

# How Universal is Access to Reproductive Health?

A review of the evidence



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# CONTENTS

<b>PREFACE</b> .....	5
<b>EXECUTIVE SUMMARY</b> .....	6
<b>CHAPTER 1. REPRODUCTIVE HEALTH AND THE MILLENNIUM DEVELOPMENT GOALS</b> .....	7
How this report is organized .....	8
<b>CHAPTER 2. MEASURING PROGRESS</b> .....	9
Reproductive health indicators and data availability .....	9
Understanding averages and uncovering disparities .....	10
Three key indicators for reproductive health .....	10
<b>CHAPTER 3. GLOBAL AND REGIONAL LEVELS AND TRENDS</b> .....	12
Adolescent birth rates: global progress slows .....	12
Wide disparities in adolescent birth rates among regions .....	12
Significant gaps in family planning demand and use .....	14
Persistent regional disparities in unmet need for family planning .....	15
Latin America and the Caribbean: a complicated picture .....	17
The Commonwealth of Independent States: additional data required .....	17
Southern Asia: increased contraceptive prevalence and large country influence .....	17
Sub-Saharan Africa: low contraceptive use and high unmet need .....	18
Stymied progress in satisfying demand for family planning .....	18
<b>CHAPTER 4. TRENDS IN SUB-SAHARAN AFRICA: DISPARITIES AND INEQUALITIES</b> .....	20
Adolescent birth rates: widening disparities within countries .....	20
Contraceptive use: influenced by wealth, education, residence and age .....	22
Disparities in unmet need for family planning .....	24
Least progress among groups of women that lag farthest behind .....	24
Diversity at the country level: Madagascar and the United Republic of Tanzania .....	27
Satisfied demand for family planning in sub-Saharan Africa: still the lowest in the world .....	27
<b>CHAPTER 5. CONCLUSION</b> .....	29
<b>NOTES AND REFERENCES</b> .....	30
<b>ANNEXES</b>	
Annex I. Millennium Development Goals, targets and indicators .....	31
Annex II. Recent country estimates for three reproductive health indicators .....	34
Annex III. Trends and disparities in reproductive health for selected countries in sub-Saharan Africa .....	39

## TABLES

Table 1. Millennium Development Goal 5 targets and indicators . . . . .	7
Table 2. Adolescent birth rate by region, 1990, 2000 and 2007 . . . . .	13
Table 3. Contraceptive prevalence rate and unmet need for family planning, by region, 1990, 2000 and around 2007 . . . . .	16
Table 4. Changes in key reproductive health indicators by country and type of change . . . . .	26

## FIGURES

Figure 1. Trend in global adolescent birth rate, 1990, 2000 and around 2007 . . . . .	12
Figure 2. Global trends in contraceptive prevalence and unmet need for family planning, 1990, 2000 and around 2007 . . . . .	15
Figure 3. Trends in proportion of demand satisfied for family planning, by region, 1990, 2000 and around 2007 . . . . .	19
Figure 4. Adolescent birth rates by background characteristics in 24 sub-Saharan African countries, at most recent survey, 1998-2008 . . . . .	20
Figure 5. Trends in adolescent birth rates by background characteristics in 24 sub-Saharan African countries with two consecutive surveys, 1988-2003 and 1998-2008 . . . . .	21
Figure 6. Contraceptive prevalence by background characteristics for 24 sub-Saharan African countries at most recent survey, 1998-2008 . . . . .	21
Figure 7. Trends in contraceptive prevalence by background characteristics for 24 sub-Saharan African countries with two consecutive surveys, 1994-2003 and 1998-2008 . . . . .	22
Figure 8. Trends in contraceptive prevalence rate by age groups for 24 sub-Saharan African countries with two consecutive surveys, 1994-2003 and 1998-2008 . . . . .	23
Figure 9. Unmet need for family planning by background characteristics in 22 sub-Saharan African countries at most recent survey, 1998-2008 . . . . .	23
Figure 10. Trends in unmet need for family planning by background characteristics in 22 sub-Saharan African countries with two consecutive surveys, 1986-2003 and 1998-2008 . . . . .	24
Figure 11. Trends in unmet need for family planning by age group for 22 sub-Saharan African countries with two consecutive surveys, 1986-2003 and 1998-2008 . . . . .	25
Figure 12. Trends in proportion of demand satisfied for family planning by background characteristics in 22 sub-Saharan African countries with two consecutive surveys, 1988-2003 and 1998-2008 . . . . .	28

## MAPS

Map 1. Adolescent birth rates by country, most recent estimates . . . . .	14
Map 2. Contraceptive prevalence, by country, most recent estimates . . . . .	18
Map 3. Unmet need for family planning, by country, most recent estimates . . . . .	19

# Preface

**E**nsuring universal access to reproductive health, empowering women, men and young people to exercise their right to reproductive health, and reducing related inequities are central to development and to ending poverty. This was recognized more than 15 years ago at the International Conference on Population and Development (ICPD) in Cairo and was reaffirmed in 2007, when universal access to reproductive health became a target of the Millennium Development Goals.

Much progress has been made since the Cairo conference. The concept of reproductive health is now accepted around the world, and in most countries policies and laws have been adopted to protect individuals and to guide programmes to improve access to maternal and child health, to make family planning more widely accessible, to prevent and treat HIV and to provide support to those living with the virus. Through these interventions, many lives have been saved and countless others have been made better. Yet much remains to be done.

UNFPA is proud to present three publications on sexual and reproductive health that assess the situation at this critical time and look at universal access from many different angles.

This report, ***How Universal is Access to Reproductive Health? A review of the evidence***, looks at current data, trends and disparities in universal access to reproductive health, the second target of Millennium Development Goal 5. While recognizing the continuing challenge of measuring key indicators for this target (adolescent fertility, contraceptive prevalence and the unmet need for family planning), the report finds that earlier progress has slowed. Moreover, disparities in access based on wealth, education and rural or urban residence have widened. The report demonstrates clearly that intensified efforts are needed to extend reproductive health to all, and that quality data is essential to monitor progress and identify priorities for action.

The two other publications are:

***Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*** is the ultimate response to a few key questions: What does universal access to reproductive health mean? Why is it important? What have we achieved so far? And where do we go from here?

***Eight Lives: Stories of reproductive health*** gives a human face to our work. This publication tells the story of eight women who have endured—and overcome—the plight of poor sexual and reproductive health.

My hope is that these publications will contribute to a deeper understanding of the complexity and the centrality of reproductive health, and that they will lead to accelerated progress, along with heightened commitment and an all-too-real sense of urgency.

**Thoraya Ahmed Obaid**  
UNFPA Executive Director  
September 2010

# Executive summary

Ten years ago, in 2000, representatives from 189 United Nations Member States adopted the Millennium Declaration, affirming their shared commitment to reducing poverty and improving the quality of life for all. These commitments were translated into eight Millennium Development Goals (MDGs), including MDG5: Improve maternal health. Under this goal are two targets: MDG5.A—to reduce maternal mortality, and MDG5.B—to achieve universal access to reproductive health.

The emphasis of this report is on identifying areas where progress has been made and where it has lagged for three indicators of access to reproductive health: adolescent birth rate, contraceptive prevalence rate and unmet need for family planning.

Empirical evidence for these three indicators is drawn from data compiled by the United Nations Population Division and from an analysis performed by UNFPA using Demographic and Health Survey data. The report reviews global, regional and country estimates to assess current levels and trends between 1990 and 2008. It also examines disparities in access in sub-Saharan Africa linked to key social and economic background characteristics: age (for contraceptive prevalence and unmet need for family planning), urban or rural residence, household wealth and educational attainment. Disaggregating data in this way emphasizes the extent and growth of internal disparities that may easily be overlooked in discussions that address only national or regional averages.

## Key findings

**Progress since 1990 has been substantial, but has stalled in the last decade.** This report finds that, since 1990, improvements in access to reproductive health have been significant and

far-reaching, with substantial declines in adolescent birth rates and increased access to and use of family planning services. However, global averages remain largely unchanged since 2000.

**Diversity among regions has grown since 2000.** All regions, with the exception of sub-Saharan Africa, showed major declines in adolescent birth rates during the 1990s. Those declines have continued since 2000 in two regions—Latin America and the Caribbean and Southern Asia. Levels of access to reproductive health are diverse among developing regions, particularly since 2000.

**The poorest, least educated women in sub-Saharan Africa have lost ground, with adolescents lagging farthest behind.** The data for 24 sub-Saharan African countries show that, while the region falls far behind the others on all three indicators, many women, including the wealthiest and those with secondary or higher levels of education, have seen notable progress in recent years. However, in many settings, the poorest, least educated women have lost significant ground, and adolescent girls retain the lowest level of contraceptive use and the highest level of unmet need for family planning.

This report demonstrates the value of high-quality disaggregated data, collected at regular intervals, for monitoring progress, understanding population dynamics, identifying underserved groups and setting priorities for expanding access to reproductive health. Investing in data and research is a critical first step to improving our understanding of factors influencing fertility among adolescents as well as factors affecting demand and use of contraceptives, and to promoting cost-effective interventions.

# Reproductive health and the Millennium Development Goals

Ten years ago, in 2000, representatives from 189 United Nations Member States adopted the Millennium Declaration, affirming their shared commitment to reducing poverty and improving the quality of life for all. These commitments were translated into eight Millennium Development Goals (MDGs), supported by 21 targets and 60 indicators<sup>1</sup> that constitute a comprehensive, mutually reinforcing and concrete blueprint for guiding priorities and measuring progress towards a 2015 deadline. The MDGs have been adopted by national governments and international institutions, including the United Nations. UNFPA, the United Nations Population Fund, is committed to all eight MDGs, but works most directly on MDG3 (Promote gender equality and empower women), MDG4 (Reduce child mortality), MDG5 (Improve maternal health) and MDG6 (Combat HIV/AIDS, malaria and other major diseases), and how they relate to each other.<sup>2</sup>

Maternal health has been treated as an integral element of the MDG agenda from the beginning. MDG5 (Improve maternal health) was originally defined using the maternal mortality ratio and the proportion of births attended by skilled health personnel as indicators. Access to skilled care at delivery provides a measure of whether women have the care they need to survive childbirth. Skilled care often means the difference between life and death: health workers, if properly trained and equipped, are able to identify potentially dangerous complications and either treat or refer women to providers with the skills to treat obstructed labour, haemorrhage and other common complications that become life-threatening without medical attention.

A 2005 World Summit reviewed progress towards the MDGs, and world leaders reaffirmed<sup>3</sup> the role of reproductive health in advancing all eight goals and maternal health in particular. Furthermore, they recognized that improving women's chances

of surviving pregnancy and childbirth relies on their access to reproductive health, including family planning. While every pregnancy carries risks that must be addressed by skilled health providers, the timing, spacing and, above all, women's ability to decide when to become mothers are essential to determining their own and their children's health. Moreover, improvements in reproductive health can contribute to gender equality, child health, universal education, halting the spread of HIV and reducing poverty overall—and vice versa. In order to achieve gains related to reproductive health, world leaders recognized that explicit attention to this area and concrete indicators of progress were required.

Following the 2005 summit, a new target—universal access to reproductive health—was added to MDG5 to reflect this reality. The target, now known as MDG5.B, includes four distinct

**TABLE 1**  
Millennium Development Goal 5 targets and indicators

## MDG5: Improve maternal health

<b>Target 5.A:</b> Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	<b>5.1</b> Maternal mortality ratio <b>5.2</b> Proportion of births attended by skilled health personnel
<b>Target 5.B:</b> Achieve, by 2015, universal access to reproductive health	<b>5.3</b> Contraceptive prevalence rate <b>5.4</b> Adolescent birth rate <b>5.5</b> Antenatal care coverage (at least one visit and at least four visits) <b>5.6</b> Unmet need for family planning

*In 2005, world leaders reaffirmed that improvements in reproductive health can contribute to gender equality, child health, universal education, halting the spread of HIV and reducing poverty overall*

but related indicators: adolescent birth rate, contraceptive prevalence rate, unmet need for family planning, and antenatal care coverage (Table 1). The target of universal access to reproductive health and the indicators that make up MDG5.B complement MDG5.A by placing maternal mortality and access to skilled care during delivery in the broader context of women's reproductive health throughout the life cycle. What is more, MDG5.B indicators have been shown to be essential and cost-effective areas for investment in maternal health.<sup>4</sup>

## How this report is organized

This report presents a summary of the empirical evidence for three of the four indicators that are used to track progress towards MDG5.B, using data compiled by the United Nations Population Division. Chapter 4 is an analysis by UNFPA of data derived from Demographic and Health Surveys (DHS) in 24 sub-Saharan African countries.<sup>5</sup>

The three indicators discussed in the report—adolescent birth rate, contraceptive prevalence rate and unmet need for family

planning—have received less attention than the two indicators for MDG5.A and the fourth indicator for MDG 5.B (antenatal care coverage).<sup>6</sup> Chapter 2 defines these three indicators and explores other concepts and challenges for measuring progress.

Chapter 3 presents country, regional and global estimates and assesses trends between 1990 and around 2007 using data from household surveys, censuses and vital registration systems.

Chapter 4 looks at disparities associated with key social and economic background characteristics: age (for contraceptive prevalence and unmet need for family planning), urban or rural residence, household wealth and educational attainment. The assessment is carried out in a descriptive manner and addresses associations between the indicators and three background characteristics that serve as important explanatory variables.<sup>7</sup> Disaggregating data in this way emphasizes the extent and growth of internal disparities that may easily be overlooked in discussions that address only national or regional averages. The analysis focuses on 24 countries in sub-Saharan Africa (representing 66 per cent of the region's population).

Chapter 5 concludes the report with a summary of findings, which are intended to inform efforts to advance universal access to reproductive health at the global, regional and country levels and to address inequities.

# Measuring progress

According to the definition first put forth in the International Conference on Population and Development's (ICPD) Programme of Action, and reaffirmed at the 2005 MDG summit, "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."<sup>8</sup> This expansive definition of reproductive health was underpinned by a shift to a comprehensive approach to health, placing a high priority on human rights.<sup>9</sup>

The factors that shape reproductive health are difficult to quantify: access to reproductive health is determined by social, cultural, financial and legal issues. These include norms regarding marriage, childbearing and sexuality as well as exclusionary factors such as social status and ethnicity. Reproductive health is also influenced by women's access to education and economic advancement and the capacity of health systems to provide quality services for all, despite differences in wealth, location of residence or age. Universal access to reproductive health affects and is affected by many aspects of life and involves individuals' most intimate relationships, including negotiation and decision-making within sexual relationships and interactions with health providers regarding contraceptive methods and options.

## Reproductive health indicators and data availability

The emphasis of this report is on identifying areas where progress has been made and where it has lagged for three MDG5.B indicators: adolescent birth rate, contraceptive prevalence rate and unmet need for family planning. These indicators highlight a set of issues and interventions that are central, but often neglected, parts of the continuum-of-care

approach to maternal, newborn and child health<sup>10</sup> supported by the health-related MDGs. Evidence suggests that these three indicators are among the most resistant to progress of all the MDG indicators.<sup>11</sup>

*Evidence suggests that these three indicators are among the most resistant to progress of all the MDG indicators*

Data from household surveys, censuses and vital registration systems are used to produce country, regional and global estimates and to assess trends over the period 1990 to around 2007. The availability and quality of data are significant factors in shaping this analysis. For example, while the lack of data on unmet need in developed regions limits the comparability of information on this indicator at the global level, this indicator is relatively well documented in other regions, most notably sub-Saharan Africa, where unmet need is believed to be among the highest in the world.

Data on adolescent birth rates are available for at least one year since 2000 for 216 countries; 187 of these countries had data available for more than one year between 2000 and 2008. Contraceptive prevalence was measured in 144 countries, 84 of which had data for more than one year. In comparison, only 75 countries had data available on unmet need for family planning, and these countries were almost exclusively in developing regions; change over time was measured in only 30 countries where data were available for more than one year. Measurements of the proportion of demand satisfied are derived from available data on contraceptive prevalence and unmet need, so can be calculated only for regions where both figures are available.

Chapter 4 presents data drawn from two recent Demographic and Health Surveys for 24 sub-Saharan African countries. The first surveys were conducted between 1986 and 2003 and the second surveys were between 1998 and 2008. The data were analysed by UNFPA to identify disparities in access to reproductive health. Of these 24 countries, all have sufficient data for tracking progress on adolescent birth rates and contraceptive prevalence. Only 22 countries have two recent surveys with data on the unmet need for family planning.

The data for these three indicators are disaggregated by region and country in Chapter 3. In Chapter 4, which focuses on sub-Saharan Africa, they are disaggregated by rural or urban residence, household wealth and educational attainment. Although other variables, such as ethnicity and displacement following conflict or disaster, also appear to influence the levels and trends of the three indicators, they are not included in this analysis due to lack of quality data.

## Understanding averages and uncovering disparities

Global, regional and country averages are a convenient way to track progress. However, they may mask dynamics within individual regions or countries. Moreover, heavily populated countries can skew figures for an entire region. For example, Southern Asia appears to have a relatively low adolescent birth rate, but when data from India are excluded, the region has one of the highest adolescent birth rates in the world.

