

Reasons behind the unmet need for contraception in developing countries

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**PRELIMINARY DRAFT, SUBJECT TO CHANGE AND
NOT READY FOR DISSEMINATION**

Abstract

Background: The level of unmet need has been adopted as an indicator of progress toward the United Nations Millennium Development Goals. While much is known about the levels of unmet need, little is known about reasons behind it. We examine reasons for nonuse among women with an unmet need for contraception in developing countries, and factors associated with these reasons. We also examine whether women's reasons for nonuse are associated with their willingness to use contraception in the future.

Data and methods: Findings are based on Demographic and Health Surveys conducted in 39 countries between 2000 and 2006. Cross-tabulations and logistic regression models were employed.

Results: The two most common reasons for nonuse are concerns about the health risks or side effects of methods and the perception of not being at risk of getting pregnant. Few women are unaware of contraception. Older women and women who had used contraception in the past were more likely than younger women and those who had not previously used a method to give program-related reasons for non-use. The intention to use a method in the future is particularly low among women who currently cite concerns with health risks and side effects.

Discussion: Programs have successfully raised women's awareness about contraception, but women increasingly believe that methods are associated with unacceptable health risks and side effects. Services must work to remove this barrier to use. They should include a wide range of contraceptive options and education about methods. Women and couples could also benefit from new contraceptive technologies,

and improvements to existing methods. Women who will not seek services need access to information outside of clinic settings through community-based programs.

Introduction

In the early decades of the family planning movement, its central justification was the reduction of pressures of population growth. In the past ten to fifteen years, and most prominently at the 1994 International Conference on Population and Development (ICPD), the motivation for supporting family planning programs has shifted towards helping women and men achieve their preferences for smaller families.¹ Studies have since demonstrated that satisfying existing demand for contraception would reduce population fertility levels while also enabling couples to meet their fertility aspirations.^{2 3} The measure of unmet need for contraception has become increasingly important in the context of the United Nations (UN) Millennium Development Goals (MDGs), and the Interagency and Expert Group on MDG Indicators has recommended that unmet need for contraception serve as an indicator of progress toward these goals.⁴

The prevalence of unmet need in developing countries is measured in the Demographic Health Surveys (DHS).^{*} Comprehensive reviews and cross-national assessments of levels of unmet need have been compiled periodically since 1990.^{5 6 7 8} Synthesis and analysis of data on reasons for nonuse of contraception among women with an unmet need are less readily available. Information of this nature can support the design of appropriate policies and the effective allocation of limited resources to reduce the incidence of unwanted pregnancy.

^{*} More information on the Demographic and Health Surveys is available at <<http://www.measuredhs.com>>.

A cross-regional review of reasons for nonuse was undertaken over a decade ago, and was based on surveys conducted before 1990.⁹ At that time, lack of knowledge of family planning was a prominent reason for nonuse, particularly in sub-Saharan African countries. The next most frequently cited set of reasons fell under the rubric of health concerns, which weighed most heavily in Asia and Latin America.

Qualitative studies on reasons for nonuse have also been undertaken.^{10 11} These enhance further our understanding of obstacles women face in their respective study populations, but they have not provided a geographically comprehensive profile of barriers to contraceptive use and they do not generally quantify the prevalence and relative importance of various reasons.

It is important to note, however, that not all women with an unmet need for contraception will use a method. Evidence shows that some women with unmet need do not intend to use a method in the future^{12 13 14 15} and it has been shown that intention is a strong predictor of use.¹⁶ Those who do are probably relatively receptive to using a method once their reasons for nonuse are resolved.

The aim of this study is to examine the reasons why women with an unmet need for contraception in developing countries are not using a method of family planning, and the factors associated with women's reasons for nonuse. We also examine the proportions of women with unmet need who say they intend to use a method in the future, and how women's reasons for nonuse are related to their level of willingness to use contraception in the future.

Data and methods

The findings in this report are based on Demographic and Health Surveys (DHS) administered to 15-49-years-old women in 39 developing countries, most of which were conducted between 2000 and 2006.

Unmet need for contraception: We employ the standard DHS definition of unmet need for contraception. According to this measure, a woman has an unmet need if she (1) is married or in a union (2) is fecund (ie, not pregnant, amenorrheic or infecund or according to her own report, or as assessed by her reproductive history);[†] (3) does not want to have a child in the next two years and (4) is not using any method of contraception, either modern or traditional. In addition, pregnant or amenorrheic women are considered to have an unmet need if they report that their current or most recent pregnancy was unplanned.

Reasons for nonuse of contraception: All married women who were not using any method of contraception and who had indicated that they did not want to have a child in the near future were asked to indicate their reasons for nonuse. The question took the general form: “You have said that you do not want a child soon/another child soon/any children/any more children, but you are not using any method to avoid pregnancy. Can you tell me why?” We examine the prevalence of specific responses in univariate analyses. For multivariate analysis of factors that predict women’s reasons for nonuse, responses were 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; reasons that are likely associated with inadequate provision of

[†] A woman is considered infecund if (a) she was married for at least five years preceding the survey and did not use a contraceptive method, did not have a birth during that time and was not pregnant at the time of the survey; (b) she is not pregnant or postpartum amenorrheic, but has not menstruated for at least 6 months; or (c) indicated that she is infecund in response to questions regarding fertility intentions or contraceptive use.

family planning services and supplies (including lack of knowledge about contraception, concerns about the health risks or side effects of methods, poor access to methods or high cost of supplies); and other reasons that fall outside these three broad categories.

All reasons given by each woman are included in univariate analysis. On average 85% percent of women gave only one reason for nonuse (*to confirm*). For multivariate analyses, assumptions were made for the few women who gave multiple reasons for nonuse about which of the responses was most important: if opposition was among a woman's stated reasons, it was considered her primary reason; otherwise if a reason pertaining to provision of supplies and services was included among her reasons, this was considered her primary reason for nonuse. If a woman gave one specific reason and additionally indicated "other" among her reasons, she was categorized according to her stated specific reason. With these assumptions, the reason that is most difficult to deal with or overcome is given the priority of being assigned as the primary reason.

Intention to use contraception: We identify proportions of women with an unmet need who indicate that they intend to use contraception in the future. In addition, we calculated the odds of intending to use a method among women according to their current reason for nonuse, controlling for other factors. Information on women's intention to use 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?"

Social and demographic characteristics: Because reasons for unmet need are likely to vary by subgroup, a number of respondents' background characteristics are considered as covariates of reasons for non use. These include: age (15-24, 25-34, and 35-49 years old), residence (urban or rural), education attainment (<7 years of schooling

or ≥ 7 years of schooling), parity (0-1 live birth, 2-3 births) and wealth (poor, non-poor). In Armenia, women are categorized according to whether or not they have completed secondary school, because the average level of educational attainment is relatively high in this country. Although nulliparous women might have different family planning needs than women who have begun childbearing, very few women in most countries were nulliparous.

