demand for contraception among adolescent girls, by region, latest data, 2002-2014



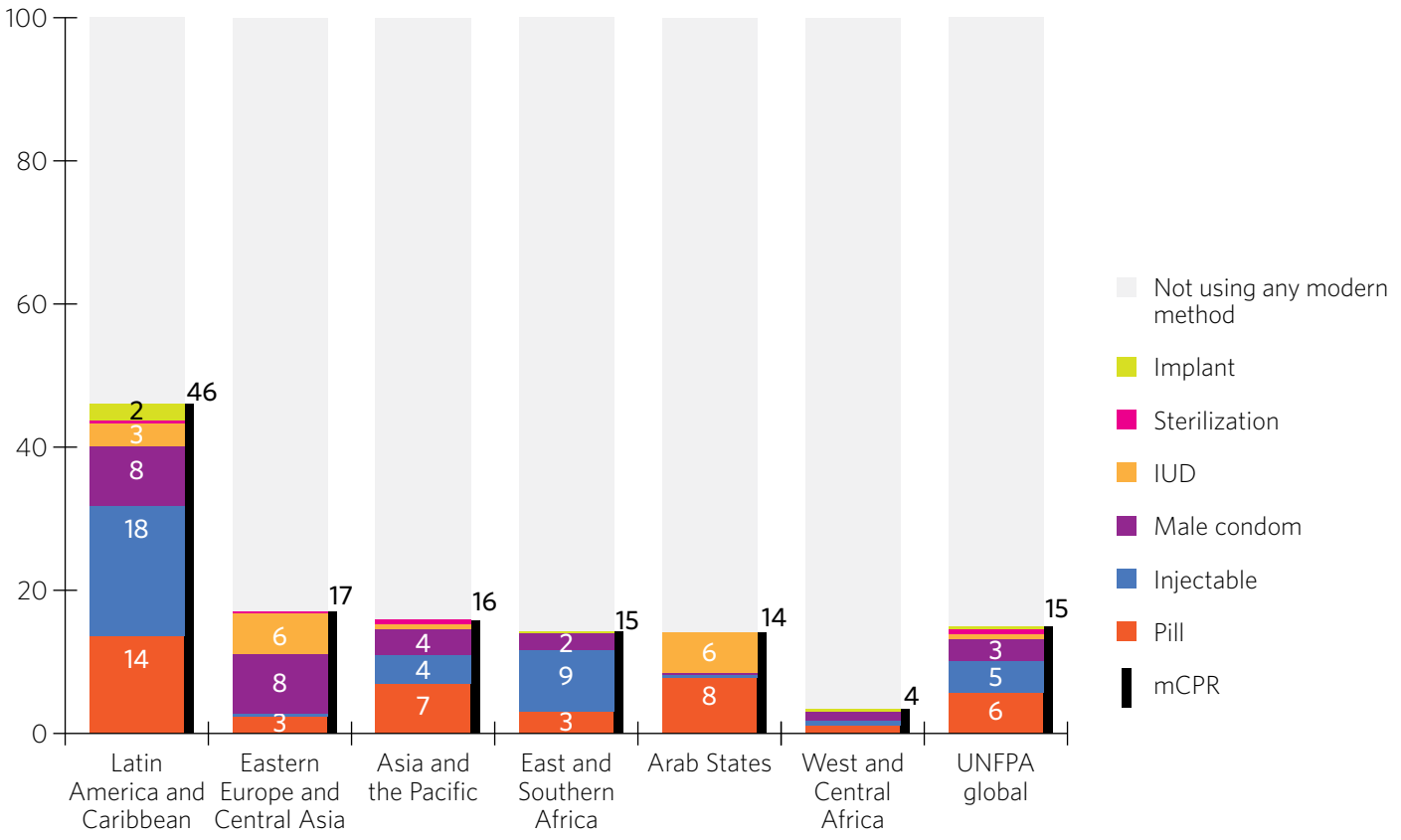
Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database (unfpaopendata.org).

3.6. Method mix among adolescents

In developing countries, about 15 per cent of adolescent girls aged 15-19 who are married or in a union are using modern contraceptive methods. The pill and injectable account for more than 70 per cent of their total use of modern methods, followed by male condoms at 21 per cent. IUDs comprise only 5 per cent of use in the developing world as a whole, but account for 38 per cent in the Arab States and 33 per cent in Eastern Europe and Central Asia (Figure 3.7).

Figure 3.7. Percentages of adolescent girls, married or in a union, using modern contraception, by region, latest data, 2002-2014



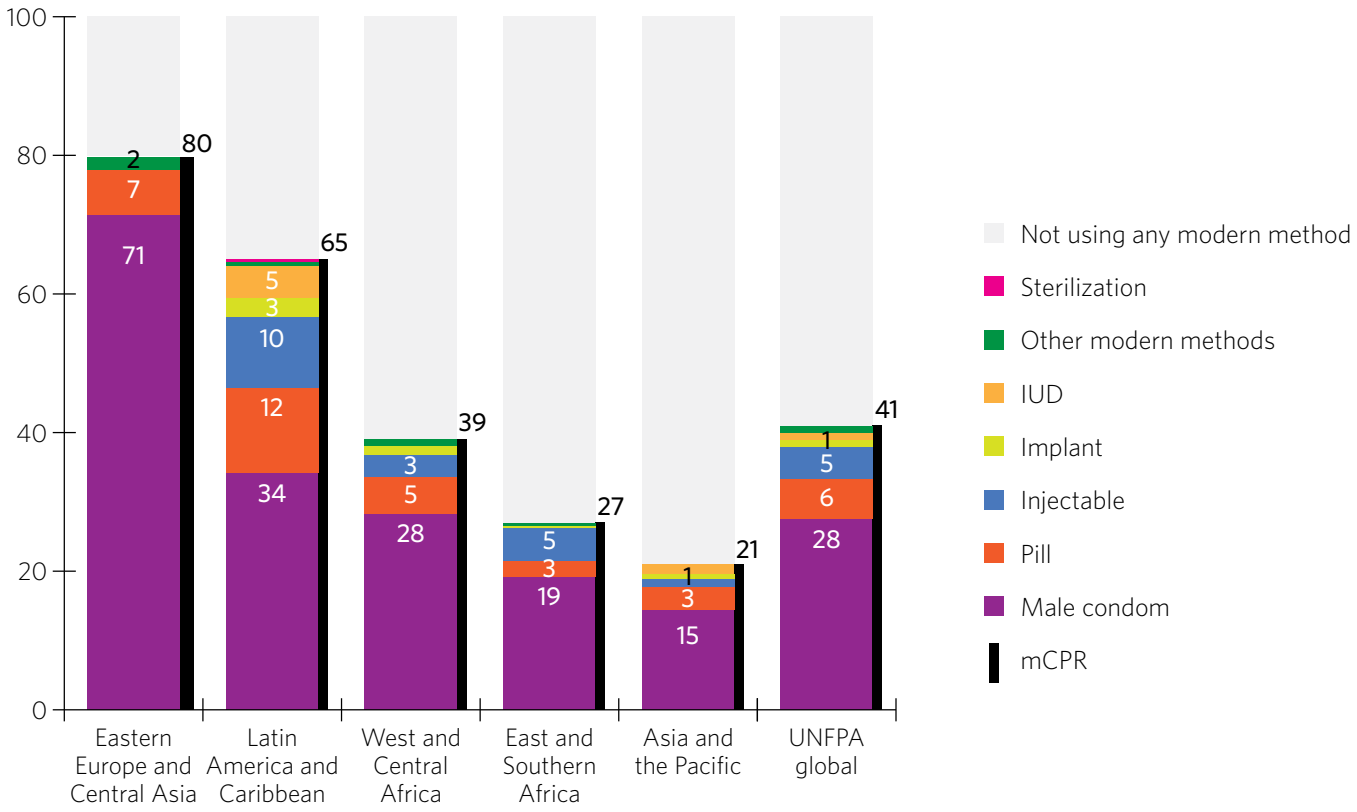
Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database (unfpaopendata.org).

While injectables account for close to 60 per cent of modern use in East and Southern Africa, the pill is responsible for 55 per cent in the Arab States region, and male condoms for close to half in Eastern Europe and Central Asia.

Figure 3.8 presents the modern method mix among unmarried and sexually active adolescent girls. In developing countries, 41 per cent of unmarried sexually active girls use modern methods. The preferred method is the male condom, which accounts for close to 70 per cent of total usage. In Eastern Europe and Central Asia, male condoms account for about 90 per cent.

Figure 3.8. Percentages of unmarried sexually active adolescent girls using modern contraception, by region, latest data, 2005-2014



Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database (unfpaopendata.org).

Unmarried sexually active girls predominantly tend to use male condoms, while those who are currently married or in a union have access to a broader range of methods. To quantify the degree to which adolescent girls use a range of methods at the country level, a method mix index was again calculated for each country, focusing on girls aged 15-19 who are currently married or in a union, using the same methodology as in Section 2.3.

As Map 3.2 shows, 31 countries are low method mix countries[22] — Albania, Algeria, Azerbaijan, Bhutan, Burundi, Congo, Cameroon, Democratic Republic of the Congo, Egypt, Ethiopia, the former Yugoslav Republic of Macedonia, Gabon, Indonesia, Kenya, Lao People's Democratic Republic, Liberia, Malawi, Mauritania, Morocco, Namibia, Niger, Rwanda, Serbia, Suriname, Tajikistan, Timor-Leste, Trinidad and Tobago, Ukraine, Uzbekistan, Yemen and Zimbabwe. Morocco has the lowest method mix, with an index at 98, as the pill accounts for 98 per cent of total mCPR in the country. These countries could benefit from a policy and programme review to assess the benefits or lack thereof of current family planning interventions.

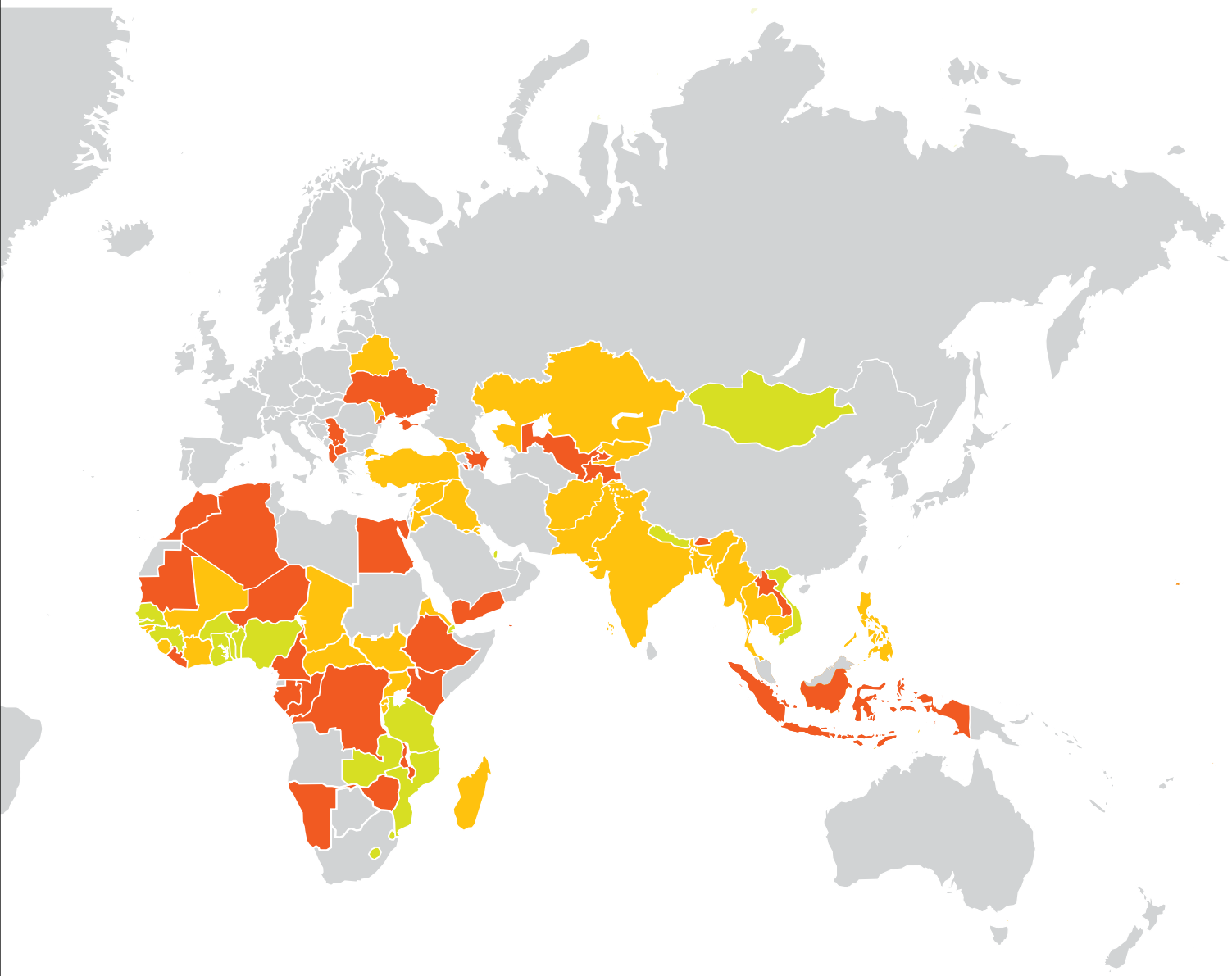
Map 3.2. Modern contraceptive method mix index for adolescent girls, married or in a union, by country, latest data, 2001-2013

High dominated by one method (index>=60)

Middle dominated by one method (index>=30&<60)

Low dominated by one method (index<30)

[22] Fifteen of these countries are GPRHCS countries.



Notes: Data not available for countries in grey.

Source: UNFPA analysis based on the UNFPA global open database (unfpaopendata.org).

3.7. Absolute number of adolescents with an unmet need for family planning

In 2014, an estimated 225 million women in the developing world had an unmet need for modern contraception.[23] The number of adolescent girls aged 15-19 with an unmet need remains in question. This section estimates the number, both for adolescent girls who are currently married or in a union, and for unmarried and sexually active adolescent girls (Table 3.2). This projection and analysis assumes that the unmet need for family planning, and marital status and sexual activity distributions among adolescent girls will remain at current levels (Figure 3.9).

For the developing world in 2015, 12.8 million adolescent girls have an unmet need for family planning. This number will increase to 15 million by 2030 if current trends continue.

Of the 12.8 million adolescent girls, about half live in Asia and the Pacific, and more than 30 per cent live in West and Central Africa, and East and Southern Africa. Due to prevalent high fertility, declining levels of mortality and a young age structure in sub-Saharan Africa, by 2030, there will be more than 6 million adolescent girls there with an unmet need for family planning.

Table 3.2. Estimated number of adolescent girls with an unmet need for family planning, by region, 2015

REGION	ABSOLUTE NUMBERS OF ADOLESCENTS GIRLS WITH AN UNMET NEED FOR FAMILY PLANNING (THOUSANDS)
Asia and the Pacific (excluding China)	6,289
Arab States	562
East and Southern Africa	2,398
Eastern Europe and Central Asia	125
Latin America and the Caribbean	1,611
West and Central Africa	1,833
UNFPA global	**12,817**

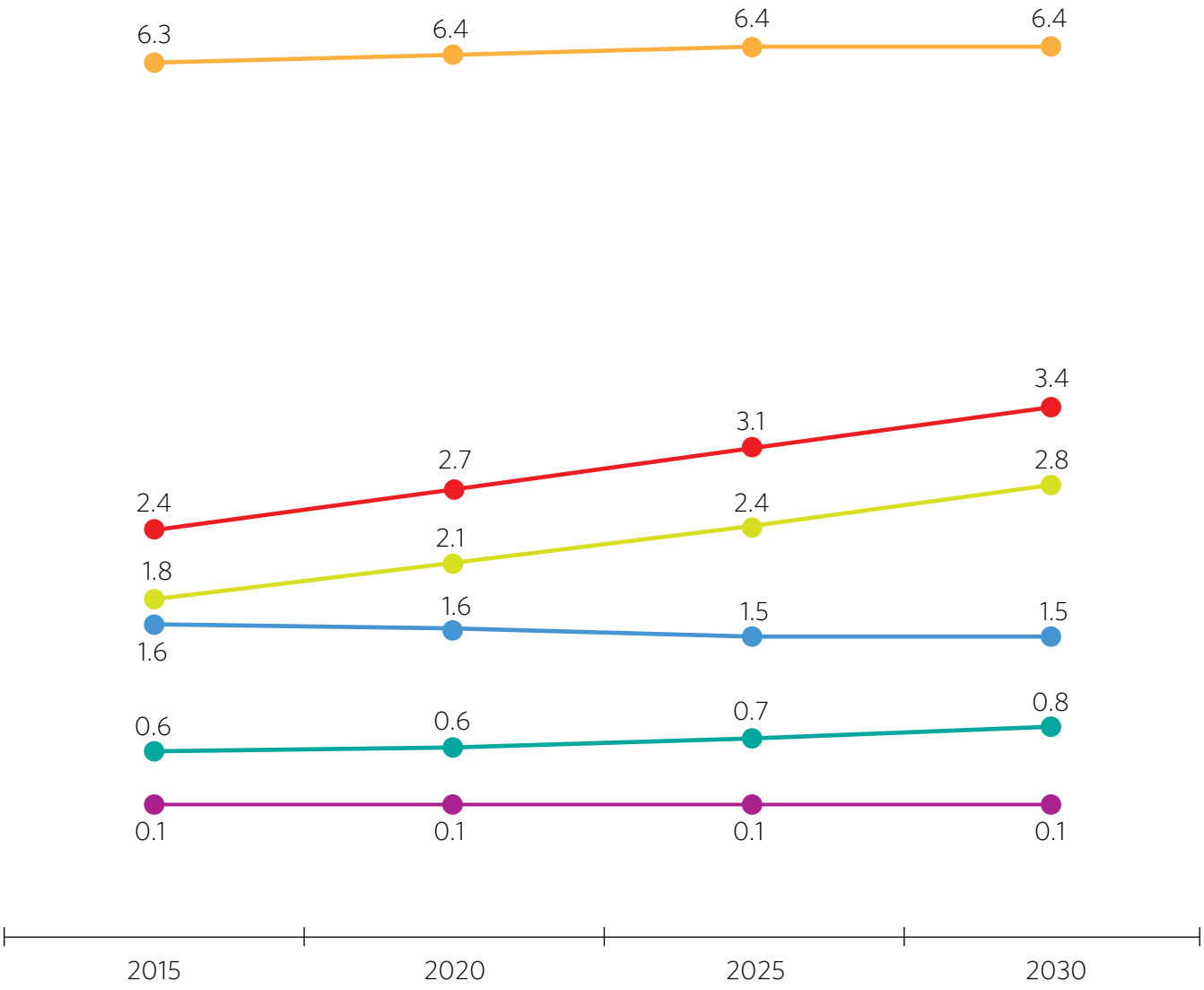
Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA analysis based on DHS and MICS data.

[23] S. Singh, J. E. Darroch and L. S. Ashford. 2014. "Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health." New York: Guttmacher Institute.

Figure 3.9. Number of adolescent girls, married or in a union, and unmarried but sexually active, with an unmet need for family planning, 2015-2030

Millions



Source: UNFPA analysis based on DHS and MICS data.

Reproductive Health Disparities and Inequalities

The birth rate among adolescents and contraceptive dynamics (measured by the CPR, UNR and PDS) are significantly affected by place of residence, level of education and household wealth. Examining demographic disparities and social and economic inequalities in family planning is critical for evidence-based programming. This understanding will help policymakers and programme managers identify the most vulnerable and marginalized populations, towards making sure that their rights are fulfilled.

Based on DHS and MICS data, and reproductive health surveys, as well as population estimates and projections, this chapter analyses disparities and inequalities across regions and within countries.

4.1. Adolescent birth rate

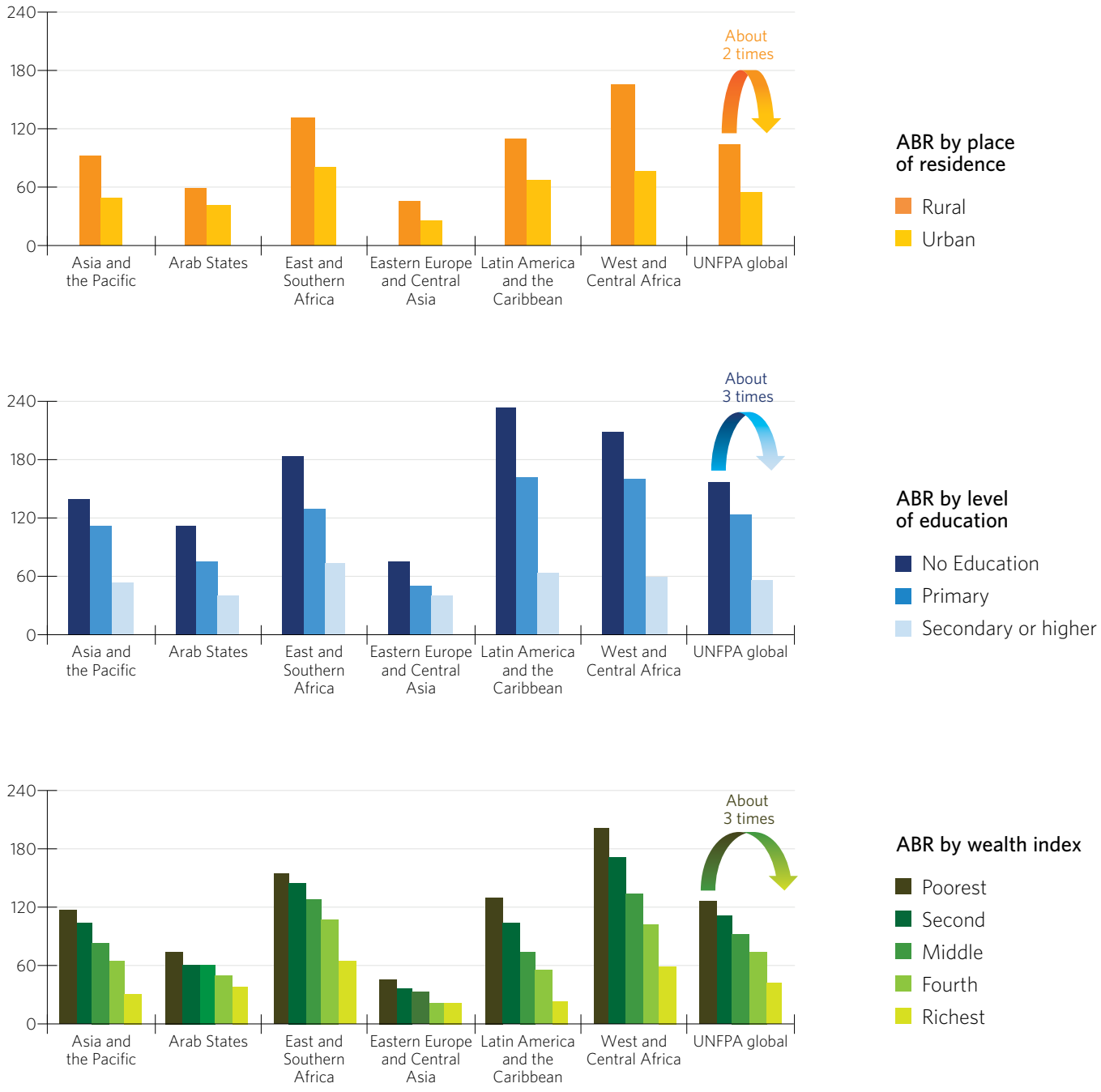
Statistical analysis based on data from 96 UNFPA programme countries shows that levels of adolescent fertility are higher in rural areas, where adolescents are poorer and less educated. This is the case in all regions. West and Central Africa has the largest disparity, where adolescents living in rural areas are more than two times as likely to give birth as their urban counterparts (167 vs. 77 births per 1,000 women aged 15-19).

The largest education inequality is in Latin America and the Caribbean, where there are 234 live births among adolescent girls with no education, versus 63 live births for girls with secondary or higher education, close to four times higher.

Latin America and the Caribbean also has the largest wealth inequality. Adolescent girls living in the poorest 20 per cent of households were 5.5 times as likely to give birth as girls in the richest 20 per cent of households (131 births versus 24 births).