*Global, regional and country averages are a convenient way to track progress; however, they may mask dynamics within individual regions or countries*

The most meaningful measure of disparity is often at the country level, where factors such as household wealth, education and residence (rural or urban) can be analysed in relation to reproductive health indicators. Measuring progress based on such factors is necessary to determine whether the most marginalized, excluded or otherwise disadvantaged groups have equal access to reproductive health.

The regional groupings of countries used in this report are those used by the United Nations to monitor the MDGs, and include developing, developed and least developed countries.<sup>12</sup>

## Three key indicators for reproductive health

The significant challenges involved in tracking universal access to reproductive health are partly met by the key indicators discussed in this report, which are quantifiable, comparable and meaningful measurements. They are also interconnected. Within the MDG agenda, these indicators are complemented by other indicators of health, gender equity and additional factors that shape reproductive health.

### Adolescent birth rate

Adolescent birth rates are the number of births per 1,000 girls between the ages of 15 and 19.<sup>13</sup> They are calculated using vital registration, census and household survey data. While the challenge of unregistered and unreported births persists, births are discrete events, and collecting data on them requires asking a relatively simple set of questions, such as the age of a woman when she delivered a child.

The adolescent birth rate is a critical indicator of opportunities available to individual girls and the vulnerabilities they experience during adolescence and beyond. In addition, it reinforces the importance of reaching people with information and services that are appropriate to their age and needs, starting from childhood and extending through the life cycle. The adolescent birth rate is also key because of the large cohort of youth in developing countries.

Adolescent birth rates are closely linked to MDG2 and MDG3, which address universal access to primary education and gender equality in education and economic opportunity. Gender-based discrimination and lack of schooling limit girls' access to the information, services and decision-making power they need to exercise their right to reproductive health, and to decide if and when to become pregnant.<sup>14</sup>

### Contraceptive prevalence and unmet need for family planning

Universal access to reproductive health will only be achieved when women have access to the information and services they need to plan the number and timing of their pregnancies. Progress in this area is therefore fundamental to reproductive health and is reflected in two indicators: contraceptive prevalence and the unmet need for family planning. The contraceptive prevalence rate is the percentage of women who are married or in union and of reproductive age (15-49 years

old), using any method of contraception, either modern or less reliable traditional methods. This indicator is necessary, but not sufficient, for identifying progress towards access to family planning, which is central to reproductive health. Contraceptive prevalence is part of a dynamic process, not a discrete event, and is therefore difficult to pin down. It is influenced by the availability and supply of contraceptives and involves the choice to begin and to continue to use contraceptives over a period of time. Furthermore, because contraceptive prevalence is often only measured for women who are married or in union, it does not provide an exact measure. For example, it does not include adolescents who are single but may be sexually active. While this is a limitation, the measurement remains meaningful in most circumstances: high adolescent birth rates tend to occur where early marriage is common.<sup>15</sup> In addition, data on contraceptive use among single girls are not available for all regions, so restricting the indicator to women who are married or in union allows for regional comparisons.

*Universal access to reproductive health will only be achieved when women have access to the information and services they need to plan the number and timing of their pregnancies*

The unmet need for family planning is the proportion of women not using contraception among women of reproductive age (15-49 years old), who are either married or in union and who are fecund and sexually active but do not want any more children or would like to delay the birth of their next child for at least two years. This indicator reflects whether women who want to delay or avoid pregnancy have access to and are using family planning services and information at a given moment. However, unmet need changes in response to both demand and supply, so it cannot merely be converted to met need through simple increases in the quantity of contraceptive supplies. When changing conditions, such as improved knowledge of the benefits of spacing pregnancies, lead to increased demand for contraception, the supply and quality of services may not keep pace. As a result, total demand often increases faster than the health system can address it, even as contraceptive prevalence increases.

The contraceptive prevalence rate (per cent) is measured as follows:

$$\frac{\text{Women using any method of contraception}}{\text{Women using and not using any method of contraception}}$$

The unmet need for family planning (per cent) is measured as follows:

$$\frac{\text{Women not using any method of contraception}}{\text{Women wanting no more children or wanting to delay the next birth}}$$

### ***Proportion of demand satisfied***

An additional measure, the proportion of demand satisfied for family planning, is derived from the above two indicators. The total demand for family planning is the (percentage) sum of contraceptive prevalence and unmet need for family planning. Of this total demand, contraceptive prevalence constitutes the proportion of demand satisfied.

Proportion of demand satisfied (per cent) is measured as follows:

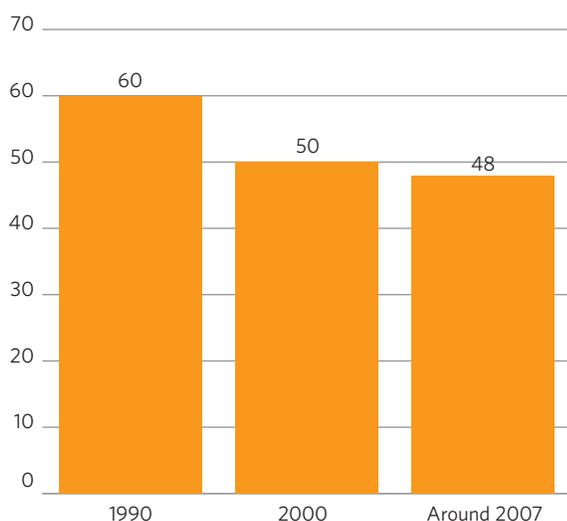
$$\frac{\text{Women using any method of contraception}}{\text{Women using any method of contraception + women not using contraception and wanting no more children or wanting to delay the next birth}}$$

Though not an MDG indicator, the proportion of demand satisfied reflects the extent to which partners, communities and the health system support women in acting on their choices, and monitors whether women's stated desires regarding contraception are being fulfilled.<sup>16</sup> It calls attention to inequities in service access and is therefore used to promote a human rights-based approach to reproductive health.

# Global and regional levels and trends

This chapter charts progress towards universal access to reproductive health using global and regional averages. For each indicator, a global overview of the level of progress and changes since 1990 is provided. This is complemented by comparisons among regions, which illustrate the diversity of situations behind the global average. The regional comparisons include an in-depth discussion of three regions: Latin America and the Caribbean, the Commonwealth of Independent States (CIS) and Southern Asia. These regions are highlighted because they appear to reflect significant progress on some or all indicators, and because they illustrate persistent challenges related to data collection and analysis. The chapter concludes with a discussion of the proportion of demand satisfied at the regional level.

**FIGURE 1**  
Decline in the global adolescent birth rate has stalled since 2000



Trend in global adolescent birth rate: 1990, 2000 and around 2007 (Number of births per 1,000 women aged 15-19)

Source: United Nations Population Division

## Adolescent birth rates: global progress slows

Around 2007, the global average adolescent birth rate was 48 births for every 1,000 girls aged 15 to 19 (Figure 1). In developing regions, there were an average of 52 births per every 1,000 girls and, in developed regions, 23—less than half that rate. Developing regions include areas with the world's highest and lowest adolescent birth rates: sub-Saharan Africa (121 births) and Eastern Asia (5 births), respectively.

Between 1990 and 2007, declines in adolescent birth rates were significant (Figure 1). However, most progress occurred during the first decade. Since 2000, progress has stalled, with an average of just two births fewer in 2007 than the 50 reported in 2000. This lack of change was reflected in the averages for both developed regions (with 25 in 2000 and 23 in 2007) and developing regions (55 in 2000 and 52 in 2007).

*Between 1990 and 2007, declines in adolescent birth rates were significant; however, most progress occurred during the first decade*

## Wide disparities in adolescent birth rates among regions

Since 1990, adolescent birth rates have declined in all regions except sub-Saharan Africa. The situation has become more complex, however, in the last decade.

Between 2000 and 2007, the decline in adolescent birth rates slowed dramatically (from 34 to 30) in the transition coun-

tries of South-Eastern Europe. This occurred after a significant drop (from 48 to 34) between 1990 and 2000 (Table 2).

Stalled progress was also evident in some developing regions, including Northern Africa (where the rate remained at 31 births in 2000 and 2007), Eastern Asia (from 6 to 5 births over the same period) and Oceania (63 to 61 births). The figures for these regions suggest that, after a substantial decline in adolescent birth rates in the 1990s, progress has slowed.

The lack of progress in regions such as Oceania, where the rate remains high, raises concerns of its own. What is more, the figures for three other regions suggest that earlier positive trends may be in danger of reversal. The world's least developed countries have, as a group, maintained the world's highest adolescent birth rates. Those rates fell from 133 to 117 between 1990 and 2000, but have since increased to 121. Sub-Saharan Africa, which includes many least developed countries, is the region with the highest adolescent birth rate. The region has seen little change since 1990, and the most

**TABLE 2**  
Adolescent birth rate by region, 1990, 2000 and 2007

MDG region	1990	2000	2007
WORLD	60.1	50.0	48.3
Developing regions	65.4	54.6	52.3
Northern Africa	43.0	31.0	30.7
Sub-Saharan Africa	124.2	118.6	120.9
Latin America & the Caribbean	91.1	80.0	73.9
Caribbean	80.9	77.0	66.7
Latin America	91.9	80.2	74.4
Eastern Asia	15.3	5.8	4.5
Eastern Asia, excluding China	4.0	3.1	2.7
Southern Asia	89.5	58.9	53.2
Southern Asia, excluding India	122.7	75.8	70.6
South-Eastern Asia	53.4	39.2	44.1
Western Asia	61.9	51.8	52.5
Oceania	83.1	63.3	61.3
Commonwealth of Independent States (CIS)	52.1	28.2	28.8
CIS, Asia	44.7	28.2	29.3
CIS, Europe	55.2	28.2	28.6
Developed regions	29.3	24.9	23.0
Transition countries of South-Eastern Europe	48.0	33.6	29.6
Least developed countries	133.3	116.7	121.0
Landlocked developing countries	106.0	104.1	103.6
Small island developing States	77.1	71.6	62.9

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

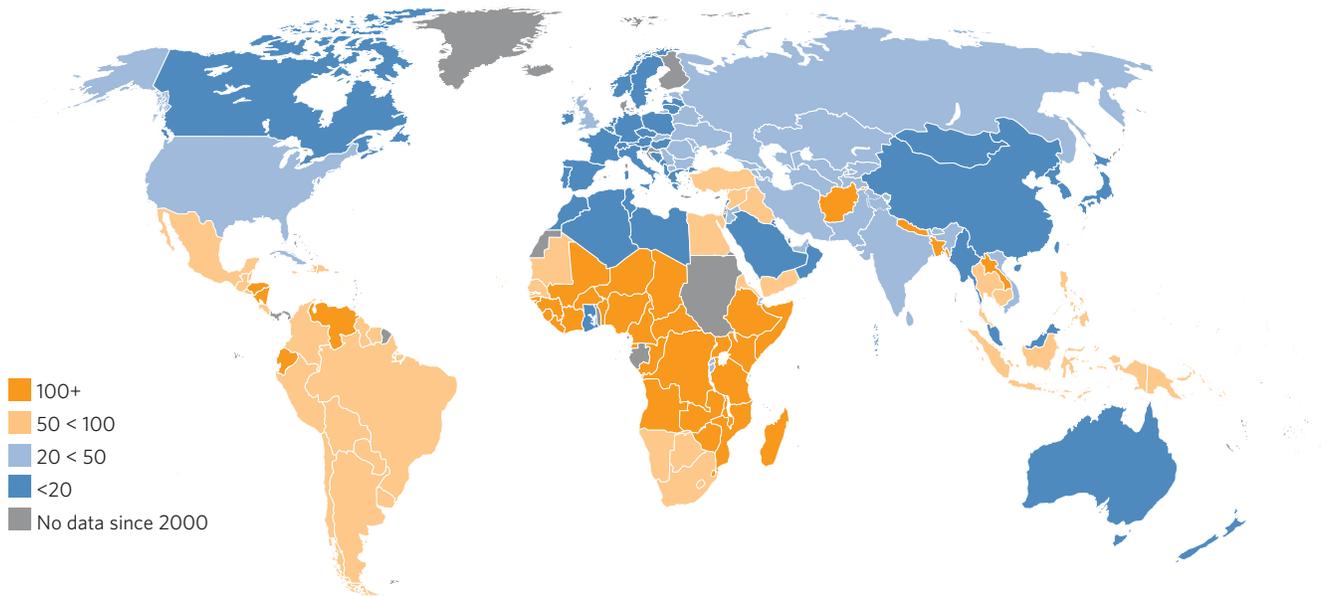
**Notes:**

The averages are based on the data available to the UN Population Division as of 10 March 2010. Data available prior to 1990 are used in estimating regional averages.

**Source:** United Nations Population Division

## MAP 1

### Countries with high adolescent birth rates are concentrated in sub-Saharan Africa and Latin America and the Caribbean



Adolescent birth rates by country, most recent estimates (Number of births per 1,000 women aged 15-19)

Source: United Nations Population Division

recent figures suggest that the rate may have increased since 2000. In addition, two regions that had seen declining rates during the 1990s may be in danger of reversal: in Western Asia, adolescent birth rates rose from 52 in 2000 to 53 in 2007, and in South-Eastern Asia, they rose from 39 to 44 over the same time period.

*Sub-Saharan Africa, which maintains the world's highest adolescent birth rate, has seen little change since 1990*

In two regions, Latin America and the Caribbean and Southern Asia, adolescent birth rates have declined significantly since 2000. In Latin America and the Caribbean, the adolescent birth rate dropped from 80 in 2000 to 74 in or around 2007. The drop was greater in the Caribbean (from 77 to 67 births) than in Latin America, increasing the gap in adolescent birth rates between the two subregions.

In Southern Asia as a whole, the adolescent birth rate declined from 59 to 53 births between 2000 and 2007. This change stood out as a positive exception to the global trend since 2000, but fell

far below the region's 30-point decline in the previous decade. As noted in Chapter 2, the inclusion of the heavily populated country of India skews the regional average. When India is excluded, the region's adolescent birth rate remains one of the highest in the world: declining from 76 in 2000 to 71 in 2007. Still, this represents major progress since 1990, when the adolescent birth rate stood at 123. The case shows that differences among individual countries in the same region can distort regional averages, at times masking large variations in levels and trends.

While the influence of heavily populated countries plays a significant role in regional averages, exploring groups of countries also illustrates the fact that high levels of adolescent pregnancy tend to be concentrated in countries within particular regions. Map 1 shows that the concentration of countries with high adolescent birth rates is most evident in sub-Saharan Africa, where both the regional average and data for individual countries tend to show very high rates.

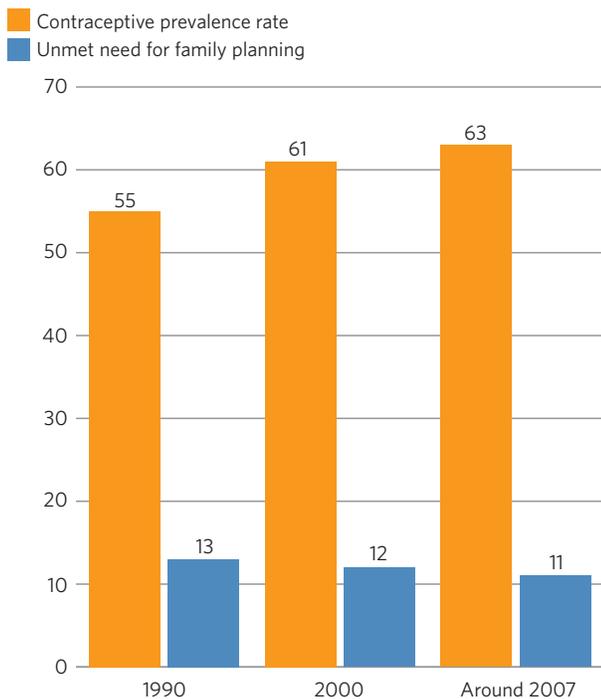
### Significant gaps in family planning demand and use

The most recent data suggest that, globally, 63 per cent of women of reproductive age who are married or in union are

using some form of contraception (either modern methods or less reliable traditional methods). In developing regions, the contraceptive prevalence rate is 62 per cent; for developed regions it is 69 per cent. These averages are based on data collected around 2007. Changes in contraceptive prevalence have been only marginal since 2000 (Figure 2), in contrast to the previous decade, when contraceptive prevalence increased substantially. At the regional level, contraceptive prevalence appears to be increasing significantly in a few places, but regions with the lowest levels of contraceptive use have shown little or no progress.