The household wealth index variable used in these analyses was developed by the DHS, drawing from extensive information collected on women's household assets, including various household possessions. The wealth index was constructed by applying a factor analysis to this information. In the present analyses, respondents who fell into the lowest one third of the sample distribution in their country with respect to wealth were classified as poor, and all others were classified as non-poor.¹⁷

Analytic approach: Using frequencies and cross-tabulations, we present the percent of women with unmet need for a family planning method in each country, the proportions citing each reason for nonuse from among the most commonly cited reasons, and the proportions of women who intend to use a method, according to their current reasons for nonuse.

Because reasons for non use were classified into three categories, we use multivariate logit models to examine factors associated with women's reasons for nonuse (the dependent variable). Opposition to family planning, either from the woman, her partner or another influential person was treated as the reference category.

Logistic regression models are used to determine whether women's current reasons for nonuse are associated with intention to use contraception in the future (the

dependent variable). Standard errors in all multivariate models take into account the complex sample design of the surveys.

We present summary measures of the regional average levels of fertility indicators, the level of unmet need and proportions of women who gave each specific reason for nonuse of contraception. These averages are weighted by the population of 15-49 year-old women in each country represented in the region, using UN population estimates for the year of the survey.

DHS staff developed sampling weights for women in each survey to correct for differential representation of some demographic groups and to render more nationally representative samples.¹⁸ We present weighted results in tables, along with unweighted sample sizes. Using the SPSS package, standard errors of estimates are computed taking into account the complex sample design. Tests of statistical significance are conducted, and significance is indicated at the .01, .05 and .10 levels, using two-tailed tests.

Results

Background

Levels of actual, wanted and unwanted fertility: The total fertility rates (TFR) in each country and regional average total fertility rates are presented in Table 1. The TFR varies considerably by region: it is at least 4.0 throughout sub-Saharan Africa, with the exception of Lesotho (3.5), and it is as high as 6.9 in Uganda. Fertility in other regions is substantially lower. In the Latin America region the TFR ranges from 2.4 (Colombia and Peru) to 4.7 (Haiti), and in South and Southeast Asia it ranges from 2.6 (Indonesia) to 4.1 (Nepal).

The wanted total fertility rate (WTFR) is calculated in the same way as the conventional total fertility rate (TFR), except that any recent births that exceed a woman's stated ideal number of children are deleted from the rate. It is essentially a measure of average number of children a woman will have if her lifetime fertility corresponds with the current levels of wanted childbearing in the population.¹⁹ Gaps between the TFR and the WTFR indicate the extent to which women are unsuccessful in avoiding unwanted pregnancies. Women will have on average 0.8 to 0.9 more children than they want in all four regions at current actual and wanted fertility rates. The gap is greatest in Haiti, where women would have on average 1.9 more children each than they wish to have.

The percent of recent births that were unwanted, another measure of unintended fertility, was higher on average in the Latin America region, where it exceeded 40% in all countries, than in the other developing regions. It ranged from 16-30% in North Africa and West Asia, from 17-45% in South and Southeast Asia and from 14-50% in Sub-Saharan Africa. The percent of pregnancies that are unintended is generally higher than the percent of births that are unwanted, because some unintended pregnancies end in abortion.

Met and unmet need for contraception: Most married women in Asia, Latin America and the Caribbean currently use some method of contraception, but most women in sub-Saharan Africa do not. Current use is particularly low in four African countries - Chad, Guinea, Mali, and Mauritania - where fewer than 10% of married women aged 15-49 were using any method at the time of the survey.

In the sub-Saharan African countries in this report, 24% of married women have an unmet need for contraception. Unmet need is lower on average in the Latin America region (12%), North Africa and West Asia (10%) and South and Southeast Asia (11%).

The percentage of women with an unmet need for a family planning method varies widely across countries within most regions. The level of unmet need in Latin America and the Caribbean ranges from 6% in Colombia to 40% in Haiti, which has the greatest level of unmet need of all 39 countries represented. Unmet need in South and Southeast Asia ranges from 9% in Indonesia to 30% in Cambodia. In sub-Saharan Africa, unmet need was lowest in Zimbabwe (13%) and highest in Rwanda (38%); in about one third of the countries in that region, the proportion of women with unmet need was 30% or greater.

Reasons for not using contraception

Women were asked to indicate all of their reasons for not using contraception. However, the average number of reasons per respondent was just over 1.1. Therefore, while Table 2 is based on all the reasons given by women for nonuse, it is likely to represent an approximation of the distribution of women's primary reasons for nonuse.

About ten to 50% of married women with an unmet need cited infrequent sexual activity as a reason for not using contraception across the countries represented (Table 2). In Latin American and the Caribbean, about half of women with an unmet need who gave this reason were sexually active within the three months preceding the survey (not shown). In Sub-Saharan Africa, x% to y% of women who gave this reason had been sexually active in the preceding three months. In the South and Southeast Asian region, 47-86% of women who cited infrequent sexual activity had unprotected sex recently in

the countries for which this information was available. All of the women in the analyses were married and can therefore be considered at risk of having sex in the future.

In many countries, significant proportions of married women believed they were not at risk of pregnancy because they were still amenorrheic postpartum or because they were breastfeeding, particularly in sub-Saharan Africa, where fertility rates are high and the average duration of breastfeeding is relatively long. In this region, 18% of women on average said that they were not contracepting for these reasons.

Much less common 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 Morocco and Zambia (10-11%).[‡]

Outside of Sub-Saharan Africa, 6-7% of women with unmet need cited personal opposition to family planning on average in each region. In sub-Saharan Africa 16% of women gave this reason on average. In most countries, women's own opposition to family planning was a more common reason for nonuse than opposition from someone else. The prevalence of others' opposition to family planning as a woman's reason for nonuse ranged from 1% (Morocco, Cambodia) to 14% (Uganda). It is possible that some women who cited personal opposition have partners who are also opposed and that they did not indicate their partners' opposition in the survey once theirs was already noted.

Fewer than 5% of women with an unmet need indicated that they had no knowledge of contraception in most countries. In the eight countries where lack of knowledge was most prevalent, 10-15% of married women with unmet need cited this

[‡] Women who indicated that they were subfecund were coded together with those who said they were infecund, so it was not possible to remove the infecund women from the group of women at risk of pregnancy. Women who responded that they were menopausal or had had a hysterectomy were classified as infecund and not at risk of getting pregnant.

reason for nonuse. This reason was more prevalent in sub-Saharan Africa than other regions, and was especially prevalent in Chad.

Perhaps surprisingly, cost and access barriers were not frequently cited reasons for nonuse among married women with an unmet need. Fewer than 10% of married women indicated cost constraints in all countries except Burkina Faso (12%). In most countries, fewer than 10% of women said they lacked access to supplies; the prevalence of this barrier was greatest in sub-Saharan Africa.

