Causes of unmet need for contraception in the developing world (extended abstract)

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Note: This abstract is excerpted from a larger report on levels and reasons for unmet need which follows. The report is currently in draft form and follows this abstract.

Background and introduction

Unintended pregnancy is a serious reproductive health problem in the developing world, and is often the result of an unmet need for contraception. Women who do not want a child soon or at all, are sexually active, fecund and not using contraception are considered to have an unmet need. While national estimates of unmet need are available, little is known about the reasons why women with unmet need do not use family planning; why those who used a method in the past decided to discontinue use; or why those who intend to use a method are not yet doing so. Understanding why women who do not want to have a child soon do not use contraception is key to providing the appropriate services and education to help them attain their fertility goals and thereby enabling them to pursue their other life achievements.

The health benefits of helping women access and effectively use family planning are far reaching. There are also critical social and economic implications of increased access to contraceptive services, including improvements in women's education and employment, and women's increased participation in social and political domains—all necessary steps in achieving broader development goals.

The purpose of this report is to highlight and explain the key reasons why women with an unmet need are not using contraception, and how these reasons vary across settings and by women's socio-demographic characteristics. Policymakers, program leaders and funding agencies should be able to use the results from this research to most effectively direct limited resources for family planning programs to populations with the greatest need for such services. The findings will enable decision-makers to develop policies and programs that will reduce inequities in access to contraceptives, and that can respond to obstacles that women with an unmet need for family planning face to using contraception.

Data and methods

The findings in this report are based on data from the Demographic and Health Surveys (DHS). We use data from surveys administered to nationally representative samples of women between the ages of 15 and 49 in 50 countries in Asia, Africa, and the Latin America region between 1995 and 2005. The countries included in this report represent 71% of the population in these three regions excluding China.

Reasons for non-use of family planning

All married women and unmarried sexually active women who were not using a modern method of family planning and who had indicated that they did not want to have a child soon or at all were asked to indicate their reasons for non-use. Responses are categorized according to whether they related to a woman's perceived low risk of getting pregnant, her opposition to family planning or the opposition of someone close to her, and reasons that relate to family planning service provision, including cost, access and education regarding methods and counseling about side effects.

Intention to use contraception

We identify proportions of women with an unmet need who indicate a willingness or intent to use family planning in the future, and explore reasons for non-use of family planning in this subgroup of women with an unmet need. Information on women's intention to contraception is taken from the question "Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?"

Discontinuation of contraceptive use

The DHS collects these contraceptive histories in countries with relatively high levels of contraceptive use. In 17 countries, women were asked about their contraceptive use in the five years prior to the survey. Women who had discontinued use of a modern method of family planning were asked why they stopped contracepting. We examine the reasons for discontinuation among women who had an unmet need at the time of the survey.

Analytic approach

We present proportions and percent distributions to identify levels of and reasons for unmet need among married women and never married women at the national level. We present the proportions of women who cite each reason, from among the most commonly cited reasons, for non-use as well as the reasons for discontinuation of use. Additionally we look at reasons for non use among population sub-groups in each country, such as women in rural and urban residences and women with varying degrees of education and wealth. Lastly, we will include findings based on multivariate analyses to study factors associated with certain reasons for non use.

Preliminary Results

Women's reasons for not using family planning (Table 1 and 2)

Perceived low risk of pregnancy

Ten to 50% of married women with an unmet need cite infrequent sexual activity as a reason for not using a method of family planning across the countries represented. A substantial proportion of these women were sexually active within the three months preceding the survey. In Latin America and Caribbean, 45-82% of never-married women with an unmet need say that they do not use family planning because they do not have sex frequently. In Sub-Saharan Africa, at least one in five never-married women cited this reason. By definition, all unmarried women at risk of an unintended pregnancy in this report had sexual intercourse in the three months prior to the survey.

Significant proportions of married women in many countries believed they were not at risk of pregnancy because they were amenorrheic postpartum or because they were breastfeeding. This reason was more commonly cited in sub-Saharan Africa than in other regions, most likely in part because higher fertility rates result in a higher prevalence of these conditions at any point in time.

Opposition to use

Opposition to family planning can stem from a woman's own beliefs or the position of her partner or another person who holds sway on her contraceptive decision-making. Opposition to family planning was relatively prominent among married women with an unmet need in Armenia and Cambodia (22% of women opposed). In sub-Saharan Africa, it was highest in Chad, Nigeria and Mali (20-28%). Among never-married women with an unmet need opposition to family planning was a slightly less prominent reason for non use, with the exception of Haiti where 27% of never married women with unmet need gave this reason.

Method-related concerns

The most common set of reasons given by married women with an unmet need for not using contraception was the fear of side effects, health issues and inconvenience of use, which are considered together here as method-related reasons. These were cited by 10-50% of married women at risk of an unintended pregnancy in every country except Burkina Faso (9%).

Concerns about side effects, health issues or inconvenience were a major barrier to use among never-married women with an unmet need. About one fourth of eligible women cited these reasons in seven of the 17 African countries covered here. As many as 36% of never-married women with unmet need in Haiti stated that they were not using a method because they either feared health or side effects or found contraception too inconvenient to use.

Access to family planning

Ten percent or less of married women with an unmet need in Latin America, Caribbean and Asia found access to be a reason they did not use a method. In six Sub Saharan African countries, 11-19% of married women did not have access or a source to obtain contraceptives. Cost was not a major reason in any country except Burkina Faso.

Very few never-married women at risk for an unintended pregnancy in the Latin American and Caribbean countries covered here said that they were unaware of any methods to prevent pregnancy (0-3%). Cost and lack of access did not seem to be major reasons for non-use among these women, either. However, 10 to 17% of never-married women with unmet need in Dominican Republic, Nicaragua and Peru shared these concerns.

In Sub-Saharan Africa, relatively large proportions of never-married women with an unmet need in Benin, Cameroon and Nigeria indicated they were not aware of a way to avoid pregnancy (10-21%). Cost was not a significant factor preventing never-married women from using a method in most of Sub-Saharan Africa, but in Benin and Mozambique, 22% and 26% of respondents respectively were not using a method because they lacked access to family planning

Married women with an unmet need who used family planning in the past (Table 3)

Women were asked their primary reason for discontinuing method use. Among married women with an unmet need for family planning, the most prevalent reasons given were issues regarding side or health effects, the dissolution of a relationship or infrequent sex, and the desire to become pregnant at the time.

About one fourth to one half of women discontinued using a method because they experienced or feared side and health effects, with the exception of Armenia (16%).

Marital dissolution and infrequent sex were cited infrequently as reasons for discontinuation in the sub-Saharan countries surveyed, but were cited by 9-29% of women in most countries outside this region. Exceptions include Morocco (42%) and Armenia (46%), where these reasons were cited more frequently than any other.

Generally fewer than 10% of women cite limited access to services or supplies as a reason for non use but in Zimbabwe 23% of women cited one of these reasons.

Married women who intend to use a method in the future (Table 4)

A significant proportion of women with an unmet need indicated that they intend to use or might use a method in the future. These women are conceivably more amenable to becoming contraceptive users when their stated reasons for current non-use are overcome. More than half of women with unmet need expressed a willingness or intention to use family planning in all countries except Chad, where only 43% of women expect to contracept in the future. Intention to use a method was particularly high in Colombia, the Dominican Republic, Peru, Bangladesh, Nepal, Burkina Faso, Malawi, Uganda and Zimbabwe, where at least 80% of women with an unmet need indicated that they might use a method in the future.

Among the women who intend to use contraception, reasons for current non-use are fairly similar to the reasons for non-use in all women with an unmet need. The most commonly cited reasons were infrequent sex, fear of health and side effects or reasons relating to breastfeeding or lactational amenorrhea.

Conclusion

Policymakers, program leaders and funding agencies rely on estimates of levels of unmet need for contraceptive services to make the case for policy and program interventions. To reduce inequities in access to contraceptives, it is also critical to determine why women who do not want children soon or at all are not using contraceptives. Clearly, the provision of contraceptive supplies is not sufficient to help many women meet their demand for family planning. Family planning programs should include counseling that informs women about side effects of methods, helps women select methods that suit their needs, and enables women to switch methods when side effects associated with a particular method are unacceptable. It also appears that many women would benefit from, first and foremost, the information with which to accurately assess their risk of conceiving a pregnancy. The findings in this paper can inform policies and the allocation of limited resources to most effectively meeting women's needs.

