United Nations | Department of Economic and Social Affairs

World Family Planning 2020

Highlights

United Nations Department of Economic and Social Affairs, Population Division

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World Family Planning 2020 Highlights

Accelerating action to ensure universal access to family planning

United Nations
New York, 2020

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Contents

Notes on regions, development groups, countries or areas

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In this publication, data for countries and areas are often aggregated in six continental regions: Africa, Asia, Europe, Latin America and the Caribbean, Northern America, and Oceania. Further information on continental regions is available from https://unstats.un.org/unsd/methodology/m49/. Countries and areas have also been grouped into geographic regions based on the classification being used to track progress towards the Sustainable Development Goals of the United Nations (see: https://unstats.un.org/sdgs/indicators/regional-groups/).

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The group of least developed countries (LDCs) includes 47 countries, located in sub-Saharan Africa (32), Northern Africa and Western Asia (2), Central and Southern Asia (4), Eastern and South-Eastern Asia (4), Latin America and the Caribbean (1), and Oceania (4). Further information is available at http://unohrlls.org/about-ldcs/.

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The classification of countries and areas by income level is based on gross national income (GNI) per capita as reported by the World Bank (June 2018). These income groups are not available for all countries and areas Further information is available at The classification of countries and areas by income level is based on gross national income (GNI) per capita as reported by the World Bank (June 2018). These income groups are not available for all countries and areas Further information is available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

Executive summary

Expanding access to contraception is an essential component of achieving universal access to sexual and reproductive health-care services, as called for in the 2030 Agenda for Sustainable Development.[1] This *Highlights* report examines global and regional progress in meeting the growing demand for family planning.

Globally, many women and couples want to postpone or avoid pregnancy. In 2020, among 1.9 billion women of reproductive age (15-49 years), 1.1 billion women are considered to have a need for family planning, meaning that they desire to limit or delay childbearing. Of these women, 851 million are using a modern method of contraception and 85 million are using a traditional method. An additional 172 million women are using no method at all, despite their desire to avoid pregnancy, and thus are considered to have an unmet need for family planning.

More women or their partners are using contraceptive methods to avoid unintended pregnancies today than in the past. Between 2000 and 2020, the contraceptive prevalence rate (percentage of women aged 15-49 who use any contraceptive method) increased from 47.7 to 49.0 per cent. Whereas contraceptive use is currently lowest in sub-Saharan Africa, at 27.8 per cent, this level is projected to increase over the next decade to 32.9 per cent. Most women who use contraception rely on modern methods, but the specific contraceptive methods used vary by region.

Still, nearly 1 in 10 women of reproductive age worldwide have an unmet need for family planning: they want to avoid or postpone pregnancy but are not using any form of contraception. While globally the proportion of women of reproductive age who have an unmet need for family planning remained around 9 per cent in the past two decades, the absolute number of women with an unmet need for family planning increased by 20 million since 2000 due to growth in the number of women of reproductive age. Over the next decade, despite expected declines in the *percentage* of women with an unmet need for family planning, sub-Saharan Africa is projected to have an increase in the absolute *number* of women with an unmet need for family planning as a result of the continued increase in the size of the population of women of reproductive age.

Between 2000 and 2020, the number of women using modern contraceptive methods grew by 188 million worldwide. This increase was driven in almost equal parts by growth in the number of women in the reproductive age range and by a rise in the percentage of such women who use modern methods of contraception. From 2020 to 2030, sub-Saharan Africa is expected to experience the largest increase among regions in the number of users of modern contraceptive methods, which could grow by 39 million, or about 60 per cent of its level in 2020. Like the global trend over the past two decades, the increasing number of women using modern contraceptive methods in sub-Saharan over the next decade will likely be driven both by a continued rise in the number of women of reproductive age and by growth in the percentage of women aged 15-49 years who use modern contraceptives.

Adolescents continue to be a vulnerable group, particularly in sub-Saharan Africa, where 1 in 10 women aged 15 to19 years gave birth in 2020 and one in five aged 15-19 years were married or in a union. Adolescents, in particular, have a substantial unmet need for sexual and reproductive health care. While the number of women aged 15-19 years with an unmet need for family planning has decreased or remained constant in most regions of the world since 2000, it has increased by more than half in sub-Saharan Africa over the same period. Between 2020 and 2030, the number of young women with an unmet need for family planning is projected to decrease or remain constant in all regions except sub-Saharan Africa.