The ratios of residence, education and wealth disparities for developing countries as a whole are 1.9, 2.8 and 3, respectively; see Figure 4.1. Trend analysis by background characteristics is based on data for 58 countries with two consecutive surveys (1998-2008 and 2004-2014), presented in Table 4.1 and Figure 4.2

Figure 4.1. Disparities and inequalities in adolescent birth rate by region, most recent data, 1998-2014 | Per 1,000 women aged 15-19

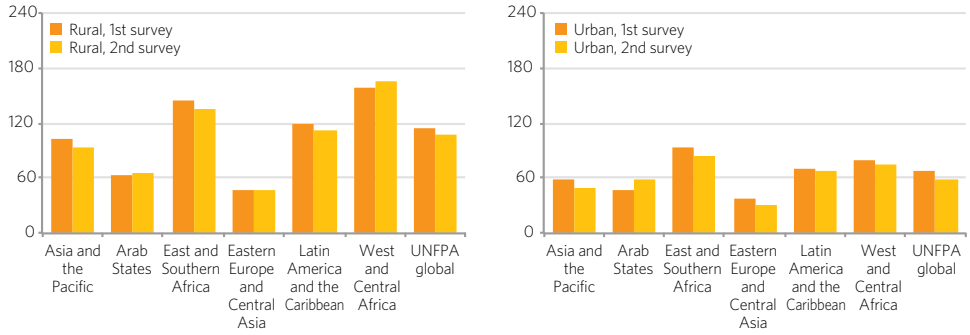


Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

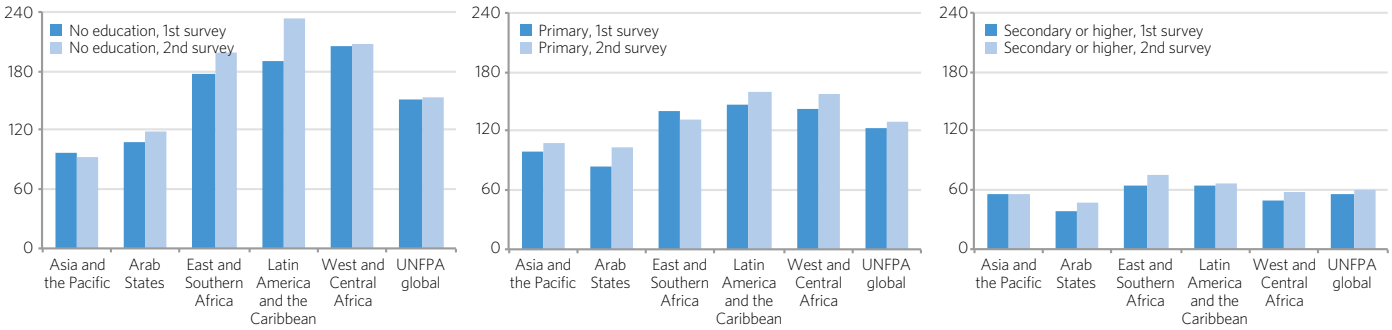
Source: UNFPA global open database (unfpaopendata.org).

Figure 4.2. Trends in adolescent birth rate by background characteristics from two consecutive surveys, 1998-2008 and 2004-2014 | Per 1,000 women aged 15-19

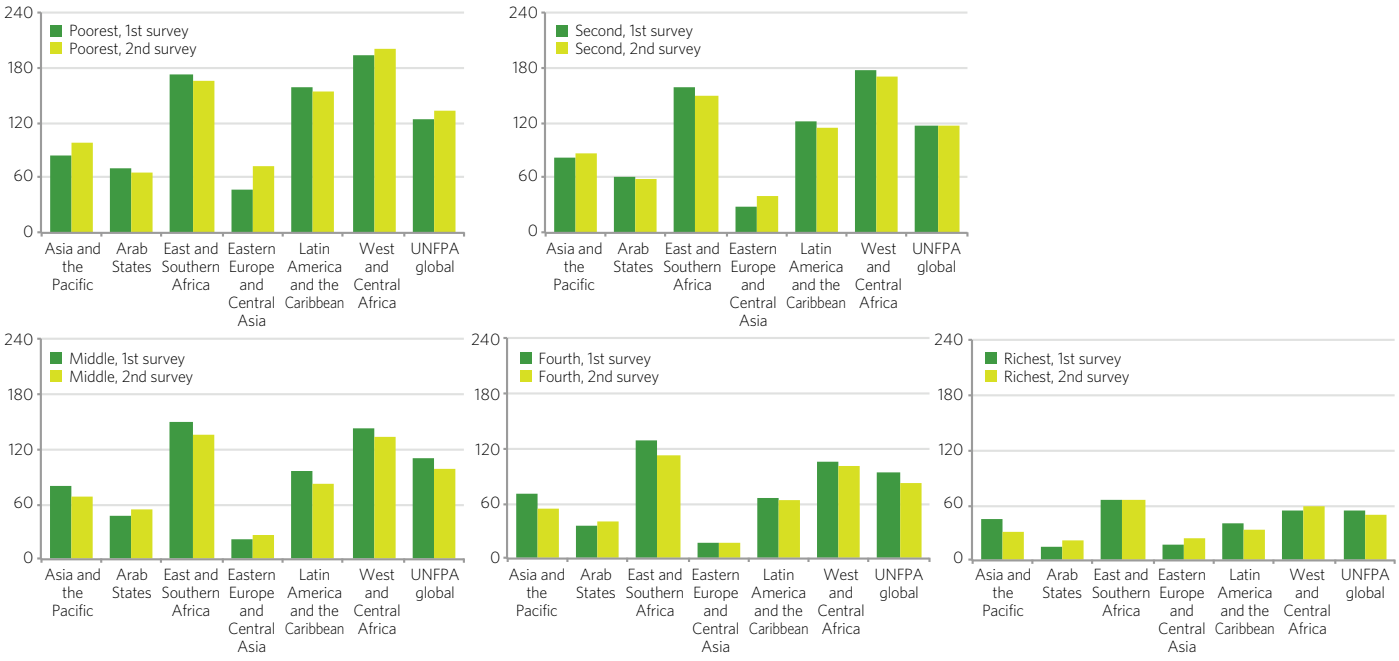
TRENDS IN ABR BY PLACE OF RESIDENCE



TRENDS IN ABR BY LEVEL OF EDUCATION



TRENDS IN ABR BY WEALTH INDEX



Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.
Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary, and population distribution of background characteristics may change over time.

Source: UNFPA global open database (unfpaopendata.org).

In most regions, the ABR has declined faster among women in urban areas compared to rural areas. For example, in East and Southern Africa, the rate has fallen by 12 per cent in urban areas, compared to only 6 per cent in rural areas. In West and Central Africa, rates have increased in rural areas by 4 per cent.

The rate among adolescent girls with no education has increased in many regions. Although the overall rate in East and Southern Africa has declined, it has risen by 12 per cent, from 178 births to 199 births, among girls with no education.

In general, girls from the wealthiest 60 per cent of households had a far lower birth rate compared to those from the poorest 40 per cent of households, but a closer look reveals a complex picture. In Asia and the Pacific, the rate among girls from the richest 20 per cent of households declined by 33 per cent, while the rate among girls from the poorest 20 per cent of households increased by 15 per cent. In the Arab States, the dynamic was the opposite, where the rate among the richest 20 per cent of girls rose by 67 per cent, compared to a decline of 6 per cent among the poorest 20 per cent. In West and Central Africa, rates have dropped in households in the middle-income range, but increased in the poorest and richest households.

Table 4.1. Trends in adolescent birth rate by background characteristics based on two consecutive surveys, 1998-2008 and 2004-2014

Percentage change

	RESIDENCE		EDUCATION			WEALTH QUINTILES				
UNFPA REGIONS	Urban	Rural	No education	Primary	Secondary or higher	Poorest	Second	Middle	Fourth	Richest
Asia and the Pacific	-15	-9	-6	8	-1	15	5	-16	-24	-33
Arab States	28	6	10	22	28	-6	-3	11	17	67
East and Southern Africa	-12	-6	12	-6	18	-4	-6	-10	-13	1
Eastern Europe and Central Asia	-17	2	-	-	-	-	-	-	-	-
Latin America and the Caribbean	-3	-5	-	-	-	-	-	-	-	-
West and Central Africa	-6	4	0	11	18	3	-3	-6	-5	8

Notes: Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary. Education disaggregates and wealth quintile disaggregates are not presented for Eastern Europe and Central Asia and Latin America and the Caribbean, as the numbers of countries with disaggregated data were insufficient for trend analysis.

Source: UNFPA global open database (unfpaopendata.org).

Disparities in the ABR have widened in many regions, with progress seen mainly among selected groups. In West and Central Africa, the ratio of residence disparity increased by 10 per cent from 2 times to 2.2 times, indicating that girls living in rural areas were 2 times more likely to give birth than their urban peers about 5-10 years ago, while today, they are 2.2 times more likely.

Inequality linked to wealth has increased in both Asia and the Pacific and Latin America and the Caribbean. In the former, the ABR ratio between adolescents of the poorest 20 per cent and the richest 20 per cent of households has increased from 1.8 to 3.2 times. The ratio in Latin America and the Caribbean has risen from 4 to 4.7 times.

Although the trend analysis here is based on data for 58 countries, covering 76 per cent of the population of women aged 15-19 in the developing world, the results should be interpreted with caution, especially for those regions with data covering less than 50 per cent of women aged 15-19: namely, the Arab States (48 per cent coverage), Eastern Europe and Central Asia (47 per cent coverage), and Latin America and the Caribbean (30 per cent coverage). Regional education and wealth quintile disaggregates may be based on a smaller number of countries. Due to changes in background characteristics—a higher percentage of women may have primary education during the second survey compared to during the first, for instance—comparison across background characteristics is not recommended. China is excluded from the Asia and the Pacific region in this analysis.

4.2. Contraceptive prevalence rate

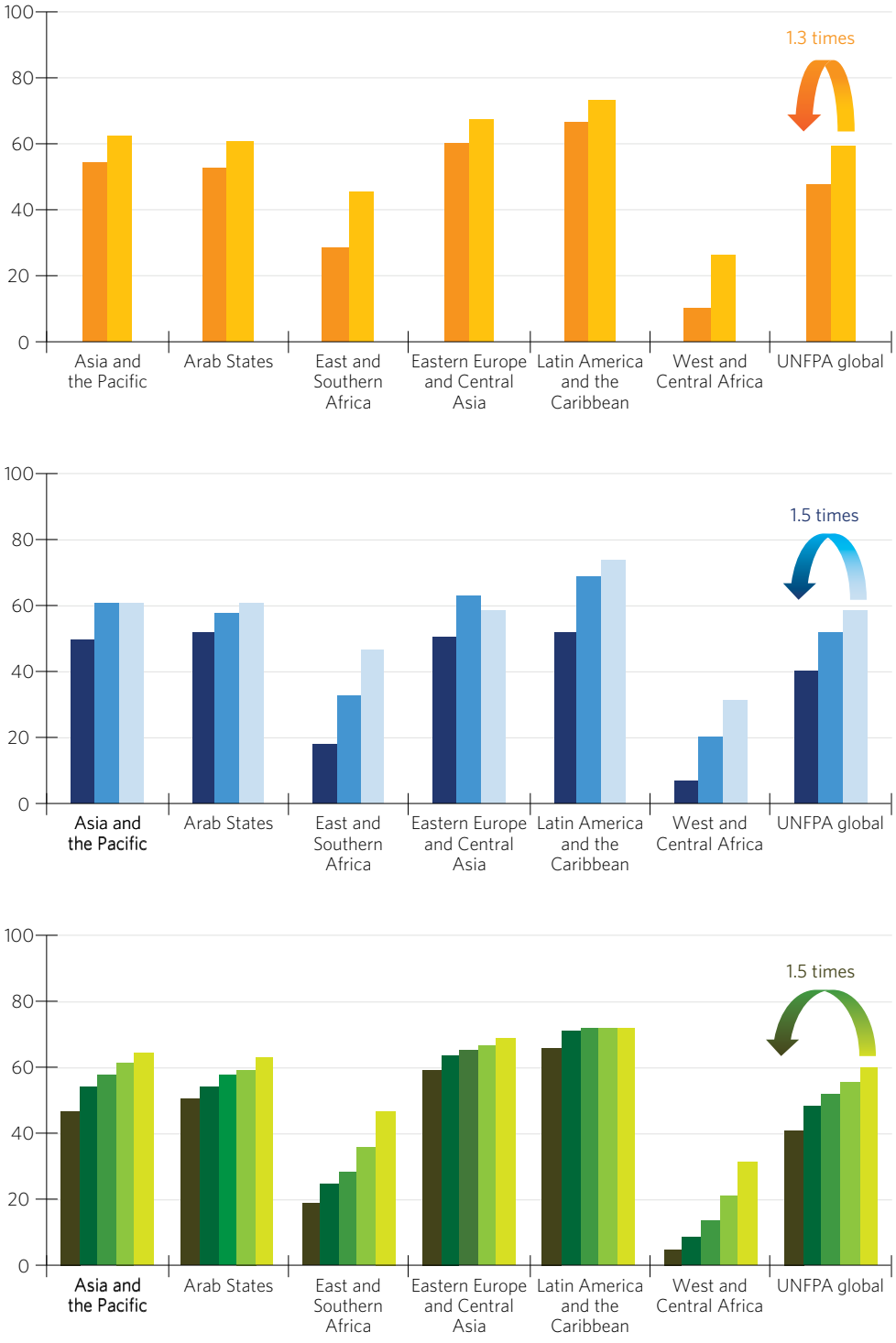
Disparities in contraceptive use linked to demographic, social and economic characteristics show important variations (Figure 4.3). In all developing regions, women with lower levels of education, living in rural areas or residing in poorer households have lower levels of use than those in urban areas, with higher levels of education or in richer households.

Wide disparities cross almost all regions, with the largest in West and Central Africa, where urban women have a CPR more than double that among rural women, at 26 per cent versus 10 per cent. The education disparity was even larger. Women with secondary or higher education were over four times more likely to use contraception than women with no education, at 31 per cent versus 7 per cent. The largest disparity was among different wealth groups. More than 30 per cent of women living in the richest 20 per cent of households used contraception, compared to only 5 per cent in the poorest 20 per cent, with a disparity ratio of six times.

The East and Southern Africa region has relatively wide disparities compared to other regions. Women with secondary or higher education were about 2.5 times more likely to use contraception compared to those with no education, at 47 per cent versus 18 per cent. Women in the richest 20 per cent of households were 2.5 times more likely to use any type of family planning method compared to those from the poorest 20 per cent, at 47 per cent versus 18 per cent.

Ratios for residence, education and wealth disparities for developing countries were 1.3, 1.5 and 1.5 times, respectively, as shown in Figure 4.3.

Figure 4.3. Disparities and inequalities in contraceptive prevalence rate among women aged 15-49, married or in a union, by region, most recent data, 2000-2014 | Percentage

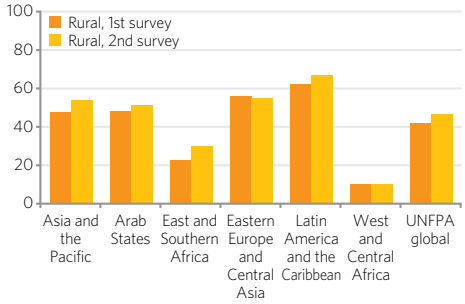


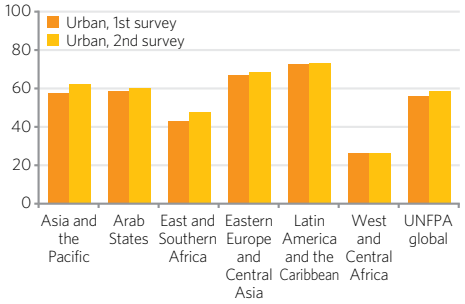
Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database (unfpaopendata.org).

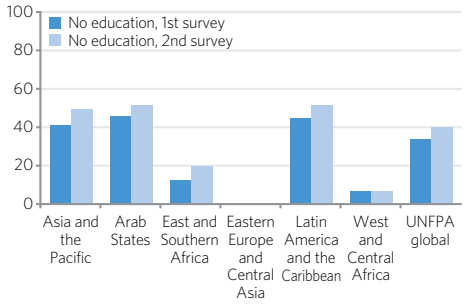
Figure 4.4. Trends in contraceptive prevalence rate among women aged 15-49, married or in a union, by background characteristics, based on two consecutive surveys, 1997-2008 and 2003-2014 | Percentage

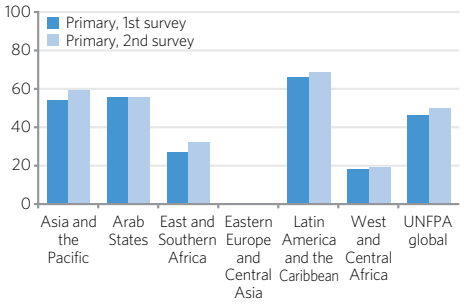
TRENDS IN CPR BY PLACE OF RESIDENCE

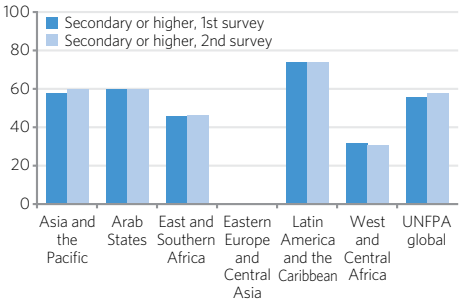




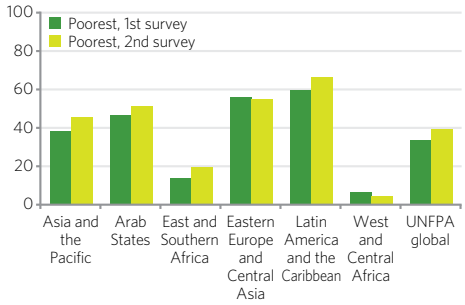
TRENDS IN CPR BY LEVEL OF EDUCATION

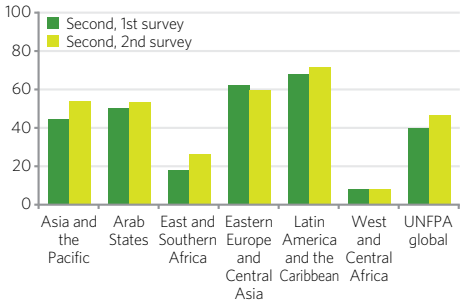


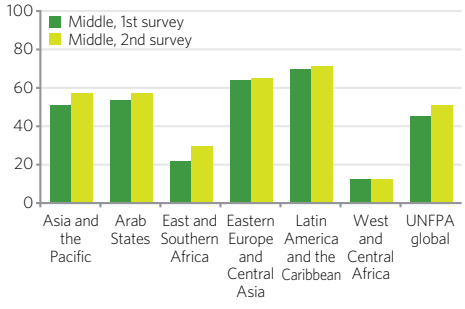


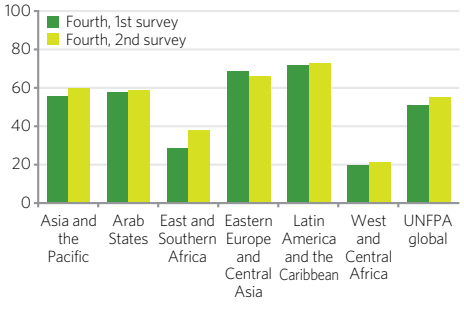


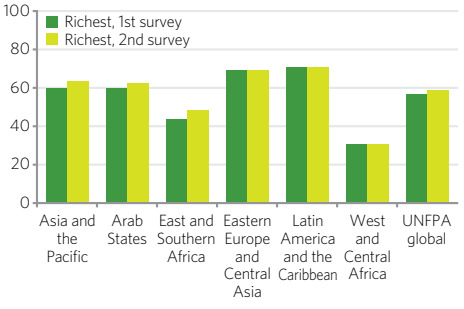
TRENDS IN CPR BY WEALTH INDEX











Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.
Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary, and population distribution of background characteristics may change over time.

Source: UNFPA global open database (unfpaopendata.org).

Trends in contraceptive use among women who are married or in a union by residence, education and wealth are shown in Table 4.2 and Figure 4.4, based on data for 67 developing countries with surveys in 1997-2008 and 2003-2014.

The East and Southern Africa region experienced the fastest increase in contraceptive use among women in urban and rural areas: 18 per cent and 49 per cent, respectively. Contraceptive use declined in rural areas of West and Central Africa and Eastern Europe and Central Asia, by 3 per cent and 1 per cent, respectively.

Table 4.2. Trends in contraceptive use among women aged 15-49, married or in a union, by background characteristics, based on surveys in 1997-2008 and 2003-2014 | Percentage change

	RESIDENCE		EDUCATION			WEALTH QUINTILES				
REGIONS	Urban	Rural	No education	Primary	Secondary or higher	Poorest	Second	Middle	Fourth	Richest
Asia and the Pacific	7	13	22	9	4	18	20	12	9	4
Arab States	3	7	13	0	1	10	5	6	3	4
East and Southern Africa	18	49	30	19	4	16	26	34	21	20
Eastern Europe and Central Asia	2	-1	-	-	-	0	-2	3	-3	0
Latin America and the Caribbean	2	7	14	3	1	12	6	3	1	0
West and Central Africa	0	-3	-5	6	-3	-17	2	5	5	0
UNFPA global	**6**	**13**	**20**	**8**	**4**	**17**	**18**	**12**	**9**	**4**

Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary. Education disaggregates are not presented for Eastern Europe and Central Asia as the number of countries with disaggregated data was insufficient for trend analysis.

Source: UNFPA global open database (unfpaopendata.org).

Critical progress in the use of contraception among women with no education is occurring in all regions except West and Central Africa, with a decline in CPR of 5 per cent. The highest increase was in Eastern and Southern Africa at 30 per cent, followed by Asia and the Pacific at 22 per cent, Latin America and the Caribbean at 14 per cent and the Arab States at 13 per cent.

Contraceptive use among women from the richest 20 per cent of households has increased in half of the regions, while remaining constant in the other half. East and Southern Africa had the fastest growth, with a 20 per cent increase. Use among women from the poorest 20 per cent of households declined by 17 per cent in West and Central Africa, from 6.2 per cent to 5.1 per cent.

Disparities in contraceptive use have narrowed in all developing regions except West and Central Africa. There, the wealth disparity in the use of contraception has increased by 20 per cent from a ratio of 5.1 times to a ratio of 6.2 times. In other words, 5-10 years ago, women from the wealthiest 20 per cent of households were 5.1 times more likely to use any method of contraception than their counterparts from the poorest 20 per cent households, while today, they are 6.2 times more likely to do so.

The largest decline in disparities in contraceptive use has taken place in East and Southern Africa. The disparity by place of residence fell by 16 per cent (from a ratio of 1.9 times to 1.6), by level of education by 37 per cent (from a ratio of 3.7 times to 2.4), and in wealth disparity by 19 per cent (from a ratio of 3.2 times to 2.6).

4.3. Unmet need for family planning

The unmet need for family planning is a relatively complex indicator because it could change as a result of trends in either supply or demand, or a combination of both. Based on data for 98 developing counties, women from the wealthiest households, living in urban areas and with higher levels of education tend to experience lower levels of unmet need. The ratios for residence, education and wealth disparities for developing countries are 1.4, 1.3 and 1.6, respectively.