Table 1: Among married women with an unmet need for contraception, reasons for not currently using a method.

Region/Country	% of married women with an unmet need	n	Infrequent/ no sex	Postpartum amenorrhea/ breastfeeding	Subfecund*	Respondent/religion opposed	Partner/ others opposed	Unaware of methods	cost too high	Knows no source/ no access	Side effects/ health fears / inconvenience	Other	DK
Latin America & Caribbean													
Bolivia	23	1791	26	15	2	6	6	12	4	7	24	12	8
Colombia	6	776	34	10	3	2	3	0	9	1	21	18	3
Dominican Republic	11	1031	25	13	5	17	2	1	3	3	26	9	5
Haiti	40	1735	14	9	2	15	3	1	3	4	43	5	4
Nicaragua	15	765	25	7	4	18	7	2	2	6	30	14	3
Peru	10	1182	29	16	6	8	8	7	1	5	32	6	1
North Africa/West Asia/Europe													
Armenia	12	418	47	1	12	22	9	1	3	1	13	3	3
Egypt	10	579	34	11	10	5	5	0	1	1	34	6	1
Morocco	10	735	52	5	10	6	1	0	1	1	26	6	2
South & Southeast Asia													
Bangladesh	11	970	32	17	1	8	6	0	1	3	19	25	0
Cambodia	27	1488	15	9	1	22	1	5	4	7	50	6	4
Indonesia	9	1860	14	12	4	4	5	1	8	2	40	20	4
Nepal	28	1911	35	27	1	4	11	1	1	10	37	5	NA
Philippines	17	1158	16	9	3	18	7	1	8	2	41	12	0
Sub Saharan Africa													
Benin	27	892	36	12	3	11	6	12	5	15	15	6	3
Burkina Faso	29	2180	28	13	1	5	11	5	12	19	9	5	8
Cameroon	20	913	31	15	5	8	5	12	4	8	13	13	6
Chad	21	457	14	9	1	28	4	15	3	9	17	6	4
Gabon	28	917	14	8	1	11	5	5	5	3	12	9	4
Ghana	34	942	22	20	3	4	3	7	8	8	34	7	4
Kenya	25	935	16	31	2	11	11	2	3	6	36	5	2
Lesotho	31	948	21	0	5	8	9	2	5	4	31	5	4
Malawi	30	2047	21	28	3	15	12	1	2	4	32	1	1
Mali	29	2138	10	12	1	20	10	10	4	11	21	7	6
Mozambique	18	1199	39	23	4	9	8	4	3	13	15	8	2
Namibia	22	395	13	14	7	14	10	6	3	4	24	10	8
Nigeria	17	631	19	18	2	24	7	9	3	9	13	7	5
Rwanda	36	1279	14	25	2	9	8	5	4	12	21	7	3
Tanzania	22	1197	24	3	0	14	11	2	1	8	32	8	1
Uganda	35	1162	15	18	6	5	14	5	7	13	25	7	3
Zambia	27	848	30	26	11	4	6	1	1	7	18	9	2
Zimbabwe	13	315	27	7	7	13	9	0	9	4	20	9	2

*May include self-reported infecundity, menopause, or hysterectomy.
Note: Some women may have chosen more than one reason

Table 2: Among never married women with an unmet need for contraception, reasons for not currently using a method.

Region/Country	% of never married women with an unmet need	n	Infrequent/ no sex	Not married	Subfecund*	Religious reasons/ personally opposed	Partner/ others opposed	Knows no method	Cost too high	No source/ no access	Side effects/ health fears/ inconvenience	Other	DK
Latin America & Caribbean													
Bolivia	6	267	57	37	2	2	0	2	1	4	6	6	8
Colombia	6	754	82	6	1	1	0	0	1	1	6	6	2
Dominican Republic	4	185	49	32	5	10	1	0	2	0	11	7	3
Haiti	10	234	36	11	0	27	2	2	0	4	36	2	10
Nicaragua	2	66	45	29	10	15	2	0	0	0	17	15	0
Peru	3	259	61	30	5	3	0	3	0	3	10	4	0
Sub Saharan Africa													
Benin	18	132	26	8	2	17	4	16	2	26	22	1	5
Burkina Faso	8	58	24	22	1	13	14	1	3	9	14	1	8
Cameroon	6	74	34	12	7	4	2	10	1	6	17	16	9
Gabon	15	298	20	2	0	6	1	4	6	5	7	8	5
Ghana	12	70	24	36	2	5	0	5	2	2	26	4	13
Kenya	7	80	64	na	6	4	5	3	1	1	24	1	8
Lesotho	8	122	20	27	2	7	3	8	5	6	21	3	12
Malawi	12	129	17	67	6	5	1	3	2	0	11	0	4
Mali	15	46	27	23	9	17	3	4	0	2	5	3	12
Mozambique	15	149	34	31	3	5	6	5	3	22	5	7	4
Namibia	11	234	20	na	15	15	7	7	5	3	22	10	8
Nigeria	11	26	7	14	9	11	0	21	3	4	26	8	5
Rwanda	2	34	51	27	7	1	4	4	3	5	0	6	7
Tanzania	11	104	49	25	0	12	1	3	1	2	22	7	0
Uganda	8	53	47	na	10	0	1	4	7	9	24	8	2
Zambia	12	72	42	33	9	1	7	3	0	5	8	7	7
Zimbabwe	4	45	44	26	12	3	0	2	6	5	7	1	2

*Includes self-reported infecundity, subfecundity, postpartum amenorrhea, breastfeeding and menopause

Table 3: Among married women with an unmet need who discontinued use in past 5 years, reasons for discontinuing use of a method, by region and country.

Region/Country	% who discontinued a method	% of women discontinuing a traditional method	% of women discontinuing a modern method	N	Reasons for discontinuing use: Wanted to get pregnant	Fatalistic	Method failed/ got pregnant	Subfecund*	Marital dissolution/ infrequent sex	Partner opposed	Health/ side effects	Inconvenient to use	Access/ availability	Cost	Other	DK
Latin America & Caribbean																
Brazil	63	10	90	328	8	1	6	3	10	4	39	7	2	4	16	0
Colombia	72	21	79	825	6	1	8	2	18	3	32	12	3	7	7	1
Dominican Republic	63	13	87	907	11	2	6	0	15	2	42	6	5	2	8	1
Guatemala	18	14	86	162	17	0	10	1	10	6	38	8	3	1	7	0
Peru	55	27	73	813	6	1	10	1	21	3	42	6	5	1	4	0
North Africa/West Asia/Europe																
Armenia	71	70	30	338	4	1	12	3	46	6	16	5	1	0	7	0
Egypt	68	3	97	551	8	0	3	1	26	3	52	6	1	0	1	0
Jordan	60	37	63	380	18	0	8	1	17	4	35	12	0	0	5	0
Morocco	65	20	80	532	14	0	6	2	42	0	25	1	0	0	8	0
Turkey	53	41	59	275	18	0	10	5	24	3	24	2	0	0	13	1
South & Southeast Asia																
Bangladesh	59	10	90	698	12	0	5	1	29	3	36	2	3	0	9	0
Indonesia	49	2	98	1106	20	3	4	0	9	1	38	5	3	5	14	0
Philippines	34	30	70	473	15	1	12	1	13	3	39	5	3	2	6	0
Vietnam	59	19	81	152	24	0	7	5	21	1	28	5	2	0	8	0
Sub Saharan Africa																
Kenya	33	14	87	391	14	0	7	1	5	10	44	4	6	4	6	0
Tanzania	30	15	85	448	24	0	5	0	8	5	40	5	9	1	4	0
Zimbabwe	63	7	93	276	18	1	2	0	4	6	34	3	11	12	8	0

Total # countries: 17

Table 4: Among married women with unmet need, percent who intend to use a method in the future, by region and country, and distribution by reasons not currently using a method.