*Regions with the lowest levels of contraceptive use have shown little or no progress*

**FIGURE 2**  
**Contraceptive prevalence has risen only slightly since 2000, while the unmet need for family planning remains largely unchanged**



Global trends in contraceptive prevalence and unmet need for family planning, 1990, 2000 and around 2007 (Percentage of women aged 15-19, married or in union, using at least one method of contraception; Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years)

Source: United Nations Population Division



The significance of contraceptive prevalence is generally informed by data on unmet need for family planning. However, as previously noted, such data are limited. The regions that lack information on unmet need include the Asian and European countries of the CIS, developing regions such as Oceania, and developed regions. The gaps in data for these areas leave a number of important questions unanswered. Among those questions are whether women have the resources, decision-making power, information and trust in available services to choose when to become pregnant. This is particularly important in regions and subregions where trends and differences in contraceptive prevalence may reflect certain changes or conditions, such as shifts in policy or government investments, social norms and other factors.

### Persistent regional disparities in unmet need for family planning

The available data on unmet need show that it is high in much of the world and that significant disparities persist among regions (Table 3). At the global level in 2007, unmet need for family planning was 11 per cent. In the least developed countries, it was more than 24 per cent.

Since 1990, the unmet need for family planning has declined significantly in a few regions, including Northern Africa, where it fell from 20 per cent in 1990 to 10 per cent in 2007. Over the same period, the region's contraceptive prevalence rate increased from 44 per cent to 60 per cent. Both indicators have seen little change since 2000, as has the adolescent birth rate, which fell from 43 to 31 between 1990 and 2000 and has since levelled off.

In sub-Saharan Africa, where data show that adolescent girls are most likely to become mothers, the percentage of women who are married or in union and currently using contraception is lowest of any region (at 22 per cent), and the unmet need for family planning is highest (25 per cent). In contrast, Eastern Asia has the highest contraceptive prevalence rate of any region in the world at 86 per cent, and the lowest unmet need for family planning (2 per cent).

**TABLE 3**

Contraceptive prevalence rate and unmet need for family planning, by region, 1990, 2000 and around 2007

MDG regions	Contraceptive prevalence, any method (%)			Unmet need for family planning (%)		
	1990	2000	Around 2007	1990	2000	Around 2007
WORLD	55.2	61.3	63.1	13.2	11.5	11.2
Developing regions	52.2	59.6	62.0	13.7	11.8	11.4
Northern Africa	44.0	58.8	60.3	19.5	11.6	9.9
Sub-Saharan Africa	12.2	20.0	21.5	26.5	24.1	24.8
Latin America & the Caribbean	62.0	70.7	71.7	15.8	10.5	10.5
Caribbean	54.2	60.2	62.2	19.7	20.4	20.1
Latin America	62.6	71.6	72.4	15.6	9.9	9.9
Eastern Asia	77.7	85.7	86.4	3.3	2.4	2.3
Eastern Asia, excluding China	73.8	76.5	76.8	..	..	..
Southern Asia	39.9	46.7	54.1	18.2	17.2	14.7
Southern Asia, excluding India	30.3	46.2	48.6	24.3	23.5	20.7
South-Eastern Asia	48.3	57.0	61.9	15.1	11.0	10.9
Western Asia	45.5	51.1	54.7	15.7	13.7	12.2
Oceania	28.3	28.1	28.1	..	..	..
Commonwealth of Independent States (CIS)	..	68.7	69.8	14.4	12.4	13.4
CIS, Asia	..	59.7	55.6	..	..	..
CIS, Europe	..	72.2	76.0	..	..	..
Developed regions	69.9	70.5	69.3	..	..	..
Transition countries of South-Eastern Europe	60.3	59.4	57.9	15.2	11.9	15.0
Least developed countries	16.5	28.0	30.7	26.1	24.0	24.4
Landlocked developing countries	24.5	30.6	33.3	24.6	24.2	24.8
Small island developing States	50.2	53.6	54.3	..	..	..

Percentage of women aged 15-49, married or in union, using any method of contraception; Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years

**Notes:**

The averages are based on data available to the United Nations Population Division as of 8 February 2010. Data available prior to 1990 are used in estimating regional averages.

**Source:** United Nations Population Division

*Eastern Asia has the highest contraceptive prevalence rate of any region in the world at 86 per cent, and the lowest unmet need for family planning (2 per cent)*

## **Latin America and the Caribbean: a complicated picture**

In sub-Saharan Africa and Eastern Asia, the links between adolescent birth rates, unmet need for family planning and contraceptive use are clear-cut and predictable. Latin America and the Caribbean present a more complicated picture when data collected between 2000 and around 2007 are considered. Though still high, adolescent birth rates have declined substantially in the region as a whole, while most other regions have not shown significant change in this area.

*Though still high, adolescent birth rates in Latin America and the Caribbean have declined substantially in the region as a whole*

When taken as a single region, the contraceptive prevalence rate for women in Latin America and the Caribbean, at 72 per cent, is higher than the average for both developing and developed regions. The unmet need for family planning, at 11 per cent, is near the global average. When split into two subregions, the situation appears more complex. The unmet need for the Caribbean alone is 20 per cent, while it is 10 per cent in Latin America. In the Caribbean, 62 per cent of women use contraception, versus 72 per cent in Latin America.

Despite a relatively high level of contraceptive use, the adolescent birth rate for Latin America and the Caribbean was high, at 80, in 2000. And though the level of contraceptive use stayed almost the same between 2000 and 2007, adolescent birth rates declined: to 74 around 2007. For the Caribbean alone, a similar lack of change in contraceptive prevalence was found. However, adolescent births decreased substantially: from 77 to 67 births for every 1,000 adolescent girls. This change in contraceptive prevalence is not unusual, given that, globally, contraceptive prevalence changed little from 2000 to 2007. What is unusual is the fact that it was accompanied by such a substantial reduction in adolescent births.

A number of possible explanations can be found for the fact that adolescent birth rates in Latin America and the Caribbean do not appear to resemble levels and follow trends seen in other regions. One explanation could have to do with the indicators themselves. Contraceptive prevalence is measured among women who are married or in union only; adolescent birth rates include both single girls and those who are married or in a union. Overall adolescent birth rates may decline without corresponding increases in contraceptive prevalence or proportion of demand satisfied for family planning when adolescents—married or unmarried—increase their use of contraceptives; when contraceptive use increases among unmarried adolescents only; or when fewer adolescents marry and/or become sexually active. These trends require deeper analysis of the impact of various influences on adolescent fertility, including changes in sexual behaviour, legal frameworks affecting access, programme development of youth-friendly services and general family planning services, as well as women's educational attainment and employment and social pressures. A complete analysis would also require information about recourse to abortion.

## **The Commonwealth of Independent States: additional data required**

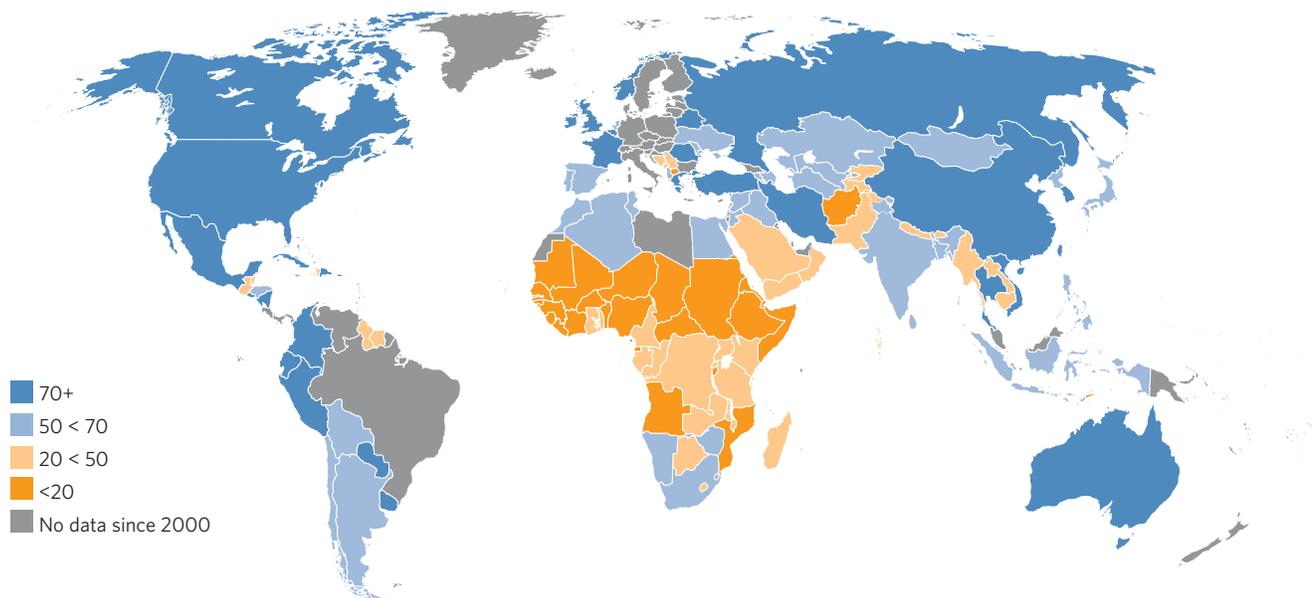
The situation in the CIS may be similar to that of Latin America and the Caribbean. But without more comprehensive data on unmet need in these countries, it is difficult to know for sure. The gap in contraceptive prevalence between Asian CIS countries (56 per cent) and European CIS countries (76 per cent) is wide. However, adolescent birth rates in Asian and European CIS countries are both 29. Data for a limited number of CIS countries identify an unmet need for family planning of 13 per cent for the region as a whole, which places it slightly above the global average, with little change since 1990 (when it stood at 14 per cent).

## **Southern Asia: increased contraceptive prevalence and large country influence**

In the few regions where contraceptive prevalence has shown signs of positive change, it has slowed in comparison to the previous decade. In addition, even where regional averages have shown substantial change, they may be heavily influenced by changes in a limited set of countries. Both of these dynamics are evident in Southern Asia (Table 3), a region comprising many countries with low levels of contraceptive

## MAP 2

### Contraceptive use is lowest in countries in sub-Saharan Africa and Southern Asia



Contraceptive prevalence, by country, most recent estimates (Percentage of women aged 15–49, married or in union, using any method of contraception)

**Source:** United Nations Population Division.

use (Map 2). Contraceptive prevalence increased from 47 per cent to 54 per cent in the region between 2000 and around 2007. However, the increase was heavily swayed by changes in India. When India is excluded, the average increase in contraceptive use in the region was much smaller, moving from 46 per cent in 2000 to 49 per cent in 2007, after a significant increase the previous decade.

### Sub-Saharan Africa: low contraceptive use and high unmet need

In sub-Saharan Africa, data on contraceptive prevalence reflect a high concentration of countries with low levels of contraceptive use (Table 3 and Map 2). In addition, unmet need is substantial enough to provide a more straightforward measure of the large gap between women's intentions regarding family planning and their access to the services, supplies and information they need to act upon them. In other regions, where contraceptive supply and use are higher, there is some evidence of a trade-off, whereby increases in contraceptive prevalence lead to consistent decreases in unmet need. This dynamic, which is likely at work in situations with high levels of contraceptive prevalence, when health systems are already strong enough to adjust to new demand, remains difficult to track: there is not yet enough data on

unmet need for family planning in countries outside of sub-Saharan Africa (Map 3).

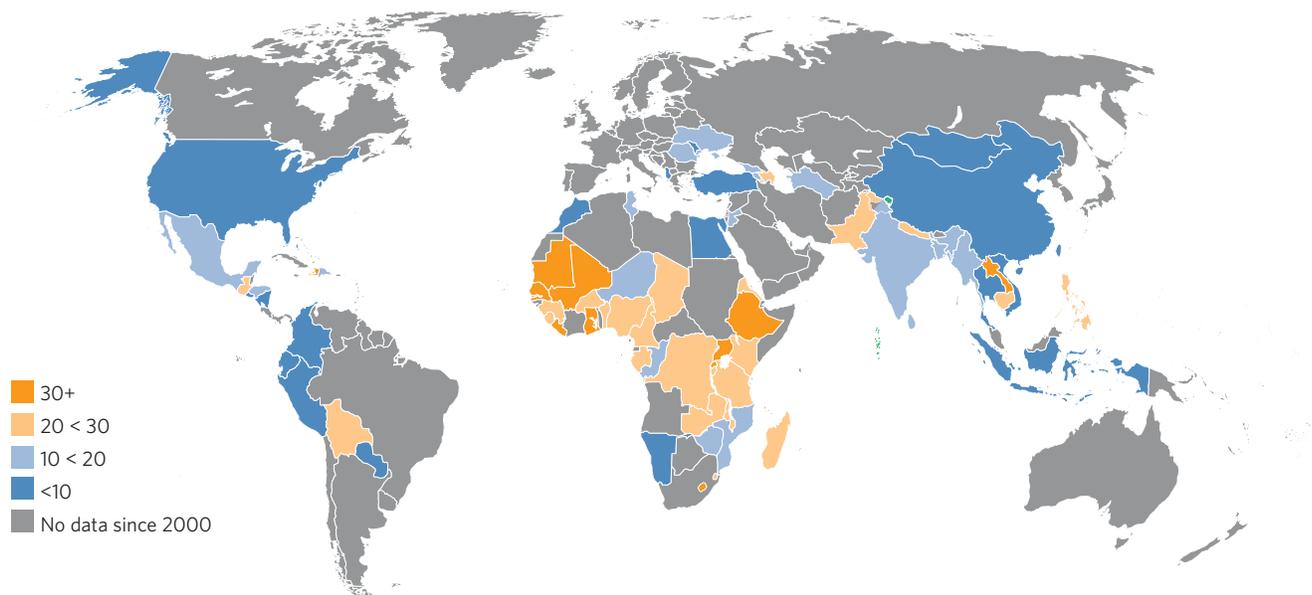
### Stymied progress in satisfying demand for family planning

Consistent with the above findings, the proportion of demand satisfied for family planning grew for most regions between 1990 and 2000 and has since stalled. As Figure 3 shows, while satisfied demand has risen since 1990 for most regions, little change has been seen since 2000. The consequences of this stagnation are most evident in sub-Saharan Africa. The dramatic increase in satisfied demand between 1990 and 2000 suggested that the extreme disparities between sub-Saharan Africa and other regions could be narrowed. However, progress stalled in 2000, leaving sub-Saharan Africa's proportion of demand satisfied for family planning lower than 50 per cent between 2000 and 2007. In contrast, the percentage for every other region surpassed 70 per cent.

The low level of satisfied demand in sub-Saharan Africa underscores how little progress has been made towards improving access to family planning services since 2000. It is no coincidence that, during this period, investment in family planning has fallen.<sup>17</sup> The total global investment in family

### MAP 3

**Sub-Saharan Africa has the most data on unmet need for family planning and appears to have the highest levels**

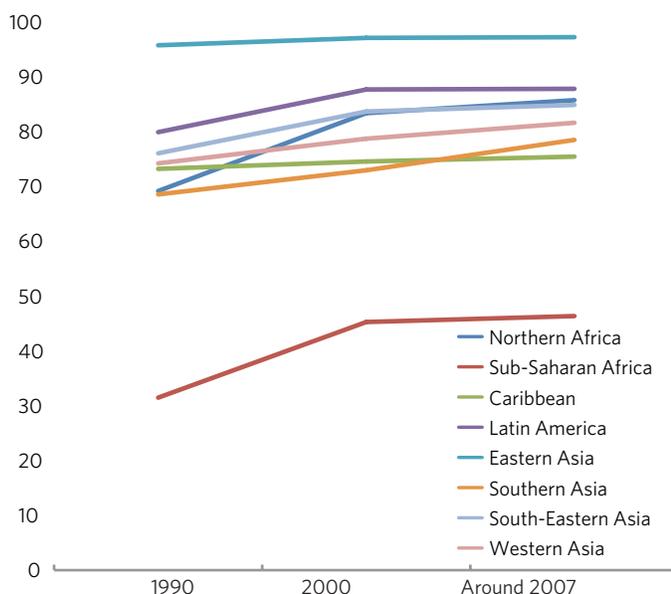


Unmet need for family planning, by country, most recent estimates (Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and do not want any more children or would like to delay the birth of their next child for at least two years).

Source: United Nations Population Division.

### FIGURE 3

**Since 2000, the proportion of demand satisfied for family planning has stalled in most regions**



Trends in proportion of demand satisfied for family planning, by region, 1990, 2000 and around 2007 (Percentage representing contraceptive prevalence as a proportion of the total demand)

Source: United Nations Population Division.

planning is now lower in all respects than in 2000: in absolute terms, as a proportion of total health spending, and in the level needed to meet current demand for family planning.<sup>18</sup>

*The total global investment in family planning is now lower in all respects than in 2000: in absolute terms, as a proportion of total health spending, and in the level needed to meet current demand*

# Trends in sub-Saharan Africa: Disparities and inequalities

**B**ecause sub-Saharan Africa continues to lag far behind the rest of the world in relation to all the indicators studied here, and carries a disproportionate burden of maternal, newborn and child ill health, the diversity and disparities within this region are explored in this chapter. Data from Demographic and Health Surveys and other household surveys make this analysis possible. The information presented below is based on data drawn from 24 sub-Saharan African countries<sup>19</sup> that have conducted two recent Demographic and Health Surveys, a first one between 1986 and 2003 and a second between 1998 and 2008.