The proportion of women of reproductive age who have their need for family planning satisfied by modern contraceptive methods (SDG indicator 3.7.1) has increased gradually in recent decades, rising from 73.6 per cent in 2000 to 76.8 per cent in 2020. However, this change has been uneven, as many women who want to avoid pregnancy continue not to use a modern method of contraception. Relatively rapid increases in the

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use of modern contraceptives have occurred in some regions, notably in sub-Saharan Africa, Latin America and the Caribbean, Central and Southern Asia, and Western Asia and Northern Africa. Nevertheless, only half of all women who wanted to avoid a pregnancy in 2020 were using a modern contraceptive method in sub-Saharan Africa (55.5 per cent) and in Oceania excluding Australia and New Zealand (52.1 per cent).

Universal access to sexual and reproductive health-care services, including family planning, information and education as called for in the 2030 Agenda, will enable more women with a need for family planning to make an informed choice about a method of contraception that is acceptable and appropriate in their circumstances. According to projections, the largest increases in the use of modern contraceptive methods are expected in countries with low levels of use at present. Provided that the right policies are in place and that sufficient resources are available, by 2030 around 80 per cent of women worldwide who have a need for family planning will be using a modern contraceptive method. Accelerated progress in the countries with the largest gaps in meeting family planning needs would also help to reduce global inequality in access to reproductive health-care services, including for family planning.

Achieving universal access to sexual and reproductive health-care services not only requires, but also sustains and advances, progress towards achieving other targets of the Sustainable Development Goals (SDGs). For example, to achieve a further increase in the proportion of demand for family planning that is satisfied by modern methods, it will be critical to ensure that all women of reproductive age can make informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1). At the same time, progress towards universal access to sexual and reproductive health-care services is expected to facilitate the achievement of other targets of the 2030 Agenda. For example, increasing the proportion of demand satisfied by modern contraceptive methods will help prevent unintended and high-risk pregnancies, thereby lowering the risks of maternal mortality (SDG indicator 3.1.1) and under-five mortality (SDG indicator 3.2.1). Similarly, if increased use of modern contraceptives reduces the risk of pregnancy and childbearing at young ages, it will facilitate educational attainment for women (SDG indicator 4.3.1) and may also contribute to reducing the percentage of women and children living in poverty (SDG indicator 1.2.1).

Despite considerable global progress in meeting the need for family planning, there remain significant international inequalities in access to modern contraceptive methods. Global advance in the next decade is contingent on the progress to be made in countries where the use of modern contraceptive methods is still low among women who want to avoid pregnancy. In these countries, located mostly in sub-Saharan Africa but also in Oceania excluding Australia and New Zealand, and in Northern Africa and Western Asia, the number of women of reproductive age who want to avoid pregnancy will continue to grow rapidly. Future population growth will pose challenges to countries that seek to expand reproductive health-care services in order to keep pace with these growing needs. Meeting the increasing demand for family planning will require a renewed commitment and decisive action by governments across the world to make family planning information, methods and services available and accessible to all.

Introduction

Expanding access to contraception is an essential component for achieving universal access to reproductive health-care services, as called for in the 2030 Agenda for Sustainable Development. The 2030 Agenda reaffirms the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, a commitment made earlier in the Programme of Action of the International Conference on Population and Development, adopted in Cairo, Egypt, in 1994.

Goal 3 of the 2030 Agenda, which seeks to ensure healthy lives and promote well-being at all ages, includes a target specifically related to reproductive health and family planning. Target 3.7 aims to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. Two indicators were selected for the global monitoring of progress towards achieving target 3.7 by 2030: (1) the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied by modern methods of contraception (SDG indicator 3.7.1), and (2) the adolescent birth rate (10-14 and 15-19 years) per 1,000 women in the respective age group (SDG indicator 3.7.2). The Population Division of the United Nations Department of Economic and Social Affairs is the custodian agency for the global monitoring of these two indicators. The Division compiles all available national data for these indicators, prepares regional and global aggregates and analyses levels and trends. The Division also works with countries to strengthen data collection and reporting and to increase compliance with internationally agreed standards for calculating these indicators.