Region/Country	% intend to use	n	Infrequent/ no sex	Postpartum amenorrhea/ breastfeeding	Subfecund*	Respondent/ religion opposed	Partner/ others opposed	Unaware of methods	cost too high	Knows no source/ no access	Side effects/ health fears / inconvenience	Other	DK
Latin America & Caribbean													
Bolivia	77	1307	26	19	1	3	5	11	4	8	21	13	9
Colombia	91	681	36	11	3	1	2	0	10	1	17	18	3
Dominican Republic	86	856	27	15	5	14	2	1	3	3	22	9	5
Haiti	72	1163	17	27	2	9	3	1	3	6	33	5	6
Nicaragua	79	567	27	9	4	13	6	2	2	7	30	15	3
Peru	80	892	29	20	3	5	8	7	1	5	32	7	1
North Africa/West Asia/Europe													
Armenia	74	302	55	1	8	20	10	1	2	1	10	2	4
Egypt	78	423	41	15	5	2	5	0	1	1	28	7	1
Morocco	64	422	63	8	3	4	1	0	1	1	20	6	1
South & Southeast Asia													
Bangladesh	89	848	31	20	1	5	5	0	1	3	18	25	1
Cambodia	69	1019	13	12	1	22	0	6	5	7	48	6	5
Indonesia	67	1155	14	17	2	2	3	1	6	2	34	23	4
Nepal	84	1578	38	31	1	2	11	1	1	10	31	3	NA
Philippines	59	611	19	15	2	12	6	1	8	3	33	14	0
Sub Saharan Africa													
Benin	74	660	34	15	1	7	7	14	5	17	13	7	3
Burkina Faso	82	1776	26	14	1	4	11	4	15	19	7	5	9
Cameroon	69	614	35	17	2	5	3	15	5	11	9	12	6
Chad	43	165	24	9	0	15	4	5	7	5	17	11	7
Gabon	65	592	15	1	1	7	5	5	7	3	9	8	4
Ghana	70	631	23	26	1	3	4	7	8	8	24	10	4
Kenya	78	711	16	38	1	6	9	2	3	7	32	6	2
Lesotho	72	656	23	0	3	7	9	2	6	4	27	2	5
Malawi	85	1696	21	29	2	14	12	1	2	5	30	1	2
Mali	66	1401	9	13	1	14	10	10	5	13	19	9	7
Mozambique	70	829	44	28	2	6	8	4	3	15	11	8	2
Namibia	75	283	13	17	5	12	9	4	3	5	24	11	10
Nigeria	54	334	20	20	1	15	6	12	3	11	12	12	5
Rwanda	69	836	11	31	1	4	9	6	5	14	17	7	3
Tanzania	74	860	27	3	1	10	10	2	2	9	26	10	1
Uganda	84	952	14	21	4	4	14	5	9	14	22	8	3
Zambia	85	699	30	30	5	3	6	2	1	8	17	10	2
Zimbabwe	79	229	29	10	4	10	8	0	10	6	21	9	2

Total # countries: 30

* includes some women who may be infecund, menopausal or had a hysterectomy

Variations in Levels of and Reasons for Unmet Need for Family Planning in Developing Countries

DRAFT – NOT FOR DISSEMINATION

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Note: This submission is a rough draft of a larger report on unmet for family planning. The section on reasons for non-use among women with unmet need (part 3 of results) will form the basis of a manuscript for a peer-reviewed journal article and the PAA presentation, and will include findings based multivariate analyses. The tables are excluded at this point to conserve space.

Background

Evidence regarding unmet need has helped justify investments in family planning programs internationally for decades.

By the time of the International Conference of Population and Development (ICPD) in 1994, unmet need also served to mediate between the concerns of governments and social scientists focused primarily on controlling population growth and those of public health professionals and human right activists who advocated for a focus on women's health and rights. Research indicating that fulfilling unmet need would result in contraceptive prevalence rates that exceeded the targets set by many countries has supported the argument that helping women achieve their own goals will also relieve population pressures, without any need for coercive policies that had marred some countries' early population programs.

Over the decades, researchers have honed the measurement of this phenomenon, drawing on advances in the conceptualization of unmet need, survey methodology and analytic tools. For the most part, the international community has now settled on a measure of unmet need initially developed by Princeton University demographer Charles Westoff. This measure draws upon data collected through large-scale, nationally representative surveys of women, the Demographic and Health Surveys (DHS), which are conducted periodically in countries across the developing world. The standardized measure has been included as part of the reports produced for each country since the late 1980s. A second measure—unmet need for a modern contraceptive method, which assumes that women using traditional methods are not sufficiently protected – can also be derived from these data.

The measure of unmet need, which already had a role in supporting the goals of the ICPD, has become increasingly salient in the context of the United Nations Millennium Development Goals (UN MDGs). The MDGs, conceived at the UN Millennium Summit in 2000, builds on the broad development objectives that were advanced at the ICPD in 1994. The goals are comprised of eight broad agenda items relating to such topics as education, gender equality and health. At the World Summit in 2005, the importance of reproductive health to the realization of the MDGs was affirmed.

The benefits of helping women access and effectively use family planning include prevention of medical conditions associated with unwanted and high-risk pregnancies and births. There are also critical social and economic implications of increased access to contraceptive services, including improvements in women's education and employment, and women's increased participation in social and political domains—all necessary steps in achieving broader development goals.

The aim of this report is to provide donor agencies, policymakers and program administrators the evidence needed to determine how to direct limited resources toward meeting women's needs for family planning in the developing world.

To design appropriate programs, decision makers need estimates of the levels of and distribution of unmet need for family planning; they also need a better understanding of women's reasons for

non-use and for discontinuation of use, and of how these reasons vary among subgroups of women. The specific objectives of this report are to:

- Synthesize the literature addressing unmet need for contraception and reasons for unmet need.
- Provide current estimates of the level of unmet need, both nationally and for key population subgroups, and identify groups with disproportionate unmet need.
- Analyze the reasons that women who do not wish to become pregnant either forgo contraceptive use or stop using a method, nationally and among key subgroups.

Data and methodology

Data source

The findings in this report are based on data from the Demographic and Health Surveys (DHS), which are designed to collect and disseminate information on fertility, family planning and other key health issues in developing countries. The surveys use a standardized questionnaire that has been developed and refined over several years. We use data from surveys administered to nationally representative samples of women between the ages of 15 and 49 in 50 countries in Asia, Africa, and the Latin America region between 1995 and 2005. The surveys included in this report are listed in Table 3.1. The number of respondents in each survey ranges from 3,848 in the Kyrgyz Republic to 90,303 women in India. The countries included in this report represent 71% of the population in these three regions excluding China (*will confirm*).

Because the definition of unmet need is constructed a bit differently for married and unmarried women, and because circumstances surrounding unmet need might differ for these two groups, we study married and never-married women separately in this report. Of the 50 surveys included in these analyses, eight were administered to ever-married women only. Of the 42 surveys that included never-married women, ten did not ask them about their fertility preferences. Thus we are able to examine the unmet need of never-married women in 32 countries in this report.

Key variables

<u>Measure of unmet need</u>

We initially employed three definitions of unmet need for married women: the first of these ascertains the family planning needs of women with lactation amenorrhea according to their fertility intentions. This definition also uses the assumption that women using traditional family planning have an unmet need. The second definition corresponds more closely with the standard DHS definition in that women with lactational amenorrhea women who report that their last pregnancy was unintended are assumed to have an unmet need because they presumably will have an unmet need upon resumption of fecundity. Unlike the standard DHS definition, however, women using traditional methods are assumed to have an unmet need for effective family planning. The third definition employed here represents the standard DHS definition. The wantedness of the most recent pregnancy is used to determine the need of amenorrheic women, and users of traditional methods are considered to have their demand satisfied. This definition is used throughout the subsequent sections of the report.

Similar measures were employed to determine unmet need among never-married women who were sexually active, with the added qualification that only never-women who had had sexual intercourse in the three months prior to the survey were assumed to be sexually active. Women who were not active sexually were assumed not to be at risk and an unwanted pregnancy.