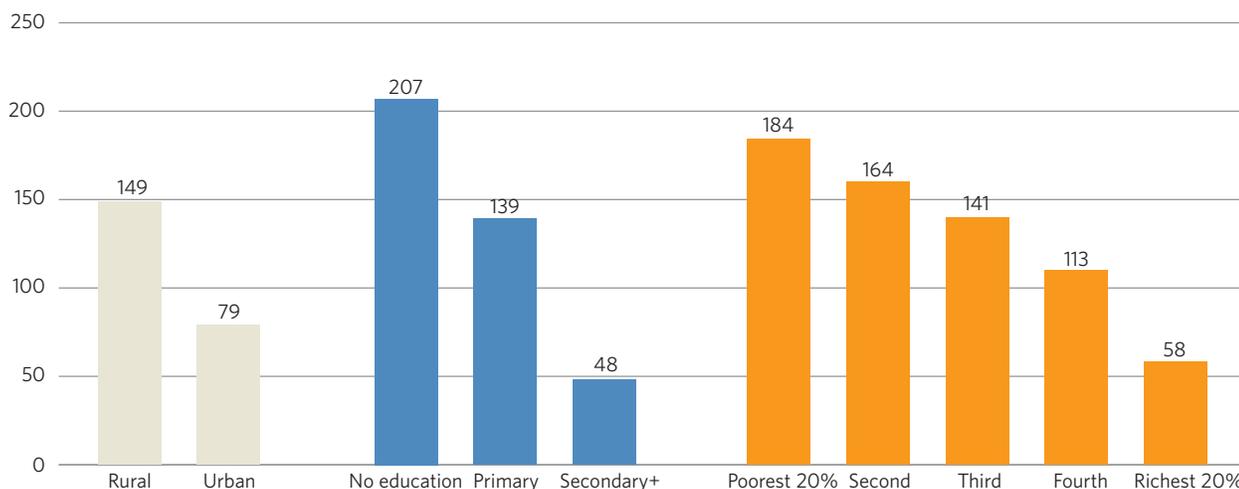
The chapter looks at the same MDG5.B indicators discussed above, but examines disparities among countries in the region.

It also looks at the disparities within countries, according to background characteristics including age, residence (urban or rural), women's level of education and household wealth.

## Adolescent birth rates: widening disparities within countries

Averages for the 24 sub-Saharan African countries studied show that fertility among adolescent girls who are the most educated, living in the wealthiest households or living in urban areas is lower than that of their poorer, less educated and rural peers (Figure 4). The disparities were most extreme when girls were grouped by educational attainment: girls with the highest level of education had an adolescent birth rate of

**FIGURE 4**  
In sub-Saharan Africa, adolescent birth rates are highest among girls who are poor, less educated and live in rural areas



Adolescent birth rates by background characteristics in 24 sub-Saharan African countries, at most recent survey, 1998-2008 (Number of births per 1,000 women aged 15-19)

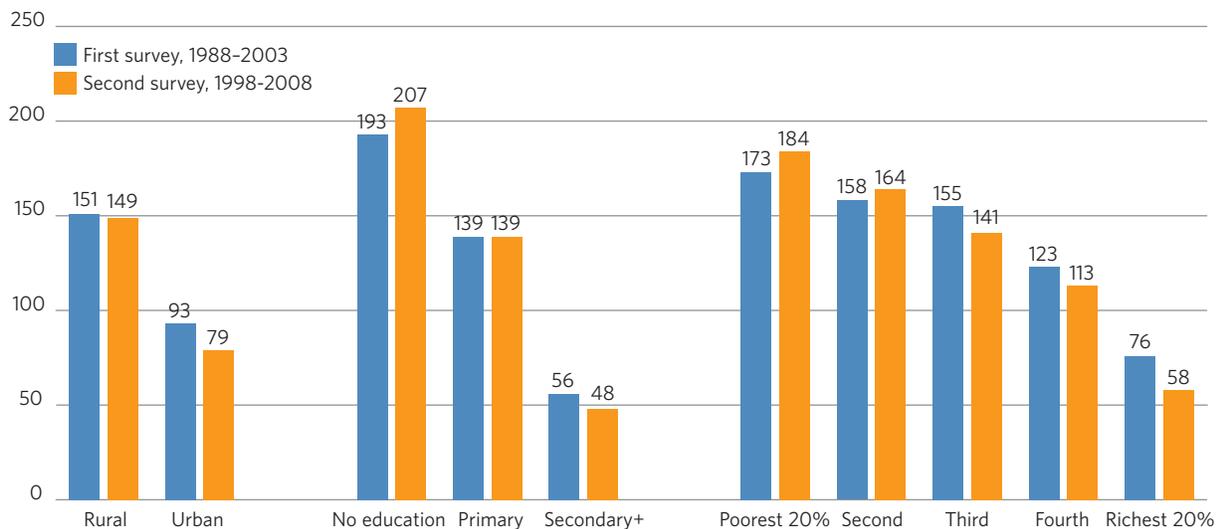
**Source:** Demographic and Health Surveys (calculated using data in Annex III).

48, on par with the global average, while girls with no education had a rate of 207.

Since 2000, disparities in adolescent birth rates in these two dozen countries have widened (Figure 5), with progress seen

only among select groups. Girls from the wealthiest 60 per cent of households as well as girls with a secondary or higher education or who lived in urban areas in 2008 had, in general, a far lower birth rate than in 2000. In contrast, rates increased for girls with the least advantages—those

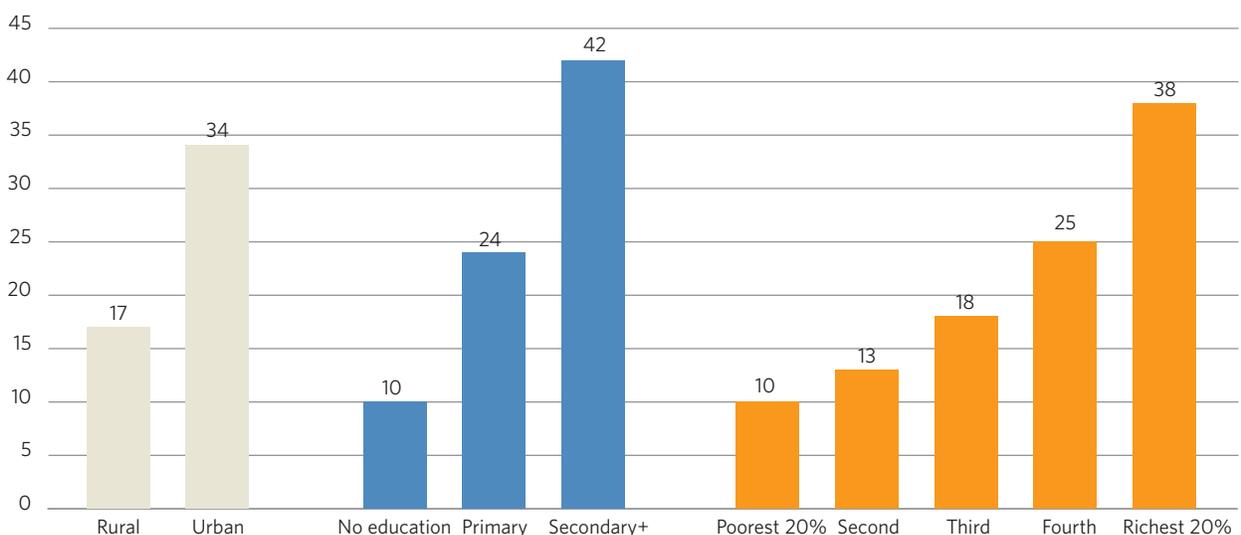
**FIGURE 5**  
**Low and declining adolescent birth rates are concentrated among girls who are wealthier, more educated and urban**



Trends in adolescent birth rates by background characteristics in 24 sub-Saharan African countries with two consecutive surveys, 1988-2003 and 1998-2008 (Number of births per 1,000 women aged 15-19)

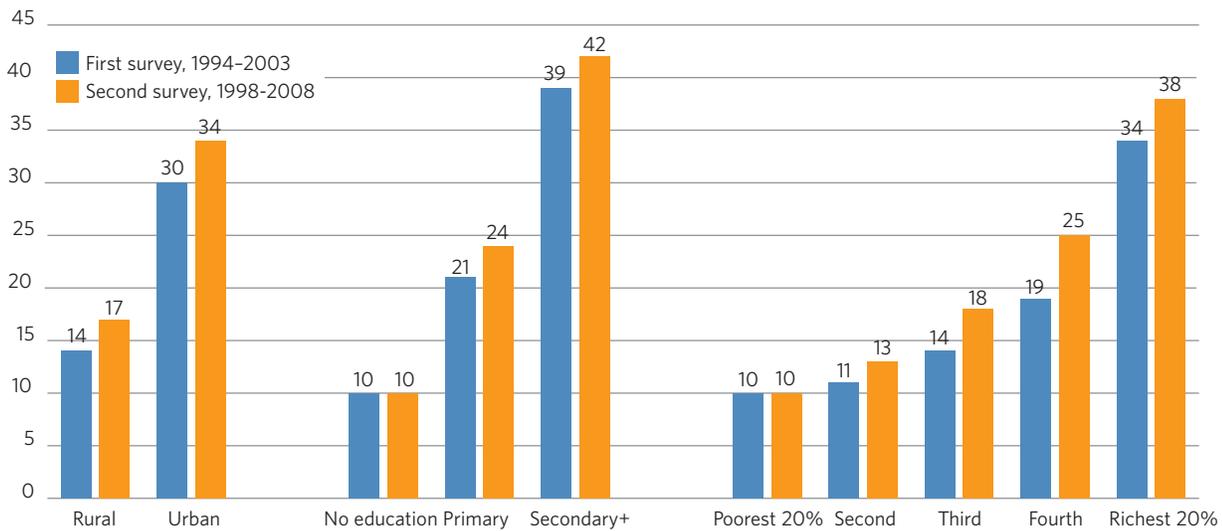
Source: Demographic and Health Surveys (calculated using data in Annex III).

**FIGURE 6**  
**The poorest, least educated and rural women have the lowest rates of contraceptive use**



Contraceptive prevalence by background characteristics for 24 sub-Saharan African countries at most recent survey, 1998-2008 (Percentage of women aged 15-49, married or in union, using any method of contraception)

Source: Demographic and Health Surveys (calculated using data in Annex III).

**FIGURE 7****Increases in contraceptive use are concentrated among wealthier, more educated and urban women**

Trends in contraceptive prevalence by background characteristics for 24 sub-Saharan African countries with two consecutive surveys, 1994-2003 and 1998-2008 (Percentage of women aged 15-49, married or in union, using any method of contraception)

**Source:** Demographic and Health Surveys (calculated using data from Annex III).

*Girls with the highest level of education had an adolescent birth rate of 48, while girls with no education had a rate of 207*

with no education or whose households were among the poorest two fifths of the population.

### Contraceptive use: influenced by wealth, education, residence and age

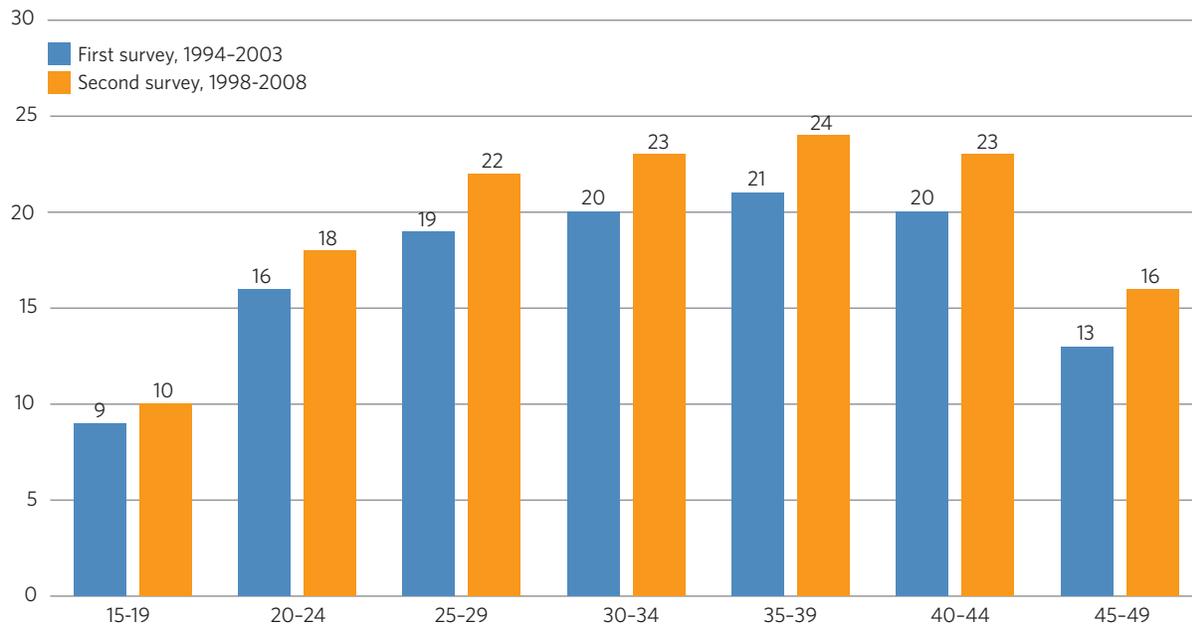
Data on contraceptive use collected from the most recent surveys in these 24 countries echo the disparities in adolescent birth rates. Levels of contraceptive use vary widely, differing by a woman's education, household wealth and place of residence (Figure 6). Though women who are most advantaged have lower contraceptive prevalence rates than the global average of 63 per cent (Table 3), they are far more likely to use contraception than their less advantaged peers. Only 10 per cent of women with no education and 10 per cent of those belonging to the poorest households use contraception. In contrast, 42 per cent of women with secondary or higher education and 38 per cent of women belonging to the wealthiest households do. For rural and urban women, the disparity is somewhat smaller, but urban women have a contraceptive

prevalence rate that is double that of their rural counterparts (34 per cent versus 17 per cent).

While there has been some growth in contraceptive use, it has been limited in degree and scope. As with adolescent birth rates, disparities in contraceptive use widened in the period between surveys (Figure 7). During this period, women from relatively wealthy households were increasingly likely to use contraception. In contrast, rates remained very low and nearly unchanged among women living in the poorest 40 per cent of households. This reflected a widening disparity in contraceptive use between wealthier and poorer women: 38 per cent of the women in the wealthiest households use contraception compared to just 10 per cent from the poorest households.