Access to a complete range of contraceptive methods offers many benefits to women, couples and children. Contraceptives enable women and couples to exercise their right to choose the timing and number of births, to avoid pregnancies that may pose a greater risk to women and children, to reduce unintended pregnancies and unsafe abortions, and to improve the socioeconomic opportunities of women and their families. Specific methods, including male and female condoms, also play a significant role in preventing the transmission of sexually transmitted infections, such as HIV, between partners. Within the 2030 Agenda, progress towards achieving target 3.7 can also support the achievement of other targets of the 2030 Agenda, such as reducing maternal mortality (target 3.1), ending preventable deaths of newborns and children under 5 years of age (target 3.2), and eliminating gender disparities in education and ensuring equal access to all levels of education (target 4.5).

This *Highlights* report presents estimates of contraceptive use and needs from 2000 to 2020 with projections to 2030, for 196 countries or areas of the world as well as regional and global trends. It describes the impact of population growth and changes in the demand for family planning on the projected number of women who will be contraceptive users or will have an unmet need for family planning over the next decade. The report also discusses global progress in meeting the demand for family planning as called for in the 2030 Agenda and explores how contraceptive use relates to progress in achieving other targets of the 2030 Agenda.

The report presents estimates of the prevalence of contraceptive use and of unmet need for family planning among adolescents aged 15-19 years. Particular population groups (e.g., young women, older women, indigenous women and women with disabilities, rural women, migrant women, minority women) are likely to face additional barriers in accessing sexual and reproductive health-care services due to underlying structural, institutional, economic or social causes of deprivation, disadvantage or discrimination. Due to a lack of data, however, the family planning needs of these groups have not been analyzed in this report. Nevertheless, relevant findings from other studies, where available, are presented.

Box 1. Definitions, data and methods

This *Highlights* report focuses on the following three family planning indicators for women aged 15-49 years.

Contraceptive prevalence rate: the percentage of women who are currently using any form of contraception. Data are presented separately for modern and traditional methods. Modern contraceptive methods include female and male sterilization, intra-uterine devices (IUD), implants, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap, and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception, and other modern methods (such as the contraceptive patch or vaginal ring). Traditional methods include, among others, rhythm methods (e.g. fertility awareness-based methods or periodic abstinence) and withdrawal. According to typical use patterns, which accounts for differences in improper implementation of specific methods, traditional methods are generally less effective at preventing pregnancy than modern methods (Polis and others, 2016).

Unmet need for family planning: the percentage of women who are fecund and sexually active, who wish to stop or delay childbearing, but who are not using any form of contraception. A woman is also considered to have an unmet need if she was pregnant at the time of data collection, but reported that the pregnancy was unwanted or mistimed, or if a woman was postpartum amenorrhoeic, not using family planning and her most recent birth was unwanted or mistimed.

Demand for family planning satisfied by modern contraceptive methods (SDG indicator 3.7.1): the percentage of women who are using modern contraceptive methods among women who have a demand for family planning (i.e. the total number of women who are using any form of contraception or have an unmet need for family planning).

Data for these indicators are compiled in *World Contraceptive Use 2020* (United Nations, 2020a), which includes 1,317 nationally representative survey-based observations from 196 countries or areas for the period 1950 to 2019. The data originate from a variety of national and international survey programmes.

Comparable survey-based estimates are not available for all years for all countries or areas. Therefore, estimates and projections of the above family planning indicators were calculated for all years from 1990 to 2030 and for 185 countries or areas with a total population of at least 90,000 and with at least one survey estimate of contraceptive use (United Nations, 2020b). The methods of the hierarchical Bayesian model used to generate these estimates are presented in Alkema and others (2013), and Kantorová and others (2020). Unless otherwise stated, the estimates presented will refer to the posterior median estimates and refer to women of reproductive age (15-49 years). Estimates of use for specific contraceptive methods are available in *Contraceptive Use by Method 2019* (United Nations, 2019b).

Special attention is also given to the contraceptive use and needs of adolescent girls and women aged 15-19 years. Regional and global estimates of adolescent birth rates (SDG indicator 3.7.2) are available in the 2019 revision of the *World Population Prospects* (United Nations, 2019a). Regional and global estimates of the proportion of women aged 15-19 who are married or in a union are available in the 2020 revision of the *Estimates and Projections of the Number of Women who are Married or in a Union* (United Nations, 2020c).