Concerns about side effects, health risks and inconvenience of methods were cited by close to one-third of women in North Africa and West, South and Southeast Asia, and more than one-fifth of women in the Latin America region and sub-Saharan Africa. At the national level, this reason was most prominent in Cambodia (50%).

In some countries, a moderate proportion of married women with unmet need indicated that they had another, unspecified reason for not using contraception, either in addition to the reasons discussed above or as a sole reason. Twenty to 25% of women indicated they had other reasons than the ones listed above for not contracepting in Bangladesh and Indonesia.

The proportion of women who said they did not know their reason for nonuse was very small -- 5% or fewer in most countries. The prevalence of this response was highest in Madagascar (11%).

Multivariate logit models were used to determine social and demographic factors associated with women's reasons for nonuse (Table 3).[§] Models examined the roles of age, place of residence and educational level, controlling for parity and wealth status.

[§] Results are not presented for Bolivia, Philippines, Chad or Namibia because multivariate models did not converge on a maximum likelihood/ because models were deemed unstable. (*check language*)

Reasons for nonuse were grouped into three broad categories: (i) those relating to program provision (lack of knowledge about contraception, concerns about the health risks or side effects, poor access to methods or high cost of supplies) (ii) reasons indicating that the woman perceives she is at low risk of getting pregnant, and (iii) opposition to family planning, either on the woman's part or on the part of her partner or another influential person (the reference category).

The odds of citing reasons that pertain to services and supplies were higher among 25-34 year-olds and women 35 and older women compared to 15-19 year-olds in many countries. In Zimbabwe, the odds ratio was 6.50 for women 35 and older compared to women under 25. It appears in some countries that service-related reasons were most frequent among 25-34 year-olds, although the significance of this pattern was not tested.

In six countries (Egypt, Nepal, Ethiopia, Lesotho, Senegal and Uganda), urban women were more likely than rural women to have reasons for nonuse that were associated with program services instead of opposition to family planning. Only in Zimbabwe were rural women significantly more likely than urban women to have service-related reasons for nonuse. In four countries (Honduras, Cambodia, Mali and Senegal), women with at least seven years of schooling were more likely than relatively uneducated women to cite service-related reasons for nonuse. The odds ratio for this association was highest in Honduras (2.8). Only in Mali and Uganda were educated women significantly less likely than women with little or no education to cite service-related reasons for nonuse.

In 24 of the 34 countries, women who had used contraception in the past were more likely than those who had not to give program-related reasons for non-use. This

relationship was strongest in Zimbabwe (OR=13.2), Indonesia (8.8) and Bangladesh (7.5).

In nine countries, women who were at least 35 years old were less likely than 15-24 year-old women to say they thought they would not get pregnant (and more likely to say there were opposed to contraception), and in only one country (Colombia) the reverse was the true.

In five countries, urban women were more likely than rural women to cite low risk of pregnancy as a reason for nonuse of contraception. Educated women exhibited significantly greater odds of citing a low risk of pregnancy compared to relatively uneducated women in 13 countries.

In 26 countries, women who had used contraception in the past were more likely than never-users to give an exposure-related reason for nonuse. The relative odds of citing low exposure to pregnancy were 13.5 in Peru and 6.1 in Bangladesh.

Intention to use a contraceptive method

More than half of women with unmet need indicated they intend to use a method of family planning in all countries except Chad, Mauritania and Senegal, where 30-48% of women indicated that they plan to use a method (Table 4).

Fifty to 92% of women who said they were having infrequent or no sex said they would use a method in the future. Among women who were amenorrheic or breastfeeding, 87-100% of women outside of sub-Saharan Africa said they would use a method in the future, as did 56-96% of women in most of sub-Saharan Africa. Exceptions were Chad (36%) and Mauritania (23%). In most countries, less than half of women who

identified themselves as generally subfecund stated an intention to use family planning in the future.

Notably, among women who said that they, their partners or others were opposed to family planning, proportions willing to use a method in the future were moderate and even high in most countries. In many countries, women who indicated that others were opposed to family planning were more likely to say they would use a method in the future than women who were personally opposed.

Among women who cited concerns about health and side effects of contraception, the level of intention to use contraception was lower than the national average in almost every country.

In contrast, women who were not using contraception because they lacked access to a source of supplies and those who cited cost constraints indicated a greater level of intent to use a method in the future than the larger group of women with unmet need in most countries.

Logistic regression models testing whether women's current reasons for nonuse were associated with their intention to use a method in the future controlled for age, parity, place of residence, level of education and wealth status (Table 5). In 23 countries, women who were not using a method because they did not think they would get pregnant were more likely say they plan to use a method in the future than women who faced opposition to contraception.

In 23 countries, women who cited cost and access barriers to use were more likely to say they would use a method in the future than women who faced opposition to family

planning . In Nicaragua, women who cited cost and access barriers had six times the odds of intending to use a method than women who cited opposition to family planning.

In four countries (Honduras, Bangladesh, Chad and Guinea), women who cited concerns with health or side effects of contraception were more likely to plan use a method in the future than women who faced opposition to family planning as a reason for nonuse. In five countries (Burkina Faso, Ghana, Lesotho, Tanzania and Uganda), women with concerns about methods were less likely to indicate they will use a method in the future than women who faced opposition to family planning.

Discussion

Unmet need for contraception has become widely accepted as a key parameter for measuring success of family programs. The higher the level of unmet need the more women and their partners are failing to protect themselves against unintended pregnancy. The majority of unintended pregnancies result in abortion and most abortions in many developing countries are unsafe,²⁰ creating a public health problem for women, their families and the health care system. Unmet need is higher in Sub-Saharan Africa than any other developing region, and levels vary widely across countries in most regions. The two most common reasons for nonuse among women with an unmet need in most countries are the woman's concerns about the health risks and side effects of methods and her perception that she is not at risk of getting pregnant. The intention to use a method in the future is particularly low among women who are currently not using for reasons associated with supplies and services.

A comparison of our findings with those from a cross-national study on reasons for unmet need in 1986-1990 indicates that obstacles to contraceptive use among women with an unmet need have changed in the past ten to twenty years.²¹ ** In the surveys from the earlier time period, lack of knowledge about family planning was far more prevalent than it has been since 2000: this reason was given by 25-44% of women in most countries in the late 1980s, whereas lack of knowledge was cited by only 0-12% of women in all of the current surveys. On the other hand, concerns about health and side effects were cited by only 6-28% of women in the earlier time period, but by 19-36% of women more recently. In all countries but two countries that were studied in both time periods, the prevalence of this reason increased by one-fold to more than three-fold.

The shift in the distribution of women's reasons for nonuse suggests that family planning programs have had a significant impact in raising women's awareness about contraception in the past two decades. During the same period of time, however, women have increasingly gained the impression, most likely either through personal experience or through other sources of information or misinformation, that contraceptive methods are associated with unacceptable health risks and side effects.