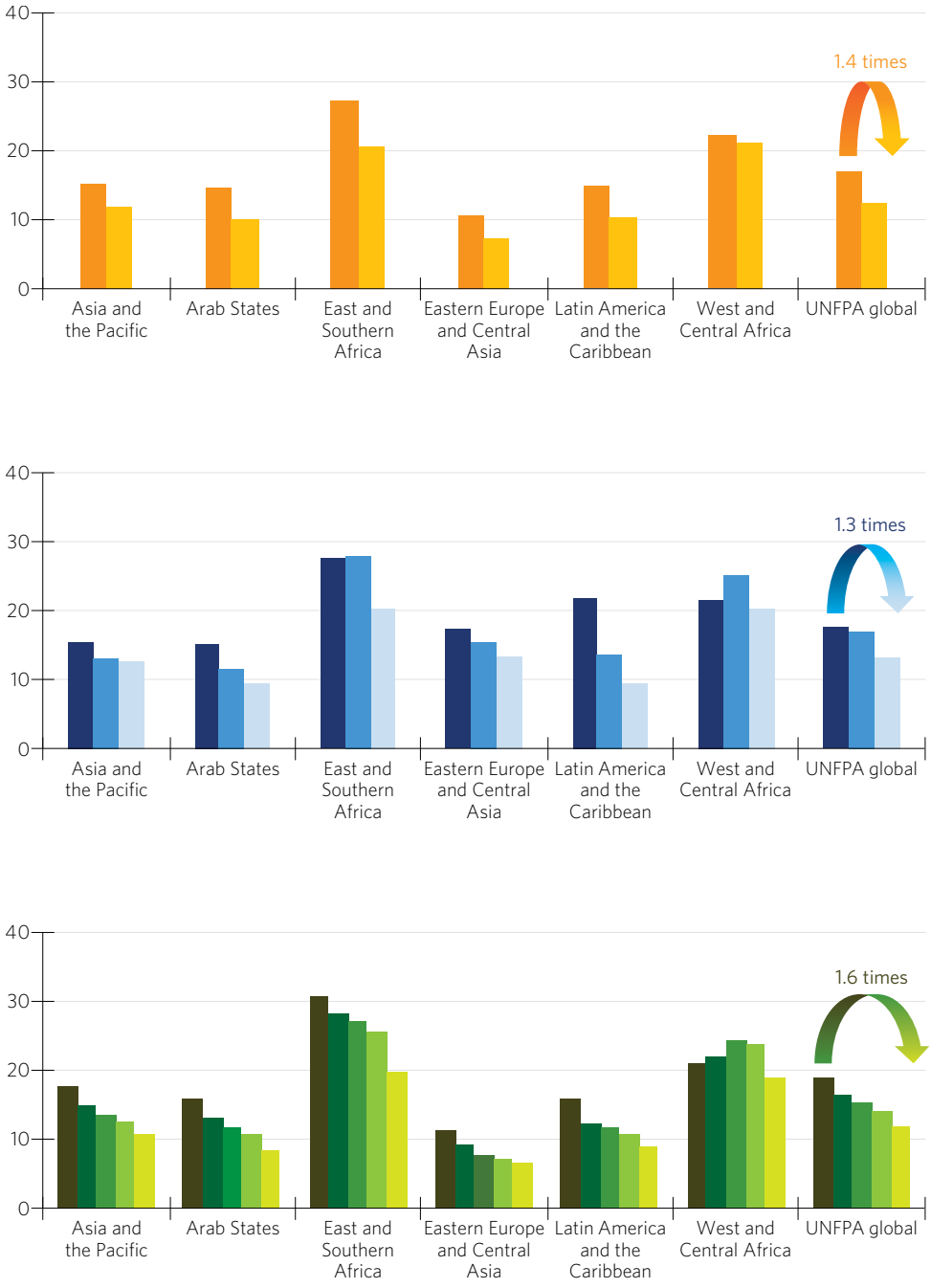
Disparities are significant in all regions except West and Central Africa (Figure 4.5), where unmet need remained consistently high across all demographic, social and economic groups, and without a clear correlation. Women with primary education had the highest UNR at 25 per cent, followed by women with no education and with secondary education or higher, at 21 per cent and 20 per cent, respectively.

The education disparity is wide in Latin America and the Caribbean, with an UNR of 22 per cent among women with no education, compared to only 10 per cent among women with secondary education or higher. Women with no education are 2.3 times more likely to have an unmet need for contraception compared to women with secondary education or higher.

The Arab States region has a large wealth disparity, at 1.9 times. The unmet need among women from the poorest quintile is 16 per cent, compared to 8 per cent among women from the richest quintile.

Table 4.3 and Figure 4.6 present trends based on 67 countries with two data points from surveys in 1997-2008 and 2003-2014. Urban areas in Asia and the Pacific, the Arab States, Eastern Europe and Central Asia, and West and Central Africa have experienced a faster decline in the UNR compared to rural areas. In East and Southern Africa and Latin America and the Caribbean, the UNR among women in rural areas (13 per cent and 20 per cent, respectively) fell faster than the rate in urban areas (4 per cent and 14 per cent, respectively).

Figure 4.5. Disparities and inequalities in unmet need for contraception among women aged 15-49, married or in a union, by region, most recent data, 2000-2014 | Percentage

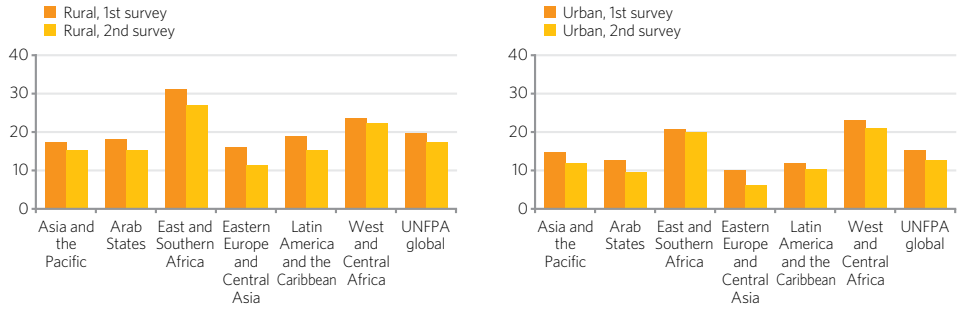


Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

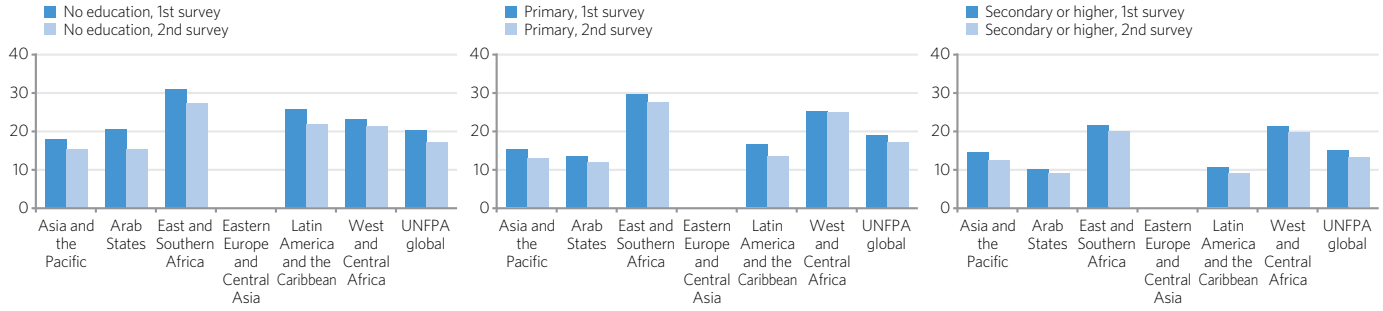
Source: UNFPA global open database (unfpaopendata.org).

Figure 4.6. Trends in unmet need for contraception among women aged 15-49, currently married or in a union, by background characteristics, 1997-2008 and 2003-2014 | Percentage

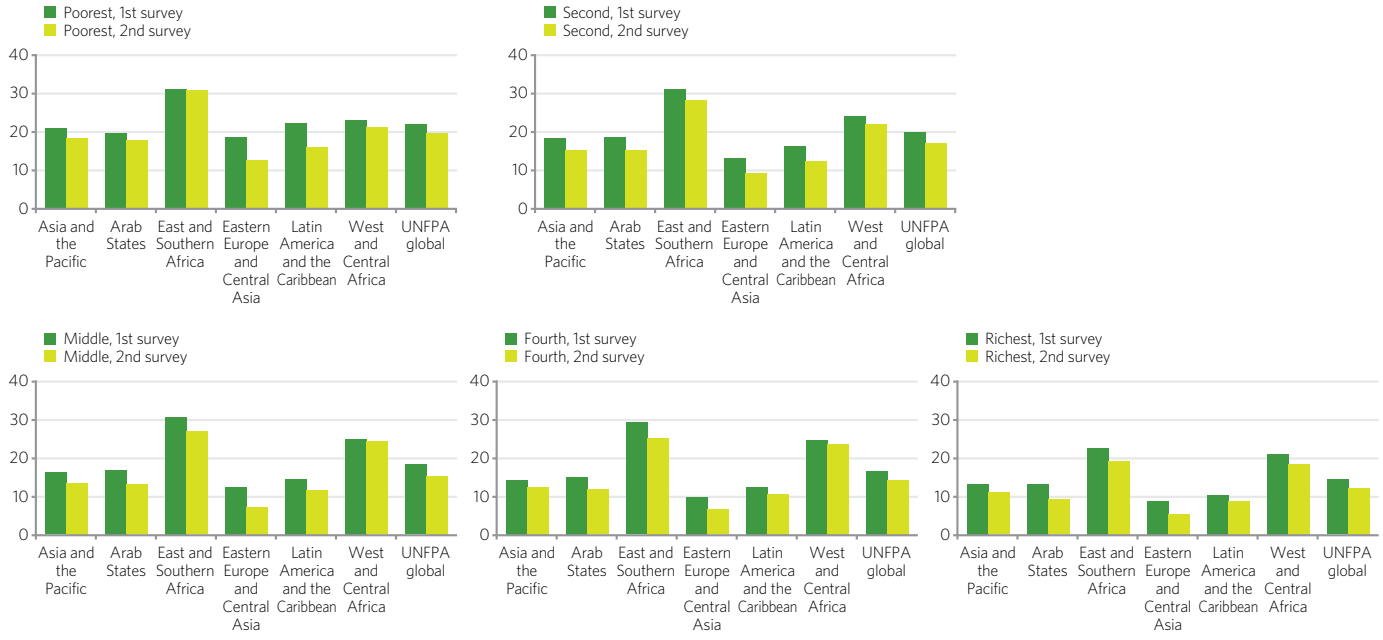
TRENDS IN UNR BY PLACE OF RESIDENCE



TRENDS IN UNR BY LEVEL OF EDUCATION



TRENDS IN UNR BY WEALTH INDEX



Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.
Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary, and population distribution of background characteristics may change over time.

Source: UNFPA global open database (unfpaopendata.org).

In East and Southern Africa and the Arab States, the UNR has decreased much faster among richer women than poorer women. For example, in East and Southern Africa, the UNR has declined by 15 per cent among women from the richest 20 per cent of households, compared to no change among women from the poorest 20 per cent. The figures are 30 per cent and 10 per cent, respectively in the Arab States.

In general, disparities in the UNR have remained constant, with a slight increase in wealth and residence disparities. Wealth disparity has widened in the Arab States, from a ratio of 1.5 to 1.9 times. Residence disparity has widened in Eastern Europe and Central Asia, from a ratio of 1.6 to 1.8 times.

Table 4.3. Trends in unmet need for family planning among women aged 15-49, currently married or in a union, by background characteristics, 1997-2008 and 2003-2014

Percentage change

	RESIDENCE		EDUCATION			WEALTH QUINTILES				
REGIONS	Urban	Rural	No education	Primary	Secondary or higher	Poorest	Second	Middle	Fourth	Richest
Asia and the Pacific	-19	-13	-15	-15	-14	-13	-17	-16	-13	-17
Arab States	-23	-17	-25	-9	-12	-10	-18	-22	-20	-30
East and Southern Africa	-4	-13	-12	-8	-10	0	-10	-13	-14	-15
Eastern Europe and Central Asia	-37	-28	-	-	-	-33	-29	-42	-33	-36
Latin America and the Caribbean	-14	-20	-16	-18	-15	-28	-25	-21	-15	-14
West and Central Africa	-8	-6	-8	-2	-7	-8	-8	-3	-5	-11
UNFPA global	**-17**	**-12**	**-14**	**-9**	**-13**	**-11**	**-15**	**-15**	**-13**	**-17**

Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary. Education disaggregates are not presented for Eastern Europe and Central Asia as the number of countries with disaggregated data was insufficient for trend analysis.

Source: UNFPA global open database (unfpaopendata.org).

4.4. Proportion of demand satisfied

Similar to contraception use and unmet need for family planning, analysis based on data for 98 developing countries shows that women living in urban areas, with higher education and belonging to wealthier households are more likely to satisfy their demand for contraception (Figure 4.7). The disparity ratios by place of residence, education and wealth for developing countries are 1.1, 1.2 and 1.2, respectively.

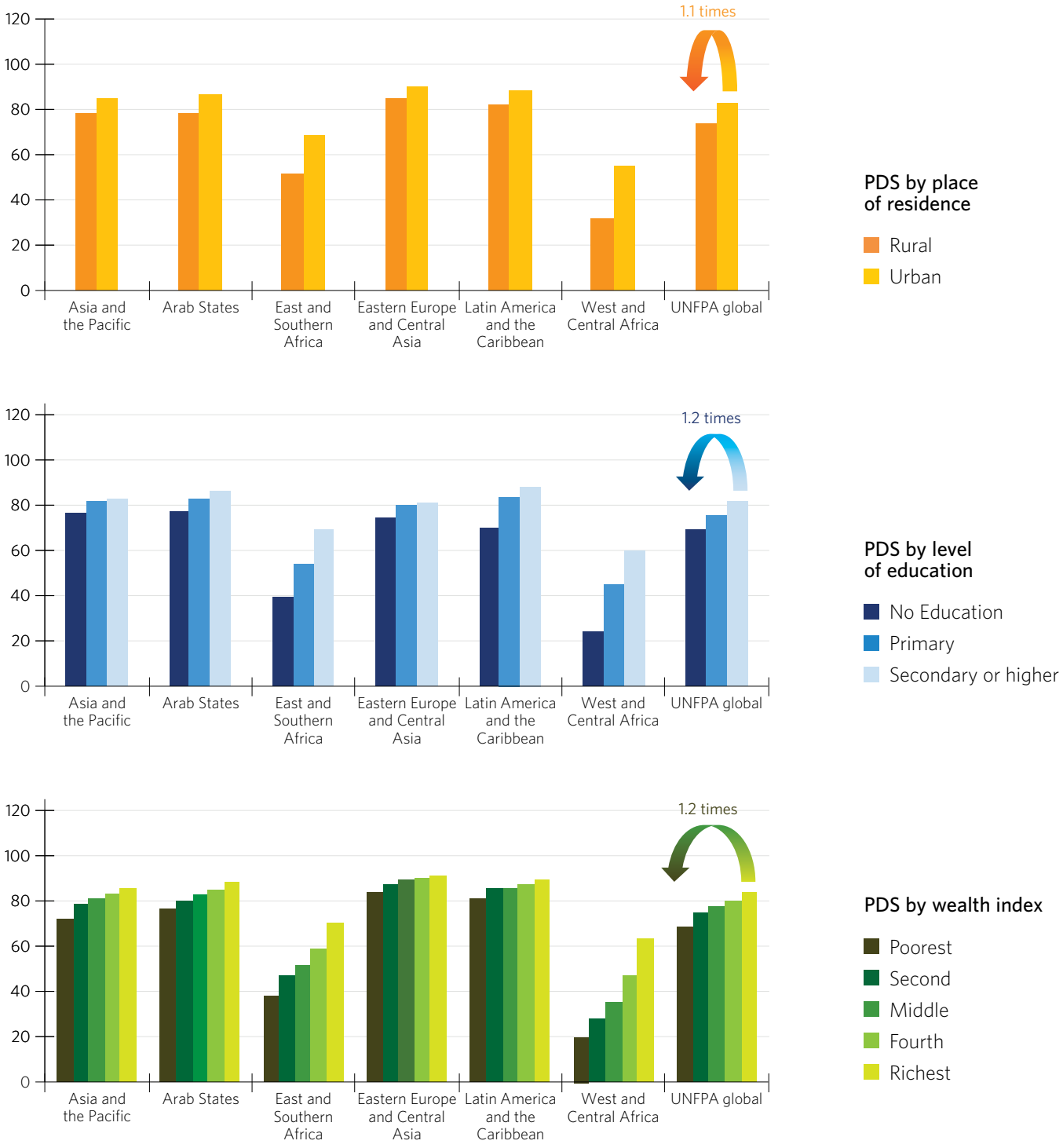
West and Central Africa and East and Southern Africa show significant disparities, much larger than other regions. In these regions, women in the richest 20 per cent of households are 3.2 times more likely to have their demand satisfied than those in the poorest 20 per cent. The disparity ratios by education and place of residence are 2.5 times and 1.8 times, respectively. In East and Southern Africa, women with secondary or higher education are 1.7 times more likely to have their demand satisfied compared to women with no education. The wealth and residence disparities are 1.9 and 1.4 times, respectively. Both regions show the largest disparity in terms of wealth, followed by education and residence.

Based on data for 67 countries with two recently completed surveys (1997-2008 and 2003-2014), satisfaction of contraceptive demand has increased across categories in all developing regions, with the only exception being women from the poorest 20 per cent of households in West and Central Africa, who saw a 7 per cent decline.

East and Southern Africa experienced the fastest increase in demand satisfied, particularly for disadvantaged groups. PDS among women with no education has increased by 49 per cent. It has risen by 14 per cent among women with primary education, and 4 per cent among women with secondary education or higher.

In all developing regions, with the exception of West and Central Africa, increases have been faster among more vulnerable groups, including women living in rural areas, with no or low levels of education, and from poorer households.

Figure 4.7. Disparities and inequalities in the proportion of demand for contraception satisfied among women aged 15-49, married or in a union, by region, most recent data, 2000-2014 | Percentage

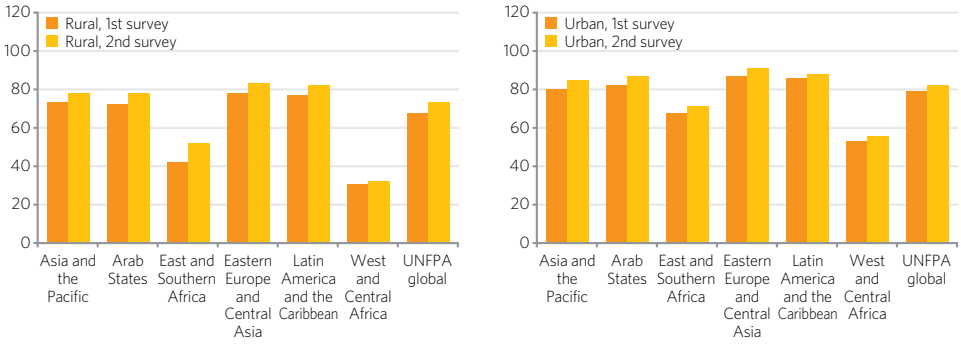


Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

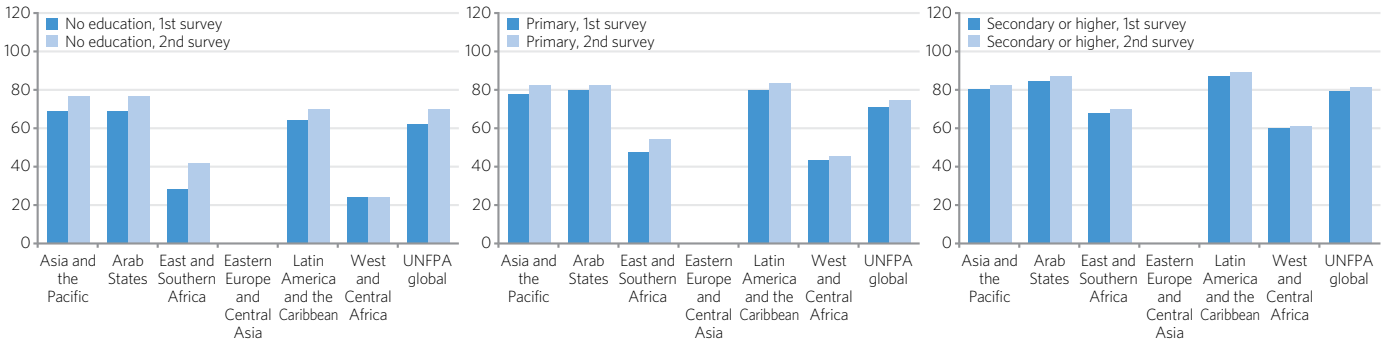
Source: UNFPA global open database (unfpaopendata.org).

Figure 4.8. Trends in proportion of demand for contraception satisfied among women aged 15-49, married or in a union, by background characteristics, 1997-2008 and 2003-2014 | Percentage

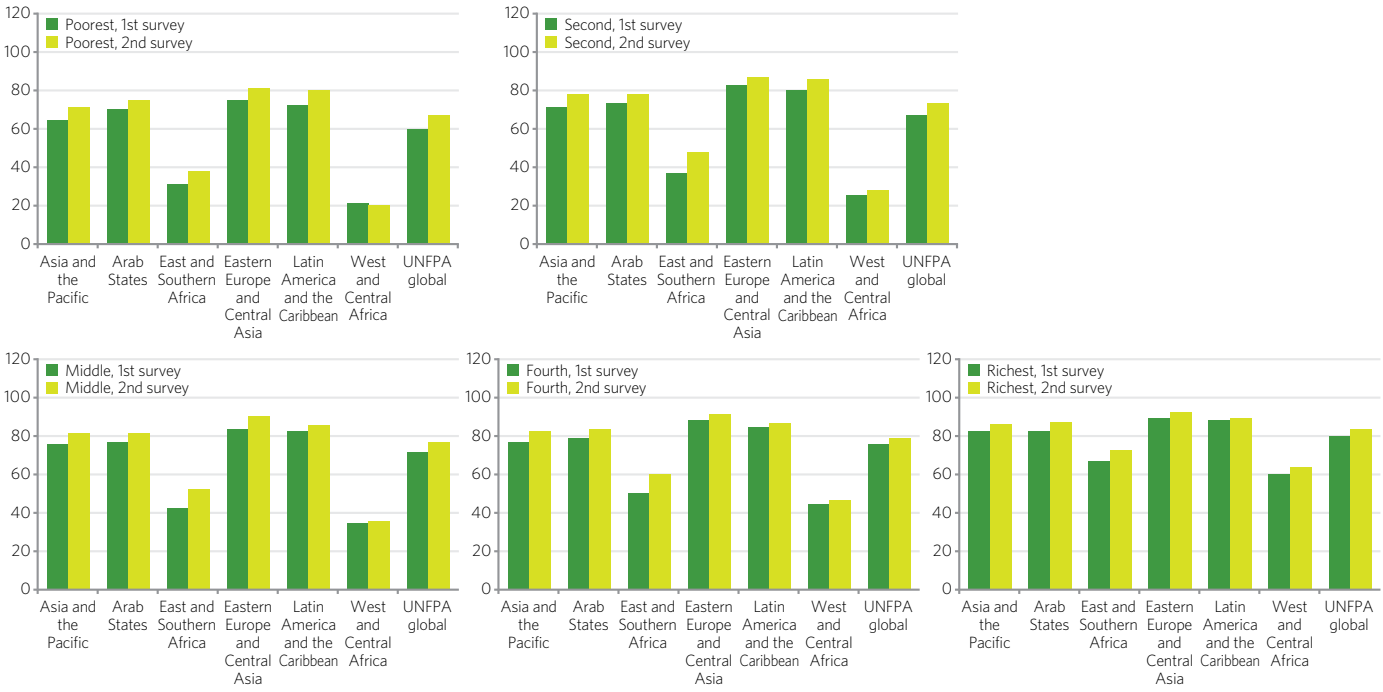
TRENDS IN PDS BY PLACE OF RESIDENCE



TRENDS IN PDS BY LEVEL OF EDUCATION



TRENDS IN PDS BY WEALTH INDEX



Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.
Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary, and population distribution of background characteristics may change over time.

Source: UNFPA global open database (unfpaopendata.org).

Table 4.4. Trends in proportion of demand for contraception satisfied among women aged 15-49, married or in a union, by background characteristics, 1997-2008 and 2003-2014 | Percentage change

	RESIDENCE		EDUCATION			WEALTH QUINTILES				
REGIONS	Urban	Rural	No education	Primary	Secondary or higher	Poorest	Second	Middle	Fourth	Richest
Asia and the Pacific	5	7	10	5	4	10	10	7	4	4
Arab States	5	7	12	2	2	6	6	7	5	6
East and Southern Africa	5	25	49	14	4	23	30	25	21	8
Eastern Europe and Central Asia	5	6	-	-	-	9	5	8	4	4
Latin America and the Caribbean	2	6	10	4	2	11	6	4	2	2
West and Central Africa	4	2	2	4	2	-7	8	5	5	5
UNFPA global	**5**	**8**	**12**	**5**	**4**	**11**	**10**	**7**	**5**	**4**

Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries. Comparison across background characteristics is not recommended as the number of countries with disaggregated data may vary. Education disaggregates are not presented for Eastern Europe and Central Asia as the number of countries with disaggregated data was insufficient for trend analysis.