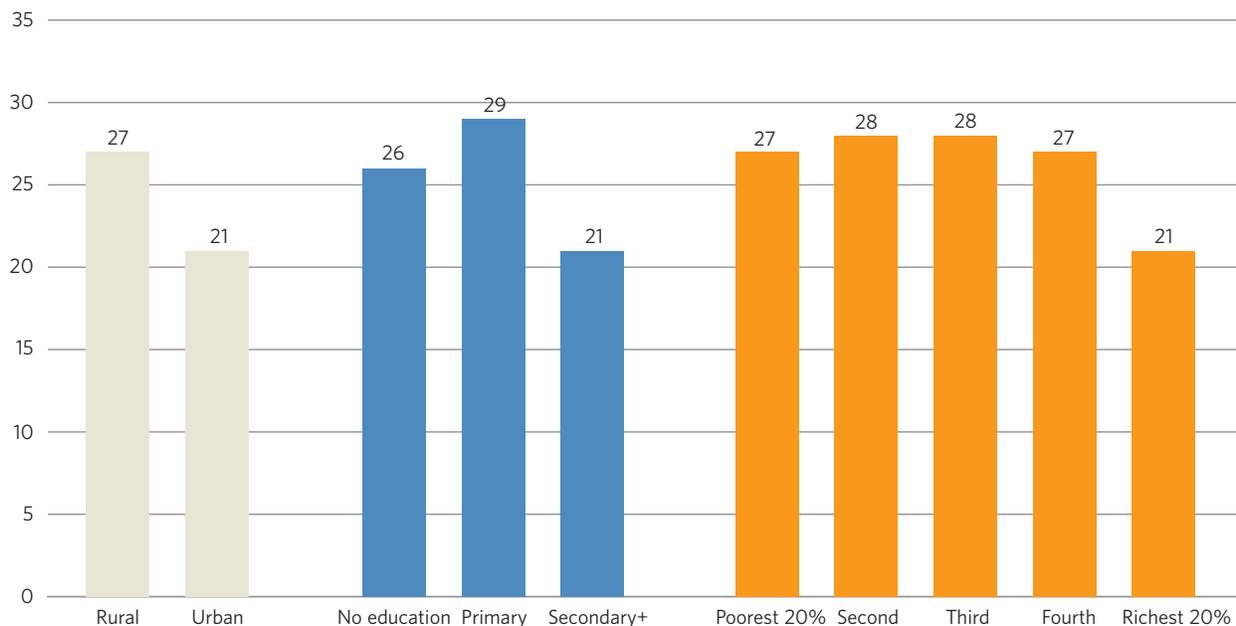
Among women who are married or in union, adolescents have the lowest rates of contraceptive use and have seen the least change since 2000 (Figure 8). A large proportion of young women in sub-Saharan Africa are married, and

*Among women who are married or in union, adolescents have the lowest rates of contraceptive use and have shown the least change since 2000*

**FIGURE 8****Adolescents remain least likely to use any form of family planning and have shown little change**

Trends in contraceptive prevalence rate by age groups for 24 sub-Saharan African countries with two consecutive surveys, 1994-2003 and 1998-2008 (Percentage of women aged 15-49, married or in union, using any method of contraception)

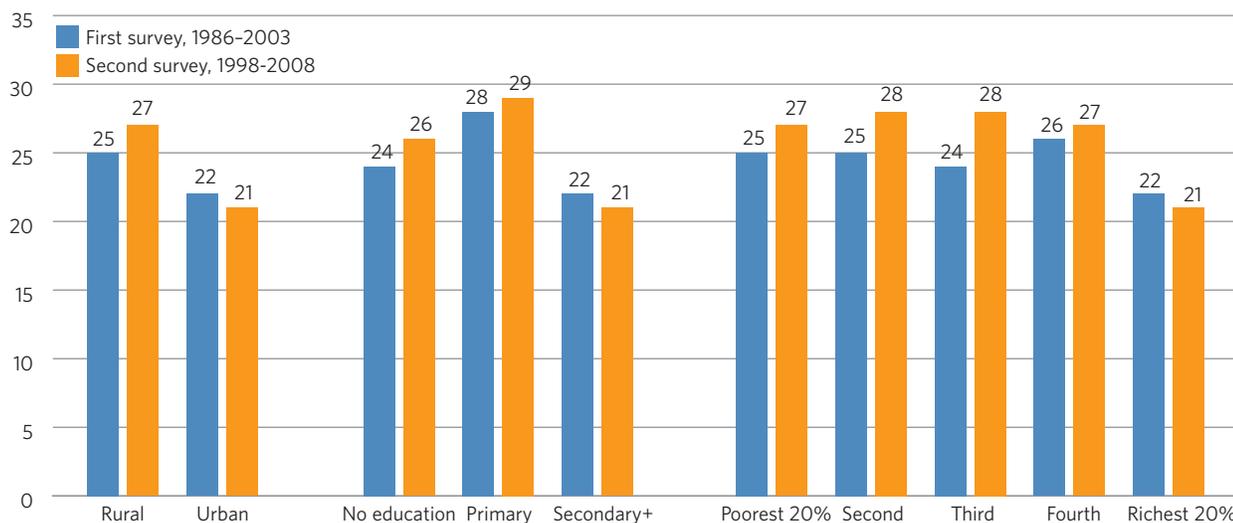
Source: Demographic and Health Surveys (calculated using data from Annex III).

**FIGURE 9****The unmet need for family planning is high, with disparities between the most advantaged and all other groups**

Unmet need for family planning by background characteristics in 22 sub-Saharan African countries at most recent survey, 1998-2008 (Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years)

Source: Demographic and Health Surveys (calculated using data in Annex III).

**FIGURE 10**  
**Little change is seen in unmet need for family planning for any group**



Trends in unmet need for family planning by background characteristics in 22 sub-Saharan African countries with two consecutive surveys, 1986-2003 and 1998-2008 (Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years)

**Source:** Demographic and Health Surveys (calculated using data in Annex III).

the adolescent birth rate is high. More needs to be done to understand the factors influencing adolescent fertility, the social pressures that affect these young women and their access to family planning services.

## Disparities in unmet need for family planning

As explained in Chapter 2, the unmet need for family planning is a complex indicator, which can change as a result of trends in both supply and demand. Unmet need for family planning in 22 sub-Saharan countries studied is high for all groups—between 21 per cent and 29 per cent (Figure 9). Furthermore, disparities are extreme. They are not limited to gaps between the groups with the most advantages and the least. Instead, the most advantaged groups have made progress, while all the others have been left behind. In other words, only the most educated women, urban women and those in the wealthiest quintile have demonstrated significantly lower levels of unmet need.

Changes in unmet need for family planning for all social and economic groups were minimal (Figure 10), with unmet need appearing to increase slightly among rural women, women

with less than a secondary education and women from households in the four poorest quintiles.

Unmet need for family planning also appears to have changed little for any age group (Figure 11), and all but the oldest women have an unmet need for family planning of around 25 per cent. This includes adolescent girls, the age group with the lowest contraceptive prevalence rate, which remained largely unchanged in the period between the first and second surveys. It also includes women in their twenties and thirties—groups with significantly higher contraceptive prevalence rates.

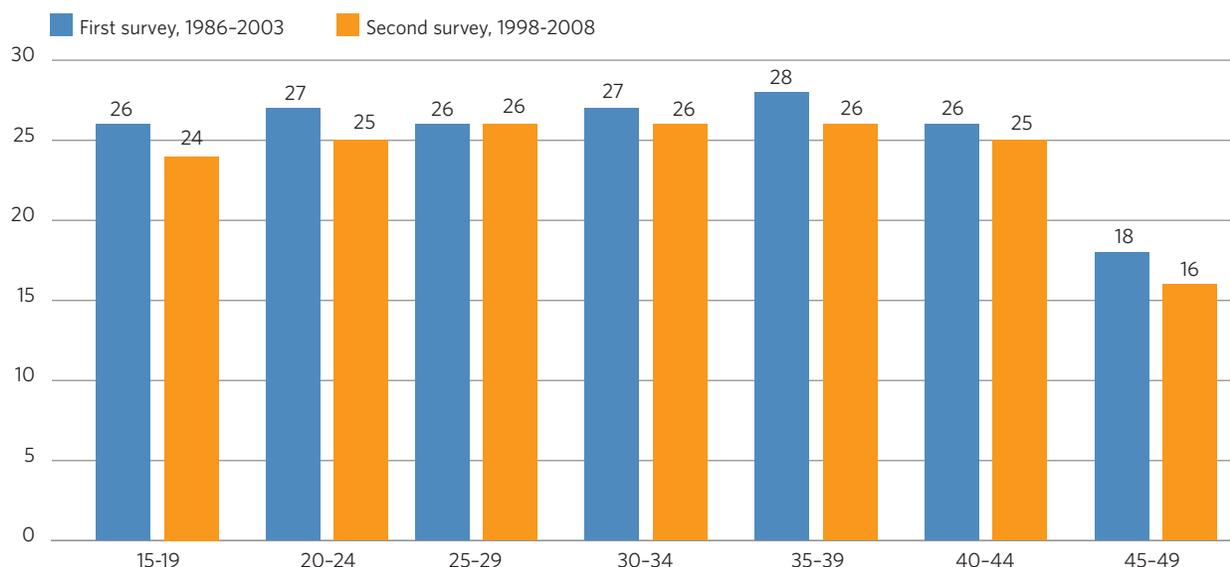
## Least progress among groups of women that lag farthest behind

Among the 24 sub-Saharan African countries studied, large variations are found in the three indicators. The most recent available data on adolescent birth rates illustrate a broad range—from 43 births for every 1,000 girls in Rwanda, to 199 births for every 1,000 girls in Niger (see Annexes II and III for country-level data).

In some countries, significant progress has been made among certain social and economic groups in reducing adolescent

**FIGURE 11**

**Except for women aged 45 and above, well over 20 per cent of women have an unmet need for family planning**



Trends in unmet need for family planning by age group for 22 sub-Saharan African countries with two consecutive surveys, 1986-2003 and 1998-2008 (Percentage of women not using contraception among women of reproductive age, either married or in union, who are fecund and sexually active and who do not want any more children or would like to delay the birth of their next child for at least two years)

**Source:** Demographic and Health Surveys (calculated using data in Annex III).

birth rates and fulfilling unmet need for family planning (Table 4). In fact, only one country, Kenya, recorded no net progress on any indicator. The majority of countries saw some significant change—either at the national level or among some groups—for all indicators (Table 4, second two columns). However, the situation in most countries reflects the disparities that are observed at regional and global levels. Change in adolescent birth rates and contraceptive use was concentrated among the most advantaged groups: women in urban areas, with a secondary or higher education, and from wealthier households. In many cases, the less advantaged groups who have the highest adolescent birth rates, lowest contraceptive prevalence and highest unmet need for family planning lost ground (Annex II). Three countries recorded national change on all three indicators as a result of progress for groups beyond those that are the most advantaged: Guinea, Niger and Rwanda (Table 4).

*In many cases, the less advantaged groups who have the highest adolescent birth rates, lowest contraceptive prevalence and highest unmet need for family planning lost ground*



**TABLE 4**

## Changes in key reproductive health indicators by country and type of change

Indicator	No net change*	Some positive change: changes among some groups only**	Significant positive change: national and for multiple groups***
<b>Adolescent birth rate</b>	Benin Cameroon Kenya Mali Senegal	Burkina Faso Chad Côte d'Ivoire Ethiopia Liberia Malawi Mozambique Namibia Nigeria United Republic of Tanzania Zambia Zimbabwe	Ghana Guinea Madagascar Niger Rwanda Togo Uganda
<b>Contraceptive prevalence rate</b>	Ghana Kenya Malawi Mali Senegal Togo Uganda	Benin Burkina Faso Nigeria United Republic of Tanzania	Cameroon Chad Côte d'Ivoire Ethiopia Guinea Liberia Madagascar Mozambique Namibia Niger Rwanda Zambia Zimbabwe
<b>Unmet need for family planning</b>	Cameroon Côte d'Ivoire Ethiopia Ghana Kenya Madagascar Malawi Zambia Zimbabwe	United Republic of Tanzania	Benin Burkina Faso Chad Guinea Mali Mozambique Namibia Niger Nigeria Rwanda Senegal Uganda

Country-level changes by indicator (adolescent birth rate, contraceptive prevalence rate and unmet need for family planning) and type of change in 24 sub-Saharan African countries with two recent surveys and data disaggregated by residence, education and household wealth

\* Change in national average between the two surveys is less than +5% or -5%.

\*\* Change in adolescent birth rate, contraceptive prevalence rate and unmet need for family planning between the two surveys is +5% or -5%, but is concentrated among more advantaged groups: women in urban areas, with the highest educational attainment or belonging to the richest 20% of households.

\*\*\* Change in adolescent birth rate, contraceptive prevalence rate and unmet need for family planning between the two surveys is +5% or -5%, and is observed in 6-10 groups defined by background characteristics (that is, the change is not limited to the most advantaged groups).

**Note:** Data for Liberia and Togo are disaggregated by education and residence; data disaggregated by household wealth are not available.

**Source:** United Nations Population Division (calculated using data from Annexes II and III)

## Diversity at the country level: Madagascar and the United Republic of Tanzania

The following cases—Madagascar and the United Republic of Tanzania—represent interpretations of mixed progress in the two countries. Progress was tracked at both the national level and among women grouped by different background characteristics.

Madagascar represents that rare and promising case where declines in adolescent birth rates and increases in contraceptive prevalence are found among all groups. The unmet need for family planning has not decreased, which could indicate growing demand for family planning.

*Madagascar represents that rare and promising case where declines in adolescent birth rates and increases in contraceptive prevalence are found among all groups*

The United Republic of Tanzania reflects a picture of mixed progress, which, though less than ideal, represents a common scenario across indicators: some groups have seen remarkable change, even between 2000 and 2007, but this has been offset by the ground lost for disadvantaged groups.

### Declining adolescent birth rates for all groups in Madagascar

In Madagascar, the aggregate adolescent birth rate declined from 180 to 150 between the first survey in 1997 and the second survey in 2003-2004. The country is unusual in that the adolescent birth rate declined by more than 5 per cent for nearly all groups, and no group reported an increase. For the most educated girls, the birth rate decreased by 43 per cent between the first and second surveys, from 98 to 56 births for every 1,000 girls. Adolescent girls with no education had a birth rate of 235 during the first survey, which decreased to 229 by the time the second survey was conducted. Disparities remained significant. For example, the rate fell from 271 to 227 among girls from the poorest households, while among the wealthiest it declined from 78 to 66. Nevertheless, progress among the least advantaged groups is a promising sign. For other groups, similar patterns were found, decreasing among both urban and rural

adolescents (whose birth rates fell from 121 to 104 and 204 to 165, respectively).

### Declining adolescent birth rates for some in the United Republic of Tanzania

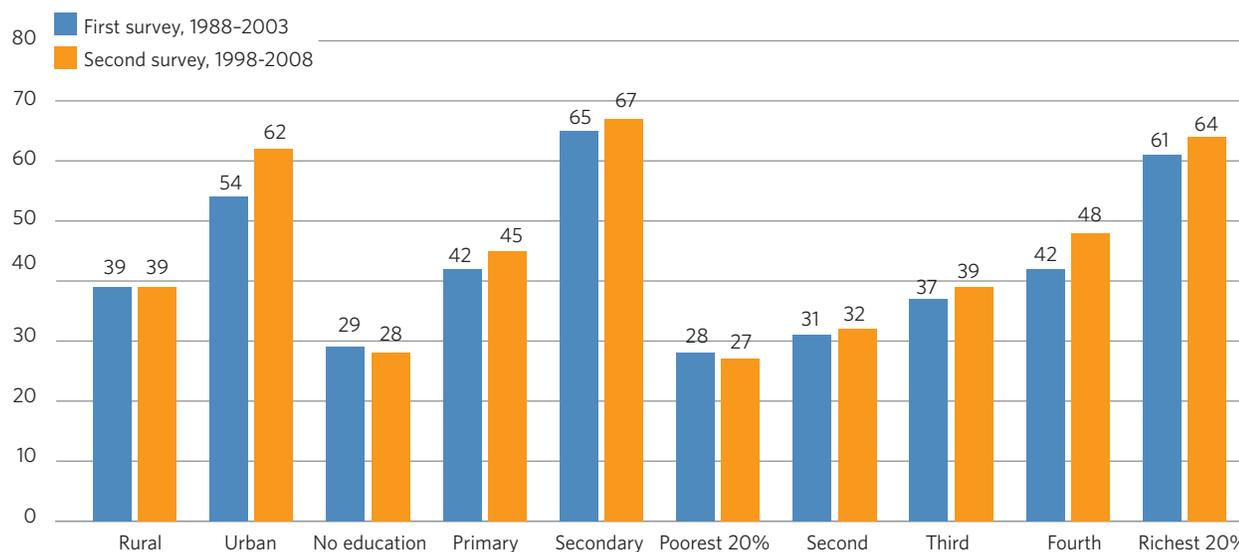
In the United Republic of Tanzania, significant progress was observed among some groups, but growing disparities meant that the national average changed by less than 5 per cent. Disparities were especially acute in relation to education. Between the first survey in 1999 and the second in 2004, the adolescent birth rate was cut in half among women with secondary or higher education, falling from 48 to 23. However, it increased from 151 to 187 for women with no education. In the same period, contraceptive prevalence increased significantly among the most educated women, rising from 44 per cent to 51 per cent, while their unmet need for family planning was halved: from 20 per cent to 10 per cent. For women with no education, contraceptive prevalence declined from 16 per cent to 13 per cent, while unmet need was constant at 22 in 2004.

## Satisfied demand for family planning in sub-Saharan Africa: still the lowest in the world

At less than 50 per cent, the proportion of demand satisfied for family planning in sub-Saharan Africa remains the lowest of all regions (Figure 3), with no change since 2000. Moreover, disparities among groups are significant.

*At less than 50 per cent, the proportion of demand satisfied for family planning in sub-Saharan Africa remains the lowest of all regions, with no change since 2000*

When data on the proportion of demand satisfied are categorized by household wealth, women's education, and rural versus urban residence, it is evident that more advantaged groups are much more likely to have their demand for family planning satisfied. In fact, for every background characteristic, the proportion of demand satisfied was over 60 per cent for women with the most access to resources: women living in urban areas, who have a secondary or higher education, or are among the richest 20 per cent of households. In contrast, their less advantaged counterparts—women living in rural

**FIGURE 12****Little progress has been made in satisfying the demand for family planning**

Trends in proportion of demand satisfied for family planning by background characteristics in 22 sub-Saharan African countries with two consecutive surveys, 1988-2003 and 1998-2008 (Percentage representing contraceptive prevalence as a proportion of total demand)

**Source:** Demographic and Health Surveys (calculated using data in Annex III).

areas, with no education, or from the poorest 20 per cent of households—reported very low levels of satisfied demand. For each group, the proportion of demand satisfied was between one third and one half that of their most advantaged peers.

When comparing progress over time, as measured by the two surveys, the proportion of demand satisfied (Figure 12) increased from 54 per cent to 62 per cent for women living in urban areas. This is due to increasing contraceptive use, since unmet need has remained stable; however, it remained

unchanged (at 39 per cent) for women in rural areas. When women are grouped by educational achievement or by household wealth, the gaps became even wider. The proportion of demand satisfied was two thirds among women with secondary or higher education and less than one third among women with no education. Similarly, the gap between women from the wealthiest and poorest households (64 per cent versus 27 per cent) was profound. The proportion of demand satisfied for family planning increased with household wealth and with women's education.