There are some limitations to the information available on women's reasons for nonuse of contraception. Women's reasons for nonuse might be multifaceted, and their response in DHS interviews might reveal only one or a few of these motivations. Also, true reasons for nonuse might be personal in nature, and women might instead provide answers that they find more acceptable to convey to an interviewer. However, in-depth

** Earlier surveys asked women to provide only their primary reason for nonuse, while recent studies solicited all reasons for nonuse. However, most women gave only one reason in recent surveys.

qualitative studies of reasons for nonuse among women with an unmet need have uncovered many of the same general barriers identified by quantitative surveys.²²

Many women with an unmet need indicated that they do intend to use contraception in the future. In most countries, women with concerns about methods were even less likely to say they will use a method in the future than women who were opposed to family planning; this association persisted in multivariate analyses controlling for factors including prior use of contraception in five countries. These findings suggest there can be long term ramifications to women's unfavorable experiences with contraception. The level of intention to use a method was relatively high among women who perceived they were at low risk of getting pregnant in some countries; women's responses about future intentions could depend on whether or not they think they will be at risk of getting pregnant in the future. Moderate levels of willingness to use a method among women who currently face opposition to contraception suggest that changes in attitudes toward contraception, perhaps at the community-level, might affect acceptability of contraception among these women.

A number of policy recommendations are supported by the findings presented here. The results indicate that family planning programs should include a range of contraceptive options to help women negotiate side effects, and they highlight the importance of providing thorough counseling and education about methods to ensure that women have an accurate understanding of the risks and side effects associated with each method. A mechanism for periodic follow-up could also make it easier for providers to counsel clients who are having difficulties with methods and possibly switch to alternate methods. Since women who are reluctant to use contraception because of anticipated

risks and side effects are unlikely to seek services and supplies, this information should also be made available outside of the clinic setting. Schools or points of antenatal care are possible sites of information delivery. Women who have misperceptions about their low risk of getting pregnant also need information and education outside of clinic settings.

The high prevalence of concerns about side effects among women with an unmet need could also reflect limitations of the methods currently available to them. As has already been recognized, there is a significant need for research to develop contraceptive methods that can be used in low resource settings and that are accompanied by minimally disruptive side effects.²³

Additional research on obstacles to contraceptive use among women with an unmet need could shed light on women's specific concerns about health and side effects of contraception, and whether these are based on fact or fiction. Research to uncover sources of women's information and perceptions about contraceptive methods could also help improve communication and education strategies. It is also important to acknowledge that many women who are not married have an unmet need for contraception. In fact, as the average age at marriage continues to increase in many countries, the window of time during which never-married women could be at risk of an unwanted pregnancy will increase. The circumstances surrounding unmet need are likely to be very different for this group of women and their needs and obstacles to contraceptive use bear attention.

Earlier research indicates that 76 million pregnancies in developing countries, representing more than one third of all pregnancies in these regions, are unintended.²⁴ Two thirds of unintended pregnancies occur to women who are not using any

contraception and who have an unmet need for a method.²⁵ Policymakers, program leaders and funding agencies can use insights into reasons why women with an unmet need are not using a method to design interventions that will improve the ability of women and couples to achieve their fertility goals and, ultimately, the health and well-being of women, their families and society.

Table 1: Total fertility rates, fertility preferences and level of unmet need in each country

| Region/Country | Year survey completed | TFR | WTFR | % of births unplanned* | % of married women 15-49 using contraception | % with unmet need |
|--------------------------------------|-----------------------|------------|------------|------------------------|--|-------------------|
| Latin America & Caribbean | | 2.8 | 1.9 | 53 | 70 | 12 |
| Bolivia | 2003 | 3.8 | 3.1 | 60 | 58 | 23 |
| Colombia | 2005 | 2.4 | 1.7 | 53 | 78 | 6 |
| Dominican Republic | 2002 | 3.0 | 2.3 | 42 | 70 | 11 |
| Haiti | 2000 | 4.7 | 2.8 | 54 | 28 | 40 |
| Honduras | 2005 | 3.3 | 2.3 | 49 | 65 | 17 |
| Nicaragua | 2001 | 3.2 | 2.3 | 48 | 69 | 15 |
| Peru | 2004 | 2.4 | 1.5 | 56 | 71 | 8 |
| North Africa/West Asia | | 2.9 | 2.1 | 21 | 33 | 10 |
| Armenia | 2005 | 1.7 | 1.6 | 16 | 53 | 13 |
| Egypt | 2005 | 3.1 | 2.3 | 17 | 19 | 10 |
| Morocco | 2004 | 2.5 | 1.8 | 30 | 63 | 10 |
| South & Southeast Asia | | 3.0 | 2.2 | 26 | 55 | 11 |
| Bangladesh | 2004 | 3.0 | 1.9 | 28 | 56 | 11 |
| Cambodia | 2000 | 3.8 | 3.0 | 32 | 24 | 30 |
| Indonesia | 2003 | 2.6 | 2.2 | 17 | 60 | 9 |
| Nepal | 2001 | 4.1 | 2.5 | 34 | 39 | 28 |
| Philippines | 2003 | 3.5 | 2.5 | 45 | 49 | 17 |
| Sub Saharan Africa | | 5.5 | 4.7 | 26 | 21 | 25 |
| Benin | 2001 | 5.6 | 4.6 | 23 | 19 | 27 |
| Burkina Faso | 2003 | 5.9 | 5.1 | 24 | 14 | 29 |
| Cameroon | 2004 | 5.0 | 4.5 | 21 | 26 | 20 |
| Chad | 2004 | 6.3 | 6.1 | 17 | 3 | 21 |
| Congo | 2005 | 4.8 | 4.4 | 33 | 44 | 16 |
| Ethiopia | 2005 | 5.4 | 4.0 | 35 | 15 | 34 |
| Gabon | 2000 | 4.2 | 3.5 | 45 | 33 | 28 |
| Ghana | 2003 | 4.4 | 3.7 | 40 | 25 | 34 |
| Guinea | 2005 | 5.7 | 5.1 | 14 | 9 | 21 |
| Kenya | 2003 | 4.9 | 3.6 | 44 | 39 | 25 |
| Lesotho | 2004 | 3.5 | 2.5 | 50 | 37 | 31 |
| Madagascar | 2004 | 5.2 | 4.7 | 15 | 23 | 24 |
| Malawi | 2004 | 6.0 | 4.9 | 39 | 32 | 28 |
| Mali | 2001 | 6.8 | 6.1 | 20 | 8 | 29 |
| Mauritania | 2001 | 4.5 | 4.1 | 28 | 8 | 32 |
| Mozambique | 2003 | 5.5 | 4.9 | 19 | 26 | 18 |
| Namibia | 2000 | 4.2 | 3.4 | 45 | 44 | 22 |
| Nigeria | 2003 | 5.7 | 5.3 | 14 | 13 | 17 |
| Rwanda | 2005 | 6.1 | 4.6 | 39 | 17 | 38 |
| Senegal | 2005 | 5.3 | 4.5 | 29 | 12 | 32 |
| Tanzania | 2004 | 5.7 | 4.9 | 22 | 26 | 22 |
| Uganda | 2001 | 6.9 | 5.3 | 38 | 23 | 35 |
| Zambia | 2002 | 5.9 | 4.9 | 39 | 34 | 27 |
| Zimbabwe | 1999 | 4.0 | 3.4 | 36 | 54 | 13 |

*Percent of all births 3 years preceding survey year.