<u>Reasons for non-use of family planning</u>

All married women who were not using a modern method of family planning and who had indicated that they did not want to have a child soon or at all were asked to indicate their reasons for non-use. Unmarried, sexually active women who were not using modern family planning were also asked about their reasons for non-use. Responses are categorized according to whether they related to a woman's perceived low risk of getting pregnant, her opposition to family planning or the opposition of someone close to her, and reasons that relate to family planning service provision, including cost, access and education regarding methods and counseling about side effects.

In earlier surveys, the DHS questionnaire allowed women to indicate only one reason for non-use of family planning. In recognition of the fact that women might face a number of obstacles to contraceptive use, more recent surveys allow women to give multiple reasons for non-use. We examine reasons for non-use in the 30 countries whose surveys allow women to provide more than one reason multiple reasons for not using family planning.

<u>Intention to use contraception</u>

We identify proportions of women with an unmet need who indicate a willingness or intent to use family planning in the future, and explore reasons for non-use of family planning in this subgroup of women with an unmet need. Information on women's intention to contraception is taken from the question "Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?"

<u>Discontinuation of contraceptive use</u>

The DHS collects these contraceptive histories in countries with relatively high levels of contraceptive use. In 17 countries, women were asked about their contraceptive use in the five years prior to the survey. Women who had discontinued use of a modern method of family planning were asked why they stopped contracepting. We examine the reasons for discontinuation among women who had an unmet need at the time of the survey.

<u>Socio-demographic characteristics</u>

We examine the levels of unmet need among socio-demographic subgroups in the countries in this study, with a view toward identifying populations with the greatest levels of unmet need. We also explore reasons for non-use of family planning in these subgroups. Variables used in this exploration include women's age, parity, region of residence, education and wealth status.

In most countries we look at unmet need among women with fewer than seven years of schooling and women with seven or more years of schooling. In Armenia, Kazakhstan, the Kyrgyz Republic and Uzbekistan we instead look at women who have completed secondary school and those who haven't, because the average level of educational attainment is relatively high these Western and Central Asian countries. (S*kip this b/c it's in the footnote to Table 4.1?*)

The household wealth index variable that is used in these analyses draws from extensive information that is collected by the DHS on women's household assets, including various

household possessions and construction of the home.[1] The wealth index was constructed by applying a factor analysis to this information. Respondents are classified here as poor if they fall into the lowest one third of the sample distribution with respect to wealth.

Analytic approach

We rely largely on proportions and percent distributions to identify levels of and reasons for unmet need among women at the national level and among population sub-groups in each country. We present the percent of women with unmet need for family planning in each country and percent distributions of these women according to whether they wish to delay or space births or whether they wish to stop childbearing. We also present proportions of women with an unmet need in numerous population subgroups, defined by socio-demographic characteristics, in each country, and the proportions who cite each reason, from among the most commonly cited reasons, for non-use.

Results

1. Characteristics of women in the surveys

Characteristics of married women in the surveys (Table 4.1)

The characteristics of married women in the surveys are presented in Table 4.1. Populations were slightly older on average in Asian, Latin America, Caribbean and North African countries than in sub-Saharan Africa. Parity also tended to be higher among the married women in sub-Saharan Africa than in other regions. In most sub-Saharan countries, more than three fourths of women had at least 2 children. Parity seems to be lowest in Kazakhstan, where nearly half of women were nulliparous or had one live birth.

The majority of women in most of the countries surveyed live in rural areas. Only in a few countries are populations at least 60% urban: Bolivia, Brazil, Colombia, Dominican Republic, Jordan, Gabon and South Africa. By definition, poor women are those in the lowest one third of the sample distribution in each country.

Most women in the countries covered here have fewer than seven years of schooling. In many sub-Saharan African countries, more than 90% of women have fewer than seven years of schooling. Only in Armenia and the Central Asian countries of Kazakhstan, Kyrgyz Republic and Uzbekistan does the proportion of women who have completed secondary school approach 90%.

Contraceptive use, fertility and wanted fertility among married women (Table 4.1 & 4.2)

Many women have used either a modern or traditional method of family planning at some point in their lives. In most countries, at least half of women have ever used a method of contraception. Ever-use of family planning was lowest in Chad, at 8%. Outside of sub-Saharan Africa, ever-use was lowest in Cambodia at 37%. Ever use was particularly high in Brazil, Colombia, Peru, Morocco and Vietnam, where it ranged from 90-96%.

Current use of family planning varies by region and country. Most married women in Asia, Latin America and the Caribbean and North Africa currently use some method of contraception. However, most women in sub-Saharan Africa do not. Current use is particularly low the Central African Republic, Cote d'Ivoire, Guinea, Mali, Mauritania, and Niger where fewer than 10% were using any method at the time of the survey.

Total fertility rates vary considerably by region (Table 4.2). The TFR is at least 4.0 throughout sub-Saharan Africa, with the exception of South Africa. It is highest in Niger, Uganda and Mali where TFRs are 7.2, 6.9 and 6.8, respectively. Fertility in other regions is generally substantially lower. In the Latin America region the TFR ranges from 2.4 (Colombia) to 5.0 (Guatemala), and in South and Southeast Asia it ranges from 1.9 (Vietnam) to 4.1 (Nepal). Women would have an average of two or fewer children in Kazakhstan, Armenia and Vietnam if current fertility rates prevailed throughout their reproductive lives.

Wanted total fertility rates are consistently lower than total fertility rates. Women in nine countries want fewer than two children, and the wanted fertility rates are lowest in Colombia, Vietnam and Armenia at 1.7, 1.6 and 1.5, respectively. The highest wanted total fertility rate is in Niger, where women want seven children each on average. The gap between the wanted and actual fertility rates is greatest in Haiti, Nepal and Uganda, where women would have on average nearly 2 more children each than they wish to have at current fertility rates.

The percent of recent births that were unplanned ranged from 4% in Uzbekistan to 62% in Bolivia. More than half of recent births were unintended in four countries in Latin America and the Caribbean (Bolivia, Colombia, Haiti and Peru). The majority of births in South Africa were also unintended.

Characteristics of never-married women in the surveys (Table 4.7)

Surveys in 32 countries – seven in the Latin America region, 24 in sub-Saharan Africa, and one in Central Asia – included never-married women. The socio-demographic characteristics of never-married women in the surveys are shown in **Table 4.7**. Not surprisingly, the vast majority of never-married women in all countries were under 25. In a few countries—Colombia, Namibia and South Africa—about a third of never-married women were between the ages of 25 and 49.

Most never-married women had not given birth yet, but never-married women in sub-Saharan Africa were more likely to have started childbearing than those in Latin America and the Caribbean. Between one quarter and one third of women had at least one child in CAR, Cote d'Ivoire, Ethiopia, Madagascar, and Mozambique. Nearly half of never-married women in Namibia and South Africa had given birth.

The majority of never-married women in Latin American and Caribbean countries surveyed live in urban areas. There is greater variation in geographic distribution in sub-Saharan Africa, with anywhere from 23% (Malawi and Rwanda) to 86% (Gabon) of never-married women living in urban areas

Unlike married women, most never-married women in Latin America and the Caribbean have at least seven years of education, with the exception of Haiti. Education levels are quite low in Chad, Rwanda and CAR, where only 15-17% of never-married women have had at least seven years of schooling. In contrast, in Kenya, Namibia, South Africa and Zimbabwe, more than three fourths never-married of women had at least seven years of schooling. In Kazakhstan in Central Asia, achievement of a secondary school education was universal among never-married women.

Family planning use is considerably lower among never-married women than among married women. Ever use is highest in Cote d'Ivoire, Gabon, Namibia and South Africa where 51-65% of never-married women have used a method at some point in their lives. Only 3% of women in Chad, Ethiopia and Rwanda have ever used a method. Current use of contraception is low in all countries. Fewer than one third of never-married women currently use a method in all countries except Gabon, Namibia and South Africa.

2. Levels of unmet need for contraception

Levels of unmet need for family planning among married women (Table 4.3 & Figure 1)

As noted earlier, researchers and program planners have paid considerable attention to the definition of unmet need. The first column of Table 4.3 presents the percent of women with an unmet need for a modern method of family planning, using a definition that ascertains the need status of women with lactational amenorrhea according to their fertility intentions. According to this definition, the percent of women with an unmet need ranges from 20% in Brazil, Colombia and the Dominican Republic to 71% in Rwanda.