# Conclusion

Progress in increasing access to reproductive health, particularly family planning, is entirely possible. The 1990s witnessed significant gains in both of these areas. As a result, many lives have been saved and countless others changed for the better.<sup>20</sup>

Since 2000, however, three key reproductive health indicators—adolescent birth rates, contraceptive prevalence and unmet need for family planning—have been at a virtual standstill in most places around the world. This stalled progress has not affected everyone in the same way: in general, those most advantaged have progressed, while the least advantaged have lost ground.

*Stalled progress since 2000 has not affected everyone in the same way: in general, those most advantaged have progressed, while the least advantaged have lost ground*

Disaggregated data reveal that some regions, countries and groups of women have experienced major gains in improving their reproductive health. However, this progress has not reached the young women who are most likely to become mothers at an early age. Nor has it reached women in rural areas, those with little education, or those from the poorest households. The disparities that appeared to be narrowing in the 1990s have widened in subsequent years.

Universal access to reproductive health can be achieved. But the target will only be reached with greater support for family planning and all other reproductive health services along the continuum of care. Efforts must focus on overcoming the

widening disparities in access. Reaching the most vulnerable or disadvantaged groups and meeting the specific needs of the largest ever cohort of young people are essential. The success of these efforts relies on fulfilling the financial requirements for reproductive health.<sup>21</sup>

This report demonstrates the value of high-quality data, collected at regular intervals and disaggregated by age and by social and economic characteristics, to monitor progress, understand population dynamics, identify underserved groups and set priorities for expanding access to reproductive health. The report underscores the need to increase and systematize the use of household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS)<sup>22</sup> as well as to strengthen health management information systems in the health sector. Investing in data and research is essential to improving our understanding of factors influencing fertility among adolescents as well as factors influencing demand and use of contraceptives. Data and research are also needed to develop policies and programmes that promote equitable and cost-effective interventions and to monitor and evaluate these efforts. Finally, data and research are critical to giving a voice to all, including those most disadvantaged.

# Notes and references

1. The initial set of targets and indicators consisted of 18 targets and 58 indicators.
2. See Annex I for a list of the MDGs and current targets and indicators.
3. The 1994 International Conference on Population and Development's Programme of Action recognized that empowering women and addressing their individual needs for health and education—including reproductive health—are critical to advancing their rights and promoting development. See the ICPD Programme of Action, available at: <<http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Programme>>, accessed 28 July 2010.
4. For further analysis of the broader benefits of family planning and reproductive health in general, see: *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*, published by UNFPA in September 2010; *Adding It Up: The benefits of investing in sexual and reproductive health care*, published by UNFPA and the Guttmacher Institute in 2009; and *Healthy Expectations: Celebrating achievements of the Cairo consensus and highlighting the urgency for action*, published by UNFPA and the Population Reference Bureau in 2009.
5. Demographic and Health Surveys are household surveys conducted at the national level on a range of population, health and nutrition issues. For more information, see: Measure DHS: <<http://www.measuredhs.com/aboutsurveys/dhs/start.cfm>>, accessed 29 August 2010.
6. More information can be found at: United Nations Statistics Division, *Millennium Development Goals Indicators* <<http://mdgs.un.org/unsd/mdg/Default.aspx>> and *UNICEF Child Info*: <[www.childinfo.org](http://www.childinfo.org)>, accessed 29 August 2010.
7. The report does not include a causal analysis.
8. United Nations Population Fund. 1995. *Report of the International Conference on Population and Development Programme of Action, Cairo*, 4-13 September 1994. New York: UNFPA, chapter VII. See: <<http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Programme#ch7>>, accessed 28 July 2010.
9. For a more detailed discussion of the history, definition and development of indicators for universal access to reproductive health, see: United Nations Population Fund. September 2010. *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*. New York: UNFPA.
10. Countdown to 2015, Maternal, Newborn and Child Survival. 2010. *Countdown to 2015 Decade Report 2000-2010*. Geneva: World Health Organization and UNICEF, p.17.
11. The fourth indicator included in target 5.B but not addressed here—antenatal care—has shown greater gains and higher levels of coverage than the other three indicators. Source: United Nations. 2010. *Millennium Development Goals Report 2010*. New York: United Nations, p. 34.
12. See *Millennium Development Goals Report 2010* for a full list of regional groupings.
13. While health and other risks associated with pregnancy are greatest for younger girls, data for 10- to 14-year-olds are far less available. The 15- to 19-year-old age group serves as a good proxy for a younger person's elevated vulnerability.
14. Women Deliver. 2009. *Focus on 5: Women's health and the MDGs*. New York: Women Deliver; Youth Coalition. 2009. *Young People and Universal Access to Reproductive Health*, see: <[http://www.youthcoalition.org/site08/html/index.php?id\\_art=202&id\\_cat=7](http://www.youthcoalition.org/site08/html/index.php?id_art=202&id_cat=7)>, accessed 29 August 2010; and Temin, Miriam, Ruth Levine and Nandini Oomman. 2010. *Why it's the Right Time: Moving on reproductive health goals by focusing on adolescent girls*. New York: Women Deliver, chapters 2 and 3.
15. For regional data on child marriage, see: *UNICEF Child Info*, <<http://www.childinfo.org/marriage.html>>, accessed 29 August 2010.
16. For further discussion of the proportion of demand satisfied, see: United Nations Population Fund. September 2010. *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*. New York: UNFPA.
17. United Nations. 2010. *Millennium Development Goals Report 2010*. New York: United Nations, p.38.
18. For more on investment trends and needs, see: United Nations. 2010. *Millennium Development Goals Report 2010*. New York: United Nations; United Nations Population Fund and Guttmacher Institute. 2009. *Adding It Up: The costs and benefits of investing in family planning*. New York: UNFPA and Guttmacher Institute; United Nations Population Fund. 2010. *Financial Resource Flows for Population Activities in 2008*. New York: UNFPA.
19. The 24 countries are: Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
20. See: United Nations Population Fund. September 2010. *Eight Lives: Stories of reproductive health*. New York: UNFPA.
21. For more discussion on the way forward to achieving universal access to reproductive health, see: United Nations Population Fund. September 2010. *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*. New York: UNFPA.
22. More information on these two programmes can be found at: *UNICEF Child Info: Data collection*, <<http://www.childinfo.org/mics.html>> (for MICS); and (for DHS): Measure DHS, *Demographic and Health Surveys Overview*, <<http://www.measuredhs.com/aboutsurveys/dhs/start.cfm>>, accessed 29 August 2010.

# Millennium Development Goals, targets and indicators

Goals and targets	Indicators for monitoring progress
<b>Goal 1: Eradicate extreme poverty and hunger</b>	
<b>Target 1.A:</b> Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below \$1 (PPP) per day 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
<b>Target 1.B:</b> Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below \$1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
<b>Target 1.C:</b> Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
<b>Goal 2: Achieve universal primary education</b>	
<b>Target 2.A:</b> Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
<b>Goal 3: Promote gender equality and empower women</b>	
<b>Target 3.A:</b> Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
<b>Goal 4: Reduce child mortality</b>	
<b>Target 4.A:</b> Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunized against measles
<b>Goal 5: Improve maternal health</b>	
<b>Target 5.A:</b> Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
<b>Target 5.B:</b> Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

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Goals and targets	Indicators for monitoring progress
<b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>	
<b>Target 6.A:</b> Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
<b>Target 6.B:</b> Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
<b>Target 6.C:</b> Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
<b>Goal 7: Ensure environmental sustainability</b>	
<b>Target 7.A:</b> Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources  <b>Target 7.B:</b> Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.1 Proportion of land area covered by forest 7.2 CO <sub>2</sub> emissions, total, per capita and per \$1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
<b>Target 7.C:</b> Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
<b>Target 7.D:</b> By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums

*Continued on next page*

Goals and targets	Indicators for monitoring progress
<b>Goal 8: Develop a global partnership for development</b>	
<p><b>Target 8.A:</b> Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction — both nationally and internationally.</p> <p><b>Target 8.B:</b> Address the special needs of the least developed countries. Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p> <p><b>Target 8.C:</b> Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p><b>Target 8.D:</b> Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</p>	<p><i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i></p> <p><b>Official development assistance (ODA)</b></p> <p>8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income</p> <p>8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)</p> <p>8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied</p> <p>8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes</p> <p>8.5 ODA received in small island developing States as a proportion of their gross national incomes</p> <p><b>Market access</b></p> <p>8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty</p> <p>8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries</p> <p>8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product</p> <p>8.9 Proportion of ODA provided to help build trade capacity</p> <p><b>Debt sustainability</b></p> <p>8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)</p> <p>8.11 Debt relief committed under HIPC and MDRI Initiatives</p> <p>8.12 Debt service as a percentage of exports of goods and services</p>
<p><b>Target 8.E:</b> In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</p>	<p>8.13 Proportion of population with access to affordable essential drugs on a sustainable basis</p>
<p><b>Target 8.F:</b> In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p>	<p>8.14 Telephone lines per 100 population</p> <p>8.15 Cellular subscribers per 100 population</p> <p>8.16 Internet users per 100 population</p>

**Note:** The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of state and government, in September 2000 (available at: <<http://www.un.org/millennium/declaration/ares552e.htm>>) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1) (available at: <<http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1>>).

# Recent country estimates for three reproductive health indicators

Country, territory or area	Adolescent birth rate		Contraceptive prevalence rate			Unmet need for family planning			
	Year	Per 1,000 women 15-19	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
Afghanistan	2001	151	2006	18.6	15.5	—	—	—	—
Albania	2008	17	2009	69.3	10.2	2002	1.3	1	0.3
Algeria	2006	4.4	2006	61.4	52	—	—	—	—
Angola	2005	165	2001	6.2	4.5	—	—	—	—
Anguilla	2006	42.1	2003	43	40.8	—	—	—	—
Argentina	2007	64.9	2001	65.3	63.8	—	—	—	—
Armenia	2007	26.4	2005	53.1	19.1	2005	13.3	3.6	9.7
Australia	2008	17.6	2002	70.8	70.8	—	—	—	—
Austria	2008	11.1	1996	50.9	46.8	—	—	—	—
Azerbaijan	2008	41.5	2006	51.1	13.2	2006	22.7	3.3	19.3
Bahrain	2007	13.8	1995	61.8	30.6	—	—	—	—
Bangladesh	2005	133	2007	55.8	47.5	2007	17.1	6.6	10.5
Belarus	2006	21.8	2006	72.6	56	—	—	—	—
Belgium	2005	10.6	2004	74.6	72.9	1992	3.4	—	3.4
Belize	2002	90.7	2006	34.3	31.2	1999	20.8	—	—
Benin	2004	114	2006	17	5.9	2006	29.9	17.6	12.3
Bhutan	2005	46.3	2000	30.7	30.7	—	—	—	—
Bolivia (Plurinational State of)	2006	89	2008	60.6	33.8	2008	20.2	6.4	13.8
Bosnia and Herzegovina	2006	15	2006	35.7	11.2	—	—	—	—
Botswana	2006	51	2000	44.4	42.1	—	—	—	—
Brazil	2006	56	1996	76.7	70.3	1996	7.3	2.6	4.7
Bulgaria	2007	41.9	1998	63.4	39.6	1998	29.7	—	29.7
Burkina Faso	2001	131	2006	17.4	13.3	2003	28.8	21.8	7
Burundi	2001	30	2006	9.1	7.5	2002	29	—	—
Cambodia	2003	52.3	2005	40	27.1	2005	25.1	8.9	16.2
Cameroon	2002	141	2006	29.2	12	2004	20.2	14.2	6
Canada	2007	14.1	2002	74	72	—	—	—	—
Cape Verde	2003	92	2005	61.3	—	2005	16.7	6.4	10.3
Central African Republic	2003	132.9	2006	19	8.6	1995	16.2	11.6	4.6
Chad	2002	193	2004	2.8	1.7	2004	23.3	19.2	4.1
Chile	2006	50.6	2006	64.2	—	—	—	—	—

Country, territory or area	Adolescent birth rate		Contraceptive prevalence rate			Unmet need for family planning			
	Year	Per 1,000 women 15-19	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
China	2006	4.6	2001	86.9	86.2	2001	2.3	—	—
China, Hong Kong SAR	2006	4.3	2007	79.5	75.4	—	—	—	—
Colombia	2005	96.2	2005	78.2	67.6	2005	5.8	2.5	3.3
Comoros	2000	94.5	2000	25.7	19.3	1996	34.6	21.8	12.9
Congo	2003	131.5	2005	44.3	12.7	2005	16.2	13	3.2
Cook Islands	2001	47	1999	43.2	38.1	—	—	—	—
Costa Rica	2008	68.5	1999	80	71.5	1993	5	2	3
Côte d'Ivoire	2006	111.1	2006	12.9	8	1999	27.7	20	7.6
Cuba	2007	44.1	2006	72.6	71.6	—	—	—	—
Czech Republic	2008	11.5	1997	72	62.6	1997	10.8	—	10.8
Democratic People's Republic of Korea	2008	0.65	2002	68.6	58.2	—	—	—	—
Democratic Republic of the Congo	2005	127	2007	20.6	5.8	2007	24.4	19.4	5
Djibouti	2000	27	2006	17.8	17.1	—	—	—	—
Dominican Republic	2005	98	2007	72.9	69.5	2007	11.4	7	4.4
Ecuador	2002	100	2004	72.7	58	2004	7.4	—	—
Egypt	2006	50	2008	60.3	57.6	2008	9.2	3.4	5.8
El Salvador	2007	67.5	2008	72.5	65.6	2003	8.9	—	—
Equatorial Guinea	2001	128	2000	10.1	6.1	—	—	—	—
Eritrea	2000	85	2002	8	5.1	2002	27	21	6
Estonia	2007	24.5	1994	70.3	56.4	—	—	—	—
Ethiopia	2003	109.1	2005	14.7	13.7	2005	33.8	20.1	13.7
France	2007	10.5	2005	71	—	1994	7.4	—	7.4
Gabon	1998	144	2000	32.7	11.8	2000	28	19.9	8
Gambia	2000	103.9	2001	17.5	12.7	—	—	—	—
Georgia	2008	43.8	2005	47.3	26.6	2005	16.3	4.3	12
Germany	2007	10	1992	70.1	65.6	—	—	—	—
Ghana	2006	70	2008	23.5	16.6	2008	35.3	22.5	12.9
Greece	2007	11.2	2001	76.2	45.9	—	—	—	—
Grenada	2000	53.9	1990	54.3	52.1	—	—	—	—
Guam	2004	51.4	2002	66.6	58.3	—	—	—	—
Guatemala	2006	92.1	2002	43.3	34.4	2002	27.6	15.1	12.5
Guinea	2003	153	2005	9.1	4	2005	21.2	13.1	8.1
Guinea-Bissau	2000	170	2006	10.3	6.1	—	—	—	—
Guyana	2003	90	2007	34.2	32.7	—	—	—	—
Haiti	2003	68.6	2006	32	23.6	2006	37.5	17	20.4
Honduras	2003	107.9	2006	65.2	56.1	2006	16.9	8.4	8.4
Hungary	2007	19.3	1993	80.6	71.3	1993	7	—	7
India	2006	45.2	2006	56.3	48.5	2006	12.8	6.2	6.6

## RECENT COUNTRY ESTIMATES FOR THREE REPRODUCTIVE HEALTH INDICATORS

Country, territory or area	Adolescent birth rate		Contraceptive prevalence rate			Unmet need for family planning			
	Year	Per 1,000 women 15-19	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
Indonesia	2005	52	2007	61.4	57.4	2007	9.1	4.3	4.7
Iran (Islamic Republic of)	2006	31.3	2002	73.3	58.9	—	—	—	—
Iraq	2005	68	2006	49.8	32.9	—	—	—	—
Ireland	2008	17.2	2004	89	89	—	—	—	—
Italy	2006	6.9	1996	62.7	40.6	1996	11.8	—	11.8
Jamaica	2006	60.3	2003	69	66.2	2003	11.7	3.6	8.1
Japan	2007	4.9	2005	54.3	44.4	—	—	—	—
Jordan	2005	28	2007	57.1	40.5	2007	11.9	4.9	7
Kazakhstan	2008	31	2006	50.7	48.7	1999	8.7	3.6	5.1
Kenya	2008	103	2009	45.5	38.9	2003	24.5	14.4	10.1
Kiribati	2005	39	2000	36.1	31.1	—	—	—	—
Kuwait	2007	13.2	1999	52	39.3	—	—	—	—
Kyrgyzstan	2007	29	2006	47.8	45.5	1997	11.6	4.5	7.2
Lao People's Democratic Republic	2005	110	2000	32.2	28.9	2000	39.5	10.5	29
Latvia	2007	17.9	1995	67.8	55.5	1995	16.8	—	16.8
Lebanon	2001	18	2004	58	34	—	—	—	—
Lesotho	2003	98	2005	37.3	35.2	2005	30.9	10.9	20
Liberia	2007	177	2007	11.4	10.3	2007	35.6	24.6	11
Libyan Arab Jamahiriya	2002	3.7	1995	45.2	25.7	—	—	—	—
Lithuania	2007	18.9	1995	50.7	33.2	1995	18	—	18
Madagascar	2008	148	2009	39.9	28.2	2004	23.6	11.3	12.3
Malawi	2005	178	2006	41	38.4	2004	27.6	17.2	10.4
Malaysia	2006	12	1994	54.5	29.8	—	—	—	—
Maldives	2007	14.3	2004	39	34	—	—	—	—
Mali	2004	190	2006	8.2	6.3	2006	31.2	21.4	9.8
Malta	2007	17.3	1993	85.8	43.2	—	—	—	—
Marshall Islands	2006	88.2	2007	44.6	42.4	—	—	—	—
Mauritania	2002	88	2007	9.3	8	2001	31.6	22.9	8.6
Mauritius	2007	35.4	2002	75.8	39.3	2002	3.5	—	—
Mexico	2008	90.3	2006	70.9	66.5	2006	12	6.2	5.7
Mongolia	2007	18.5	2005	66	60.6	2003	4.6	2	2.6
Montenegro	2007	17.4	2006	39.4	17.2	—	—	—	—
Morocco	2005	18	2004	63	52	2004	10	3.5	6.6
Mozambique	2001	185	2004	16.5	11.8	2004	18.4	10.8	7.5
Myanmar	2001	17.4	2001	37	32.8	2001	19.1	6.3	12.8
Namibia	2004	74	2007	55.1	53.5	2007	6.7	3.8	2.9
Nauru	2005	84	2007	35.6	23	—	—	—	—
Nepal	2004	106.3	2006	48	44.2	2006	24.6	9.4	15.2
Netherlands	2007	3.8	2008	69	67	—	—	—	—