TFR=Total fertility rate

WTFR=Wanted total fertility rate

Table 2. Reasons for not currently using any method by region among married women 15-49

| Region/Country | n | Infrequent/ no sex | | Postpartum amenorrhea/ breastfeeding | | Subfecund* | | Respondent opposed | Partner/ others opposed | Unaware of methods | Cost too high | No source/ access | Health/side effects/ inconvenience | Other | | |
|--------------------------------------|------|-----------------------|----|--|----|------------|----|-----------------------|-------------------------------|--------------------------|---------------------|-------------------------|--|-------|----|----|
| | | 35 | 12 | 4 | 2 | 5 | 5 | | | | | | | 13 | 3 | DK |
| Latin America & Caribbean | | | | | | | | | | | | | | | | |
| Bolivia | 1791 | 26 | 15 | 2 | 12 | 4 | 6 | 6 | 6 | 12 | 4 | 7 | 24 | 13 | 3 | 8 |
| Colombia | 776 | 34 | 10 | 3 | 15 | 3 | 2 | 2 | 3 | 0 | 9 | 1 | 21 | 18 | 3 | 3 |
| Dominican Republic | 1031 | 25 | 13 | 5 | 13 | 5 | 17 | 2 | 2 | 1 | 3 | 3 | 26 | 9 | 5 | 5 |
| Haiti | 1735 | 14 | 9 | 2 | 9 | 2 | 15 | 3 | 3 | 1 | 3 | 4 | 43 | 5 | 4 | 4 |
| Honduras | 1401 | 47 | 15 | 4 | 15 | 4 | 11 | 6 | 6 | 1 | 2 | 3 | 20 | 12 | 4 | 4 |
| Nicaragua | 765 | 25 | 7 | 4 | 7 | 4 | 18 | 7 | 7 | 2 | 2 | 6 | 30 | 14 | 3 | 3 |
| Peru | 415 | 48 | 16 | 4 | 16 | 4 | 3 | 5 | 5 | 0 | 3 | 11 | 19 | 10 | 1 | 1 |
| North Africa/West Asia | | | | | | | | | | | | | | | | |
| Armenia | 437 | 43 | 10 | 9 | 10 | 9 | 6 | 6 | 6 | 0 | 1 | 1 | 31 | 2 | 1 | 1 |
| Egypt | 1388 | 49 | 8 | 8 | 8 | 8 | 22 | 8 | 8 | 0 | 2 | 1 | 13 | 4 | 1 | 1 |
| Morocco | 735 | 40 | 12 | 8 | 12 | 8 | 5 | 7 | 7 | 0 | 0 | 1 | 34 | 1 | 1 | 1 |
| | | 52 | 5 | 10 | 5 | 10 | 6 | 1 | 1 | 0 | 1 | 1 | 26 | 6 | 2 | 2 |
| South & Southeast Asia | | | | | | | | | | | | | | | | |
| Bangladesh | 970 | 21 | 14 | 2 | 14 | 2 | 7 | 6 | 6 | 1 | 5 | 3 | 33 | 19 | 2 | 2 |
| Cambodia | 1488 | 32 | 17 | 1 | 17 | 1 | 8 | 6 | 6 | 0 | 1 | 3 | 19 | 25 | 0 | 0 |
| Indonesia | 1860 | 15 | 9 | 1 | 9 | 1 | 22 | 1 | 1 | 5 | 4 | 7 | 50 | 6 | 4 | 4 |
| Nepal | 1911 | 14 | 12 | 4 | 12 | 4 | 4 | 5 | 5 | 1 | 8 | 2 | 40 | 20 | 4 | 4 |
| Philippines | 1158 | 35 | 27 | 1 | 27 | 1 | 4 | 11 | 11 | 1 | 1 | 10 | 37 | 5 | NA | NA |
| | | 16 | 9 | 3 | 9 | 3 | 18 | 7 | 7 | 1 | 8 | 2 | 41 | 12 | 0 | 0 |
| Sub Saharan Africa | | | | | | | | | | | | | | | | |
| Benin | 892 | 19 | 18 | 2 | 18 | 2 | 16 | 8 | 8 | 7 | 4 | 10 | 22 | 8 | 4 | 4 |
| Burkina Faso | 2180 | 36 | 12 | 3 | 12 | 3 | 11 | 6 | 6 | 12 | 5 | 15 | 15 | 6 | 3 | 3 |
| Cameroon | 913 | 28 | 13 | 1 | 13 | 1 | 5 | 11 | 11 | 5 | 12 | 19 | 9 | 5 | 8 | 8 |
| Chad | 457 | 31 | 15 | 5 | 15 | 5 | 8 | 5 | 5 | 12 | 4 | 8 | 13 | 13 | 6 | 6 |
| Congo | 794 | 14 | 9 | 1 | 9 | 1 | 28 | 4 | 4 | 15 | 3 | 9 | 17 | 6 | 4 | 4 |
| Ethiopia | 2444 | 21 | 27 | 2 | 27 | 2 | 10 | 6 | 6 | 8 | 8 | 4 | 17 | 7 | 6 | 6 |
| Gabon | 917 | 6 | 19 | 1 | 19 | 1 | 17 | 8 | 8 | 11 | 2 | 15 | 21 | 14 | 3 | 3 |
| Ghana | 942 | 23 | 2 | 2 | 2 | 2 | 17 | 7 | 7 | 8 | 9 | 5 | 18 | 15 | 5 | 5 |
| Guinea | 1072 | 22 | 20 | 3 | 20 | 3 | 4 | 3 | 3 | 7 | 8 | 8 | 34 | 7 | 4 | 4 |
| Kenya | 935 | 18 | 40 | 3 | 40 | 3 | 25 | 7 | 7 | 5 | 3 | 8 | 26 | 1 | 0 | 0 |
| Lesotho | 948 | 16 | 31 | 2 | 31 | 2 | 11 | 11 | 11 | 2 | 3 | 6 | 36 | 5 | 2 | 2 |
| Madagascar | 950 | 21 | 0 | 5 | 0 | 5 | 8 | 9 | 9 | 2 | 5 | 4 | 31 | 5 | 4 | 4 |
| Malawi | 1597 | 9 | 10 | 1 | 10 | 1 | 9 | 6 | 6 | 13 | 4 | 13 | 40 | 2 | 11 | 11 |
| Mali | 2138 | 18 | 23 | 4 | 23 | 4 | 10 | 7 | 7 | 1 | 1 | 4 | 34 | 8 | 3 | 3 |
| Mauritania | 999 | 10 | 12 | 1 | 12 | 1 | 20 | 10 | 10 | 10 | 4 | 11 | 21 | 7 | 6 | 6 |
| Mozambique | 1199 | 19 | 11 | 2 | 11 | 2 | 40 | 9 | 9 | 13 | 1 | 9 | 20 | 8 | 5 | 5 |
| Namibia | 395 | 39 | 23 | 4 | 23 | 4 | 9 | 8 | 8 | 4 | 3 | 13 | 15 | 8 | 2 | 2 |
| Nigeria | 631 | 13 | 14 | 7 | 14 | 7 | 14 | 10 | 10 | 6 | 3 | 4 | 24 | 10 | 8 | 8 |
| Rwanda | 1540 | 19 | 18 | 2 | 18 | 2 | 24 | 7 | 7 | 9 | 3 | 9 | 13 | 7 | 5 | 5 |
| Senegal | 2166 | 10 | 41 | 3 | 41 | 3 | 19 | 7 | 7 | 6 | 2 | 5 | 18 | 6 | 1 | 1 |
| Tanzania | 1197 | 16 | 25 | 1 | 25 | 1 | 18 | 11 | 11 | 4 | 3 | 6 | 24 | 7 | 3 | 3 |
| Uganda | 1162 | 24 | 3 | 0 | 3 | 0 | 14 | 11 | 11 | 2 | 1 | 8 | 32 | 8 | 1 | 1 |
| Zambia | 848 | 15 | 18 | 6 | 18 | 6 | 5 | 14 | 14 | 5 | 7 | 13 | 25 | 7 | 3 | 3 |
| Zimbabwe | 315 | 30 | 26 | 11 | 26 | 11 | 4 | 6 | 6 | 1 | 1 | 7 | 18 | 9 | 2 | 2 |
| | | 27 | 7 | 7 | 7 | 7 | 13 | 9 | 9 | 0 | 9 | 4 | 20 | 9 | 2 | 2 |