The second and third columns of Table 4.3 are based on the standard DHS measure of unmet need. The second column presents levels of unmet need for a modern method of family planning. Among married women in all countries, the prevalence of unmeet that is determined according to amenorrheic women's fertility intentions is higher than the prevalence of unmet need that is based on the status of women's most recent pregnancies. In Indonesia, Chad and Niger, the former estimate of the unmet need is more than twice the latter estimate.

The third column presents proportions of women with an unmet need for any method; women using a traditional method are assumed to have their unmet need satisfied according to this definition. According the DHS definitions 9-14% of married women in Central and Western Asia and North Africa have an unmet need for any method of contraception. Levels in Latin America and the Caribbean range from 6-7% in Brazil and Colombia to 40% in Haiti. Unmet need in South and Southeast Asia ranges from 5% in Vietnam to 28% in Nepal. Unmet need levels exceed 20% in most of sub-Saharan Africa.

Unmet need for a modern method is similar to unmet need for any method in countries where use of traditional methods is low. In many countries, however, unmet need for family planning is substantially higher when women using traditional methods are considered to have an unmet need. Notable differentials are seen in Bolivia and Turkey with a 26 percentage point difference between levels of unmet need for a modern method and for any method, and especially in Armenia where 12% have an unmet need for any method but 52% have an unmet need for a modern method.

When proportions of women with unmet need are linked to DHS & UN estimates of the population of women aged 15-49 in each country, it is estimated that about 24% of women in sub-Saharan Africa are at risk of unwanted pregnancy, as are 14% of women in South and Southeast Asia. Unmet need is lower on average in Central Asia (12), North Africa and West Asia (10%) and the Latin America region (9%).

In absolute numbers, almost 98 million married women are at risk of an unwanted pregnancy in the 50 countries in this report. Women in India carry by far the largest share of the world's unmet need, and 40 million women in that country alone are at risk of an unintended pregnancy. Although no country approaches India in this respect, other countries with large numbers of

married women living with an unmet need include Brazil, Bangladesh, the Philippines, Ethiopia and Nigeria, with 3.3-5.3 million women living with an unmet need in each country.

Married women with an unmet need for spacing vs. limiting births (Table 4.4)

Women with unmet need can fall under two categories: those who wish to delay or space their births and those who wish to have no more children. In most countries in Asia, Latin America and the Caribbean and North Africa, similar proportions of women with unmet need want to space or delay their births and to stop having children, or slightly higher proportions of women want to limit their births. In Bolivia and Armenia many more women with unmet need want to limit their births than delay them—73-78% of them wish to limit and 22-27% wish to space or delay births. In Latin America and the Caribbean, only Dominican Republic has a greater proportion of women with unmet need who want to delay or space their births than to not have a child later.

In most of the countries surveyed in Sub-Saharan Africa, women with unmet need are more likely to wish to have a have a child sometime in the future than to want to stop childbearing entirely. In Chad and Niger, 84-89% of women with unmet need wanted to space or delay their births, while only 11-16% did not want to have any or more children. The only two countries in the region in which slightly higher proportions of women with unmet need wanted to limit their childbearing rather than delay it were Namibia and South Africa.

Unmet need for family planning in socio-demographic subgroups of married women (Tables 4.5 and 4.6)

Levels of unmet need are highest in younger women and decline with age in most countries outside of sub-Saharan Africa (Table 4.5). In many sub-Saharan African countries, levels of unmet need are roughly similar across age groups. In a few countries in this region (Cameroon, Gabon, Mozambique, Zambia, Zimbabwe), unmet need is slightly higher among women over 35 than in younger age groups.

In many countries, women who have had more than three live births tend to have higher levels of unmet need than women who are nulliparous or who have had one to three live births. Exceptions include the Dominican Republic and India, where women with no children have higher levels of unmet need than women who have started childbearing.

Urban and rural women experience unmet need for family planning fairly equally in about half of the countries in this report, and unmet need is higher among rural women in most other countries. In the Central African Republic, Chad, Mauritania, and Niger, unmet need is greater among urban women than rural women.

Unmet need is often higher among married women with relatively little schooling compared to more educated women. In the Central African Republic and Chad, however, women with more than seven years of schooling were more likely to have an unmet need than women with little or no education.

Unmet need is seen more often in poor women in than in nonpoor women in 19 countries. Some of the largest differentials in unmet need by economic status are in Latin America and the Caribbean and South and Southeast Asia, and especially in Bolivia, Guatemala and Cambodia. In most sub-Saharan African countries, levels of unmet need are fairly equal across wealth. In Benin, the Central African Republic and Guinea, non-poor women are have higher levels of unmet need than poor women. The pattern in Gabon, Ghana, Kenya, Namibia, South Africa and Zimbabwe more closely resembles other parts of the world, with poor women more likely than non-poor women to have an unmet need than non poor women.

Levels of unmet need are disaggregated by region of residence and educational level simultaneously in Table 4.6. For the most part, the distribution of unmet need by educational status is similar in urban areas as it is the countries as the whole, in that women with little or no education are more likely to have an unmet need than educated women. In rural areas, it appears that in Ethiopia educated women are more likely than uneducated women to have an unmet need

When levels of unmet need are simultaneously disaggregated by region of residence and poverty status, patterns in urban and rural areas reflect patterns in the countries overall. Exceptions include Cote d'Ivoire, Rwanda and Senegal, where the level of unmet need is similar across poverty status in the country as a whole, but in urban areas poor women clearly carry the larger burden with respect to unmet need, and in Ethiopia, where the burden of unmet need falls entirely on the non-poor.

Levels of unmet need for family planning among never-married women (Table 4.8)

The impact of the definition of unmet need on the findings is strikingly different for never-married women compared to married women. Among never-married women, the definition that relies on amenorrheic women's future fertility intentions tends to yield lower estimated levels of unmet need than the definition that relies on amenorrheic women's fertility intentions at the time of their most recent conception. It seems that, whereas their most recent births were admittedly unintended, some of these women do intend to continue expanding the families they have started.

The second and third columns of Table 4.8 present the use the present the standard DHS measures of unmet need for a modern method and unmet for any method of family planning, respectively. In some countries (Peru, Cameroon, Cote d'Ivoire Gabo, Togo) unmet need for a modern method is more than double the level of unmet need for a modern or traditional method, suggesting that reliance on traditional methods is high among never-married women in these countries.

Levels on unmet need for any method in Sub-Saharan Africa range from only 1-2% of never-married women in Ethiopia and Rwanda to 15-18% in Benin, Gabon, Mali and Mozambique. In Kazakhstan, the only country in Central Asia with information on fertility preferences of never-married women, 7% of never-married women have an unmet need for a modern method of contraception and 5% have unmet need for any method.

In Latin America, the largest number of women with an unmet need is in Brazil (682,000). In sub-Saharan Africa, 758,000 never-married women are at risk of an unintended pregnancy in

Nigeria and 602,000 are at risk of an unintended pregnancy in South Africa. Survey estimates of the level of unmet need are not available for the North Africa region or South and Southeast Asia, including India. Altogether, 4.1 million never-married women are at risk of an unwanted pregnancy in the 32 sub-Saharan African, Latin American and Caribbean countries represented here.

Unmet need for spacing vs. limiting births, never-married women (Table 4.9)

The vast majority of never-married women who want to avoid pregnancy but are not using a method would like to have a child later in their lifetimes. In Kazakhstan, 92% of women who have an unmet need for any method of family planning would like to space or delay their births and the remaining 8% would like to limit their births. In Latin America and Caribbean, only 63% of women with an unmet need in Nicaragua would like to have another child later, compared to 94% in Haiti.

At least 90% of never-married women who have an unmet need for family planning want to have another child eventually in many sub-Saharan African countries. In South Africa and Namibia, however, substantial proportions of never-women with unmet need want to limit their births (42-43%).

Unmet need for family planning in socio-demographic subgroups of never-married women (Table 4.10)

Levels of unmet need are relatively similar across age groups of never-married women in Latin America and the Caribbean and most Sub-Saharan countries. In Benin, Cote d'Ivoire and Gabon, there is a substantially higher level of unmet need among women 35 and older than in younger women. In most countries, unmet need is higher among never-married women who have already given birth than among those who are still nulliparous.