## RECENT COUNTRY ESTIMATES FOR THREE REPRODUCTIVE HEALTH INDICATORS

Country, territory or area	Adolescent birth rate		Contraceptive prevalence rate			Unmet need for family planning			
	Year	Per 1,000 women 15-19	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
New Zealand	2007	32	1995	75	72.3	—	—	—	—
Nicaragua	2005	108.5	2007	72.4	68.8	2007	7.5	—	—
Niger	2004	198.9	2006	11.2	5	2006	15.8	13.3	2.5
Nigeria	2006	123	2008	14.6	8.1	2008	20.2	15	5.2
Norway	2008	9.3	2005	88.4	82.2	—	—	—	—
Occupied Palestinian Territory	2006	59.8	2006	50.2	38.9	—	—	—	—
Oman	2008	8.1	2000	31.7	24.6	—	—	—	—
Pakistan	2005	20.3	2008	27	19.3	2007	24.9	10.9	14
Palau	2005	28.7	2003	32.8	29.7	—	—	—	—
Papua New Guinea	2000	70	1996	25.9	19.6	—	—	—	—
Paraguay	2003	65	2008	79.4	70.1	2004	6.6	—	—
Peru	2004	59	2005	71.3	47.1	2005	8.1	2.9	5.1
Philippines	2006	53	2008	50.7	33.6	2008	22.3	9	13.4
Poland	2006	14	1991	72.7	28	—	—	—	—
Portugal	2007	17	2006	67.1	62.9	—	—	—	—
Puerto Rico	2006	60.1	2002	84.1	72.2	1996	4	2	2
Qatar	2007	15.6	1998	43.2	32.3	—	—	—	—
Republic of Korea	2007	2.3	2006	79.6	76.3	—	—	—	—
Republic of Moldova	2005	29	2005	67.8	42.6	2005	6.7	2.5	4.2
Réunion	2007	44.7	1997	66.6	63.5	—	—	—	—
Romania	2007	35.6	2004	70.3	38.2	2004	11.9	—	—
Russian Federation	2007	28.7	2007	79.5	70	—	—	—	—
Rwanda	2006	43	2008	36.4	26.1	2005	37.9	24.5	13.4
Samoa	2006	28.6	1998	24.5	23.2	—	—	—	—
Sao Tome and Principe	2001	91	2000	29.3	27.4	—	—	—	—
Saudi Arabia	2006	7	2007	23.8	—	—	—	—	—
Senegal	2007	96	2005	11.8	10	2005	31.6	24.3	7.3
Serbia	2007	22.3	2005	41.2	18.6	—	—	—	—
Sierra Leone	2006	143	2008	8.2	6	2008	27.6	16.4	11.2
Singapore	2007	5.2	1997	62	53	—	—	—	—
Slovakia	2007	20.6	1997	79.8	65.6	—	—	—	—
Slovenia	2007	5.1	1995	78.9	63.2	1995	9.2	—	9.2
Solomon Islands	2005	70	2007	34.6	27.3	—	—	—	—
Somalia	2005	123	2006	14.6	1.2	—	—	—	—
South Africa	2007	54	2003	60.3	60.3	1998	15	4.7	10.3
Spain	2007	13.3	2006	65.7	62.3	1995	11.8	6.3	5.4
Sri Lanka	2005	28	2007	68	52.7	2000	18.2	6.2	12
Sudan	1997	72	2006	7.6	5.7	1993	26	—	—
Suriname	2007	65.9	2006	45.6	45	—	—	—	—

## RECENT COUNTRY ESTIMATES FOR THREE REPRODUCTIVE HEALTH INDICATORS

Country, territory or area	Adolescent birth rate		Contraceptive prevalence rate			Unmet need for family planning			
	Year	Per 1,000 women 15-19	Year	Any method (%)	Modern method (%)	Year	Total (%)	Spacing (%)	Limiting (%)
Swaziland	2004	111	2007	50.6	46.8	2007	24	7.4	16.7
Sweden	2007	6	1996	75.2	64.8	—	—	—	—
Switzerland	2007	4.3	1995	82	77.5	—	—	—	—
Syrian Arab Republic	2004	75	2006	58.3	42.6	—	—	—	—
Tajikistan	2005	27.3	2005	37.9	33.1	—	—	—	—
Thailand	2005	43.3	2006	81.1	79.8	2006	3.1	—	—
The former Yugoslav Republic of Macedonia	2007	20.9	2006	13.5	9.8	—	—	—	—
Timor-Leste	2004	59.2	2003	10	7	2003	3.8	3.7	0.1
Togo	1996	88.6	2006	16.8	11.1	1998	32.3	21.4	10.9
Trinidad and Tobago	2004	32.5	2006	42.5	37.7	—	—	—	—
Tunisia	2007	6.2	2006	60.2	51.5	2001	12.1	—	—
Turkey	2001	51	2003	71	42.5	2003	6	2.3	3.7
Turkmenistan	2006	21	2000	61.8	45.2	2000	10.1	5.2	4.9
Tuvalu	2005	23.3	2007	30.5	22.4	—	—	—	—
Uganda	2004	159	2006	23.7	17.9	2006	40.6	24.5	16.1
Ukraine	2007	29.9	2007	66.7	47.5	2007	10.3	3.9	6.4
United Arab Emirates	2002	21.5	1995	27.5	23.6	—	—	—	—
United Kingdom	2005	25.9	2009	84	84	—	—	—	—
United Republic of Tanzania	2003	139	2005	26.4	19.5	2005	21.8	15.1	6.7
United States of America	2007	41.3	2007	78.6	73	2002	6.3	—	—
United States Virgin Islands	2007	51.5	2002	78.4	72.6	—	—	—	—
Uruguay	2007	59.6	2004	77	75	—	—	—	—
Uzbekistan	2006	25.5	2006	64.9	59.3	1996	13.7	6.6	7
Vanuatu	1999	92	1995	39	32.1	—	—	—	—
Venezuela (Bolivarian Republic of)	2007	100.8	1998	70.3	61.7	1998	18.9	6.7	12.2
Viet Nam	2007	35	2008	79.5	68.8	2002	4.8	2	2.8
Yemen	2005	80	2006	27.7	19.2	1997	38.6	17.2	21.4
Zambia	2005	151	2007	40.8	26.5	2007	26.5	17.1	9.4
Zimbabwe	2003	101.3	2006	60.2	57.9	2006	12.8	7.7	5.1

**Note:** Data compiled by United Nations Population Division.

# Trends and disparities in reproductive health for selected countries in sub-Saharan Africa

## Adolescent birth rates for 24 sub-Saharan African countries with two recent Demographic and Health Surveys, according to background characteristics

Country	Year	Total (births to girls age 15-19)	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Benin</b>												
	2001	109	72	142	148	94	21	176	151	155	90	35
	2006	112	71	145	176	90	30	176	155	140	102	38
	% change	2.8	-1.4	2.1	18.9	-4.3	42.9	0.0	2.6	-9.7	13.3	8.6
<b>Burkina Faso</b>												
	1999	131	72	148	147	102	48	163	134	135	156	89
	2003	119	60	143	142	91	38	142	162	139	133	61
	% change	-9.2	-16.7	-3.4	-3.4	-10.8	-20.8	-12.9	20.9	3.0	-14.7	-31.5
<b>Cameroon</b>												
	1998	137	86	168	226	146	89	202	198	162	100	63
	2004	138	105	183	235	173	77	204	189	158	114	71
	% change	0.7	22.1	8.9	4.0	18.5	-13.5	1.0	-4.5	-2.5	14.0	12.7
<b>Chad</b>												
	1996-97	190	189	190	200	179	106	178	177	191	201	205
	2004	187	166	194	205	176	109	140	217	220	188	170
	% change	-1.6	-12.2	2.1	2.5	-1.7	2.8	-21.3	22.6	15.2	-6.5	-17.1
<b>Côte d'Ivoire</b>												
	1994	140	109	168	164	142	76	191	192	159	134	72
	1998-99	127	82	169	168	116	39	225	147	191	115	52
	% change	-9.3	-24.8	0.6	2.4	-18.3	-48.7	17.8	-23.4	20.1	-14.2	-27.8
<b>Ethiopia</b>												
	2000	100	50	114	124	70	40	84	113	131	119	67
	2005	104	35	122	156	70	17	143	131	128	113	47
	% change	4.0	-30.0	7.0	25.8	0.0	-57.5	70.2	15.9	-2.3	-5.0	-29.9
<b>Ghana</b>												
	2003	74	42	113	120	118	48	133	113	113	50	16
	2008	66	49	82	150	124	39	110	83	89	53	14
	% change	-10.8	16.7	-27.4	25.0	5.1	-18.8	-17.3	-26.5	-21.2	6.0	-12.5
<b>Guinea</b>												
	1999	168	115	204	195	141	43	210	207	214	167	93
	2005	154	104	187	196	127	56	197	217	171	125	101
	% change	-8.3	-9.6	-8.3	0.5	-9.9	30.2	-6.2	4.8	-20.1	-25.1	8.6

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total (births to girls age 15-19)	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Kenya</b>												
	1998	111	90	119	214	135	45	163	143	108	103	63
	2003	114	88	123	209	132	49	174	141	111	94	81
	% change	2.7	-2.2	3.4	-2.3	-2.2	8.9	6.7	-1.4	2.8	-8.7	28.6
<b>Liberia</b>												
	1986	188	174	202	187	204	169	—	—	—	—	—
	2007	141	101	182	223	149	69	210	199	159	125	75
	% change	-25.0	-42.0	-9.9	19.3	-27.0	-59.2	—	—	—	—	—
<b>Madagascar</b>												
	1997	180	121	204	235	195	98	271	215	206	141	78
	2003- 2004	150	104	165	229	166	56	227	209	161	122	66
	% change	-16.7	-14.0	-19.1	-2.6	-14.9	-42.9	-16.2	-2.8	-21.8	-13.5	-15.4
<b>Malawi</b>												
	2000	172	134	180	241	182	82	185	170	176	173	159
	2004	162	109	175	238	183	77	186	206	191	154	92
	% change	-5.8	-18.7	-2.8	-1.2	0.5	-6.1	0.5	21.2	8.5	-11.0	-42.1
<b>Mali</b>												
	2001	185	129	218	208	168	61	200	246	225	203	108
	2006	188	141	219	220	182	78	229	206	228	199	127
	% change	1.6	9.3	0.5	5.8	8.3	27.9	14.5	-16.3	1.3	-2.0	17.6
<b>Mozambique</b>												
	1997	171	174	171	197	170	44	191	144	178	208	126
	2003	179	143	207	220	185	59	234	197	208	188	111
	% change	4.7	-17.8	21.1	11.7	8.8	34.1	22.5	36.8	16.9	-9.6	-11.9
<b>Namibia</b>												
	2000	88	82	92	191	117	68	95	99	100	78	69
	2006	78	58	92	230	141	58	104	86	102	64	39
	% change	-11.4	-29.3	0.0	20.4	20.5	-14.7	9.5	-13.1	2.0	-17.9	-43.5
<b>Niger</b>												
	1998	218	129	243	241	167	63	260	231	229	246	148
	2006	199	118	222	223	158	51	223	208	223	223	134
	% change	-8.7	-8.5	-8.6	-7.5	-5.4	-19.0	-14.2	-10.0	-2.6	-9.3	-9.5
<b>Nigeria</b>												
	2003	126	88	146	238	150	46	184	162	152	98	58
	2008	121	70	148	247	165	45	205	180	120	86	27
	% change	-4.0	-20.5	1.4	3.8	10.0	-2.2	11.4	11.1	-21.1	-12.2	-53.4
<b>Rwanda</b>												
	2000	52	59	50	86	48	28	51	49	60	53	49
	2005	42	35	43	105	34	22	52	42	45	41	31
	% change	-19.2	-40.7	-14.0	22.1	-29.2	-21.4	2.0	-14.3	-25.0	-22.6	-36.7

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total (births to girls age 15-19)	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Senegal</b>												
	1997	103	58	142	133	80	34	189	147	109	83	36
	2005	101	64	137	142	80	20	163	148	116	75	37
	% change	-1.9	10.3	-3.5	6.8	0.0	-41.2	-13.8	0.7	6.4	-9.6	2.8
<b>United Republic of Tanzania</b>												
	1999	138	95	154	151	142	48	196	141	178	117	81
	2004	132	90	151	187	133	23	173	159	164	129	71
	% change	-4.3	-5.3	-1.9	23.8	-6.3	-52.1	-11.7	12.8	-7.9	10.3	-12.3
<b>Togo</b>												
	1988	131	66	176	166	125	66	—	—	—	—	—
	1998	89	51	118	150	78	26	142	129	114	79	35
	% change	-32.1	-22.7	-33.0	-9.6	-37.6	-60.6	—	—	—	—	—
<b>Uganda</b>												
	2000	178	119	192	260	200	82	225	226	204	149	112
	2006	152	103	164	248	182	78	222	185	156	141	94
	% change	-14.6	-13.4	-14.6	-4.6	-9.0	-4.9	-1.3	-18.1	-23.5	-5.4	-16.1
<b>Zambia</b>												
	2001- 2002	160	127	185	221	189	101	194	209	180	154	94
	2007	146	99	189	239	198	88	215	174	193	153	63
	% change	-8.8	-22.0	2.2	8.1	4.8	-12.9	10.8	-16.7	7.2	-0.6	-33.0
<b>Zimbabwe</b>												
	1999	112	93	125	142	170	85	162	108	106	130	74
	2005	99	70	120	194	149	81	149	125	111	108	44
	% change	-11.6	-24.7	-4.0	36.6	-12.4	-4.7	-8.0	15.7	4.7	-16.9	-40.5

## Contraceptive prevalence rates for 24 sub-Saharan African countries with two recent Demographic and Health Surveys, according to background characteristics

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Benin</b>												
	2001	18.6	21.1	17.3	15.8	20.1	39	12.2	13.2	18.9	20.3	29.7
	2006	17	24.4	12.8	12.4	25.3	39.3	7.7	11.5	13.6	19	33.6
	% change	-8.6	15.6	-26.0	-21.5	25.9	0.8	-36.9	-12.9	-28.0	-6.4	13.1
<b>Burkina Faso</b>												
	1999	11.9	29.4	9.3	9.7	23.1	52.2	8	11.5	9.1	7.4	24.7
	2003	13.8	34.2	10.1	10.7	26.5	52	7.6	11.4	10.2	9.8	32.4
	% change	16.0	16.3	8.6	10.3	14.7	-0.4	-5.0	-0.9	12.1	32.4	31.2
<b>Cameroon</b>												
	1998	19.3	34.6	12.9	3.2	20.4	41.6	6.1	7.7	17.2	28.2	40.7
	2004	26	36.2	16.2	3.7	25.2	47.6	7.3	14.5	25	39	45.9
	% change	34.7	4.6	25.6	15.6	23.5	14.4	19.7	88.3	45.3	38.3	12.8