Source: UNFPA global open database (unfpaopendata.org).

Globally, disparities in PDS have narrowed, with the most progress in East and Southern Africa. West and Central Africa is the only region with wider disparities based on residence and wealth—the ratio of wealth disparity has increased from 2.8 to 3.2 times. This illustrates that 5-10 years ago, women from the wealthiest 20 per cent of households were 2.8 times more likely to have their demand satisfied than their counterparts from the poorest 20 per cent of households, while today, they are 3.2 times more likely to satisfy their demand.

The trend analysis for the CPR, UNR and PDS is based on data for 67 developing countries, covering about 78 per cent of women of reproductive age currently married or in a union in the developing world. The results should be interpreted with caution, in particular, for regions where data cover less than 50 per cent of the population. This applies here only to Latin America and the Caribbean, with a coverage rate of 22 per cent.

Regional education disaggregates and wealth quintile disaggregates may be calculated based on a smaller number of countries. China is excluded from Asia and the Pacific in this analysis.

While we are able to identify important progress in contraceptive dynamics across regions, this progress is not completely reflected in the observed changes among adolescents, particularly when comparing the birth rates among them. One possible explanation is the persistence of norms and customs across regions that inhibit access to contraceptives among adolescents girls and therefore deny them their reproductive rights. In West and Central Africa, for example, the lower level of contraceptive use is not necessarily the result only of lack of access to and/or utilization of methods, but also of the interaction of more complex issue and factors related to culture, social norms, gender inequality, and the status of women and girls.

4.5. Diversity at country level: sub-Saharan Africa

Sub-Saharan Africa continues to lag behind the rest of the world, carrying a disproportionate burden of teenage pregnancy and maternal deaths. Variations and diversities are common within its two regions, with more significant progress seen in East and Southern Africa compared to West and Central Africa. Some countries have made great progress in achieving the targets of the MDGs, while others may be off track and lag far behind. This section examines the diversity in the ABR and family planning among girls aged 15-19 at the country level based on data for 25 sub-Saharan Africa countries with a household survey at or after 2010.

Figure 4.9a presents these countries according to the current level of the ABR and the percentage of change. Two main groups are noteworthy. For the first, the ABR has declined substantially (lower two quadrants of Figure 4.9a). For the second, it has increased substantially (upper two quadrants of Figure 4.9a). Among this second group are countries showing recent increases above 100 live births per 1,000 women aged 15-19. They comprise Burkina Faso, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Liberia, Niger, Nigeria and Zimbabwe, as highlighted in the orange zone.

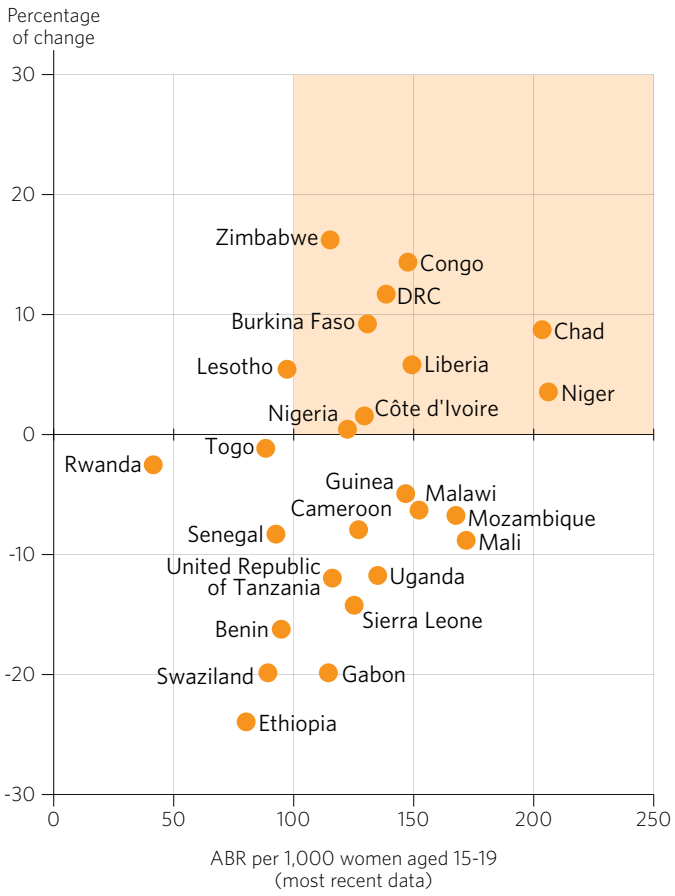
Figure 4.9b presents countries according to PDS and the percentage of change. For one set of countries, the PDS increased substantially (upper two quadrants of Figure 4.9b), while in a second set, it has declined (lower two quadrants of Figure 4.9b). Among the second set are countries with low levels among adolescent girls (40 per cent or less, lower left quadrant) and with declines in the PDS. These countries are Benin, Cameroon, Chad, Democratic Republic of the Congo, Gabon, Guinea, Mozambique, Nigeria and Togo.

Map 4.1 presents levels and trends in the ABR and PDS among girls aged 15-19 who are married or in a union, across sub-Saharan Africa. Of the 25 countries with surveys completed since 2010, 5 had a significant increase in the ABR: Burkina Faso, Chad, Congo, Democratic Republic of the Congo and Zimbabwe. Zimbabwe had the largest increase at 16 per cent, from 99 births to 115 births. Ethiopia has the fastest decline, of 24 per cent, from 104 births to 79 births.

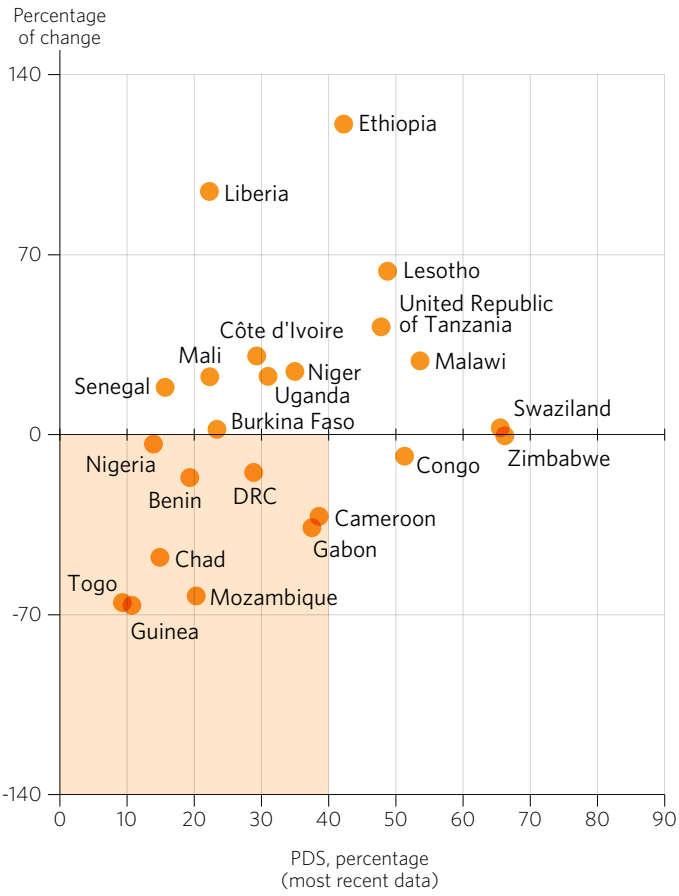
Eight of the 25 countries show a significant decline in the PDS among adolescent girls: Benin, Cameroon, Chad, Democratic Republic of the Congo, Gabon, Guinea, Mozambique and Togo. The largest decline happened in Guinea, at 66 per cent, from 31 per cent to 11 per cent. Rwanda increased from 13 per cent to 84 per cent, more than five times. Reasons for a decreasing PDS can be a fall in the use of contraception, an increase in the unmet need for family planning, or a combination of both. Further analysis of both the supply and demand sides for each country will help explain the PDS decline.

Figure 4.9. Levels and percentage changes in the adolescent birth rate and proportion of demand satisfied among girls aged 15-19, married or in a union, selected countries, based on two consecutive surveys, 2000-2008 and 2010-2014

4.9A. LEVELS AND PERCENTAGE CHANGES IN ADOLESCENT BIRTH RATE

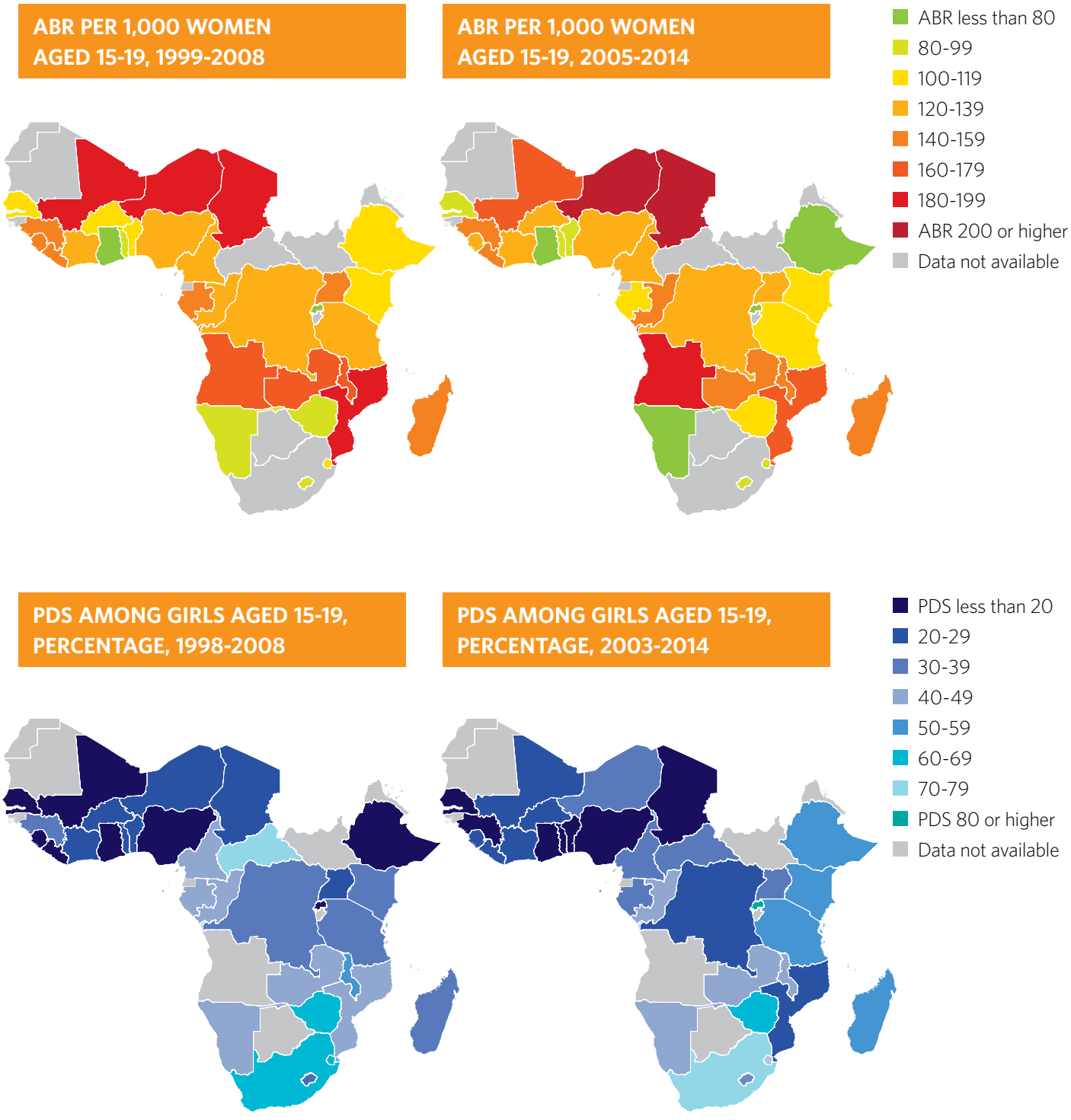


4.9B. LEVELS AND PERCENTAGE CHANGES IN PROPORTION OF DEMAND SATISFIED



Source: UNFPA analysis based on its global open database (unfpaopendata.org).

Map 4.1. Trends in adolescent birth rate and proportion of demand satisfied among adolescent girls, married or in a union, sub-Saharan Africa



Programmatic Interventions: Ethiopia and Nigeria Case Studies

There are many determinants of contraceptive use, including access to and availability of modern methods. UNFPA has been supporting voluntary family planning in 46 priority developing countries through its Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). Since 2010, Ethiopia and Nigeria, two of these countries, have conducted GPRHCS surveys on a yearly basis to examine how well their commodity supply chain is functioning, and assess the extent to which clients are served by quality reproductive health services. Results have been used to monitor the provision of a range of methods and stock-out occurrences at service delivery points on a yearly basis, with the ultimate goal of identifying challenges and improving the supply chain to increase access to family planning methods and reproductive health care.

This chapter compares the results of GPRHCS surveys in Ethiopia and Nigeria, against the contraceptive use dynamics observed in the most recent DHS surveys for Ethiopia (2014 mini-EDHS) and Nigeria (2013 NDHS), highlighting changes.

The results facilitate the pairing of changes in contraceptive use dynamics with resulting dynamics in reproductive health commodity security, with a special focus on contraceptive availability and stock-outs. The chapter also documents the timing for changes in contraceptive use dynamics and reproductive health commodity security by service delivery point (SDP), contrasting changes in contraceptive use with method availability at the SDP level.

5.1. Reproductive health commodity security

The enhancement of reproductive health commodity security (RHCS) builds on the availability of a minimum number of modern methods for contraception, a set of essential and lifesaving medicines, and programme capacity to minimize stock-outs at different levels of delivery. RHCS programmes in Ethiopia and Nigeria have targeted these three areas. Data analysis focuses on three main indicators: the percentage of SDPs with a minimum set of family planning services available, the percentage of SDPs with stock-outs at the time of the survey or during the last six months, and the percentage of SDPs with seven essential medicines available, including two that are life saving. Table 5.1 includes data from two points in time.[24]

In general, the majority of SDPs had 3-5 contraceptive methods available at the time of the surveys (95 per cent in Ethiopia and 86 per cent in Nigeria). During the last five years, these numbers have been steadily high, indicating the high level of effectiveness of the GPRHCS. But some individual methods are available at rates below the averages. In Ethiopia, implants were available in 88 per cent of SDPs, IUDs in 83 per cent, female sterilization in 69 per cent and female condoms in 4 per cent. Averages vary according to geography, with urban and more developed areas showing higher percentages of SDPs offering needed services.[25]

The GPRHCS also seeks to reduce stock-outs of modern methods at the SDP level. Ethiopia in 2014 experienced no stock-outs in only 25 per cent of SDPs, compared to 77 per cent in Nigeria. Between 2010 and 2014, however, 75 per cent of the SDPs in Ethiopia were affected by stock-outs. In Nigeria, the opposite trend is observed since 44 per cent of SDPs had no stocks-outs in 2011, rising to 77 per cent in 2014. Stock-outs appear to be less frequent in tertiary SDPs.

The presence of seven essential medicines presents more of a challenge for the GPRCHS when looking at the type of SDP. In Ethiopia in 2014, 70 per cent of SDPs overall offered these, compared to only 40 per cent in Nigeria. Ethiopia almost doubled the percentage from 2010 of only 38 per cent, while Nigeria fell from 85 per cent. In both countries, primary SDPs were less likely to have all seven medicines—only 41 per cent had them in Ethiopia and 18 per cent in Nigeria in 2014. Secondary SDPs in Nigeria, at only 58 per cent, face an important challenge.

[24] National Health Facility Assessment on Reproductive Health Commodities and Services in Ethiopia (2010 and 2014) and Nigeria (2011 and 2014).

[25] Very similar to the differentials observed on the demand side of users.

Table 5.1. Percentage of methods available, stock-outs and availably of seven essential medicines by type of SDP[26]

SERVICE DELIVERY POINTS	ETHIOPIA		NIGERIA	
	2010	2014	2011	2014
AT LEAST 3/5 METHODS*				
Primary	98	96	84	86
Secondary	98	95	94	82
Tertiary	100	100	97	93
Total	**98**	**95**	**89**	**83**
STOCK-OUTS				
Primary	98	24	45	79
Secondary	100	28	40	77
Tertiary	100	15	58	71
Total	**99**	**25**	**44**	**77**
ESSENTIAL MEDICINES				
Primary	21	41	77	18
Secondary	69	88	92	56
Tertiary	73	100	100	88
Total	**38**	**70**	**85**	**40**

* Primary = 3 methods, secondary and tertiary = 5 methods.

[26] Primary-level SDPs include clinics, health posts and community-based distribution through health workers. Secondary-level SDPs may include larger clinics and hospitals where medical specialists and other health professionals generally do not have first contact with patients. Tertiary-level SDPs may include larger regional hospitals where specialized consultative care and more advanced treatment are provided, usually for inpatients and on referral from the primary and secondary health provider. UNFPA. 2014. "The Global Programme to Enhance Reproductive Health Commodity Security Annual Report 2013."

5.2. Contraceptive dynamics in Ethiopia and Nigeria

In Ethiopia, fertility has declined substantially during the last 10 years, from an average of 5.4 children in 2005 to 4.1 in 2014 (Table 5.2).[27] This change in total fertility rate (TFR) has been accompanied by an important increase in contraceptive use; CPR has steadily risen from 15 per cent in 2005 to 42 per cent in 2014.

In Nigeria, the TFR and CPR did not change during 2008-2013, remaining at 5.5 and 15 per cent, respectively. Contraceptive use is much higher among women who are not married and are sexually active; the CPR is 2 and 4.5 times higher in Ethiopia and Nigeria, respectively.

In both countries, PDS has increased to include half of the women demanding contraception (that is, those using plus those in need of contraception), but for different reasons. In Ethiopia, the increase is due to a combination of the rising CPR and a decline in the UNR. Change in Nigeria is exclusively due to a 20 per cent decline in the UNR from 20 per cent to 16 per cent.

Table 5.2. Total fertility rate, contraceptive prevalence rate, unmet need for contraception rate, total demand for contraception and proportion of demand satisfied

	TFR	CPR*	UNR	TD	PDS
ETHIOPIA					
2014	4.1	42	---	---	---
2011	4.8	29	25	54	53
2005	5.4	15	34	49	31
NIGERIA					
2013	5.7	15	16	31	49
2008	5.5	15	20	35	42

* The CPR among women who are not married or in a union and are sexually active was 57 per cent in Ethiopia in 2011 and 68 per cent in Nigeria in 2013.

[27] TFR as reported in the 2014 mini-EDHS and 2005 EDHS.

Method mix

Another component of contraceptive use dynamics is the method mix, or distribution of contraceptive users by type of method used (see Table 5.3). Ethiopia's 15-year increase in CPR among women who are married or in a union is due exclusively to higher use of modern methods, but in particular, the steady growth in the use of injections from just 3 per cent in 2000 to 31 per cent in 2014. The use of implants has recently increased to 5 per cent. The main characteristic of the method mix in Ethiopia is the dominance of injections.

By contrast, in Nigeria, where the CPR has remained constant recently, modern methods account for two out of three family planning uses (10 per cent for modern methods compared to 5 per cent for traditional methods). Among modern methods, injections, condoms and the pill appear to be the preferred methods, but with small percentages (3 per cent, 2 per cent and 2 per cent, respectively). Traditional methods have marginally increased as preferred methods. Nigerian women seem to prefer a wider variety of methods, but still at very low levels of use.

Similar analysis for women who are not married and are sexually active shows different results. This group not only has higher levels of contraceptive use, at 57 per cent in Ethiopia and 68 per cent in Nigeria, but also a different method mix compared to women married or in a union. Although injection is still the preferred method in Ethiopia, use of male condoms is higher, at 11 per cent in Ethiopia and 40 per cent in Nigeria, as is use of the pill, at 5 per cent and 8 per cent, respectively. Pill use in Ethiopia among women who are not married and are sexually active declined substantially from 18 per cent in 2000 to just 5 per cent in 2011.

Two main questions emerge. First, why is contraceptive use higher among women who are not currently married but are sexually active, compared to those who are married or in a union? Second, why is the method mix more diversified for the first group? Answers to these questions can be explored by looking at reasons for not using contraception among women with an unmet need for contraception, and the informed choices that users make about secondary effects and availability of other methods.

Table 5.3. Distribution of women aged 15-49, married or in a union, and who are not married and are sexually active, according to use of contraception and method used

COUNTRY, DHS SURVEY	ANY METHOD	ANY MODERN METHOD	PILL	IUD	INJECTIONS	CONDOM	FEMALE STERILIZATION	IMPLANTS	FEMALE CONDOM	ANY TRADITIONAL METHOD	NOT CURRENTLY USING	TOTAL
CURRENTLY MARRIED OR IN UNION												
ETHIOPIA												
2014	41.8	40.4	2.6	1.1	31	0.3	0.1	5	0	1.4	58.2	100
2011	28.6	27.3	2.1	0.3	20.8	0.2	0.5	3.4	0	1.2	71.4	100
2005	14.7	13.9	3.1	0.2	9.9	0.2	0.2	0.2	0	0.8	85.3	100
2000	8.1	6.3	2.5	0.1	3.1	0.3	0.3	0	0	1.7	91.9	100
NIGERIA												
2013	15.1	9.8	1.8	1.1	3.2	2.1	0.3	0.4	0.0	4.7	84.9	100
2008	14.6	9.7	1.7	1.0	2.6	2.4	0.4	0.0	0.0	4.1	85.4	100
2003	12.6	8.2	1.8	0.7	2.0	1.9	0.2	0.0	0.0	3.3	87.4	100
UNMARRIED SEXUALLY ACTIVE												
ETHIOPIA												
2011	56.7	52.3	5.4	0.2	32	10.8	1.3	2.4	0.3	4.2	43.3	100
2005	54.9	43.3	3.1	0	16.9	23.3	0	0	0	11.6	45.1	100
2000	40.7	35.7	18	0	6.4	11.3	0	0	0	4.8	59.3	100
NIGERIA												
2013	68.1	54.9	8.0	1.0	2.5	39.5	0.1	0.4	0.0	11.2	31.9	100
2008	61.0	42.4	4.4	0.5	1.9	35.1	0.1	0.1	0.2	11.6	39.0	100
2003	49.9	38.6	9.5	1.0	3.4	23.8	0.3	0.0	0.0	8.2	50.1	100

Method source

In the DHS studies, users of modern methods were asked about the place where they obtained the method of contraception. The responses are clustered in three main categories: public, private medical sector and other.[28] The supply and distribution of contraceptive methods is mainly concentrated in public or private providers (Table 5.3).

In Nigeria, only 29 per cent of methods are provided by the public sector, compared to 82 per cent in Ethiopia (mostly implants and injections, see Table 5.4). The private sector on the other hand in Nigeria is the main provider of modern methods (6 out of 10 methods), offering over 70 per cent of condoms and pills, for instance. The main provider of implants, IUDs, injections and sterilization is the public sector.

Table 5.4. Source of contraception

SOURCE	ETHIOPIA		NIGERIA	
	2011 DHS	2000 DHS	2013 DHS	2003 DHS
Public	82	77.5	28.9	22.8
Private medical	13.4	15.5	59.9	57.7
Other private	1.3	4.2	9	14.3
Other	3.3	2.8	2.2	5.2
Total	100	100	100	100
Number	3,086	720	4,014	597

[28] Public includes: government hospital, government health centre, family planning clinic, mobile clinic, fieldworker and other public sector. Private medical sector includes: private hospital/clinic, pharmacy, private doctor, mobile clinic, fieldworker, or other private medical sector. Other sources include: shop, church, friend/relative.

5.3. Reasons for not using contraception

The evidence presented here illustrates the type of analysis that can be developed by combining data from the DHS and Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS surveys. The analysis identifies the possible contradiction between the high availability of modern methods in all SDPs, and Nigeria's low CPR as well as the high concentration on injections in Ethiopia. If SDPs in Ethiopia are offering, in addition to injectables, female sterilization at 69 per cent, IUDs at 88 per cent, implants at 88 per cent, male condoms at 97 per cent and pills at 97 per cent, why haven't these services increased the CPR estimates? Ethiopia has also been affected by stock-outs in the majority of SDPs, which could explain the lack of effectiveness of commodity and services interventions. This is not necessarily the case in Nigeria, where availability of methods is high and stock-outs are recently low.