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

Table 3. Odds ratios of the association of sociodemographic characteristics with the probability of citing supply-side or exposure-related reasons for not using contraception, by country†

| Country | n | Relative odds of citing a "supply-side" reason for non-use | | | | | | | | | | Relative odds of citing an exposure-related reason | | | | | | | | | |
|--------------------------------------|------|--|--------|-----------|----------|-----------|--------|-----------------|---------|---------|---------|--|----------|-----------|--------|-----------------|-----|--|--|--|--|
| | | Age | | Residence | | Education | | Ever use of fp* | | Age | | Residence | | Education | | Ever use of fp* | | | | | |
| | | < 25 | ≥ 25 | Rural | Urban | < 7yrs | ≥ 7yrs | No | Yes | < 25 | ≥ 25 | Rural | Urban | < 7yrs | ≥ 7yrs | No | Yes | | | | |
| Latin America & Caribbean | | | | | | | | | | | | | | | | | | | | | |
| Colombia | 787 | 2.89 | 2.58 | 2.31 | 2.37 | 2.49** | | | 2.11 | 3.40* | 2.67* | 3.03** | 3.66*** | | | | | | | | |
| Dominican Republic | 966 | 0.85 | 0.77 | 0.64 | 0.93 | 2.63*** | | | 2.04 | 0.74 | 1.06 | 1.83** | 3.00*** | | | | | | | | |
| Haiti | 1603 | 1.14 | 0.83 | 1.06 | 0.76 | 1.63* | | | 0.92 | 0.44** | 0.98 | 0.62 | 1.67** | | | | | | | | |
| Honduras | 1422 | 2.32*** | 2.43** | 0.70 | 2.98** | 2.19*** | | | 1.69** | 1.05 | 0.69 | 3.08*** | 3.93*** | | | | | | | | |
| Nicaragua | 684 | 0.83 | 0.77 | 1.16 | 0.72 | 3.30*** | | | 0.80 | 0.71 | 1.93* | 0.95 | 4.05*** | | | | | | | | |
| Peru | 453 | 1.41 | 0.44 | 1.74 | 0.60 | 8.11*** | | | 2.31 | 0.74 | 2.50 | 1.15 | 13.48*** | | | | | | | | |
| North Africa/West Asia | | | | | | | | | | | | | | | | | | | | | |
| Armenia | 458 | 2.51* | 2.33 | 1.44 | 0.93 | 1.64 | | | 1.22 | 1.35 | 1.19 | 1.33 | 2.64*** | | | | | | | | |
| Egypt | 1436 | 0.79 | 1.33 | 2.30*** | 1.05 | 3.54*** | | | 0.79 | 0.76 | 0.89 | 1.21 | 4.23*** | | | | | | | | |
| Morocco | 689 | 0.83 | 0.41 | 1.74 | 1.51 | 3.53*** | | | 0.76 | 0.36 | 1.81 | 2.38 | 3.81*** | | | | | | | | |
| South & Southeast Asia | | | | | | | | | | | | | | | | | | | | | |
| Bangladesh | 770 | 0.62 | 0.61 | 1.15 | 1.91 | 7.48*** | | | 0.47** | 0.26*** | 0.81 | 2.82*** | 6.07*** | | | | | | | | |
| Cambodia | 1497 | 1.16 | 1.32 | 0.86 | 1.42 | 1.11 | | | 1.08 | 1.27 | 1.19 | 1.24 | 1.04 | | | | | | | | |
| Indonesia | 1527 | 1.19 | 2.03 | 0.64 | 1.42 | 8.79*** | | | 0.46 | 0.70 | 0.70 | 1.38 | 9.10*** | | | | | | | | |
| Nepal | 1840 | 1.34 | 1.72 | 2.02* | 0.71 | 2.63*** | | | 1.46 | 0.96 | 1.34 | 1.57 | 3.27*** | | | | | | | | |
| Sub-Saharan Africa | | | | | | | | | | | | | | | | | | | | | |
| Benin | 826 | 1.68 | 2.05 | 0.94 | 1.02 | 1.43 | | | 1.39 | 1.83 | 1.46 | 1.08 | 0.89 | | | | | | | | |
| Burkina Faso | 784 | 0.88 | 0.90 | 0.78 | 0.90 | 1.26 | | | 0.93 | 1.17 | 0.78 | 0.72 | 0.82 | | | | | | | | |
| Cameroon | 343 | 0.77 | 0.94 | 0.95 | 2.39*** | 4.61*** | | | 0.94 | 1.76 | 1.42 | 1.86** | 1.44 | | | | | | | | |
| Congo | 1666 | 1.25 | 0.41 | 0.48 | 0.56 | 3.21 | | | 1.94 | 1.63 | 1.15 | 0.45** | 0.37 | | | | | | | | |
| Ethiopia | 432 | 0.57* | 0.56* | 4.10*** | 1.12 | 3.48*** | | | 0.64* | 0.58* | 1.94* | 0.92 | 2.15** | | | | | | | | |
| Gabon | 897 | 2.06 | 1.25 | 1.18 | 1.33 | 1.73** | | | 1.48 | 0.67 | 0.81 | 1.53 | 2.21** | | | | | | | | |
| Ghana | 1069 | 0.80 | 2.30 | 1.52 | 0.91 | 1.10 | | | 0.62 | 1.69 | 1.44 | 0.94 | 2.46*** | | | | | | | | |
| Guinea | 808 | 0.66 | 0.95 | 1.01 | 1.14 | 0.74 | | | 1.12 | 0.78 | 1.03 | 1.09 | 0.85 | | | | | | | | |
| Kenya | 755 | 1.10 | 1.23 | 1.53 | 1.12 | 1.88*** | | | 0.62 | 0.74 | 0.99 | 1.77** | 2.61*** | | | | | | | | |
| Lesotho | 743 | 0.52* | 0.47* | 2.62** | 0.89 | 1.69** | | | 0.43** | 0.45* | 4.97*** | 1.08 | 2.11*** | | | | | | | | |
| Madagascar | 1487 | 0.49 | 0.76 | 0.70 | 1.03 | 1.75 | | | 0.34** | 0.31* | 0.77 | 0.68 | 5.83*** | | | | | | | | |
| Malawi | 1862 | 0.98 | 0.62 | 0.93 | 1.51** | 2.71*** | | | 0.73 | 0.50** | 0.75 | 2.23*** | 3.12*** | | | | | | | | |
| Mali | 831 | 1.89** | 1.49 | 1.08 | 0.55* | 0.86 | | | 1.02 | 0.53* | 1.23 | 1.11 | 1.34 | | | | | | | | |
| Mauritania | 1122 | 1.55 | 1.31 | 1.16 | 0.91 | 1.55* | | | 1.15 | 1.00 | 1.66 | 1.03 | 1.64* | | | | | | | | |
| Mozambique | 547 | 0.79 | 1.10 | 1.34 | 0.43 | 2.18*** | | | 0.77 | 0.72 | 1.36 | 1.35 | 1.24 | | | | | | | | |
| Nigeria | 1439 | 0.91 | 0.54 | 1.60 | 0.93 | 1.77* | | | 1.15 | 0.97 | 0.95 | 1.03 | 2.13** | | | | | | | | |
| Rwanda | 2027 | 1.02 | 0.68 | 0.72 | 0.98 | 1.91*** | | | 0.78 | 0.50** | 0.87 | 1.43* | 2.80*** | | | | | | | | |
| Senegal | 1052 | 1.31 | 1.43 | 1.73*** | 2.22** | 1.72*** | | | 0.99 | 0.89 | 1.31 | 2.19* | 1.76*** | | | | | | | | |
| Tanzania | 940 | 0.89 | 0.79 | 1.15 | 0.77 | 2.88*** | | | 0.43*** | 0.34*** | 1.19 | 0.89 | 2.85*** | | | | | | | | |
| Uganda | 790 | 1.39 | 1.28 | 1.87** | 0.62* | 1.42 | | | 1.98* | 1.33 | 1.81* | 0.73 | 2.46*** | | | | | | | | |
| Zambia | 310 | 1.09 | 0.53 | 0.83 | 0.95 | 1.20 | | | 0.89 | 0.37** | 1.34 | 0.92 | 1.48 | | | | | | | | |
| Zimbabwe | 2.71 | 6.19** | 0.31** | 0.92 | 13.17*** | 0.85 | | | 1.20 | 1.20 | 0.69 | 0.85 | 2.89*** | | | | | | | | |