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Chad</b>												
	1996-97	4.1	9.4	2.7	2.7	7.5	24.3	3.5	1.9	2.4	3.9	10.1
	2004	11.1	14.3	10.3	10.3	10.6	28	10.6	7.9	10.4	11.2	16
	% change	170.7	52.1	281.5	281.5	41.3	15.2	202.9	315.8	333.3	187.2	58.4
<b>Côte d'Ivoire</b>												
	1994	11.4	19.3	6.9	5.2	20	38.7	3.7	5.7	8.1	14.5	28.2
	1998-99	15	24.2	10.2	7.7	25.2	40.3	4.8	6.4	12.1	19.8	38
	% change	31.6	25.4	47.8	48.1	26.0	4.1	29.7	12.3	49.4	36.6	34.8
<b>Ethiopia</b>												
	2000	8.1	35.6	4.3	4.6	16.4	44.8	3.5	3.4	3.1	4.8	28.3
	2005	14.7	46.7	10.9	10	23.4	52.6	4.2	6.6	12	15.5	37
	% change	81.5	31.2	153.5	117.4	42.7	17.4	20.0	94.1	287.1	222.9	30.7
<b>Ghana</b>												
	2003	25.2	31.4	20.9	15.3	26.1	33.8	14	24	24.9	29	34.6
	2008	23.5	27.1	20.9	13.6	26.6	28.1	14.2	20.3	21.8	29	31.4
	% change	-6.7	-13.7	0.0	-11.1	1.9	-16.9	1.4	-15.4	-12.4	0.0	-9.2
<b>Guinea</b>												
	1999	6.2	13.9	3.4	4	13.3	27	1.7	3.6	3.6	9	15.1
	2005	9.1	14.9	7	7.5	13.3	25.1	5.3	6.2	7.6	10.9	17.1
	% change	46.8	7.2	105.9	87.5	0.0	-7.0	211.8	72.2	111.1	21.1	13.2
<b>Kenya</b>												
	1998	39	49.6	36.2	22.8	34.5	56.7	20.6	30.4	38.2	46.6	58.8
	2003	39.3	47.6	37	12	36.6	61.8	17.9	31.9	42	50.7	51.5
	% change	0.8	-4.0	2.2	-47.4	6.1	9.0	-13.1	4.9	9.9	8.8	-12.4
<b>Liberia</b>												
	1986	6.4	11.6	3.3	2.8	7.3	26.8	—	—	—	—	—
	2007	11.4	18.8	7.7	7.7	12.1	20.9	3.6	5.7	14.2	15.4	20.4
	% change	78.1	62.1	133.3	175.0	65.8	-22.0	—	—	—	—	—
<b>Madagascar</b>												
	1997	19.4	34.5	14.3	3	16.2	42.3	5.8	6.8	12.8	26	45.7
	2003-2004	27.1	40.9	23.1	7.4	24.5	47.8	9.5	14	22.8	33.2	51.5
	% change	39.7	18.6	61.5	146.7	51.2	13.0	63.8	105.9	78.1	27.7	12.7
<b>Malawi</b>												
	2000	30.6	41.2	28.9	26	31.3	45.1	25.2	29.4	29.3	29.8	39.5
	2004	32.5	37.2	31.6	27	32.6	44.2	25.3	27.9	30.4	36.7	40.6
	% change	6.2	-9.7	9.3	3.8	4.2	-2.0	0.4	-5.1	3.8	23.2	2.8
<b>Mali</b>												
	2001	8.1	17.8	4.9	5.9	13.1	33.1	4.7	4.3	3.9	7.9	21.3
	2006	8.2	15.2	5.1	5.6	14.1	29	3.7	5	4.6	8	19.1
	% change	1.2	-14.6	4.1	-5.1	7.6	-12.4	-21.3	16.3	17.9	1.3	-10.3

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Mozambique</b>												
	1997	5.6	17.7	2.7	3	6.7	30.2	1.3	2.1	3.6	5.7	18.1
	2003	25.5	33.2	22.4	19.8	28.5	55.8	19.1	21.1	26.4	22.5	42
	% change	355.4	87.6	729.6	560.0	325.4	84.8	1369.2	904.8	633.3	294.7	132.0
<b>Namibia</b>												
	2000	43.7	53.9	35.3	27.8	33.5	56	26	29.2	34.5	47.5	65.2
	2006	55.1	65.4	44.6	33.7	46.1	64.1	31.9	46.8	47.7	66.4	71.1
	% change	26.1	21.3	26.3	21.2	37.6	14.5	22.7	60.3	38.3	39.8	9.0
<b>Niger</b>												
	1998	8.2	22.9	5.5	6.4	17.5	39.9	3.6	4.8	5.7	7.3	22.5
	2006	11.2	23	9.1	9.8	17.2	31.7	10.9	8	7.4	10.1	20.9
	% change	36.6	0.4	65.5	53.1	-1.7	-20.6	202.8	66.7	29.8	38.4	-7.1
<b>Nigeria</b>												
	2003	12.6	20.2	9.2	4	16.7	28.1	6.9	5.6	9.1	13.5	30
	2008	14.6	25.9	9.4	3.6	17.2	29.5	3.2	5.2	11.4	21.3	35
	% change	15.9	28.2	2.2	-10.0	3.0	5.0	-53.6	-7.1	25.3	57.8	16.7
<b>Rwanda</b>												
	2000	13.2	26.9	10.9	9	12	34.3	7.4	8.1	11.1	13.3	25.5
	2005	17.4	31.6	15.2	10.8	17.3	40.4	11	15.2	15.7	14.8	31.8
	% change	31.8	17.5	39.4	20.0	44.2	17.8	48.6	87.7	41.4	11.3	24.7
<b>Senegal</b>												
	1997	12.9	23.8	7.1	8.4	21.9	43	6.6	7.3	9.7	15.6	27.2
	2005	11.8	20.3	6	6.5	20.2	33.9	3.7	6.3	10.3	16	24.6
	% change	-8.5	-14.7	-15.5	-22.6	-7.8	-21.2	-43.9	-13.7	6.2	2.6	-9.6
<b>United Republic of Tanzania</b>												
	1999	25.4	37.3	21.7	16.3	28.7	44.2	15.4	19.1	24.3	29	37.6
	2004	26.4	41.8	21.6	13.4	30	50.6	15.6	18.9	21.4	29.8	45.2
	% change	3.9	12.1	-0.5	-17.8	4.5	14.5	1.3	-1.0	-11.9	2.8	20.2
<b>Togo</b>												
	1988	33.9	32.3	34.5	33.5	32	42.1	—	—	—	—	—
	1998	23.5	27	22	20.6	25.2	33.6	20.1	21.5	23.9	22.4	29.7
	% change	-30.7	-16.4	-36.2	-38.5	-21.3	-20.2	—	—	—	—	—
<b>Uganda</b>												
	2000	22.8	46.3	19.3	13.2	21.2	49.1	15.1	13.7	17.2	23.8	45.8
	2006	23.7	43.1	20.8	13.2	22.4	45.6	9.9	15.7	19.4	27.6	47.5
	% change	3.9	-6.9	7.8	0.0	5.7	-7.1	-34.4	14.6	12.8	16.0	3.7
<b>Zambia</b>												
	2001-2002	34.2	45.7	27.9	23.2	30.9	49.2	23	24.6	30	37.4	56.7
	2007	40.8	48.4	36.7	35	37.8	50.6	40.5	34.2	31.3	44.3	54.2
	% change	19.3	5.9	31.5	50.9	22.3	2.8	76.1	39.0	4.3	18.4	-4.4

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Zimbabwe</b>												
	1999	53.5	63.1	48.1	40.8	48.8	60.8	46.3	47.5	46	55.5	68.6
	2005	60.2	69.8	55.3	34.7	53.9	66.7	48	57.1	56.1	66.5	72.1
	% change	12.5	10.6	15.0	-15.0	10.5	9.7	3.7	20.2	22.0	19.8	5.1

**Unmet need for family planning for 22 sub-Saharan African countries with two recent Demographic and Health Surveys, according to background characteristics**

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Benin</b>												
	2001	27.2	30.2	25.7	26.6	30.5	25.5	22.4	27.7	27.4	28.5	30.8
	2006	29.9	29	30.4	30.2	31.5	24.4	30.3	30.1	31.2	31.3	26.5
	% change	9.9	-4.0	18.3	13.5	3.3	-4.3	35.3	8.7	13.9	9.8	-14.0
<b>Burkina Faso</b>												
	1999	25.8	24.1	26.1	26	27.6	15.6	25.6	24.3	24.1	29.6	25.6
	2003	28.8	22.7	30	29.9	25.1	14.9	28.6	30.1	30.7	31.5	22.4
	% change	11.6	-5.8	14.9	15.0	-9.1	-4.5	11.7	23.9	27.4	6.4	-12.5
<b>Cameroon</b>												
	1998	19.7	18.4	20.2	19.5	22.4	15.9	19.1	21.4	23.1	18.8	16.7
	2004	20.2	19.5	20.9	19.8	22.7	17.4	19	22.6	23.7	20	16.2
	% change	2.5	6.0	3.5	1.5	1.3	9.4	-0.5	5.6	2.6	6.4	-3.0
<b>Chad</b>												
	1996-97	9.7	13.1	8.7	8.7	13	17.4	9.5	7.8	8.7	10.8	12.5
	2004	19.1	23.3	18.2	17.1	27.2	24	16.9	18.6	19.5	17.8	23.1
	% change	96.9	77.9	109.2	96.6	109.2	37.9	77.9	138.5	124.1	64.8	84.8
<b>Côte d'Ivoire</b>												
	1994	27.1	29.5	25.8	26.1	32.3	23	23.4	27.3	28.6	31.3	25.5
	1998-99	27.7	26.4	28.3	28.8	27.2	20.5	26.3	27.9	37.1	24.9	21.7
	% change	2.2	-10.5	9.7	10.3	-15.8	-10.9	12.4	2.2	29.7	-20.4	-14.9
<b>Ethiopia</b>												
	2000	35.2	24.9	36.6	34.7	41.2	28.9	36.3	36.5	34	38.2	30.3
	2005	33.8	16.8	35.8	34.5	37	16.9	33.1	37.9	36.8	36.2	24
	% change	-4.0	-32.5	-2.2	-0.6	-10.2	-41.5	-8.8	3.8	8.2	-5.2	-20.8
<b>Ghana</b>												
	2003	34	28	38.1	35.1	39.6	30.3	40.7	37.7	34.5	33	23.9
	2008	35.3	32.3	37.6	35.1	41	33	36.2	42.8	39.4	34.9	24.2
	% change	3.8	15.4	-1.3	0.0	3.5	8.9	-11.1	13.5	14.2	5.8	1.3
<b>Guinea</b>												
	1999	24.2	25.9	23.5	23.8	28.2	24.9	21.1	21.3	26.2	27.5	25.7
	2005	21.2	22.2	20.9	20.3	25.2	29.1	18.8	20.1	23	22.3	22.7
	% change	-12.4	-14.3	-11.1	-14.7	-10.6	16.9	-10.9	-5.6	-12.2	-18.9	-11.7

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Kenya</b>												
	1998	23.9	17.2	25.6	24.7	27.8	15.1	37.5	28.1	21.1	19.9	12.5
	2003	24.5	17.2	26.6	21.4	30.3	13.2	32.7	30.3	26.8	17.4	17
	% change	2.5	0.0	3.9	-13.4	9.0	-12.6	-12.8	7.8	27.0	-12.6	36.0
<b>Liberia</b>												
	1986	—	—	—	—	—	—	—	—	—	—	—
	2007	35.6	40.4	42.6	38.6	37.1	34.8	32.3	21.2	34.4	36.2	32.6
	% change	—	—	—	—	—	—	—	—	—	—	—
<b>Madagascar</b>												
	1997	25.6	19.4	27.7	23.8	29.5	19	31	24.6	29.2	25.5	17.7
	2003-2004	23.6	19.1	25	24.8	25.9	18.9	26.8	26.6	25.6	24	16.8
	% change	-7.8	-1.5	-9.7	4.2	-12.2	-0.5	-13.5	8.1	-12.3	-5.9	-5.1
<b>Malawi</b>												
	2000	29.7	23.2	30.7	30.8	29.7	24.3	32.8	31.2	30	29.9	24.4
	2004	27.6	23	28.5	29.8	27.4	23.8	31.9	29.7	28.3	27.3	21.8
	% change	-7.1	-0.9	-7.2	-3.2	-7.7	-2.1	-2.7	-4.8	-5.7	-8.7	-10.7
<b>Mali</b>												
	2001	28.5	31.4	27.6	28.4	31.2	25.3	28.9	27.5	27.4	28.9	30.1
	2006	31.2	32.4	30.7	30.5	31.6	38.1	31.7	30.6	30.8	29.3	33.6
	% change	9.5	3.2	11.2	7.4	1.3	50.6	9.7	11.3	12.4	1.4	11.6
<b>Mozambique</b>												
	1997	22.5	26.4	21.5	20.2	24.6	23.3	22.4	21	17.4	24.9	27.6
	2003	18.4	19.7	17.8	17.4	19.7	14.6	16.6	18.1	18.4	21.1	18.7
	% change	-18.2	-25.4	-17.2	-13.9	-19.9	-37.3	-25.9	-13.8	5.7	-15.3	-32.2
<b>Namibia</b>												
	2000	22.1	21.1	23	23.3	27.1	18.3	26.1	25.2	26.3	22.5	15
	2006	20.6	15.5	25.7	29.6	26.2	15.7	32.1	23.5	25.3	16.4	11
	% change	-6.8	-26.5	11.7	27.0	-3.3	-14.2	23.0	-6.7	-3.8	-27.1	-26.7
<b>Niger</b>												
	1998	16.6	21.3	15.8	16.3	20.7	15.7	17.2	15.2	14	17.9	20.3
	2006	15.8	23.7	14.4	15.3	18	23.4	15.7	14.8	15.1	13.6	20.6
	% change	-4.8	11.3	-8.9	-6.1	-13.0	49.0	-8.7	-2.6	7.9	-24.0	1.5
<b>Nigeria</b>												
	2003	16.9	17.3	16.7	14.1	21	19.6	14.9	15.6	16.7	19.9	18
	2008	20.2	19.3	20.6	19.2	22.6	20	18.4	20.3	21.8	23.1	18.2
	% change	19.5	11.6	23.4	36.2	7.6	2.0	23.5	30.1	30.5	16.1	1.1
<b>Rwanda</b>												
	2000	35.6	33.9	35.9	36.7	36.4	27.1	36.6	36.1	38.3	35.9	31.1
	2005	37.9	34.4	38.4	38.8	38.8	28.6	40	37.5	39.5	38.1	33.9
	% change	6.5	1.5	7.0	5.7	6.6	5.5	9.3	3.9	3.1	6.1	9.0

## TRENDS AND DISPARITIES IN REPRODUCTIVE HEALTH FOR SELECTED COUNTRIES IN SUB-SAHARAN AFRICA

Country	Year	Total	Urban/rural		Level of education			Wealth quintiles				
			Urban	Rural	No education	Primary	Secondary+	Poorest 20%	Second	Third	Fourth	Richest 20%
<b>Senegal</b>												
	1997	34.8	34.7	34.9	34.4	41.4	26.9	33.5	35	36.2	39	30.2
	2005	31.6	32	31.3	31.3	34.6	26.3	30.4	31.1	33.7	33.6	28.9
	% change	-9.2	-7.8	-10.3	-9.0	-16.4	-2.2	-9.3	-11.1	-6.9	-13.8	-4.3
<b>United Republic of Tanzania</b>												
	1999	21.8	20	22.4	20.5	22.6	20.2	22.3	26.6	20.2	19.4	20.8
	2004	21.8	16.6	23.5	22	22.7	10.4	23.9	22	25.8	22.5	15.4
	% change	0.0	-17.0	4.9	7.3	0.4	-48.5	7.2	-17.3	27.7	16.0	-26.0
<b>Togo</b>												
	1988	—	—	—	—	—	—	—	—	—	—	—
	1998	32.3	27.7	34.2	31.9	36	24.2	35.2	31.5	34	33.2	27.5
	% change	—	—	—	—	—	—	—	—	—	—	—
<b>Uganda</b>												
	2000	34.6	23.4	36.2	34.5	37.3	21.9	34.4	37	37.2	38.3	25.7
	2006	40.6	27	42.6	44.6	42.3	27	46.5	45.9	43.6	39.7	26.2
	% change	17.3	15.4	17.7	29.3	13.4	23.3	35.2	24.1	17.2	3.7	1.9
<b>Zambia</b>												
	2001-2002	27.4	25.5	28.5	27.2	29.2	23	27.9	30.4	28.5	29.2	20.8
	2007	26.5	23.2	28.2	27.6	28.4	21.3	26.4	31.4	29.7	25.4	19
	% change	-3.3	-9.0	-1.1	1.5	-2.7	-7.4	-5.4	3.3	4.2	-13.0	-8.7
<b>Zimbabwe</b>												
	1999	12.9	7.9	15.8	16.1	16.1	9.1	16.8	16	16.9	10.3	6.7
	2005	12	7.8	14.2	22.7	14.1	9.6	18.8	14	11.6	8.8	7.1
	% change	-7.0	-1.3	-10.1	41.0	-12.4	5.5	11.9	-12.5	-31.4	-14.6	6.0

**Note:** Demographic and Health Surveys conducted between 1986-2003 and 1998-2008 are sources for annex data, with analysis conducted by UNFPA.





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