Urban and rural never-married women experience unmet need for family planning fairly equally in most countries. In Benin and the Central African Republic, the level of unmet need among never-married women is modestly higher in urban areas than in rural areas and in Cote d'Ivoire, Gabon and Togo the differential leans slightly toward women in rural areas.

In all the Latin American and Caribbean countries represented in the report, the level of unmet need was similar among never-married women with less than years of schooling and those with at least seven years schooling. The same was true for most Sub-Saharan countries with exceptions in Cote d'Ivoire, Mozambique and Togo, where less educated women were more likely to be at risk of an unintended pregnancy than women with at least seven years of schooling.

Levels of unmet need were also fairly constant across poverty status. Exceptions include Kazakhstan and Benin, where poor women have greater levels of unmet need, and Cote d'Ivoire, Gabon and South Africa, where unmet need was concentrated in nonpoor women.

3. Reasons for non-use among women with unmet need

Married women's reasons for not using family planning (Table 5.1)

The most commonly cited reasons given by for not using contraception given by married women with an unmet need who were not pregnant at the time of the survey pertained to a perceived low risk of pregnancy and reasons associated with methods themselves, such as fear of side effects, health concerns and inconvenience of using contraception

Perceived low risk of pregnancy

Ten to 50% of women with an unmet need cite infrequent sexual activity as a reason for not using a method of family planning across the countries represented. This reason was most prevalent in Armenia (47%) and Morocco (52%), and was also cited by about a third of women in Colombia, Egypt, Bangladesh, Nepal, Benin, Cameroon, Mozambique and Zambia.

A substantial proportion of these women were sexually active within the three months preceding the survey, including about half of women with an unmet need in Latin American and Caribbean countries who indicated infrequent sexual activity. In Benin, Cameroon, Mozambique and Zambia, 20-46% percent of these women had had unprotected sex recently. Information on sexual activity was not available from Nepal and Bangladesh, where many women cited this reason for non-use. Elsewhere in this region, among the women in Cambodia, Indonesia and the Philippines who gave this reason, 47-86% of these women had unprotected sex recently.

Significant proportions of married women in many countries believed they were not at risk of pregnancy because they were still amenorrheic postpartum or because they were breastfeeding. This reason was more commonly cited in sub-Saharan Africa than in other regions, most likely in part because higher fertility rates result in a higher prevalence of these conditions at any point in time. A quarter or more of women in Nepal, Kenya, Malawi, Mozambique, Rwanda, and Zambia said that they were not contracepting for these reasons.

It is worth noting that, while women in many traditional countries tend to breastfeed for an extensive period, often the duration of exclusive breastfeeding is quite short (*cite*); the contraceptive benefits of lactation are limited to exclusive breastfeeders and extend for just a few months postpartum.

In the three countries with the highest proportions of women citing lactational amenorrhea (Nepal, Malawi, and Kenya) 32-43% of these women were not amenorrheic at the time of the survey. Moreover, ovulation is known to precede the return of menses in the period of post-partum amenorrhea. Therefore, many women who perceive that they cannot get pregnant for these reasons might in fact be at risk of an unintended pregnancy.

Much less frequently stated exposure-related reasons for not using contraception among married women with an unmet need were self reported subfecundity or infecundity. The highest prevalence of these reasons was in Armenia, Egypt, Morocco and Zambia, where 10-12% of

married women who were classified as having an unmet need for contraception cited these reasons.

Opposition to use

Opposition to family planning can stem from a woman's own beliefs or the position of her partner or another person who holds sway on her contraceptive decision-making. Some women who cited personal opposition may have partners who are also opposed, though they might not have indicated their partners' opposition in the survey once theirs was already noted, and vice-versa.

In some countries, opposition to contraception was low among married women with an unmet need and in others this reason was cited fairly frequently. Opposition to family planning was relatively prominent among married women with an unmet need in Armenia and Cambodia (22% of women opposed). In sub-Saharan Africa, it was highest in Chad, Nigeria and Mali (20-28%). On the other hand, in many countries fewer than 10% of women cited opposition to family planning.

Method-related concerns

The most common set of reasons given by married women with an unmet need for not using contraception was the fear of side effects, health issues and inconvenience of use, which are considered together here as method-related reasons. These were cited by 10-50%[1] of married women at risk of an unintended pregnancy in every country in the report except for Burkina Faso (9%).

In the Latin America region, one-quarter to one-third of married women in Bolivia, Dominican Republic, Nicaragua and Peru, and 43% of married women in Haiti with an unmet need stated fear of side effects, health issues or inconvenience as a reason they did not use family planning.

In North Africa and West Asia, 26-34% of women in Egypt and Morocco cited method-related reasons, but only 13% did among women in Armenia, where use of traditional family planning is high.

Method-related reasons were fairly prevalent in South and Southeast Asia, where half of married women with unmet need women in Cambodia cited these reasons, as did 37- 41% of eligible women in Indonesia, Nepal and Philippines.

About one-quarter to one-third of married women with an unmet need did not want to use contraception because of method-related concerns in seven Sub-Saharan African countries. Few women in Burkina Faso said that side effects kept them from using contraception, where relatively large numbers indicated that they lacked access to a source of contraception or costs were too high.

Lack of awareness of family planning

[1] (or 13-50%, once we resolve data question about Gabon, where all reasons add up to <100%).

Most married women with an unmet need seemed to be aware of family planning. Only 0-2% of women with an unmet need had no knowledge of any method in 16 countries. In four countries in Sub-Saharan Africa (Benin, Cameroon, Chad and Malawi), 10-15% of married women with unmet need citing lack of knowledge of contraception as the reason they were not using a method. Bolivia was the only country outside of Sub-Saharan Africa in which a substantial proportion of married women with unmet need cited this reason (12%).

Cost and access

Cost was not a frequently cited obstacle to use among married women with an unmet need for family planning. Fewer than 5% of married women in 22 countries indicated cost constraints. The highest proportion of women who felt that contraception was prohibitively expensive was in Burkina Faso (12%).

Also, fewer than 5% of married women at risk for unintended pregnancies did not have access to a source of contraception in 13 countries. However, 10-20% of women in seven Sub-Saharan African countries (Benin, Burkina Faso, Malawi, Mali, Rwanda and Uganda) and 10% of women in Nepal said they had no source of or access to family planning.

Other and unknown reasons

Women were allowed to indicate more than one reason for non-use of contraception. In some countries, a moderate proportion of married women with unmet need indicated that they had another reason for not using family planning, either in addition to or instead of the reasons discussed above. Ten to 25% of women indicated they had unspecified reasons for not contracepting in Bolivia, Colombia, Nicaragua, Bangladesh, Indonesia, the Philippines, Cameroon and Namibia. Up to 8% of married women with an unmet need for contraception indicated that they did not know why they were not using a method

Table 5.2 Women who are not using contraception because of side effects, health concerns, or inconvenience of methods

The most common set of reasons given by married women with an unmet need for not using contraception is reasons associated with methods themselves, including concerns about side effects, health and inconvenience of use. We explore here the sub-groups of women who are most likely to face these barriers to contraceptive use.

Latin America and the Caribbean

As noted earlier, 21-43% of women in the Latin American region indicated that method-related concerns prevented them from using family planning. A closer look at the women in these countries reveals that patterns across socio-demographic subgroups cannot be generalized to the whole region.

In Bolivia, Colombia and the Dominican Republic, the prevalence of concerns about methods is fairly evenly distributed among urban and rural women, women with different levels of wealth and education and across age groups, with approximately 15-30% of women in all of these groups facing this obstacle to use.

In Haiti and Nicaragua, prevalence of method-related concerns was higher than in the other countries in the region, and was especially prominent in urban areas and among nonpoor women. These concerns were less prevalent among women under 25 relative to older women.

In Peru, method-related concerns were slightly more concentrated in rural areas, among poor women and among women with little schooling. Again, older women were more likely to share these concerns than women under 25 years old.

North Africa/West Asia

In Armenia, method-related concerns are greatest among women who have completed secondary school and women who are 25-34 years old. In the North African countries of Egypt and Morocco, method-related concerns are concentrated among poor women, women with little schooling and those who are at least 25 years old.