† This analysis includes all women who have unmet need for contraception. Odds ratios in each row are based on a multinomial logit model that includes age, parity, education, residence, wealth status, and ever use of contraception as explanatory factors. Reference group for the outcome variable is women who cited self or other people's opposition to family planning as a reason for non-use. *p<0.10 **p<0.05 ***p<0.01. Models deemed unstable by SPSS in Bolivia, Chad, Philippines and Namibia.

Table 4. Percentage of married women 15–49 with unmet need who intend to use a method, by country and region, according to their reasons for not currently using a method

| Region/country | Among women with the following reasons for non-use, % who intend to use a method in the future | | | | | | | | | | | |
|--------------------------------------|--|-----------------------|--|--------------------|-----------------------|-------------------------------|--------------------------|---------------------|-------------------------|--|-------|---------------|
| | % intend to use | Infrequent/ no sex | Postpartum amenorrhea/ breastfeeding | Subferti- cund* | Respondent opposed | Partner/ others opposed | Unaware of methods | Cost too high | No source/ access | Health/side effects/ inconvenience | Other | Don't know |
| Latin America & Caribbean | | | | | | | | | | | | |
| Bolivia | 77 | 71 | 93 | 40 | 42 | 62 | 66 | 78 | 85 | 65 | 81 | 84 |
| Colombia | 91 | 92 | 100 | 59 | 57 | 64 | † | 96 | † | 84 | 88 | 94 |
| Dominican Republic | 86 | 92 | 97 | 63 | 70 | 64 | † | 84 | 95 | 78 | 87 | 86 |
| Haiti | 72 | 77 | 95 | 42 | 42 | 76 | 81 | 93 | 88 | 51 | 76 | 84 |
| Honduras | 84 | 87 | 95 | 55 | 51 | 72 | † | 91 | 81 | 73 | 75 | 75 |
| Nicaragua | 79 | 80 | 97 | 54 | 52 | 68 | † | † | 87 | 76 | 79 | 77 |
| Peru | 89 | 89 | 97 | † | † | 84 | † | † | 96 | 79 | 91 | † |
| North Africa & West Asia | | | | | | | | | | | | |
| Armenia | 79 | 87 | 92 | 37 | 65 | 71 | † | † | † | 56 | † | † |
| Egypt | 78 | 86 | 97 | 31 | 32 | 69 | na | † | † | 59 | † | † |
| Morocco | 64 | 71 | 86 | 17 | 43 | † | † | † | † | 46 | 55 | 24 |
| South & Southeast Asia | | | | | | | | | | | | |
| Bangladesh | 89 | 87 | 99 | † | 51 | 81 | † | † | 100 | 86 | 88 | na |
| Cambodia | 69 | 60 | 92 | 47 | 68 | 51 | 84 | 85 | 75 | 67 | 62 | 77 |
| Indonesia | 67 | 65 | 87 | 42 | 38 | 34 | 65 | 53 | 74 | 56 | 73 | 70 |
| Nepal | 84 | 89 | 94 | † | 37 | 79 | 66 | 82 | 86 | 71 | 57 | 71 |
| Philippines | 59 | 63 | 87 | 41 | 37 | 45 | 55 | 51 | 58 | 45 | 59 | † |
| Sub-Saharan Africa | | | | | | | | | | | | |
| Benin | 74 | 70 | 89 | 37 | 45 | 84 | 86 | 86 | 84 | 63 | 92 | 73 |
| Burkina Faso | 82 | 77 | 87 | 50 | 64 | 79 | 72 | 96 | 83 | 66 | 89 | 85 |
| Cameroon | 69 | 75 | 78 | 32 | 37 | 44 | 79 | 85 | 86 | 54 | 66 | 69 |
| Chad | 43 | 65 | 36 | † | 19 | 35 | 13 | † | 18 | 43 | 66 | 61 |
| Congo | 78 | 86 | 86 | † | 50 | 49 | 83 | 65 | † | 70 | 88 | † |
| Ethiopia | 72 | 68 | 87 | 33 | 53 | 75 | 66 | 97 | 81 | 69 | 77 | 65 |
| Gabon | 65 | 72 | † | † | 46 | 68 | 62 | 84 | 64 | 59 | 59 | 64 |
| Ghana | 70 | 69 | 90 | 36 | 40 | 84 | 73 | 71 | 68 | 49 | 94 | 62 |
| Guinea | 61 | 54 | 65 | 21 | 43 | 60 | 82 | 83 | 80 | 60 | † | † |
| Kenya | 78 | 79 | 93 | 49 | 41 | 66 | 64 | 93 | 89 | 69 | 97 | 65 |
| Lesotho | 72 | 77 | † | 32 | 57 | 71 | 79 | 80 | 89 | 60 | 57 | 83 |
| Madagascar | 60 | 72 | † | † | 26 | 44 | 64 | 76 | 68 | 43 | 95 | 62 |
| Malawi | 84 | 87 | 94 | 58 | 63 | 82 | † | 85 | 95 | 77 | 94 | 76 |
| Mali | 66 | 63 | 72 | † | 45 | 67 | 66 | 81 | 80 | 62 | 82 | 75 |