Context matters for the observed and discussed trends presented before and as such will add clarity to evidence included here. A more detailed analysis related to policies, national investments, services, etc. is beyond the scope of this analysis, which is presenting the implicit results from them, but without identifying them.

From the point of view of the service provider, there seems to be a mismatch between the provider of the methods reported in the DHS and the structure observed in the SDPs by the GPRCHS survey assessments. In Nigeria, 87 per cent of SDPs are public, while in the 2013 DHS, 71 per cent of contraceptive methods were provided by the private sector; similar values for Ethiopia are 82 per cent and 77 per cent, respectively. Greater dissemination and utilization of the GPRCHS studies may be warranted, particularly when data from household surveys (DHS and MICS) become available.

Two additional pieces of analysis that could help to understand trends in supply and demand for modern contraception in Ethiopia and Nigeria, and identify ways forward, relate to the reasons expressed for not using contraception among women with an unmet need for it (Table 5.5) and levels of informed choice for quality of care.

The main reasons for not using contraception among women with an unmet need fall in four main groups: fertility-related reasons, opposition to use, lack of knowledge and method-related reasons. In both countries, an important percentage of women with unmet need were in the postpartum period and or breastfeeding (20 per cent and 13 per cent in Ethiopia, respectively, and 23 per cent breastfeeding in Nigeria). In both countries, fertility-related reasons are of greater relevance among younger mothers (aged 15-19 and 20-24). Counselling could help women fulfil their unmet need for contraception during their postpartum or breastfeeding periods.

There are considerable percentages of women indicating opposition to the use of contraception by themselves or their husbands/partners, or due to religious prohibitions (over 10 per cent in both countries and particularly among women aged 15-19 with an unmet need for contraception). Lack of knowledge (method and source) is another factor compromising use in both countries. Existing programmes should target both groups with information campaigns and community awareness efforts.

Method-related reasons were offered by 15 per cent or more of women with an unmet need for contraception. They expressed fear of side effects and health fears, at an overall rate of 15 per cent in Nigeria and 24 per cent in Ethiopia, although with lower percentages among younger women. One additional piece of evidence from this analysis is that only a few women indicated "lack of access to contraception" as a reason for not using contraception (5 percent or less). Programmes need to make sure that women both have access to and can use methods without concerns that lead to avoidance.

Table 5.5. Reasons for not using contraception among women with an unmet need*

REASONS	NIGERIA				ETHIOPIA			
	15-49	15-24	15-19	20-24	15-49	15-24	15-19	20-24
FERTILITY-RELATED ISSUES								
Not having sex	5	5	5	5	5	4	4	5
Infrequent sex	14	9	7	10	3	6	10	4
Menopausal/hysterectomy	--	2	--	--	1	--	--	--
Subfecund/infecund	2	--	--	--	1	--	--	--
Postpartum/amenorrheic	5	3	3	3	20	18	10	24
Breastfeeding	23	35	40	33	13	13	11	14
Fatalistic	8	7	7	7	11	7	4	9
OPPOSITION TO USE								
Respondent opposed	16	14	12	15	3	3	5	2
Husband/partner opposed	11	12	9	13	7	11	12	10
Others opposed	1	2	3	1	1	1	2	--
Religious prohibition	7	8	7	9	6	6	6	7
LACK OF KNOWLEDGE								
Knows no method	8	12	14	11	4	4	3	5
Knows no source	5	7	8	6	4	6	10	4
METHOD-RELATED REASONS								
Fear side effects/health concerns	15	8	3	10	24	14	9	18
Lack of access/far	2	1	3	1	3	5	3	5
Costs too much	2	1	--	1	1	1	--	2
Inconvenient to use	3	2	2	2	5	4	3	5
Interferes with the body process	7	4	4	5	5	4	2	5
Preferred method not available	1	1	--	1	--	--	--	--
No method available	1	2	1	2	--	--	1	--
OTHER	2	1	1	--	8	11	14	9
DON'T KNOW	1	1	--	1	2	4	7	2

*Includes not pregnant women, not using contraception, wanted to postpone for 24+ months, had sex recently (during the last 12 months).

Guaranteeing informed choice[29] to current and future users of contraception about side effects or problems of method use is an indication of the fulfilment of basic reproductive rights and of quality of care. In the long run, it contributes to the relevance, effectiveness, efficiency and sustainability of family planning programmes.

Only 28 per cent of women aged 15-49 using modern methods* in Ethiopia indicated they were informed about side effects or problems of the method used, compared to 60 per cent in Nigeria (Table 5.6). This finding is very much supported by the evidence presented in Table 5.5 in which 1 almost one of four Nigerian women (15-49) in need of contraception indicated "fear of side effects and health concerns" as the main reason for not using contraception (15 percent in Ethiopia). Similar values were observed on informed choice related to what to do if side effects occur, and to other methods that could be used. As with other variables and analysis presented in this paper, residents of rural areas, with lower levels of education and living in the poorest households have lower levels of informed choice for contraception. In Ethiopia, for example, 37 per cent of the women in the richest households can make an informed choice, compared to only 18 per cent among the poorest ones.

Adolescents and youth systematically experience less informed choice. In Nigeria, less than 40 per cent of women aged 15-19 who are married or in a union and less than half of this group aged 20-24 reported having informed choice, compared to more than 70 per cent in the 35-39 age group. By contrast, in Ethiopia, lower levels of informed choice appear to be similar across age groups.

[29] This indicator is produced based on information on users of female sterilization, IUDs, injections, implants and pills who began their current period of method use in the five years before the DHS.

Table 5.6. Percentage who were informed about side effects or problems of method used, among women who started their last episode of modern contraceptive method within five years preceding the survey*

BACKGROUND CHARACTERISTICS	ETHIOPIA DHS 2011	NIGERIA DHS 2013
15-19	23.9	35.4
20-24	27.9	44.5
25-29	29.9	54.8
30-34	26.4	60.9
35-39	26.7	70.3
40-44	34.1	64.7
45-49	15.5	70.2
Urban	38.1	61.5
Rural	23.1	59.1
No education	20.5	60.6
Primary	31	57.5
Secondary	46.3	59.3
Higher	44.9	69.6
Poorest	17.8	44.1
Poorer	23.5	57.4
Middle	19.5	58.5
Richer	28.1	61.6
Richest	36.6	62.2
Total	27.6	60.5

*Users of the pill, IUDs, injections, female sterilization and Norplant.

Conclusion and Discussion

6.1. Global trends

The importance of reproductive health and access to family planning in particular are now well recognized, to not only improve women's chances of surviving pregnancy and childbirth, but also to contribute to related issues such as gender equality, better child health, an improved response to HIV, greater education outcomes and poverty reduction. This report profiles existing data around the main MDG5b indicators to identify progress achieved, and old and new challenges that could be addressed under the SDGs, particularly the nine targets under SDG3. The report highlights the most vulnerable and disadvantaged population groups, and their access to and use of reproductive health services.

Worldwide in 2012, 1 of 20 adolescents aged 15-19 had a live birth, although during the last 25 years, significant progress has been made in reducing adolescent childbearing, especially between 1990 and 2000. The decline has been almost universal across regions and countries. Reductions occurred amid increasing school participation, rising demand for contraception and a falling proportion of adolescents ever married. Challenges remain, however, because by 2012, the ABR was still as high as 75 live births or more per 1,000 girls in sub-Saharan Africa, Latin America and South Asia, excluding India. Sub-Saharan Africa has made the least progress, and in 2012, the region continued to show the highest ABR at 118 births per 1,000 girls, slightly lower than the rate in 1990 of 123 births.

In 2015, two out of three women, or about 64 per cent of women of reproductive age who are married or in a union, use some form of contraception, either modern or traditional, and another 12 per cent have an unmet need for contraception.

Increased contraceptive use among these women has been slow since 2000, edging up globally only 3.4 per cent, compared to an increase of 11.2 per cent between 1990 and 2000. A faster increase was observed in regions with relatively low levels of contraceptive use, such as East and Southern Africa, up 61.4 per cent; West and Central Africa, up 28.5 per cent, and the Arab States, up 13.8 per cent. Since 2000, the UNR has declined in all regions but West and Central Africa, where contraceptive dynamics have kept it around 24 per cent.

Combining contraceptive use and unmet need shows that in 2015, about 84 per cent of women aged 15-49 who were married or in a union had their family planning demand satisfied, but with substantial variation across regions and countries. The highest CPR and the lowest UNR resulted in the highest PDS, at 87 per cent, in Latin America and the Caribbean and Asia and the Pacific. In contrast, the lowest CPR and the highest UNR led to the lowest PDS, at 42 per cent, in West and Central Africa. Although PDS has increased over time, since 2000, the trend has slowed. At the country level, less than half of women who are married or in a union in most Africa countries and who need contraception have their family planning demand satisfied.

While the MDGs are close to an end, through the SDGs, it is critical for the international community to reaffirm the promise of universal access to reproductive health and family planning, and increase investment in this area. Special attention needs to go to those regions and countries lagging behind and making little or slower progress.

6.2. Contraceptive method mix

In the developing world, 55 per cent of women aged 15-49 who are married or in a union use modern contraception. The most common methods, female sterilization and the IUD, account for more than 60 per cent of modern method use. The pill and male condom are together responsible for 24 per cent.

Latin America and the Caribbean have the highest level of modern contraceptive use among all regions, and relatively balanced distribution of different methods. Three methods alone account for 73 per cent of use, however: female sterilization at 37 per cent, the pill at 22 per cent and male condoms at 13 per cent. In other regions, one or two methods seem to dominate. Low levels of informed choice around contraception are strongly associated with contraceptive dynamics. In Africa, for example, almost half of the women who are married or in a union and use modern contraception have not been informed about side effects or problems of the method used, about what to do if they experience side effects and/or about other methods. There is a clear need for better policies, and more effective and efficient interventions that guarantee women and men can choose from a range of methods based on their family planning needs and goals.

6.3. Family planning and adolescent sexual and reproductive health

Worldwide, some 1.2 billion adolescents, aged 10-19, comprise more than 16 per cent of the total population. An estimated 250 million adolescent girls live in developing countries, accounting for about one-sixth of all women of reproductive age. More than one in five of these adolescent girls are currently married or in a union, and 3 per cent are unmarried but sexually active. Women giving birth under age 20 face a higher risk of maternal mortality through obstructed labour, obstetric fistula and losses in terms of education and employment. Children born to married or unmarried adolescent mothers are at greater risk of death and undernourishment, and have a higher school dropout rate. In 2015, 15.2 million adolescent girls will give birth, a figure rising to 19.6 million by 2035 if current patterns remain unchanged.

Adolescents face many sexual and reproductive health risks, often associated with early, unprotected sexual activity. Programmes that help them meet their family planning needs are a critical priority across the developing world, given statistics showing that adolescent girls are the most vulnerable group in terms of gaps in family planning. Adolescents face more obstacles than adults to obtaining contraceptives, including due to restrictive laws and policies. They may fear that their confidentiality will not be respected as well as the stigma associated with early sex. Adolescent girls may not feel comfortable visiting clinics to obtain contraception, even if they are youth friendly. In many regions, adolescent girls often marry much older husbands, leaving them will little power to negotiate contraceptive use and family planning.

TD and PDS among adolescent girls have increased, but current levels are still remarkably lower than for other age groups, with use at 20 per cent, compared to 60 per cent for women aged 30-34. The UNR is highest among adolescents, at 23 per cent, compared to 15 per cent for women aged 30-34.

As a result, adolescents have the lowest PDS, at 46 per cent versus 65 per cent or higher for other age groups. Expanding access to family planning services to adolescents is of great importance given great demand. It will require political and financial commitments from governments and civil society to use existing evidence to develop policies and interventions that focus particularly on the most vulnerable groups of adolescents—those who live in rural areas, are out of school, have little or no education and/or reside in the poorest households.

Among adolescent girls, those who are unmarried and sexually active account for a smaller proportion than those who are married or in a union. But the first group should still be considered on the international family planning agenda, and their family planning demands fulfilled. Sexually active adolescents, especially those who are unmarried, may feel stigma related to needing family planning services. In some countries and areas, laws and regulations prevent them from accessing services. Consequences of unintended pregnancies affect them in many ways, however, including in terms of dropping out of school, poorer quality sexual and reproductive health, cultural stigmas and social pressures, and lost opportunities for employment and income.

About 15 per cent of adolescent girls who are married or in a union are using modern contraception. Single methods seem to dominate, such as injectables in East and Southern Africa, the pill in the Arab States, and male condoms in Eastern Europe and Central Asia. Comparing the needs for contraception among adolescent girls who are currently married or in a union, with those of unmarried and sexually active adolescent girls shows that total demand for contraception among the latter, at 92 per cent, is double that of the former, at 43 per cent. Unmarried but sexually active adolescents not only have high levels of contraceptive use but also high levels of unmet need at 41 per cent.

In terms of method mix, unmarried and sexually active adolescents prefer the male condom, which accounts for close to 70 per cent of modern contraceptive use, and goes as high as 90 per cent in countries in Eastern Europe and Central Asia. Contraceptive use depends heavily on only one method. Levels of informed choice were low, with close to 60 per cent of users of modern methods not informed about side effects, what to do if experiencing them or other methods. Policy and programme reviews could assess the benefits of current family planning interventions and identify shortfalls that need to be addressed.

In 2015, 12.8 million adolescent girls have an unmet need for family planning. This number will increase to 15 million by 2030 if current trends continue. Of the 12.8 million adolescent girls, about half live in Asia and the Pacific and more than 30 per cent live in West and Central Africa and East and Southern Africa. Due to high fertility, declining mortality and young populations in Sub-Saharan Africa, by 2030, 6 million adolescent girls there will have an unmet need for family planning, close to the estimated 6.4 million in Asia and the Pacific.

6.4. Reproductive health disparities and inequalities

Births rates among adolescents and contraceptive dynamics are significantly affected by place of residence, level of education and household wealth. Examining the demographic disparities and social and economic inequalities in family planning is critical for informing programming with the correct evidence. This understanding will help policymakers and programme managers to identify the most vulnerable and marginalized populations, towards making sure that their rights are fulfilled.

Adolescent fertility rates are considerably higher in rural areas, among those without or with low levels of education, and in the poorest households. These disparities and inequalities are consistently found in all regions. Although the ABR has declined in all regions except the Arab States, a faster decline is observed in urban areas compared to rural areas. Rates among girls with no education or in the poorest 20 per cent of households have increased in some regions.

In all developing regions, women in rural areas, in poor households and with no or low levels of education have lower levels of contraceptive use. Substantial progress has been made among women with no education in all regions but West and Central Africa. Use among women in the richest 20 per cent of households has increased in half of the regions, while remaining constant in the other half. Disparities have narrowed in all developing regions except West and Central Africa, where the wealth disparity in the use of contraception has increased by 20 per cent. Women from the wealthiest 20 per cent of households there, 5-10 years ago, were 5.1 times more likely to use any method of contraception than their counterparts from the poorest 20 per cent of households, while today, they are 6.2 times more likely to do so.

The UNR is a relatively complex indicator, because it can change as a result of trends in either supply or demand, or a combination of both. This report has showed that women from the wealthiest households, living in urban areas and with higher levels of education experience lower levels of unmet need. These disparities occur in all regions but West and Central Africa, where the UNR has remained consistently high across all demographic, social and economic groups. In general, disparities in unmet need have remained constant in the recent past, with a slight increase according to wealth and place of residence.

Similar to contraceptive use and unmet need for family planning, women in urban areas, with more education and in wealthier households continue demonstrating a higher PDS. Satisfied demand has increased across categories in all developing regions, except for women from the poorest 20 per cent of households in West and Central Africa. East and Southern Africa has experienced the fastest rise, particularly for disadvantaged groups. In all developing regions, with the exception of West and Central Africa, the PDS has climbed faster among more vulnerable groups.

6.5. Programmatic interventions: Ethiopia and Nigeria case studies

There are many determinants of contraceptive use in developing countries, including access and availability to modern methods. For Ethiopia and Nigeria, a comparison of survey results contrasted changes in contraceptive use with method availability at SDPs. This revealed a possible contradiction between the high availability of modern methods in all SDPs, and Nigeria's low levels of CPR, and Ethiopia's high concentration on injections. If SDPs in Ethiopia are offering other methods, why haven't CPR estimates increased? Stock-outs in the majority of Ethiopian SDPs could explain the lack of effectiveness of commodity and services interventions.

This is not necessarily the case in Nigeria, where availability of methods is high and stock-outs are low. From the point of view of the service provider, there seems to be a mismatch between the provider of the methods reported in the DHS and the structure observed in the SDPs of the National Health Facility Assessments (NHFA). In Nigeria, 87 per cent of the SDPs are public, while in the 2013 DHS, 71 per cent of the methods were provided by the private sector.

In trying to understand these differences, this paper documented the main reasons for not using contraception among women with an unmet need as well as levels of informed choice. Important percentages of women with an unmet need in both countries were in the postpartum period and/or breastfeeding, while fertility-related reasons were of greater relevance among younger mothers. Since postpartum or breastfeeding periods carry the potential for pregnancy, counselling needs to target women in this group.

Considerable percentages of women indicate opposition to contraceptive use, among themselves as well as their husbands/partners, and due to religious stipulations as well as a lack of knowledge. To break down opposition to contraception, existing programmes should develop information campaigns and community awareness. Method-related reasons explain a significant amount of unmet need. They include fear of side effects and health concerns, although these obstacles diminish among younger generations. Programmes need to reach out to women to ensure they have access to and can use methods that meet their needs.

Only 28 per cent of women aged 15-49 who use modern methods in Ethiopia said they were informed about potential side effects or problems, compared to 60 per cent in Nigeria. Similar values were observed on what to do if experiencing side effects and the selection of other methods. Adolescents and youth have lower levels of informed choice. In Nigeria, less than 40 per cent of those aged 15-19 and less than half of those aged 20-24 who are currently married or in a union reported having informed choice, compared to more than 70 per cent among those aged 35-39. In Ethiopia, lower levels of informed choice appear to be similar across age groups.

Guaranteeing informed choice to current and future users of contraception fulfils basic reproductive rights and indicates quality of care. In the long run, it contributors to the relevance, effectiveness, efficiency and sustainability of family planning programmes.

Annex

Table 1. Disparities and inequalities in adolescent birth rate by country, most recent data, 1998-2014

COUNTRIES AND AREAS	ADOLESCENT BIRTH RATE (ABR), PER 1,000 WOMEN AGED 15 TO 19, 1998-2014	ADOLESCENT BIRTH RATE (ABR), PER 1,000 WOMEN AGED 15 TO 19, BY RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 1998-2014										DATA SOURCE
		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Albania	17	10	22	-	-	-	18	14	36	12	4	2008-09 DHS
Algeria	4	5	4	-	-	-	-	-	-	-	-	2006 MICS
Angola	191	126	238	285	201	61	249	243	252	197	116	2011 MIS
Argentina	52	-	-	-	-	-	94	61	49	41	6	2011-12 MICS
Armenia	28	18	42	-	-	-	50	31	23	20	12	2010 DHS
Azerbaijan	33	20	49	32	77	34	35	58	36	28	9	2006 DHS
Bangladesh	118	91	129	188	146	116	171	135	123	98	84	2011 DHS
Belize	64	39	85	-	-	-	96	88	62	53	23	2011 MICS
Benin	94	67	120	158	101	39	153	136	108	73	45	2011-12 DHS
Bhutan	59	30	77	113	70	29	112	95	97	36	10	2010 MICS
Bolivia (Plurinational State of)	88	67	132	280	176	62	181	116	96	65	32	2008 DHS
Bosnia and Herzegovina	8	21	2	-	-	-	-	-	-	-	-	2011-12 MICS
Burkina Faso	130	69	161	170	107	31	160	177	173	133	62	2010 DHS
Burundi	65	58	66	108	56	24	68	76	69	61	53	2010 DHS
Cambodia	46	26	52	85	71	30	92	46	45	39	27	2010 DHS
Cameroon, Republic of	127	89	175	239	183	79	202	173	146	96	66	2011 DHS
Cape Verde	90	80	102	-	-	-	-	-	-	-	-	2005 DHS
Central African Republic	229	182	263	287	231	137	256	306	229	219	155	2010 MICS
Chad	203	171	216	224	203	147	216	218	234	196	164	2010 MICS
Colombia	84	73	122	276	212	79	141	114	78	59	29	2010 DHS
Comoros	70	66	72	153	136	39	118	97	77	38	28	2012 DHS
Congo, Democratic Republic of the	138	104	162	184	187	110	184	161	152	135	84	2013-14 DHS
Congo, Republic of the	147	125	204	238	216	124	220	185	162	122	79	2011-12 DHS
Costa Rica	54	25	98	-	-	-	-	-	-	-	-	2011 MICS
Côte d'Ivoire	129	82	197	163	157	61	240	182	140	87	64	2012 DHS
Dominican Republic	90	84	108	-	-	-	175	112	73	61	36	2013 DHS
Ecuador	100	87	119	281	173	66	145	129	94	64	38	2004 RHS
Egypt	51	32	64	118	75	49	67	60	56	42	24	2008 DHS
El Salvador	89	73	108	-	-	-	-	-	-	-	-	2008 RHS
Eritrea	77	51	97	120	76	35	66	100	107	81	37	2002 DHS
Ethiopia	79	27	100	164	62	19	118	123	99	62	33	2011 DHS
Gabon	114	104	199	172	231	94	217	156	130	79	32	2012 DHS
Gambia	118	75	161	210	128	59	185	148	125	116	45	2010 MICS
Georgia	48	37	63	-	-	-	-	-	-	-	-	2005 RHS
Ghana	66	49	82	150	124	39	110	83	89	53	14	2008 DHS
Guatemala	98	78	114	-	-	-	-	-	-	-	-	2008 RHS
Guinea	146	102	178	191	154	76	205	191	164	128	83	2012 DHS
Guinea-Bissau	141	95	189	237	130	44	185	194	175	108	62	2010 DHS
Guyana	101	50	123	-	-	-	222	112	104	47	32	2009 DHS
Haiti	66	53	77	170	99	41	90	92	89	62	18	2012 DHS
Honduras	101	81	123	132	161	68	168	128	95	83	50	2011-12 DHS
India	90	57	105	163	112	55	134	122	98	72	33	2005-06 DHS
Indonesia	48	32	70	91	125	40	93	72	45	35	13	2012 DHS
Iraq	82	82	83	122	122	45	90	80	93	83	67	2011 MICS
Jamaica	70	72	67	-	-	-	100	107	77	48	7	2011 MICS
Jordan	26	34	24	-	-	-	38	47	41	28	9	2012 DHS
Kazakhstan	23	17	32	-	-	-	26	34	18	18	22	2010-11 MICS
Kenya	103	92	107	208	128	54	154	113	75	103	85	2008-09 DHS

COUNTRIES AND AREAS	ADOLESCENT BIRTH RATE (ABR), PER 1,000 WOMEN AGED 15 TO 19, 1998-2014	ADOLESCENT BIRTH RATE (ABR), PER 1,000 WOMEN AGED 15 TO 19, BY RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 1998-2014										DATA SOURCE
		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Kyrgyzstan	44	23	59	-	-	-	59	58	62	44	18	2012 DHS
Lao People's Democratic Republic	94	44	114	190	136	52	183	120	96	72	31	2011-12 MICS
Lesotho	97	64	110	302	138	73	147	128	101	70	66	2009 DHS
Liberia	149	121	206	227	167	114	237	202	193	137	61	2013 DHS
Madagascar	148	74	164	267	174	67	241	203	167	105	59	2008-09 DHS
Malawi	152	109	162	239	178	79	187	191	172	138	91	2010 DHS
Maldives	11	6	12	-	-	-	11	12	13	6	8	2009 DHS
Mali	172	122	192	209	194	88	194	220	191	181	109	2012-13 DHS
Moldova, Republic of	34	26	39	-	-	-	50	59	40	18	13	2005 DHS
Mongolia	38	30	59	73	90	32	79	45	49	11	26	2010 MICS
Morocco	32	24	43	63	32	10	51	36	44	21	13	2003-04 DHS
Mozambique	167	141	183	214	183	117	184	182	197	194	102	2011 DHS
Namibia	78	58	92	230	141	58	104	86	102	64	39	2006-07 DHS
Nepal	81	43	87	176	130	53	103	105	95	72	32	2011 DHS
Nicaragua	106	83	139	221	163	62	159	140	114	70	46	2006-07 RHS
Niger	206	112	231	235	192	92	249	213	225	232	137	2012 DHS
Nigeria	122	62	162	226	169	53	213	175	117	79	35	2013 DHS
Pakistan	44	27	53	76	50	20	67	65	43	30	18	2012-13 DHS
Palestine	67	62	81	-	-	-	-	-	-	-	-	2010 MICS
Paraguay	63	47	85	-	-	-	-	-	-	-	-	2008 RHS
Peru	64	49	109	-	-	-	124	108	57	37	14	2012 DHS
Philippines	57	52	63	142	139	55	89	73	68	48	24	2013 DHS
Russian Federation	29	23	49	-	-	-	42	33	31	18	19	2011 RHS
Rwanda	41	40	41	116	45	19	69	43	33	42	27	2010 DHS
Samoa	44	30	48	-	-	-	-	-	-	-	-	2009 DHS
Sao Tome and Principe	94	68	123	46	154	49	160	133	107	72	30	2008-09 DHS
Senegal	93	60	125	143	92	27	180	115	77	75	46	2010-11 DHS
Serbia	24	7	47	-	-	-	108	16	21	5	0	2010 MICS
Sierra Leone	125	82	155	182	167	89	161	158	156	130	63	2013 DHS
Somalia	123	102	140	137	97	30	118	145	149	128	83	2006 MICS
South Africa	76	56	99	105	113	69	108	109	66	68	22	1998 DHS
South Sudan	158	165	155	174	140	82	149	173	167	167	141	2010 MICS
Swaziland	89	79	91	277	138	77	124	87	95	93	51	2010 MICS
Tajikistan	54	52	54	95	95	53	42	49	63	52	61	2012 DHS
Tanzania, United Republic of	116	71	136	232	140	31	178	159	125	109	57	2010 DHS
Thailand	60	55	63	-	-	-	85	59	74	67	16	2012-13 MICS
The former Yugoslav Republic of Macedonia	13	4	21	-	-	-	-	-	-	-	-	2011 MICS
Timor-Leste, Democratic Republic of	51	35	57	74	100	35	60	51	74	48	30	2009-10 DHS
Togo	88	76	99	167	126	49	98	137	78	101	56	2010 MICS
Tunisia	3	2	6	4	6	3	3	3	5	4	0	2011-12 MICS
Turkey	35	32	47	-	-	-	-	-	-	-	-	2008 DHS
Turkmenistan	30	36	26	-	-	-	-	-	-	-	-	2000 DHS
Uganda	135	91	146	199	168	78	186	184	160	108	77	2011 DHS
Ukraine	34	29	48	-	-	-	76	40	26	18	26	2012 MICS
Viet Nam	46	15	59	126	171	38	95	56	28	39	15	2010-11 MICS
Yemen	80	66	86	128	57	49	129	81	70	75	55	2006 MICS
Zambia	146	99	189	239	198	88	215	174	193	153	63	2007 DHS
Zimbabwe	115	72	144	225	188	96	176	139	143	111	49	2010-11 DHS

Notes: – Data not available or not enough number of cases. Data presented in this statistical table generally reflect information available as of June 2015. Source: UNFPA global open database (unfpaopendata.org) and Reproductive Health Survey.