South and Southeast Asia

In the five Asian countries represented from this region, women 25 years old and older with an unmet need were more likely to cite method-related obstacles to use compared to younger women. In other respects, the distribution of method-related obstacles must be observed on a country-specific level in this region. In Bangladesh these obstacles are concentrated among poor women and women with fewer than seven years of schooling (20-24%). In Indonesia, on the other hand, non-poor women and educated women were relatively more likely to cite side or health effects (41-42%). In Cambodia and the Philippines, method-related barriers to use were relatively equally distributed across urban and rural regions of residence and across women of all levels of wealth and educational attainment. In Nepal, this barrier to use was heavily concentrated among uneducated women and women over 35 years old (38-53%).

Sub-Saharan Africa

In the overwhelming majority of countries in sub-Saharan Africa, urban women with an unmet need were more likely than rural women to cite fear of side effects as a reason for not using family planning. This pattern was especially strong in Benin, Burkina Faso, Cameroon and Nigeria, where the proportion of urban women citing the concerns was more than double the proportion of rural women. In most countries in the region, equal proportions of poor and nonpoor women cited these obstacles and in the remaining countries, nonpoor women were more likely than poor women to indicate these concerns.
Similarly, method-related obstacles tended to be evenly distributed across women of all levels of educational attainment, although in some countries the relatively well-educated women with unmet need were more likely to have these concerns. The association with educational level was

by far the strongest in Benin and Burkina Faso. In general, the probability of citing method-related concerns directly associated with age, except in Namibia.

Table 5.3 Women who are not using contraception because they are unaware of options or lack access to family planning

Although small proportions of women at the national level cited constraints in access or knowledge as reasons they were exposed to the risk of an intended pregnancy in most countries, it is worth determining whether these obstacles are more substantial in population subgroups, as these barriers often can be overcome with the provision of services and counseling.

Latin America and the Caribbean

Throughout the Latin American and Caribbean countries covered here, married women with an unmet need who are poor, relatively less educated or who live in rural areas are more likely to face poor access to family planning or knowledge of methods than their nonpoor, better educated and urban counterparts. Differentials were especially strong in Bolivia, where 26-32% of rural, poor or less educated women cited lack of access or knowledge, compared to 8-10% of women who were urban, nonpoor or relatively educated.

North Africa/West Asia

Lack of access and poor knowledge of methods were cited with low frequency among married women in this region. The only subgroups in which these barriers to use were notable were Armenian women with little schooling and those under 25 years old; in both groups, roughly 10% indicated these reasons for non-use.

South and Southeast Asia

Among married women with an unmet need for family planning In Bangladesh, Cambodia, Indonesia, Nepal and the Philippines, about twice as many poor women indicated a lack of access or knowledge than wealthier women. The highest prevalence of this reason was among poor women in Cambodia (17%). Women who indicated these reasons for non-use were also more likely to live in rural areas and to have little or no education. Women of all ages were equally likely to lack access to family planning or sufficient knowledge of methods in all countries except Indonesia, where women over 35 were more likely to indicate these obstacles to use.

Sub-Saharan Africa

In the population of married women with an unmet need in sub-Saharan Africa, rural women were more likely than urban women to have poor access to or insufficient knowledge of family planning. In Benin, Burkina Faso and Chad, 30-36% of rural women faced these barriers to use, and in several other countries more than 10% of rural women cited them. In general, poor women in Sub-Saharan Africa were also more likely to face access and knowledge-related

obstacles than wealthier women. In Burkina Faso, 43% of poor women lacked access or knowledge. Not surprisingly, women with little or no schooling were more likely to indicate these reasons for non-use than women with at least seven years education in all countries. Age was not a significant determinant of the likelihood of facing these issues, although in Rwanda and Chad younger women seemed more likely to cite them, whereas in Ghana older women were more likely to cite them.

Never-married women's reasons for not using family planning (Table 5.4)

Never-married women at risk of an unintended pregnancy cited a variety of reasons for not using family planning. The most frequently cited reasons for non-use were perceived low risk of pregnancy because of infrequent sexual activity, a perception that they should not or need not use contraception because they are not married, and concerns about side or health effects of contraception.

Exposure-related reasons

In Latin America and Caribbean, 45-82% of never-married women with an unmet need say that they do not use family planning because they do not have sex frequently. By definition, all unmarried women at risk of an unintended pregnancy in this report had sexual intercourse in the three months prior to the survey. Also by definition, these women were not using a traditional method of family planning, such as the rhythm method, to control their fertility.

Another 6-37% of women in the Latin America region indicated that they did not use family planning because they weren't yet married. About one-third of never-married women with unmet need in Bolivia, Dominican Republic, Nicaragua and Peru cited this reason. Fewer never-married women with unmet need in Haiti and Colombia (6-11%) cited this reason than the other Latin American and Caribbean countries in this report.

In Sub-Saharan Africa, at least one in five never-married women with an unmet need did not consider themselves to be sufficiently sexually active to warrant using family planning, except in Malawi (17%) and Nigeria (7%). In Tanzania, Rwanda and Kenya, 49-64% of never-married women with unmet need cited infrequent sexual activity.

About one-quarter to one-third of never-married women with an unmet need for family planning did not use a method because they were not married in most sub-Saharan countries represented. In Malawi, two-thirds of never-married women with unmet need cited this reason.

A small proportion of women cite sub-fecundity as the reason they are not using a method. This includes self-reported fecundity, postpartum amenorrhea, breastfeeding and menopause. Ten to 15% of never-married women with unmet need in Nicaragua, Namibia, Uganda and Zimbabwe were not using a method because they felt sub-fecundity limited their risk of pregnancy.

Opposition to use

Opposition to family planning – either on personal or religious grounds – was more prominent among never-married women in Haiti (27%) than in any other country in this report. In the Dominican Republic and Nicaragua, 10-15% of never-women with unmet need were personally opposed to family planning. Considerably fewer never-married women gave this reason in Bolivia, Colombia and Peru (1-3%), and few women in Latin America and the Caribbean were influenced not to use a method because their partners or other people opposed contraception use (0-2%).

In Sub-Saharan Africa, personal opposition to using family planning was strongest in Benin, Burkina Faso, Mali, Nigeria, Namibia and Tanzania, where 13-17% of never-married women with unmet need were said they were opposed to contraception. In Burkina Faso, 14% of women faced opposition from partners or other friends and family, either in conjunction with or in contrast to their own feelings about family planning.

Access to family planning and concerns about methods

Very few never-married women at risk for an unintended pregnancy in the Latin American and Caribbean countries covered here said that they were unaware of any methods to prevent pregnancy (0-3%). Cost and lack of access did not seem to be major reasons for non-use among these women, either. However, as many as 36% of never-married women with unmet need in Haiti stated that they were not using a method because they either feared health or side effects or found contraception too inconvenient to use. Ten to 17% of never-married women with unmet need in Dominican Republic, Nicaragua and Peru shared these concerns.

In sub-Saharan Africa, relatively large proportions of never-married women with an unmet need in Benin, Cameroon and Nigeria indicated they were not aware of a way to avoid pregnancy (10-21%). Cost was not a significant factor preventing never-married women from using a method in sub-Saharan Africa, but in Benin and Mozambique, 22% and 26% of respondents respectively were not using a method because they lacked access to family planning. Concerns about side effects, health issues or inconvenience were a major barrier to use among never-married women with an unmet need. About one fourth of eligible women cited these reasons in seven of the 17 African countries covered here.

Married women with an unmet need who used family planning in the past (Table 6.1)

Surveys in seventeen countries asked married women about their use of family planning in the five years preceding the survey. Contraceptive histories were primarily collected in countries with high contraceptive prevalence, so it is not very surprising that, in many of these countries, the majority of women with an unmet need at the time of the survey had used contraception in the recent past. Prior use was exceptionally low in Guatemala, at 18%, and was also relatively low in the Philippines, Kenya and Tanzania (30-34%). The vast majority of women who indicated recent use of family planning had used a modern method. Only in Armenia, where use of traditional methods is high, did as few as 30% of those who discontinued method use cite use of modern methods in the recent past.