| Mauritania | 30 | 31 | 23 | † | 18 | 43 | 24 | † | 20 | 35 | 41 | 29 |
| Mozambique | 70 | 75 | 83 | 29 | 43 | 71 | 64 | 72 | 79 | 57 | 69 | 66 |
| Namibia | 75 | 70 | 92 | 52 | 64 | 68 | 47 | 66 | 92 | 71 | 79 | 84 |
| Nigeria | 54 | 54 | 58 | † | 33 | 44 | 68 | 50 | 68 | 51 | 90 | 50 |
| Rwanda | 75 | 56 | 89 | 51 | 47 | 60 | 88 | 82 | 84 | 61 | 91 | † |
| Senegal | 48 | 50 | 56 | 11 | 16 | 42 | 57 | 77 | 64 | 40 | 69 | 73 |
| Tanzania | 74 | 80 | 91 | 75 | 51 | 65 | 75 | † | 81 | 58 | 89 | † |
| Uganda | 84 | 78 | 94 | 54 | 57 | 79 | 84 | 97 | 89 | 72 | 94 | 83 |
| Zambia | 85 | 83 | 94 | 38 | 71 | 79 | 92 | 87 | 91 | 80 | 94 | 86 |
| Zimbabwe | 79 | 79 | 96 | 44 | 52 | 65 | † | 83 | † | 74 | 78 | 72 |

*Includes some women who may be infertile or menopausal or have had a hysterectomy.

†Too few cases citing specific reason for analysis (<20).

Table 5. Odds ratios of the association of reasons for contraceptive non-use with intention to use a method in the future among married women, by country

| Country | n | Exposure | Supply: | |
|--------------------------------------|------|-------------------------------------|----------------------------------|--|
| | | Perceived low risk of pregnancy (1) | Unaware of methods/ Cost/ access | Side effects/ health fears / inconvenience |
| Latin America & Caribbean | | | | |
| Bolivia | 1464 | 1.37 | 1.37 | 0.79 |
| Colombia | 782 | 3.19* | 6.59*** | 1.41 |
| Haiti | 1600 | 4.42*** | 6.31*** | 0.68 |
| Honduras | 1332 | 2.84*** | 1.93 | 1.19 |
| Nicaragua | 671 | 3.20*** | 4.40*** | 1.89** |
| Peru | 433 | 3.87* | 8.39** | 1.65 |
| North Africa/West Asia | | | | |
| Armenia | 452 | 3.27*** | 0.73 | 0.62 |
| Egypt | 1429 | 2.29*** | 0.96 | 0.91 |
| Morocco | 676 | 1.78* | 0.48 | 0.95 |
| South & Southeast Asia | | | | |
| Bangladesh | 702 | 3.88*** | 12.45* | 3.93** |
| Indonesia | 1440 | 3.34*** | 1.96* | 1.60 |
| Nepal | | | | |
| Philippines | 1057 | 2.42*** | 1.42 | 1.01 |
| Sub Saharan Africa | | | | |
| Benin | 808 | 1.27 | 3.93*** | 0.89 |
| Burkina Faso | 1798 | 1.04 | 1.78*** | 0.47*** |
| Cameroon | 761 | 2.02*** | 5.69*** | 0.96 |
| Chad | 439 | 3.57*** | 0.91 | 2.30** |
| Congo | | | | |
| Ethiopia | 1615 | 2.26*** | 1.81*** | 1.17 |
| Gabon | | | | |
| Ghana | 893 | 1.79** | 1.65* | 0.51*** |
| Guinea | 1067 | 1.59*** | 4.85*** | 1.48** |
| Kenya | 787 | 4.52*** | 5.48*** | 1.32 |
| Lesotho | 877 | 0.71 | 1.89* | 0.57*** |
| Madagascar | 737 | 5.26*** | 3.15*** | 1.18 |
| Malawi | 1474 | 2.41*** | 5.71*** | 1.13 |
| Mali | 1841 | 1.43* | 2.31*** | 1.28 |
| Mauritania | 815 | 1.03 | 1.39 | 1.35 |
| Mozambique | 1084 | 1.43 | 1.92** | 0.68 |
| Namibia | 369 | 2.21** | 1.07 | 1.33 |
| Nigeria | 530 | 1.47 | 3.00*** | 1.07 |
| Rwanda | 1415 | 4.09*** | 4.49*** | 1.23 |
| Senegal | 1991 | 1.213*** | 4.66*** | 1.18 |
| Tanzania | 1143 | 1.55** | 2.07** | 0.44*** |
| Uganda | 925 | 0.94 | 2.53*** | 0.52** |
| Zambia | 773 | 0.55 | 1.44 | 0.64 |
| Zimbabwe | 302 | 1.63 | 3.66 | 1.71 |

†This analysis is among married women who have unmet need. Odds ratios in each row are based on a logistic regression model that includes reasons for non-use, age, parity, residence, education, wealth status and ever use of contraception as explanatory factors. The reference category for the outcome variable is the group of women who do not intend to use a method.

(1) Includes infrequent or no sex, post-partum amenorrhic, breastfeeding, and subfecund.

*p<=0.10 **p<=0.05 ***p<=0.01

Models deemed unstable by SPSS in Dominican Republic and Cambodia

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