Table 2. Disparities and inequalities in contraceptive prevalence rate among women aged 15-49, married or in union, by country, most recent data, 2000-2014

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	CONTRACEPTIVE PREVALENCE RATE (CPR), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Albania	69	55	53	74	66	75	66	74	66	67	69	72	74	2008-09 DHS
Algeria	61	20	43	63	60	57	62	66	56	60	63	62	65	2006 MICS
Armenia	55	19	40	58	51	-	-	-	53	47	52	60	62	2010 DHS
Azerbaijan	51	6	38	52	50	51	25	51	55	48	47	48	57	2006 DHS
Bangladesh	61	47	58	64	60	61	62	60	62	63	61	60	61	2011 DHS
Barbados	59	55	53	58	62	-	-	-	53	55	56	63	66	2012 MICS
Belarus	63	58	56	64	60	-	-	-	55	62	61	64	68	2012 MICS
Belize	55	36	50	58	53	42	56	58	42	54	54	61	63	2011 MICS
Benin	13	8	10	15	12	11	15	21	8	11	13	14	18	2011-12 DHS
Bhutan	66	30	57	64	66	68	66	58	69	66	65	66	62	2010 MICS
Bolivia (Plurinational State of)	61	41	57	66	53	42	56	68	46	55	62	67	71	2008 DHS
Bosnia and Herzegovina	46	-	37	47	46	-	-	-	42	43	47	50	46	2011-12 MICS
Burkina Faso	16	7	16	34	11	12	27	51	7	9	10	17	37	2010 DHS
Burundi	22	10	22	35	21	18	25	41	17	18	22	21	33	2010 DHS
Cambodia	51	27	43	55	50	43	50	57	45	48	51	53	56	2010 DHS
Cameroon, Republic of	23	16	22	33	14	4	22	40	3	14	23	35	41	2011 DHS
Central African Republic	16	13	16	27	9	7	16	34	9	8	11	19	31	2010 MICS
Chad	5	4	5	9	4	4	6	10	4	4	3	4	9	2010 MICS
Colombia	79	61	72	79	79	72	80	80	76	79	80	81	80	2010 DHS
Comoros	19	20	19	30	14	13	19	27	13	17	19	24	23	2012 DHS
Congo, Democratic Republic of the	20	13	19	31	15	11	16	30	13	17	17	22	36	2013-14 DHS
Congo, Republic of the	45	36	46	46	42	34	43	47	39	41	46	47	50	2011-12 DHS
Costa Rica	76	64	77	78	74	59	77	77	70	75	78	81	78	2011 MICS
Côte d'Ivoire	18	11	17	23	15	13	26	30	12	16	15	21	28	2012 DHS
Cuba	74	67	76	73	79	-	-	-	-	-	-	-	-	2010-11 MICS
Djibouti	18	16	20	18	5	13	21	33	-	-	-	-	-	2006 MICS
Dominican Republic	72	55	61	71	73	66	72	72	68	76	69	72	74	2013 DHS
Egypt	60	23	45	64	58	58	62	61	55	57	61	61	65	2008 DHS
Eritrea	8	2	6	17	4	4	12	22	2	3	4	13	20	2002 DHS
Ethiopia	29	24	35	53	23	22	36	62	13	22	24	32	52	2011 DHS
Gabon	31	25	34	33	21	14	22	36	21	29	32	35	36	2012 DHS
Gambia	13	4	11	19	9	11	17	20	8	10	13	14	22	2010 MICS
Ghana	24	14	22	27	21	14	27	28	14	20	22	29	31	2008 DHS
Guinea	6	3	5	9	4	5	8	11	3	5	5	6	10	2012 DHS
Guinea-Bissau	10	7	10	19	7	6	17	31	6	5	7	14	23	2006 MICS
Guyana	43	30	39	43	42	22	40	44	33	41	45	44	49	2009 DHS
Haiti	35	26	36	36	34	30	35	37	32	31	37	38	33	2012 DHS
Honduras	73	56	69	76	71	64	73	75	67	72	75	75	76	2011-12 DHS
India	56	13	33	64	53	52	60	60	42	51	57	63	68	2005-06 DHS
Indonesia	62	48	61	62	62	43	62	63	56	64	64	63	61	2012 DHS
Iraq	53	21	41	55	47	46	51	57	44	52	53	55	58	2011 MICS
Jordan	61	28	47	61	62	46	58	63	58	61	60	64	63	2012 DHS
Kazakhstan	51	19	35	54	48	-	-	-	46	46	50	56	57	2010-11 MICS
Kenya	46	23	36	53	43	14	44	59	20	40	50	57	55	2008-09 DHS
Kyrgyzstan	36	5	22	39	35	-	-	-	38	37	35	32	40	2012 DHS
Lao People's Democratic Republic	50	26	42	53	49	38	54	52	39	46	53	57	53	2011-12 MICS
Lesotho	47	28	44	58	42	32	40	54	30	38	47	50	62	2009 DHS
Liberia	20	13	23	23	17	15	20	29	14	17	22	26	23	2013 DHS
Madagascar	40	25	37	54	37	21	39	55	20	29	40	49	57	2008-09 DHS

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	CONTRACEPTIVE PREVALENCE RATE (CPR), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Malawi	46	29	42	54	45	40	46	53	39	44	45	48	53	2010 DHS
Maldives	35	15	23	34	35	44	37	28	37	35	34	33	34	2009 DHS
Mali	10	7	10	23	7	8	13	28	3	5	6	14	24	2012-13 DHS
Mauritania	9	6	10	16	4	5	12	22	2	3	8	14	19	2007 MICS
Moldova, Republic of	68	58	63	67	68	23	77	68	67	66	69	67	70	2005 DHS
Mongolia	55	52	47	52	59	47	58	55	58	55	55	54	52	2010 MICS
Montenegro	39	-	36	37	44	-	-	-	47	44	39	33	36	2005-06 MICS
Morocco	67	38	59	69	66	67	67	71	65	65	68	68	71	2011 PAPFAM
Mozambique	12	6	12	22	7	6	11	32	3	6	7	14	30	2011 DHS
Namibia	55	41	54	65	45	34	46	64	32	47	48	66	71	2006-07 DHS
Nepal	50	18	30	60	48	53	47	47	40	46	48	52	60	2011 DHS
Nicaragua	72	61	71	75	70	66	72	76	65	70	75	76	79	2006-07 RHS
Niger	14	7	15	29	11	12	21	32	10	9	10	15	26	2012 DHS
Nigeria	15	2	10	27	9	3	20	31	2	5	13	23	37	2013 DHS
Pakistan	35	10	21	45	31	30	41	43	21	30	38	42	46	2012-13 DHS
Palestine	52	15	36	52	54	49	55	50	48	49	51	54	59	2010 MICS
Peru	75	61	76	76	74	69	74	77	72	77	77	76	75	2011 DHS
Philippines	55	37	51	57	54	29	53	56	50	58	60	57	50	2013 DHS
Russian Federation	68	50	62	69	65	-	-	-	62	67	69	70	72	2011 RHS
Rwanda	52	33	45	53	51	43	53	60	43	47	53	57	57	2010 DHS
Saint Lucia	56	57	63	52	56	-	-	-	-	-	-	-	-	2012 MICS
Samoa	29	8	23	30	28	-	-	-	28	27	29	24	35	2009 DHS
Sao Tome and Principe	38	22	39	33	44	18	41	38	36	36	34	42	44	2008-09 DHS
Senegal	13	6	9	22	7	9	22	27	5	7	13	17	25	2010-11 DHS
Serbia	61	45	61	60	61	-	-	-	58	58	65	62	62	2010 MICS
Sierra Leone	17	8	14	27	13	14	19	26	13	12	13	20	28	2013 DHS
Somalia	15	7	15	17	13	14	16	23	12	14	14	15	19	2006 MICS
South Africa	60	47	62	62	55	-	-	-	-	-	-	-	-	2003 DHS
South Sudan	4	2	3	5	4	3	8	14	4	3	3	4	7	2010 MICS
Suriname	48	42	41	49	44	19	42	52	32	48	49	50	56	2010 MICS
Swaziland	65	54	68	72	63	55	59	70	58	61	63	69	70	2010 MICS
Syrian Arab Republic	58	22	40	64	52	45	58	65	42	53	61	64	68	2006 MICS
Tajikistan	28	2	10	32	27	-	-	-	25	25	25	29	36	2012 DHS
Tanzania, United Republic of	34	15	30	46	31	22	37	52	23	27	29	43	51	2010 DHS
Thailand	79	73	74	78	80	78	83	77	83	80	80	80	75	2012-13 MICS
The former Yugoslav Republic of Macedonia	40	33	30	43	38	-	-	-	35	35	39	46	46	2011 MICS
Timor-Leste, Democratic Republic of	22	8	16	30	20	16	26	26	15	16	18	25	34	2009-10 DHS
Togo	15	5	15	18	14	11	17	20	13	12	13	17	20	2010 MICS
Trinidad and Tobago	43	41	34	-	-	-	-	-	41	37	39	46	50	2006 MICS
Tunisia	63	-	42	64	60	58	66	62	62	62	61	63	65	2011-12 MICS
Turkey	73	40	63	74	69	-	-	-	63	71	75	74	79	2008 DHS
Turkmenistan	62	27	53	62	61	50	63	62	62	63	59	64	62	2000 DHS
Uganda	30	14	23	46	27	18	28	44	15	23	29	35	46	2011 DHS
Ukraine	66	51	56	68	59	-	-	-	56	62	67	70	69	2012 MICS
Uzbekistan	65	22	48	63	66	-	-	-	66	67	64	64	63	2006 MICS
Viet Nam	78	21	53	78	78	75	81	77	77	79	79	76	78	2010-11 MICS
Yemen	28	10	25	42	21	23	34	42	15	16	27	35	44	2006 MICS
Zambia	41	28	42	48	37	35	38	51	41	34	31	44	54	2007 DHS
ZimbabweX	59	36	60	62	57	43	55	61	54	54	58	61	65	2010-11 DHS

Notes: – Data not available or not enough number of cases. Data presented in this statistical table generally reflect information available as of June 2015. Source: UNFPA global open database (unfpaopendata.org), Reproductive Health Survey and Pan-Arab Project for Family Health Survey.

Table 3. Disparities and inequalities in unmet need for family planning among women aged 15-49, married or in union, by country, most recent data, 2000-2014

COUNTRIES AND AREAS	UNR PER CENT, 2000-2014	UNMET NEED FOR CONTRACEPTION (UNR), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Albania	13	17	18	10	15	16	15	10	16	14	14	12	9	2008-09 DHS
Algeria	11	18	10	10	12	13	10	9	15	11	11	10	8	2006 MICS
Armenia	14	27	17	12	16	-	-	-	14	19	14	10	11	2010 DHS
Azerbaijan	15	16	16	15	16	15	28	15	16	17	16	18	11	2006 DHS
Bangladesh	14	17	15	11	14	12	13	15	14	12	13	15	13	2011 DHS
Barbados	20	37	34	21	18	-	-	-	24	28	23	16	13	2012 MICS
Belarus	7	15	14	7	8	-	-	-	11	7	8	7	5	2012 MICS
Belize	16	31	26	14	17	17	17	15	26	18	16	11	10	2011 MICS
Benin	33	35	34	33	32	32	35	32	32	31	31	36	33	2011-12 DHS
Bhutan	12	27	17	10	12	11	13	15	11	13	13	10	12	2010 MICS
Bolivia (Plurinational State of)	20	38	27	16	27	28	24	14	34	24	20	14	9	2008 DHS
Bosnia and Herzegovina	9	-	24	9	9	-	-	-	13	10	9	7	8	2011-12 MICS
Burkina Faso	25	22	24	22	25	25	26	15	25	26	26	25	21	2010 DHS
Burundi	32	19	30	26	33	34	31	25	32	38	31	31	30	2010 DHS
Cambodia	17	16	17	12	18	18	18	14	21	20	16	16	12	2010 DHS
Cameroon, Republic of	24	26	25	23	24	24	26	21	26	24	25	23	19	2011 DHS
Central African Republic	27	27	27	28	26	26	28	27	26	26	29	29	25	2010 MICS
Chad	28	25	28	31	28	27	32	36	25	28	27	30	32	2010 MICS
Colombia	8	24	14	8	9	14	8	8	12	8	8	7	6	2010 DHS
Comoros	32	47	42	24	35	34	33	29	41	34	33	28	24	2012 DHS
Congo, Democratic Republic of the	28	31	29	28	27	27	29	27	28	27	28	29	26	2013-14 DHS
Congo, Republic of the	18	35	23	18	19	25	20	17	20	21	16	20	14	2011-12 DHS
Costa Rica	8	20	9	8	8	15	7	8	12	9	7	5	5	2011 MICS
Côte d'Ivoire	27	27	33	25	29	28	29	19	31	30	28	27	20	2012 DHS
Cuba	9	11	9	9	8	-	-	-	-	-	-	-	-	2010-11 MICS
Djibouti	22	16	22	22	25	22	26	17	-	-	-	-	-	2006 MICS
Dominican Republic	11	27	21	11	10	11	11	11	13	11	13	10	7	2013 DHS
Egypt	12	7	9	10	13	14	14	10	15	13	12	11	8	2008 DHS
Eritrea	29	44	30	26	30	28	31	25	29	29	33	29	21	2002 DHS
Ethiopia	26	33	22	16	29	28	27	10	32	28	29	28	15	2011 DHS
Gabon	27	41	30	26	32	35	29	25	33	30	28	23	21	2012 DHS
Gambia	22	22	23	21	22	21	19	24	23	22	25	22	17	2010 MICS
Ghana	36	62	42	33	38	36	41	33	37	43	40	35	24	2008 DHS
Guinea	24	23	27	26	23	23	29	27	22	21	22	27	27	2012 DHS
Guinea-Bissau	25	32	35	23	26	26	26	18	23	26	30	25	20	2006 MICS
Guyana	29	35	30	30	28	40	29	28	38	28	25	27	24	2009 DHS
Haiti	35	57	41	34	36	35	39	33	36	41	35	36	31	2012 DHS
Honduras	11	18	13	10	12	15	11	10	14	11	9	10	10	2011-12 DHS
India	14	27	22	11	15	15	13	13	19	16	14	12	10	2005-06 DHS
Indonesia	11	7	8	12	11	13	12	11	14	10	10	11	12	2012 DHS
Iraq	8	8	9	8	9	10	8	7	11	8	8	7	5	2011 MICS
Jordan	12	13	11	12	11	17	15	11	17	11	12	9	11	2012 DHS
Kazakhstan	12	21	18	11	12	-	-	-	14	11	12	12	10	2010-11 MICS
Kenya	26	30	30	20	28	27	30	17	38	32	23	20	18	2008-09 DHS
Kyrgyzstan	18	10	23	16	19	-	-	-	16	18	20	22	15	2012 DHS
Lao People's Democratic Republic	20	23	21	19	20	26	17	19	26	22	18	16	19	2011-12 MICS
Lesotho	23	30	28	15	27	24	27	18	37	30	22	21	13	2009 DHS
Liberia	31	47	39	30	33	29	35	32	35	32	32	29	27	2013 DHS
Madagascar	19	27	18	17	19	20	20	16	23	22	18	17	16	2008-09 DHS

COUNTRIES AND AREAS	UNR PER CENT, 2000-2014	UNMET NEED FOR CONTRACEPTION (UNR), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Malawi	26	25	27	23	27	28	27	21	30	28	27	25	22	2010 DHS
Maldives	29	37	32	27	29	24	27	32	29	30	29	29	27	2009 DHS
Mali	26	23	25	24	27	26	27	23	25	26	28	28	23	2012-13 DHS
Mauritania	25	18	27	27	23	23	27	28	21	20	28	28	26	2007 MICS
Moldova, Republic of	11	14	13	12	11	21	8	11	9	13	12	11	12	2005 DHS
Mongolia	22	14	18	24	20	22	20	22	20	21	21	26	24	2010 MICS
Montenegro	26	-	23	28	24	-	-	-	23	25	29	27	28	2005-06 MICS
Morocco	11	11	13	10	12	12	9	9	14	12	10	11	10	2011 PAPFAM
Mozambique	29	23	23	30	28	28	29	29	28	28	28	28	32	2011 DHS
Namibia	21	34	20	16	26	30	26	16	33	23	25	17	11	2006-07 DHS
Nepal	28	42	38	20	29	23	31	32	32	29	29	27	22	2011 DHS
Nicaragua	11	17	12	11	11	13	11	9	13	12	11	9	7	2006-07 RHS
Niger	16	13	18	17	16	16	18	16	18	15	15	16	16	2012 DHS
Nigeria	16	13	17	15	17	15	19	16	14	15	20	19	13	2013 DHS
Pakistan	20	15	21	17	22	22	19	17	25	23	19	19	15	2012-13 DHS
Palestine	16	22	22	15	16	17	15	16	21	17	16	15	10	2010 MICS
Peru	6	16	8	7	8	10	8	5	10	6	6	5	4	2011 DHS
Philippines	18	29	22	17	18	24	18	17	21	17	16	16	18	2013 DHS
Russian Federation	8	7	8	7	11	-	-	-	11	9	8	6	7	2011 RHS
Rwanda	21	6	17	18	21	25	21	13	26	24	19	19	16	2010 DHS
Saint Lucia	17	32	23	22	16	-	-	-	-	-	-	-	-	2012 MICS
Samoa	46	52	42	45	46	-	-	-	47	48	48	44	41	2009 DHS
Sao Tome and Principe	38	48	41	42	32	40	36	40	44	39	41	33	32	2008-09 DHS
Senegal	30	31	30	31	30	30	32	29	31	30	33	30	28	2010-11 DHS
Serbia	7	7	12	6	8	-	-	-	9	7	6	5	6	2010 MICS
Sierra Leone	25	31	26	26	25	24	25	27	24	26	25	25	25	2013 DHS
Somalia	26	21	22	26	26	27	24	25	28	25	29	26	23	2006 MICS
South Africa	14	18	17	13	17	-	-	-	-	-	-	-	-	2003 DHS
South Sudan	26	26	25	28	26	26	30	32	22	26	25	29	29	2010 MICS
Suriname	17	37	26	15	22	39	22	13	31	21	15	12	11	2010 MICS
Swaziland	13	29	15	9	15	17	18	10	21	18	13	10	8	2010 MICS
Syrian Arab Republic	11	13	14	9	13	14	11	10	14	14	11	9	8	2006 MICS
Tajikistan	23	13	28	21	23	-	-	-	27	22	22	24	20	2012 DHS
Tanzania, United Republic of	25	16	25	20	27	30	25	17	31	27	29	23	16	2010 DHS
Thailand	7	12	8	7	7	10	7	7	5	7	8	7	7	2012-13 MICS
The former Yugoslav Republic of Macedonia	17	-	35	17	18	-	-	-	20	18	15	15	18	2011 MICS
Timor-Leste, Democratic Republic of	32	27	35	30	32	32	31	32	36	31	34	29	28	2009-10 DHS
Togo	37	50	42	35	39	36	40	36	40	37	41	38	31	2010 MICS
Trinidad and Tobago	27	39	33	-	-	-	-	-	26	31	28	26	22	2006 MICS
Tunisia	7	-	16	6	8	6	6	8	9	7	7	8	5	2011-12 MICS
Turkey	6	15	9	5	9	-	-	-	13	8	5	4	4	2008 DHS
Turkmenistan	13	13	10	14	12	21	16	13	12	11	15	14	14	2000 DHS
Uganda	34	31	35	23	37	34	38	24	42	39	34	34	23	2011 DHS
Ukraine	5	14	8	5	6	-	-	-	7	7	6	4	3	2012 MICS
Uzbekistan	8	10	10	9	7	-	-	-	9	7	7	7	10	2006 MICS
Viet Nam	4	16	10	5	4	7	4	4	5	4	4	5	4	2010-11 MICS
Yemen	24	30	26	14	28	25	22	17	32	30	23	20	14	2006 MICS
Zambia	27	23	25	23	29	28	29	21	27	31	30	26	19	2007 DHS
Zimbabwe	15	19	14	13	15	15	16	14	17	19	13	13	11	2010-11 DHS

Notes: – Data not available or not enough number of cases. Data presented in this statistical table generally reflect information available as of June 2015. Source: UNFPA global open database (unfpaopendata.org), Reproductive Health Survey and Pan-Arab Project for Family Health Survey.