Women were asked their primary reason for discontinuing method use. Among married women with an unmet need for family planning, the most prevalent reasons given were issues regarding side or health effects, the dissolution of a relationship or infrequent sex, and the desire to become pregnant at the time.

About one fourth to one half of women discontinued using a method because they experienced or feared side and health effects, with the exception of Armenia (16%). This reason was far more common in the subset of women with an unmet need who had previously used a method than among all women with an unmet need. The most notable contrast is in Bangladesh, where 19% of women with an unmet need cited concerns about side effects, compared with 36% of the subset of women who had used a method in the past.

Marital dissolution and infrequent sex were cited infrequently as reasons for discontinuation in the sub-Saharan countries surveyed, and were cited by 9-29% of women in most countries outside this region. Exceptions include Morocco (42%) and Armenia (46%), where these reasons were cited more frequently than any other.

Some women discontinued contraceptive use because they wanted to become pregnant. This was the motivation for discontinuation in 4-20% of women in most countries, and 25% of women in Vietnam and Tanzania. Even though these women discontinued use of a method in the past because they wanted to get pregnant, it is important to note that they did not want a child soon and were not using a method at the time of the survey. *(Possibly note here or later that some of these women might now be relying on lactational amenorrhea, but not entirely effectively. They don't seem to be averse to use, so their unmet need might be related to poor assessment of risk.)*

Other reasons for discontinuing use included method failure and limited access to services or supplies. About 10% of women in Guatemala, Peru, Armenia, Turkey and the Philippines cited method failure. In Colombia, Kenya, and Tanzania, 10% of women with and unmet need for family planning cited access, availability, or cost as a reason for discontinuing, and in Zimbabwe 23% of women cited one of these reasons.

Married women who intend to use a method in the future (Table 7.1)

A significant proportion of women with an unmet need indicated that they intend to use or might use a method in the future. These women are conceivably more amenable to becoming contraceptive users when their stated reasons for current non-use are overcome. More than half of women with unmet need expressed a willingness or intention to use family planning in all countries except Chad, where only 43% of women expect to contracept in the future. Intention to use a method was particularly high in Colombia, the Dominican Republic, Peru, Bangladesh, Nepal, Burkina Faso, Malawi, Uganda and Zimbabwe, where at least 80% of women with an unmet need indicated that they might use a method in the future.

Among the women who intend to use contraception, reasons for current non-use are fairly similar to the reasons for non-use in all women with an unmet need. The most commonly cited

reasons were infrequent sex, fear of health and side effects or reasons relating to breastfeeding or lactational amenorrhea.

About a quarter or more of women who intend to use in 19 countries said they were not already using a method because they were having sex infrequently. A particularly large proportion of women cited this reason in Armenia, Egypt, Morocco and Mozambique (40-63%).

Fifteen to 38% of women in 18 countries said they were not using a method currently because they were breastfeeding or still amenorrheic postpartum, including at least 30% of women in Nepal, Kenya, Rwanda and Zambia. Fewer than 10% of women offered this reason in in Nicaragua, Armenia, Chad, Gabon or Tanzania.

Fear of health or side effects was the most frequently cited reason in 10 countries of the 30 countries in the table. At least 40% of women in Haiti, Cambodia, Indonesia and the Philippines who expressed a willingness to use contraception cited method-related reasons for not already using a method. In the African countries of Burkina Faso, Cameroon, Gabon, Mozambique and Nigeria, fears of side and health effects were cited by only 9-13% of eligible respondents.

Other commonly cited reasons for non-use among women with unmet need who intend to use a method were related to opposition—either personal, religious and partner influenced. The juxtaposition of their stated opposition to family planning and their indication that they might use a method in the future suggest some degree of ambivalence to family planning among these women. At least 25% of women cited opposition in Armenia, Malawi, Mali and Tanzania. Opposition to use was not a significant reason for non-use among women who expressed that they might contracept in Bolivia, Colombia, Egypt, Indonesia, Cameroon, Ghana and Zambia.

In some sub-Saharan African countries, access issues including high costs and lack of a source of supplies posed a significant barrier among women who expressed an interest in contracepting. Access was especially prevalent in Benin, Burkina Faso and Zambia where 22-34% of women who expressed interest in contracepting cited this reason for not currently using.

Additionally, at least one in 10 women with an unmet need who were interested in using a method to avoid pregnancy in the future were not aware of any methods of contraception in Bolivia, Benin, Cameroon, Mail and Nigeria.

Conclusions and recommendations

Policymakers, program leaders and funding agencies rely on estimates of levels of unmet need for contraceptive services to make the case for policy and program interventions. To reduce inequities in access to effective contraceptives, it is also critical to determine which subgroups of women have particularly high levels of need.

More than 1 in 7 married women and 1 in 13 never-married women are at risk of an unwanted pregnancy across the fifty countries in this report. *(Insert information on total numbers of women with unmet need in the developing world here, when calculations are done.)*

Women in sub-Saharan Africa are more likely than women in other parts of the world to have an unmet need for family planning. Outside of sub-Saharan Africa, unmet need remains high in parts of South and Southeast Asia. Unmet need is relatively low in the Latin America region, North Africa and West and Central Asia, according to the findings from countries represented here.

Outside of sub-Saharan Africa, some patterns are apparent in the distribution of unmet need, with rural women, women with little or no education, and poor women somewhat more likely to be at risk of unplanned pregnancies than urban women, education women, or wealthy women.

No single pattern in the distribution of unmet need can be ascribed to the African subcontinent as a whole, however. For example, while unmet need is concentrated in rural areas in about half of the sub-Saharan African countries in this study, there are as many exceptions as there are countries that comply with this pattern. But the results do offer a profile of the women most likely to be at risk of family planning at the country level. In South Africa, women with an unmet need tend to live in rural areas, to have had little schooling and to be relatively poor. In the Central African Republic, unmet need is concentrated in urban areas and among educated and non-poor women. In Benin, unmet need is distributed roughly evenly across region of residence, educational level and poverty status.

Reasons for not using family planning

The most common set of reasons given by married women with an unmet need for not using contraception is reasons associated with methods themselves, such as concerns about side effects, health and inconvenience of use. Method-related reasons for non-use is even more prevalent among women with an unmet need who had used family planning in the recent past. The prevalence of these concerns is particularly high in South and Southeast Asia (with the exception of Bangladesh), where barriers related to access seem to be relatively low. A smaller but still significant proportion of women in sub-Saharan Africa indicated that side effects prevented them from contracepting.

Clearly, the provision of contraceptive supplies is not sufficient to help many women meet their demand for family planning. Family planning programs should include counseling that informs women about side effects of methods, helps women select methods that suit their needs, and

enables women to switch methods when side effects associated with a particular method are unacceptable.

Whereas method-related barriers to use were concentrated in urban areas in some countries, the prevalence of unmet need that is attributed to limited knowledge of family planning or access to services is higher in rural areas than urban areas, and is greater among poor women and uneducated women compared to nonpoor women and educated women, in all the regions represented. The findings imply that there is still an unmet need for basic family planning service provision in many rural areas in the developing world.

Perhaps as importantly, significant proportions of married women with an unmet need in many countries believed they were not at risk of pregnancy. Many felt they were protected from risk because they were breastfeeding or not having sex frequently. Among never-married women, infrequent sexual activity was by far the most common reason for not contracepting in many countries, as was the notion that they should not or need not adopt a method until they are married.

These findings also carry important program-related implications. They reveal that many women would benefit from, first and foremost, the information with which to accurately assess their risk of conceiving a pregnancy. As noted earlier, some women may be correct in their assessment that they are not at risk of conceiving, while many others are probably unknowingly exposed to the risk of having an unintended pregnancy.

Opposition to fertility control is far less prevalent among women with an unmet need than a reluctance to contend with side effects or the belief that they are not at risk. Among women who are opposed to family planning - for example in Cambodia, Armenia, Chad and Nigeria – the provision of counseling and supplies are likely to have a limited impact. Shifts in cultural values over the long term and improved opportunities for education and contribution to the work force are more likely to affect women's attitudes toward fertility control.

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[1] (Filmer and Pritchett)