Table 4. Disparities and inequalities in the proportion of demand for contraception satisfied among women aged 15-49, married or in union, by country, most recent data, 2000-2014

COUNTRIES AND AREAS	PDS PER CENT, 2000-2014	PROPORTION OF DEMAND SATISFIED (PDS), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Albania	84	77	75	89	81	82	81	88	81	83	83	85	90	2008-09 DHS
Algeria	85	53	81	86	84	82	86	88	79	85	86	87	89	2006 MICS
Armenia	80	41	70	83	76	-	-	-	80	71	79	86	86	2010 DHS
Azerbaijan	77	28	71	78	76	77	48	77	78	74	75	73	84	2006 DHS
Bangladesh	82	74	79	85	81	84	83	80	82	84	82	80	83	2011 DHS
Barbados	75	60	61	74	77	-	-	-	69	66	71	80	84	2012 MICS
Belarus	90	79	80	91	88	-	-	-	84	90	89	90	93	2012 MICS
Belize	78	54	66	80	76	72	77	79	62	75	77	85	87	2011 MICS
Benin	28	19	22	31	26	26	30	40	21	26	29	28	35	2011-12 DHS
Bhutan	85	52	77	86	85	86	84	79	86	84	83	87	84	2010 MICS
Bolivia (Plurinational State of)	75	52	68	81	66	60	70	83	58	69	76	82	88	2008 DHS
Bosnia and Herzegovina	84	-	60	84	84	-	-	-	76	82	85	87	85	2011-12 MICS
Burkina Faso	40	23	40	61	31	32	51	77	23	26	28	41	65	2010 DHS
Burundi	40	35	43	58	38	34	44	62	35	31	42	40	53	2010 DHS
Cambodia	75	63	72	82	73	70	74	81	68	71	76	77	82	2010 DHS
Cameroon, Republic of	50	39	47	60	37	15	45	66	10	37	48	60	69	2011 DHS
Central African Republic	37	33	37	49	25	23	36	56	25	23	27	40	55	2010 MICS
Chad	15	15	16	23	12	13	16	22	15	13	11	13	21	2010 MICS
Colombia	91	72	84	91	90	84	91	91	87	91	91	92	94	2010 DHS
Comoros	38	29	31	55	29	28	37	49	24	34	37	46	48	2012 DHS
Congo, Democratic Republic of the	42	29	40	52	36	29	35	53	31	38	37	44	58	2013-14 DHS
Congo, Republic of the	71	51	67	72	69	57	69	74	67	66	75	70	78	2011-12 DHS
Costa Rica	91	77	89	91	91	79	91	91	85	90	91	95	94	2011 MICS
Côte d'Ivoire	40	29	34	48	34	32	47	62	28	35	35	44	59	2012 DHS
Cuba	89	86	89	89	91	-	-	-	-	-	-	-	-	2010-11 MICS
Djibouti	45	50	48	46	16	36	45	66	-	-	-	-	-	2006 MICS
Dominican Republic	87	67	75	86	88	86	87	87	84	88	84	88	91	2013 DHS
Egypt	84	77	83	87	81	80	82	86	78	82	84	85	89	2008 DHS
Eritrea	22	5	17	39	11	11	29	46	6	8	12	31	49	2002 DHS
Ethiopia	52	42	61	77	45	45	57	86	29	45	46	53	78	2011 DHS
Gabon	54	38	53	56	40	29	43	59	39	50	54	60	64	2012 DHS
Gambia	38	17	32	48	28	34	47	46	25	30	34	39	57	2010 MICS
Ghana	40	18	35	45	36	28	39	46	28	32	35	45	56	2008 DHS
Guinea	19	11	16	25	16	17	21	28	12	19	18	18	27	2012 DHS
Guinea-Bissau	29	18	23	46	21	20	39	63	21	17	19	36	53	2006 MICS
Guyana	60	46	56	59	60	35	58	61	46	59	64	62	67	2009 DHS
Haiti	49	31	47	51	48	46	47	53	47	44	52	52	52	2012 DHS
Honduras	87	76	84	89	86	81	87	88	83	87	89	88	89	2011-12 DHS
India	80	32	61	85	78	78	82	82	69	76	81	84	88	2005-06 DHS
Indonesia	84	88	88	84	85	76	83	86	81	86	86	85	83	2012 DHS
Iraq	87	73	82	88	85	83	86	89	80	86	86	89	92	2011 MICS
Jordan	84	69	81	84	85	73	80	85	78	85	84	88	86	2012 DHS
Kazakhstan	82	48	66	83	80	-	-	-	77	81	81	82	85	2010-11 MICS
Kenya	64	43	54	73	61	35	59	78	34	55	69	74	75	2008-09 DHS
Kyrgyzstan	67	35	49	71	65	-	-	-	71	68	64	60	73	2012 DHS
Lao People's Democratic Republic	71	54	67	73	71	60	76	73	60	68	75	78	73	2011-12 MICS
Lesotho	67	49	61	79	61	57	60	75	45	56	68	71	82	2009 DHS
Liberia	39	22	37	44	34	35	36	48	28	35	40	47	47	2013 DHS
Madagascar	68	48	68	76	66	51	66	77	46	57	69	74	78	2008-09 DHS

COUNTRIES AND AREAS	PDS PER CENT, 2000-2014	PROPORTION OF DEMAND SATISFIED (PDS), PER CENT, BY AGE, RESIDENCE, EDUCATION AND HOUSEHOLD WEALTH QUINTILE, 2000-2014												DATA SOURCE
		AGE GROUP		RESIDENCE		EDUCATION			WEALTH QUINTILES					
		15-19	20-24	Urban	Rural	No education	Primary	Secondary +	Poorest 20%	Second	Third	Fourth	Richest 20%	
Malawi	64	53	61	70	62	59	63	72	56	62	62	66	71	2010 DHS
Maldives	55	29	42	55	55	64	57	46	56	54	54	54	56	2009 DHS
Mali	28	22	30	49	21	24	34	55	12	17	18	33	51	2012-13 DHS
Mauritania	27	24	27	37	15	18	30	44	7	15	21	33	42	2007 MICS
Moldova, Republic of	86	80	83	84	87	53	91	86	89	84	85	86	85	2005 DHS
Mongolia	71	78	72	68	75	68	74	71	74	73	73	68	69	2010 MICS
Montenegro	60	-	61	57	65	-	-	-	67	63	58	55	56	2005-06 MICS
Morocco	86	78	82	87	84	85	88	89	83	85	87	86	88	2011 PAPFAM
Mozambique	29	20	34	42	21	16	28	53	10	17	21	33	49	2011 DHS
Namibia	73	54	73	81	63	53	64	80	49	67	65	80	87	2006-07 DHS
Nepal	64	30	44	75	63	70	60	59	56	62	63	66	73	2011 DHS
Nicaragua	87	79	85	88	86	84	86	89	83	85	87	90	92	2006-07
Niger	47	35	44	63	42	43	54	67	36	36	39	49	62	2012 DHS
Nigeria	48	14	37	64	34	15	51	66	11	25	40	55	74	2013 DHS
Pakistan	64	41	51	72	59	58	68	72	46	56	67	69	75	2012-13 DHS
Palestine	77	41	62	77	77	75	79	75	70	74	76	79	85	2010 MICS
Peru	93	79	91	92	91	87	91	94	88	93	93	94	96	2011 DHS
Philippines	76	56	70	77	75	56	75	77	70	78	79	78	74	2013 DHS
Russian Federation	89	87	89	90	86	-	-	-	85	88	90	92	92	2011 RHS
Rwanda	71	84	73	75	71	63	72	82	63	66	74	76	78	2010 DHS
Saint Lucia	77	64	73	71	78	-	-	-	-	-	-	-	-	2012 MICS
Samoa	39	13	35	40	38	-	-	-	38	36	38	36	46	2009 DHS
Sao Tome and Principe	51	32	48	44	58	31	53	49	45	48	46	56	58	2008-09 DHS
Senegal	30	16	23	42	19	23	41	49	14	20	29	36	47	2010-11 DHS
Serbia	90	86	84	92	89	-	-	-	87	89	91	92	91	2010 MICS
Sierra Leone	40	20	36	51	35	37	43	49	34	32	34	45	53	2013 DHS
Somalia	36	25	40	40	34	34	40	48	30	36	32	37	45	2006 MICS
South Africa	81	73	79	83	77	-	-	-	-	-	-	-	-	2003 DHS
South Sudan	13	8	12	15	13	11	21	30	15	11	9	11	20	2010 MICS
Suriname	74	53	61	77	67	33	66	80	51	70	77	81	84	2010 MICS
Swaziland	83	66	82	88	81	77	77	87	73	78	83	87	90	2010 MICS
Syrian Arab Republic	84	63	74	87	79	77	84	86	75	80	85	88	89	2006 MICS
Tajikistan	55	16	26	60	53	-	-	-	48	53	53	54	65	2012 DHS
Tanzania, United Republic of	58	48	54	70	53	42	60	75	42	50	50	65	76	2010 DHS
Thailand	92	86	91	92	92	89	93	92	94	92	91	92	91	2012-13 MICS
The former Yugoslav Republic of Macedonia	70	-	47	72	68	-	-	-	64	66	73	76	72	2011 MICS
Timor-Leste, Democratic Republic of	41	22	31	50	38	34	45	45	30	35	35	47	55	2009-10 DHS
Togo	29	9	26	34	26	24	31	36	24	25	25	31	40	2010 MICS
Trinidad and Tobago	61	52	51	-	-	-	-	-	61	54	58	64	69	2006 MICS
Tunisia	90	-	72	91	88	90	91	89	87	90	90	89	93	2011-12 MICS
Turkey	92	73	88	93	89	-	-	-	84	90	94	95	96	2008 DHS
Turkmenistan	83	67	85	82	83	71	80	83	84	86	80	82	82	2000 DHS
Uganda	47	31	39	67	42	34	42	64	26	37	46	51	67	2011 DHS
Ukraine	93	78	87	94	91	-	-	-	89	91	92	95	96	2012 MICS
Uzbekistan	89	69	83	87	90	-	-	-	89	91	90	90	86	2006 MICS
Viet Nam	95	57	84	95	95	92	96	95	94	95	96	94	95	2010-11 MICS
Yemen	54	26	50	75	43	48	61	72	32	36	54	64	76	2006 MICS
Zambia	61	55	63	68	56	56	57	70	60	52	51	64	74	2007 DHS
Zimbabwe	80	66	81	82	79	74	77	82	76	74	82	82	86	2010-11 DHS

Notes: – Data not available or not enough number of cases. Data presented in this statistical table generally reflect information available as of June 2015. Source: UNFPA global open database (unfpaopendata.org), Reproductive Health Survey and Pan-Arab Project for Family Health Survey.

Table 5. Use of contraception among currently married women age 15-19, by method type, most recent data, 2000-2014

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	mCPR PER CENT, 2000-2014	mCPR EXCLUDING LAM, PER CENT, 2000-2014	MODERN METHOD MIX									DATA SOURCE
				Sterilization, Female	Sterilization, Male	Pill	Injectable	IUD	Male condom	Vaginal barrier methods	Implant	Other modern methods	
Afghanistan	7	6	6	0	0	3	3	0	0	0	0	0	2010-11 MICS
Albania	55	13	12	0	0	2	1	0	9	0	0	0	2008-09 DHS
Algeria	20	17	17	0	0	17	0	0	0	0	0	0	2006 MICS
Argentina	34	33	33	0	0	20	2	1	10	0	0	0	2011-12 MICS
Armenia	19	3	0	0	0	0	0	0	0	0	0	0	2010 DHS
Azerbaijan	6	3	2	0	0	0	0	0	2	0	0	0	2006 DHS
Bangladesh	47	42	42	0	0	26	9	0	7	0	1	0	2011 DHS
Barbados	55	51	51	0	0	19	2	0	28	0	2	0	2012 MICS
Belarus	58	48	48	0	0	6	0	12	31	0	0	0	2012 MICS
Belize	36	34	34	0	0	13	17	1	3	0	0	0	2011 MICS
Benin	8	4	3	0	0	1	1	0	1	0	0	0	2011-12 DHS
Bhutan	30	30	30	0	0	4	23	0	3	0	0	0	2010 MICS
Bolivia (Plurinational State of)	41	27	25	0	0	3	14	3	4	0	0	0	2008 DHS
Burkina Faso	7	6	6	0	0	1	2	0	3	0	1	0	2010 DHS
Burundi	10	8	8	0	0	1	6	2	0	0	0	0	2010 DHS
Cambodia	27	19	19	0	0	11	6	0	2	0	0	0	2010 DHS
Cameroon, Republic of	16	12	12	0	0	0	1	0	10	0	0	0	2011 DHS
Cape Verde	55	54	54	1	0	24	15	2	11	0	0	1	2005 DHS
Central African Republic	13	7	7	0	0	3	0	0	4	0	0	0	2010 MICS
Chad	4	1	1	0	0	1	0	0	0	0	0	0	2010 MICS
Colombia	61	55	55	2	0	10	24	4	8	0	8	0	2010 DHS
Comoros	20	14	12	0	0	1	4	0	6	0	1	0	2012 DHS
Congo, Democratic Republic of the	13	5	5	0	0	1	0	0	4	0	0	0	2013-14 DHS
Congo, Republic of the	36	26	26	0	0	4	0	0	20	0	0	3	2011-12 DHS
Costa Rica	64	64	64	0	1	25	29	0	8	0	0	0	2011 MICS
Côte d'Ivoire	11	7	7	0	0	3	1	0	2	0	0	0	2012 DHS
Cuba	67	67	67	0	0	13	3	19	30	2	0	0	2010-11 MICS
Djibouti	16	16	16	0	0	6	5	0	6	0	0	0	2006 MICS
Dominican Republic	55	52	50	0	0	31	13	1	4	0	1	1	2013 DHS
Egypt	23	20	20	0	0	5	1	14	0	0	0	0	2008 DHS
Eritrea	2	2	2	0	0	0	1	0	0	0	0	0	2002 DHS
Ethiopia	24	23	23	0	0	3	19	0	0	0	2	0	2011 DHS
Gabon	25	16	16	0	0	2	0	0	13	0	0	0	2012 DHS
Gambia	4	2	2	0	0	1	1	0	0	0	0	1	2010 MICS
Georgia	17	9	9	0	0	4	0	1	3	0	0	0	2005 MICS
Ghana	14	8	8	0	0	2	2	0	1	2	0	0	2008 DHS
Guinea	3	3	1	0	0	0	1	0	0	0	0	0	2012 DHS
Guinea-Bissau	7	5	5	0	0	0	0	2	2	0	0	0	2010 MICS
Guyana	30	30	30	3	0	6	4	1	17	0	0	0	2009 DHS
Haiti	26	24	24	0	0	2	16	0	5	0	1	0	2012 DHS
Honduras	56	49	49	0	0	15	26	3	5	0	0	0	2011-12 DHS
India	13	7	7	1	0	2	0	0	3	0	0	0	2005-06 DHS
Indonesia	48	48	48	0	0	9	37	1	0	0	1	0	2012 DHS
Iraq	21	11	11	0	0	7	1	2	1	0	0	0	2011 MICS
Jordan	28	22	18	0	0	11	1	4	1	0	0	0	2012 DHS
Kazakhstan	19	18	18	1	0	2	0	6	10	0	0	0	2010-11 MICS
Kenya	23	20	19	0	0	3	14	0	2	0	0	0	2008-09 DHS
Kyrgyzstan	5	5	5	0	0	1	0	2	2	0	0	0	2012 DHS
Lao People's Democratic Republic	26	22	22	0	0	16	5	0	1	0	0	0	2011-12 MICS

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	mCPR PER CENT, 2000-2014	mCPR EXCLUDING LAM, PER CENT, 2000-2014	MODERN METHOD MIX									DATA SOURCE
				Sterilization, Female	Sterilization, Male	Pill	Injectable	IUD	Male condom	Vaginal barrier methods	Implant	Other modern methods	
Lesotho	28	27	27	0	0	7	14	0	6	0	0	0	2009 DHS
Liberia	13	13	13	0	0	2	11	0	0	0	1	0	2013 DHS
Madagascar	25	17	15	0	0	5	9	0	1	0	1	0	2008-09 DHS
Malawi	29	26	26	0	0	2	21	0	3	0	0	0	2010 DHS
Maldives	15	10	10	0	0	2	1	0	7	0	0	0	2009 DHS
Mali	7	7	7	0	0	1	4	0	0	0	1	0	2012-13 DHS
Mauritania	5	3	3	0	0	3	0	0	0	0	0	0	2000-01 DHS
Moldova, Republic of	58	34	30	0	0	4	0	11	14	0	0	1	2005 DHS
Mongolia	52	52	52	0	0	13	9	12	18	0	0	0	2010 MICS
Morocco	38	33	33	0	0	32	0	1	0	0	0	0	2011 PAPFAM
Mozambique	6	6	6	0	0	3	2	0	2	0	0	0	2011 DHS
Myanmar	49	49	49	0	0	18	30	1	0	0	0	0	2009-10 MICS
Namibia	41	39	39	0	0	3	27	0	8	0	1	0	2006-07 DHS
Nepal	18	14	14	0	0	3	5	0	7	0	0	0	2011 DHS
Nicaragua	61	60	59	1	0	20	34	2	2	0	0	0	2006-07 RHS
Niger	7	6	3	0	0	3	0	0	0	0	0	0	2012 DHS
Nigeria	2	1	1	0	0	0	0	0	0	0	0	0	2013 DHS
Pakistan	10	7	6	0	0	1	1	1	3	0	0	1	2012-13 DHS
Palestine	15	8	8	0	0	3	0	3	1	0	0	0	2010 MICS
Peru	64	45	45	0	0	7	29	1	8	0	0	0	2010 DHS
Philippines	37	21	19	0	0	12	6	2	1	0	0	0	2013 DHS
Rwanda	33	31	29	0	0	7	20	1	2	0	0	0	2010 DHS
Saint Lucia	57	48	48	0	0	13	8	0	26	0	0	0	2012 MICS
Sao Tome and Principe	22	21	21	0	0	11	3	0	7	0	0	0	2008-09 DHS
Senegal	6	5	5	0	0	2	2	0	1	0	0	0	2010-11 DHS
Serbia	45	11	11	0	0	0	0	0	11	0	0	0	2010 MICS
Sierra Leone	8	8	6	0	0	1	3	0	0	0	1	0	2013 DHS
Somalia	7	0	0	0	0	0	0	0	0	0	0	0	2006 MICS
South Sudan	2	1	1	0	0	0	0	0	1	0	0	0	2010 MICS
Suriname	42	42	42	0	0	29	3	0	9	0	0	0	2010 MICS
Swaziland	54	54	54	0	0	11	24	0	20	0	0	0	2010 MICS
Syrian Arab Republic	22	11	11	0	0	6	1	4	0	0	0	0	2006 MICS
Tajikistan	2	2	1	0	0	0	0	1	0	0	0	0	2012 DHS
Tanzania, United Republic of	15	12	12	0	0	2	5	0	4	0	1	0	2010 DHS
Thailand	73	68	68	1	0	43	20	0	3	0	0	0	2012-13 MICS
The former Yugoslav Republic of Macedonia	33	8	8	0	0	0	2	0	6	0	0	0	2011 MICS
Timor-Leste, Democratic Republic of	8	7	7	0	0	1	6	0	0	0	0	0	2009-10 DHS
Togo	5	4	4	0	0	1	2	0	1	0	0	0	2010 MICS
Trinidad and Tobago	41	39	39	0	0	6	2	2	29	0	0	0	2006 MICS
Turkey	40	18	18	0	0	4	1	4	9	0	0	0	2008 DHS
Uganda	14	13	13	0	0	1	8	0	4	0	1	0	2011 DHS
Ukraine	51	38	37	0	0	3	0	1	33	0	0	0	2012 MICS
Uzbekistan	22	19	19	1	0	1		14	2	0	0	0	2006 MICS
Vanuatu	35	35	35	0	0	21	7	3	3	0	0	0	2007 MICS
Viet Nam	21	15	15	0	0	5	1	6	4	0	0	0	2010-11 MICS
Yemen	10	6	6	0	0	5	0	1	0	0	0	0	2006 MICS
Zambia	28	22	17	0	0	7	7	0	3	0	0	0	2007 DHS
Zimbabwe	36	35	35	0	0	30	4	0	1	0	0	0	2010-11 DHS

Notes: Data presented in this statistical table generally reflect information available as of August 2015.
Source: DHS, MICS, Reproductive Health Survey and Pan-Arab Project for Family Health Survey.

Table 6. Use of contraception among unmarried but sexually active women age 15-19, by method type, most recent data, 2000-2014

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	mCPR PER CENT, 2000-2014	mCPR EXCLUDING LAM, PER CENT, 2000-2014	MODERN METHOD MIX									DATA SOURCE
				Sterilization, Female	Sterilization, Male	Pill	Injectable	IUD	Male condom	Vaginal barrier methods	Implant	Other modern methods	
Albania	76	29	29	0	0	1	0	0	28	0	0	0	2008-09 DHS
Belarus	80	75	75	0	0	6	0	0	68	0	0	1	2012 MICS
Belize	50	50	50	0	0	15	10	0	23	0	0	1	2011 MICS
Benin	39	24	24	0	0	3	3	0	15	0	1	2	2011-12 DHS
Bhutan	32	32	32	0	0	5	24	0	3	0	0	0	2010 MICS
Bolivia (Plurinational State of)	69	46	46	0	0	6	6	1	33	0	0	0	2008 DHS
Burkina Faso	50	49	49	0	0	4	2	0	42	0	0	0	2010 DHS
Burundi	5	5	5	0	0	2	0	0	1	0	2	0	2010 DHS
Cameroon, Republic of	61	51	51	0	0	1	1	0	48	0	0	0	2011 DHS
Cape Verde	70	68	68	0	0	16	7	0	45	0	0	0	2005 DHS
Central African Republic	19	16	16	0	0	5	0	0	11	0	0	1	2010 MICS
Chad	12	10	10	0	0	1	1	0	8	0	0	1	2010 MICS
Colombia	79	71	71	0	0	11	17	3	34	0	6	0	2010 DHS
Congo, Democratic Republic of the	44	20	20	0	0	0	0	0	18	0	0	1	2013-14 DHS
Congo, Republic of the	73	44	44	0	0	1	0	0	39	0	0	4	2011-12 DHS
Costa Rica	48	48	48	0	0	25	5	0	18	0	0	0	2011 MICS
Côte d'Ivoire	35	29	29	0	0	6	0	0	23	0	0	0	2012 DHS
Cuba	88	88	88	0	0	19	0	22	47	0	0	0	2010-11 MICS
Dominican Republic	61	57	57	0	0	21	9	2	22	0	0	3	2013 DHS
Ethiopia	52	52	52	0	0	1	33	0	12	0	7	0	2011 DHS
Gabon	62	53	53	0	0	2	0	0	50	0	0	1	2012 DHS
Ghana	53	33	33	0	0	10	0	0	23	0	0	0	2008 DHS
Guinea	27	22	22	0	0	1	4	0	16	0	1	0	2012 DHS
Guyana	61	61	61	0	0	3	4	0	54	0	0	1	2009 DHS
Haiti	31	29	29	0	1	0	3	0	25	0	0	0	2012 DHS
Honduras	71	54	54	0	0	9	8	0	37	0	0	0	2011-12 DHS
India	43	25	25	0	0	0	0	0	22	0	0	4	2005-06 DHS
Kazakhstan	74	74	74	0	0	23	0	0	49	0	0	1	2010-11 MICS
Kenya	27	23	23	0	0	2	2	0	20	0	0	0	2008-09 DHS

COUNTRIES AND AREAS	CPR PER CENT, 2000-2014	mCPR PER CENT, 2000-2014	mCPR EXCLUDING LAM, PER CENT, 2000-2014	MODERN METHOD MIX									DATA SOURCE
				Sterilization, Female	Sterilization, Male	Pill	Injectable	IUD	Male condom	Vaginal barrier methods	Implant	Other modern methods	
Lao People's Democratic Republic	3	3	3	0	0	0	0	0	3	0	0	0	2011-12 MICS
Lesotho	45	41	41	0	0	0	4	0	38	0	0	0	2009 DHS
Liberia	33	31	31	0	0	5	16	0	4	0	5	0	2013 DHS
Madagascar	32	14	14	0	0	4	7	0	3	0	0	0	2008-09 DHS
Malawi	31	30	30	0	0	0	3	0	27	0	0	0	2010 DHS
Mali	23	22	22	0	0	4	7	1	5	0	6	0	2012-13 DHS
Moldova, Republic of	77	52	52	0	0	2	0	1	48	0	0	1	2005 DHS
Mongolia	40	37	37	0	0	4	3	2	29	0	0	0	2010 MICS
Mozambique	27	27	27	0	0	5	1	0	21	0	0	1	2011 DHS
Namibia	77	76	76	0	0	4	24	0	48	0	0	0	2006-07 DHS
Nicaragua	59	51	51	4	0	19	15	1	11	0	0	0	2006-07 RHS
Nigeria	61	50	50	0	0	6	0	0	41	0	0	3	2013 DHS
Peru	88	60	60	0	0	5	11	0	43	0	0	2	2010 DHS
Philippines	43	20	16	0	0	7	0	2	8	0	0	0	2013 DHS
Rwanda	27	27	27	0	0	0	7	0	20	0	0	0	2010 DHS
Saint Lucia	61	58	58	0	1	22	3	0	31	0	0	0	2012 MICS
Sao Tome and Principe	44	44	44	0	0	6	0	0	38	0	0	0	2008-09 DHS
Senegal	25	23	23	0	0	0	5	0	17	0	2	0	2010-11 DHS
Serbia	93	90	90	0	0	10	0	0	78	0	0	2	2010 MICS
Sierra Leone	56	54	54	0	0	11	24	1	2	0	15	0	2013 DHS
Suriname	41	41	41	0	0	23	1	0	16	0	0	1	2010 MICS
Swaziland	56	56	56	0	0	6	13	0	35	0	0	1	2010 MICS
Tanzania, United Republic of	40	35	35	0	0	7	8	0	20	0	0	0	2010 DHS
Togo	38	37	37	0	0	2	2	1	31	0	0	0	2010 MICS
Trinidad and Tobago	41	41	41	0	0	7	3	0	32	0	0	0	2006 MICS
Uganda	45	35	35	0	0	1	10	0	24	0	0	0	2011 DHS
Ukraine	86	82	82	0	0	2	0	0	77	3	0	0	2012 MICS
Zambia	41	38	37	0	0	1	5	0	31	0	0	0	2007 DHS
Zimbabwe	35	35	35	0	0	2	2	0	31	0	0	0	2010-11 DHS

Notes: Data presented in this statistical table generally reflect information available as of August 2015.
Source: DHS, MICS, and Reproductive Health Survey.

Table 7. Trends in contraceptive prevalence rate (CPR), unmet need for family planning (UNR), proportion of demand for contraception satisfied (PDS) among women aged 15-49, married or in union, 1990-2015

COUNTRIES AND AREAS	ABR PER 1,000 WOMEN AGED 15 TO 19	CPR					UNR					PDS				
	1999-2014	1990	2000	2010	2015	Annual rate of increase (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of reduction (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of increase, (per cent), 1990-2015
Afghanistan	90	5	7	23	29	7.0	29	29	29	27	0.3	15	20	44	52	4.9
Albania	18	68	70	66	66	-0.1	11	10	14	13	-0.8	86	88	83	84	-0.1
Algeria	12	46	60	59	59	1.0	19	13	13	13	1.6	70	82	82	82	0.6
Angola	191	5	8	15	19	5.4	28	29	29	28	0.0	15	21	34	40	4.0
Antigua and Barbuda	67	53	58	62	63	0.7	19	16	14	14	1.3	74	78	81	82	0.4
Argentina	70	54	60	61	62	0.5	20	17	16	15	1.0	73	78	80	80	0.4
Armenia	23	53	56	57	59	0.5	20	20	14	13	1.6	72	74	81	82	0.5
Aruba	34	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Australia	14	72	67	68	68	-0.2	9	11	11	10	-0.6	89	86	87	87	-0.1
Austria	8	55	59	68	68	0.8	16	14	10	10	1.8	78	81	87	87	0.5
Azerbaijan	47	45	53	54	57	1.0	19	15	15	14	1.3	70	78	79	80	0.6
Bahamas	40	61	64	66	67	0.4	15	13	12	12	1.0	80	83	84	85	0.2
Bahrain	15	55	62	65	66	0.8	17	13	12	11	1.6	76	82	85	85	0.4
Bangladesh	83	36	55	60	64	2.3	25	18	14	12	2.9	59	76	81	84	1.4
Barbados	49	54	58	59	60	0.4	19	17	17	16	0.7	74	77	78	79	0.3
Belarus	22	57	63	67	65	0.6	15	12	10	11	1.5	79	84	87	86	0.4
Belgium	8	74	69	68	69	-0.3	7	9	9	9	-1.3	92	89	88	88	-0.2
Belize	64	44	51	54	58	1.1	25	21	19	17	1.6	64	71	74	78	0.8
Benin	98	11	17	15	17	1.8	29	28	31	31	-0.3	28	37	32	36	1.0
Bhutan	28	14	32	64	68	6.2	30	27	13	11	4.1	33	55	84	86	3.9
Bolivia (Plurinational State of)	89	35	53	60	63	2.4	34	25	20	18	2.5	50	68	75	78	1.7
Bosnia and Herzegovina	11	51	51	46	48	-0.2	17	16	17	17	0.0	75	76	72	74	-0.1
Botswana	39	35	44	53	56	1.9	26	23	18	17	1.8	57	66	74	77	1.2
Brazil	65	71	77	80	79	0.4	12	9	8	8	1.7	86	89	91	91	0.3
Brunei Darussalam	17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bulgaria	43	78	67	67	67	-0.6	8	15	14	14	-1.9	90	82	82	83	-0.3
Burkina Faso	136	17	13	16	19	0.5	28	30	25	27	0.2	37	31	39	41	0.4
Burundi	65	9	16	22	28	4.7	28	30	32	30	-0.3	24	35	40	48	2.8
Cambodia	57	8	25	50	58	8.0	31	32	17	13	3.6	20	43	75	82	5.6
Cameroon, Republic of	128	12	20	25	29	3.5	23	22	23	22	0.1	35	48	53	56	2.0
Canada	13	74	76	74	73	0.0	8	7	8	8	-0.2	91	92	90	90	0.0
Cape Verde	92	30	54	61	62	2.9	29	19	16	15	2.7	51	73	79	81	1.9
Central African Republic	229	12	20	20	24	2.7	21	22	23	23	-0.4	36	48	46	50	1.3
Chad	203	2	4	4	6	4.0	20	20	22	23	-0.6	10	17	16	21	2.8
Chile	50	54	60	64	65	0.8	19	16	14	13	1.5	73	79	82	83	0.5
China	6	79	86	84	83	0.2	5	3	4	4	1.4	94	97	96	96	0.1
China, Hong Kong SAR	4	84	86	80	80	-0.2	4	3	5	5	-1.3	96	96	94	94	-0.1
China, Macao SAR	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Colombia	85	67	76	79	78	0.6	14	11	8	8	2.0	83	88	91	91	0.3
Comoros	71	16	25	21	24	1.7	35	34	32	31	0.5	31	43	40	43	1.4
Congo, Democratic Republic of the	135	14	19	20	23	2.0	28	28	28	27	0.2	33	41	42	45	1.3
Congo, Republic of the	147	26	36	45	47	2.4	25	23	19	18	1.4	50	61	71	73	1.5
Costa Rica	67	73	79	81	79	0.3	8	6	5	6	1.2	90	93	94	93	0.1
Côte d'Ivoire	125	8	14	17	20	3.8	29	29	24	24	0.8	21	33	42	46	3.1
Croatia	12	63	64	65	66	0.1	13	12	12	11	0.4	83	84	85	85	0.1
Cuba	50	70	70	74	74	0.2	11	11	9	9	0.8	87	87	90	90	0.1

COUNTRIES AND AREAS	ABR PER 1,000 WOMEN AGED 15 TO 19	CPR					UNR					PDS				
	1999-2014	1990	2000	2010	2015	Annual rate of increase (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of reduction (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of increase, (per cent), 1990-2015
Cyprus	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Czech Republic	11	71	72	79	78	0.4	10	10	7	7	1.6	87	88	92	92	0.2
Denmark	2	73	72	71	71	-0.1	9	9	9	9	-0.3	89	89	88	88	0.0
Djibouti	21	4	8	19	24	7.0	30	31	31	30	0.0	12	21	38	44	5.1
Dominica	47	53	58	61	63	0.7	19	16	15	14	1.2	74	78	81	82	0.4
Dominican Republic	90	55	67	72	72	1.1	19	14	11	11	2.4	74	83	87	87	0.6
Ecuador	100	53	67	72	73	1.3	20	12	9	9	3.1	73	85	89	89	0.8
Egypt	56	43	56	60	60	1.3	23	14	12	12	2.6	65	80	83	83	1.0
El Salvador	63	49	62	70	71	1.5	22	17	13	12	2.5	69	79	85	86	0.9
Equatorial Guinea	177	7	11	13	16	3.1	31	32	33	33	-0.2	19	25	28	33	2.2
Eritrea	85	6	8	15	20	5.2	30	29	29	29	0.1	16	22	34	41	3.8
Estonia	16	62	63	64	65	0.2	14	13	13	13	0.4	82	82	83	84	0.1
Ethiopia	71	3	6	26	36	10.5	34	37	28	25	1.2	7	15	49	59	8.4
Fiji	28	43	46	48	50	0.6	22	21	20	19	0.6	66	68	71	72	0.3
Finland	7	76	75	75	75	-0.1	7	8	8	8	-0.2	91	91	91	91	0.0
France	9	79	80	75	74	-0.2	5	4	6	6	-1.0	94	95	93	92	-0.1
French Guiana	84	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
French Polynesia	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Gabon	115	21	30	32	34	1.9	30	29	27	25	0.6	42	50	54	57	1.3
Gambia	88	10	13	12	11	0.3	29	29	28	28	0.1	26	30	29	28	0.2
Georgia	40	33	41	48	52	1.8	24	22	18	17	1.5	57	65	73	75	1.1
Germany	8	72	68	66	67	-0.3	8	10	11	10	-1.0	90	87	86	87	-0.1
Ghana	65	15	21	24	22	1.5	36	36	35	34	0.2	30	37	41	40	1.2
Greece	9	70	65	69	69	0.0	10	12	10	10	-0.2	88	85	87	87	0.0
Grenada	53	53	58	62	64	0.8	20	16	14	13	1.5	73	78	81	83	0.5
Guadeloupe	21	44	51	56	58	1.2	23	20	17	16	1.4	65	72	76	78	0.7
Guam	60	43	51	53	54	0.9	21	18	17	17	0.9	67	74	75	76	0.5
Guatemala	92	27	40	54	57	3.0	29	26	19	17	2.0	49	60	74	77	1.8
Guinea	154	2	6	7	8	5.5	25	25	24	25	0.0	7	20	22	23	4.8
Guinea-Bissau	137	6	8	14	17	4.5	23	23	21	22	0.2	19	26	40	44	3.3
Guyana	97	36	37	41	45	0.8	30	30	29	27	0.4	55	55	58	63	0.5
Haiti	65	11	26	34	38	4.8	43	41	36	33	1.1	21	39	48	53	3.7
Honduras	99	44	59	71	73	2.0	25	18	12	11	3.4	64	76	86	87	1.3
Hungary	20	77	77	75	75	-0.1	7	7	8	8	-0.4	91	91	91	90	0.0
Iceland	7	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
India	39	42	49	57	60	1.4	20	17	14	13	1.7	68	75	80	82	0.8
Indonesia	47	49	55	61	63	1.0	17	15	12	11	1.7	74	78	83	85	0.5
Iran (Islamic Republic of)	35	56	73	77	77	1.3	16	8	7	7	3.7	77	90	92	92	0.7
Iraq	68	19	40	52	55	4.2	26	21	15	14	2.5	42	65	77	79	2.5
Ireland	9	70	71	67	67	-0.2	10	10	11	11	-0.5	88	88	85	86	-0.1
Israel	10	67	69	71	71	0.3	11	10	9	9	0.8	86	88	89	89	0.1
Italy	6	63	64	65	65	0.1	12	12	12	11	0.3	84	84	85	85	0.1
Jamaica	72	56	68	72	72	1.0	18	12	10	10	2.5	76	85	88	88	0.6
Japan	4	59	55	55	57	-0.1	15	17	17	16	-0.2	80	77	76	78	-0.1
Jordan	27	40	54	59	62	1.8	26	17	13	12	3.2	60	76	82	84	1.3
Kazakhstan	31	56	62	53	56	0.0	17	13	17	16	0.4	76	82	76	78	0.1

Table 7. Trends in contraceptive prevalence rate (CPR), unmet need for family planning (UNR), proportion of demand for contraception satisfied (PDS) among women aged 15-49, married or in union, 1990-2015

COUNTRIES AND AREAS	ABR PER 1,000 WOMEN AGED 15 TO 19	CPR					UNR					PDS				
	1999-2014	1990	2000	2010	2015	Annual rate of increase (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of reduction (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of increase, (per cent), 1990-2015
Kenya	101	28	39	49	57	2.8	37	28	24	19	2.7	44	58	67	76	2.2
Kiribati	49	29	33	24	28	-0.2	26	26	28	27	-0.1	52	56	47	51	-0.1
Korea, Democratic People's Republic of	1	62	68	70	70	0.5	14	12	11	11	1.2	81	86	87	87	0.3
Korea, Republic of	2	77	79	79	79	0.1	6	6	6	6	0.3	92	93	93	93	0.0
Kuwait	8	39	46	54	56	1.5	24	21	17	16	1.6	62	69	75	78	0.9
Kyrgyzstan	42	53	54	42	42	-0.9	14	14	17	17	-0.7	79	80	71	71	-0.4
Lao People's Democratic Republic	94	14	32	48	54	5.3	31	29	21	18	2.2	31	52	69	75	3.5
Latvia	15	67	68	68	68	0.1	12	12	12	12	0.3	84	85	85	85	0.1
Lebanon	18	63	63	62	63	0.0	13	13	14	13	0.1	83	83	82	83	0.0
Lesotho	94	21	33	50	60	4.3	34	32	23	18	2.5	37	51	68	77	2.9
Liberia	147	7	10	15	20	4.2	33	34	34	32	0.2	18	22	30	39	3.1
Libya	4	39	44	45	49	0.9	24	22	22	20	0.8	62	66	67	71	0.6
Lithuania	14	54	58	63	63	0.6	18	16	13	13	1.2	76	79	83	83	0.4
Luxembourg	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Madagascar	147	14	23	40	46	4.6	31	27	20	19	2.1	31	46	67	71	3.3
Malawi	143	12	30	46	58	6.4	36	31	26	19	2.5	25	49	64	75	4.4
Malaysia	13	52	53	55	57	0.4	18	17	16	15	0.6	74	75	77	79	0.2
Maldives	14	28	41	36	42	1.7	30	26	28	25	0.7	48	61	57	63	1.0
Mali	178	4	7	10	12	4.2	26	30	27	27	-0.2	14	19	26	31	3.1
Malta	16	84	83	82	81	-0.1	4	4	5	5	-0.8	96	95	95	94	-0.1
Martinique	20	48	54	59	60	0.9	21	18	16	15	1.3	69	75	78	80	0.6
Mauritania	71	3	8	11	14	5.7	30	32	31	31	-0.1	10	19	26	31	4.6
Mauritius	31	75	75	76	76	0.1	7	7	7	7	0.2	92	92	92	92	0.0
Mexico	84	59	71	72	73	0.8	20	12	11	11	2.6	75	86	87	87	0.6
Micronesia (Federated States of)	33	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Moldova, Republic of	25	68	67	64	63	-0.3	11	11	13	13	-0.7	86	86	84	83	-0.1
Mongolia	40	55	66	56	58	0.2	15	10	15	14	0.2	78	87	79	80	0.1
Montenegro	12	54	54	37	34	-1.8	16	16	23	24	-1.4	77	77	62	59	-1.0
Morocco	32	40	60	67	68	2.2	23	13	10	10	3.4	64	82	87	88	1.3
Mozambique	166	4	12	14	18	5.6	25	24	27	28	-0.3	15	33	34	39	3.9
Myanmar	17	16	36	46	52	4.7	25	22	19	16	1.8	39	62	71	76	2.7
Namibia	78	30	43	55	57	2.6	24	24	19	17	1.3	56	65	74	77	1.3
Nepal	87	18	33	48	52	4.2	34	31	27	24	1.4	35	51	64	69	2.7
Netherlands	5	75	68	67	68	-0.4	7	10	10	10	-1.5	92	87	87	87	-0.2
New Caledonia	23	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
New Zealand	22	71	73	72	71	0.0	9	9	9	9	0.1	88	90	89	89	0.0
Nicaragua	92	45	66	78	80	2.2	26	16	8	7	5.2	63	81	91	92	1.5
Niger	210	4	9	12	15	5.3	19	18	17	18	0.4	18	33	43	47	3.9
Nigeria	123	7	14	14	16	3.1	21	20	21	22	-0.1	26	41	40	42	2.0
Norway	6	74	79	80	79	0.2	8	6	6	6	1.2	90	93	93	93	0.1
Oman	12	13	32	32	37	4.2	34	31	32	28	0.7	28	51	50	57	2.8
Pakistan	48	12	27	32	39	4.7	30	28	23	20	1.6	28	49	59	65	3.3
Palestine	67	40	51	54	57	1.4	23	19	17	15	1.6	64	73	76	79	0.8
Panama	89	58	57	56	61	0.2	17	18	19	16	0.4	77	76	75	80	0.1
Papua New Guinea	65	25	29	35	37	1.5	29	28	26	25	0.6	47	51	57	60	1.0
Paraguay	63	49	65	78	77	1.9	18	12	6	6	4.2	73	85	93	92	1.0

COUNTRIES AND AREAS	ABR PER 1,000 WOMEN AGED 15 TO 19	CPR					UNR					PDS				
	1999-2014	1990	2000	2010	2015	Annual rate of increase (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of reduction (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of increase, (per cent), 1990-2015
Peru	68	55	68	75	74	1.1	23	15	7	9	3.7	71	82	92	89	0.9
Philippines	59	42	48	51	55	1.1	28	24	21	18	1.8	60	67	71	75	0.9
Poland	14	69	69	69	69	0.0	10	10	10	10	0.0	87	87	87	87	0.0
Portugal	12	74	76	77	77	0.2	8	7	6	7	0.7	90	92	92	92	0.1
Puerto Rico	45	75	79	79	78	0.2	7	6	6	6	0.8	91	93	93	93	0.1
Qatar	16	35	42	41	44	0.8	23	21	20	19	0.8	60	67	67	69	0.6
Reunion	43	72	70	72	72	0.0	9	10	9	9	0.2	89	87	89	89	0.0
Romania	36	60	66	69	69	0.6	13	10	9	10	1.3	82	87	88	88	0.3
Russian Federation	27	64	72	71	69	0.3	12	9	9	10	1.0	84	89	89	88	0.2
Rwanda	41	18	14	49	54	4.4	38	36	22	20	2.5	32	28	69	73	3.3
Saint Kitts and Nevis	75	47	53	58	59	1.0	22	19	17	16	1.4	68	74	78	79	0.6
Saint Lucia	50	48	53	55	57	0.7	22	19	18	17	1.0	69	73	76	77	0.5
Saint Vincent and the Grenadines	70	58	62	64	65	0.4	16	14	13	13	1.0	78	81	83	84	0.3
Samoa	39	23	25	29	32	1.3	42	44	47	42	0.0	35	36	38	43	0.8
San Marino	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	110	22	30	38	41	2.5	38	38	37	33	0.5	36	44	51	55	1.7
Saudi Arabia	7	27	29	32	37	1.2	27	27	26	24	0.5	50	51	55	60	0.8
Senegal	80	8	10	13	18	3.5	33	32	30	30	0.4	19	25	31	38	2.8
Serbia	22	60	62	59	58	-0.2	13	12	12	13	-0.1	82	84	82	81	0.0
Seychelles	62	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sierra Leone	131	3	5	11	17	7.0	27	28	28	26	0.2	10	15	28	39	5.6
Singapore	3	66	64	65	66	0.0	12	12	12	11	0.1	85	84	85	86	0.0
Slovakia	21	70	72	71	71	0.1	10	9	10	10	0.2	87	89	88	88	0.0
Slovenia	5	76	77	75	75	-0.1	8	7	8	8	-0.2	91	91	91	90	0.0
Solomon Islands	62	29	32	36	39	1.2	25	23	22	21	0.6	54	58	62	64	0.7
Somalia	123	4	9	18	24	6.7	30	31	30	29	0.1	13	23	37	44	5.0
South Africa	54	50	58	63	65	1.1	20	16	13	12	2.0	71	79	83	84	0.7
South Sudan	158	1	2	4	7	9.1	29	29	29	30	-0.1	2	6	12	19	8.4
Spain	9	67	71	67	67	0.0	13	11	13	12	0.1	84	87	84	85	0.0
Sri Lanka	24	65	70	71	72	0.4	11	9	7	7	1.5	86	89	91	91	0.2
Sudan	102	9	8	12	16	2.3	29	28	29	29	0.0	24	22	29	36	1.7
Suriname	66	43	44	49	52	0.8	24	24	21	19	0.9	64	65	70	73	0.5
Swaziland	89	22	31	62	64	4.4	35	33	17	15	3.4	38	48	79	81	3.0
Sweden	3	72	71	70	70	-0.1	9	10	10	10	-0.3	89	88	88	88	0.0
Switzerland	3	78	79	77	77	-0.1	6	5	6	6	-0.4	93	94	93	92	0.0
Syrian Arab Republic	75	37	47	55	58	1.8	24	21	17	15	1.9	60	70	77	79	1.1
Tajikistan	47	31	34	33	33	0.2	23	22	22	22	0.2	57	61	60	60	0.2
Tanzania, United Republic of	128	11	24	34	41	5.2	28	24	25	23	0.7	29	51	58	64	3.2
Thailand	60	70	77	79	79	0.5	9	6	5	6	2.0	88	92	94	93	0.2
The former Yugoslav Republic of Macedonia	19	51	50	47	49	-0.2	18	18	19	18	-0.1	74	73	71	73	-0.1
Timor-Leste, Democratic Republic of	54	22	13	24	29	1.1	19	20	29	26	-1.3	54	39	45	53	-0.1
Togo	77	26	22	18	21	-0.8	42	36	35	34	0.9	39	38	34	39	0.0
Tonga	30	27	30	33	35	1.0	30	29	29	28	0.3	47	50	53	56	0.7
Trinidad and Tobago	36	50	41	47	50	0.0	18	23	20	19	-0.2	73	65	70	72	0.0
Tunisia	7	53	64	63	64	0.8	16	11	11	11	1.7	77	85	85	86	0.5
Turkey	29	62	67	73	74	0.7	15	12	7	6	3.5	81	85	92	92	0.5

Table 7. Trends in contraceptive prevalence rate (CPR), unmet need for family planning (UNR), proportion of demand for contraception satisfied (PDS) among women aged 15-49, married or in union, 1990-2015

COUNTRIES AND AREAS	ABR PER 1,000 WOMEN AGED 15 TO 19	CPR					UNR					PDS				
	1999-2014	1990	2000	2010	2015	Annual rate of increase (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of reduction (per cent), 1990-2015	1990	2000	2010	2015	Annual rate of increase, (per cent), 1990-2015
Turkmenistan	21	53	59	55	57	0.3	17	14	16	15	0.5	76	81	78	79	0.2
Turks and Caicos Islands	29	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuvalu	42	25	28	31	34	1.2	30	30	29	28	0.4	45	48	52	55	0.8
Uganda	140	7	19	27	30	5.8	32	37	36	33	-0.1	18	34	43	47	3.9
Ukraine	27	67	68	66	67	0.0	11	11	10	10	0.4	86	87	87	87	0.1
United Arab Emirates	34	25	34	44	48	2.6	28	25	21	20	1.4	47	57	67	71	1.6
United Kingdom	21	76	79	82	81	0.3	7	6	5	5	1.4	91	93	95	94	0.1
United States of America	27	72	74	76	75	0.2	7	7	6	7	0.3	91	92	92	92	0.0
United States Virgin Islands	59	61	67	69	69	0.5	15	12	11	11	1.3	80	85	86	87	0.3
Uruguay	60	81	78	77	77	-0.2	6	7	8	8	-1.2	94	92	91	91	-0.1
Uzbekistan	26	53	66	67	67	0.9	15	10	10	10	1.9	78	87	87	88	0.5
Vanuatu	78	32	39	44	47	1.6	30	27	26	24	0.8	52	59	63	66	1.0
Venezuela (Bolivarian Republic of)	101	59	69	70	70	0.7	19	13	12	12	1.8	76	84	85	85	0.5
Viet Nam	36	58	74	78	77	1.1	16	8	6	7	3.7	78	90	93	92	0.7
Yemen	67	9	20	32	38	5.8	38	38	30	27	1.4	19	35	51	58	4.5
Zambia	145	15	30	44	51	5.0	30	28	24	20	1.6	33	52	65	72	3.1
Zimbabwe	120	45	55	60	66	1.6	21	17	14	11	2.5	68	76	81	85	0.9

Notes: – Data not available. The adolescent birth data in this statistical table includes national statistics and national estimates beyond survey data from DHS, MICS and Reproductive Health Survey.These numbers are used for the generation of regional aggregates in Chapter 2.

Data sources: United Nations Population Division and United Nations Inter-Agency and Expert Group on Millennium Development Goals Indicators.

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Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled

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The Global Goals
FOR SUSTAINABLE DEVELOPMENT

GOAL 3 GOOD HEALTH

ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

Target 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

GOAL 5 GENDER EQUALITY

ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS

Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

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