To assess the past and future effects of population growth on the number of contraceptive users and the proportion of women whose demand is satisfied by modern methods, a demographic decomposition method (Das Gupta, 1993) is used. Data on the number of women aged 15-49 years are obtained from the 2019 revision of *World Population Prospects* (United Nations, 2019a).

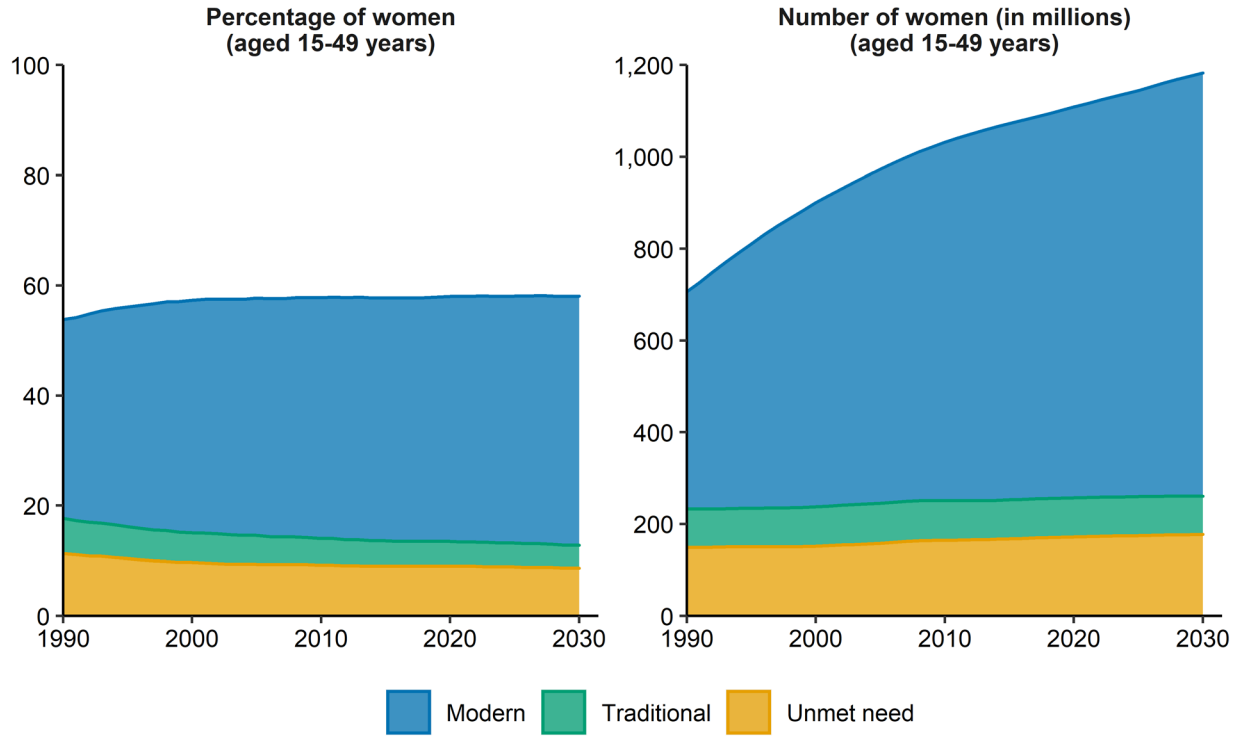
Trends and prospects in contraceptive use and needs

More women and couples want to avoid pregnancy

The number of women with a demand for family planning has increased markedly over the past two decades, from 900 million in 2000 to nearly 1.1 billion in 2020 (figure 1). An additional 100 million women are projected to have a demand for family planning by 2030. Although the proportion of women of reproductive age with a demand for family planning has remained largely constant at approximately 58 per cent, modern contraceptive users have accounted for a growing share of the demand for family planning, a trend which is projected to continue. Between 2000 and 2020, the number of women using a modern contraceptive method increased from 663 million to 851 million. An additional 70 million women are projected to be added by 2030. The number of users of traditional methods remains around 85 million. Simultaneously, population growth is projected to add an additional five million women with an unmet need for family planning between 2020 and 2030, despite a projected decline in the proportion of women with unmet need.

Figure 1.

Estimates and projections of the proportion and number of women aged 15-49 years who use modern or traditional contraceptive methods or who have an unmet need for family planning, the world, 1990-2030



Source: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

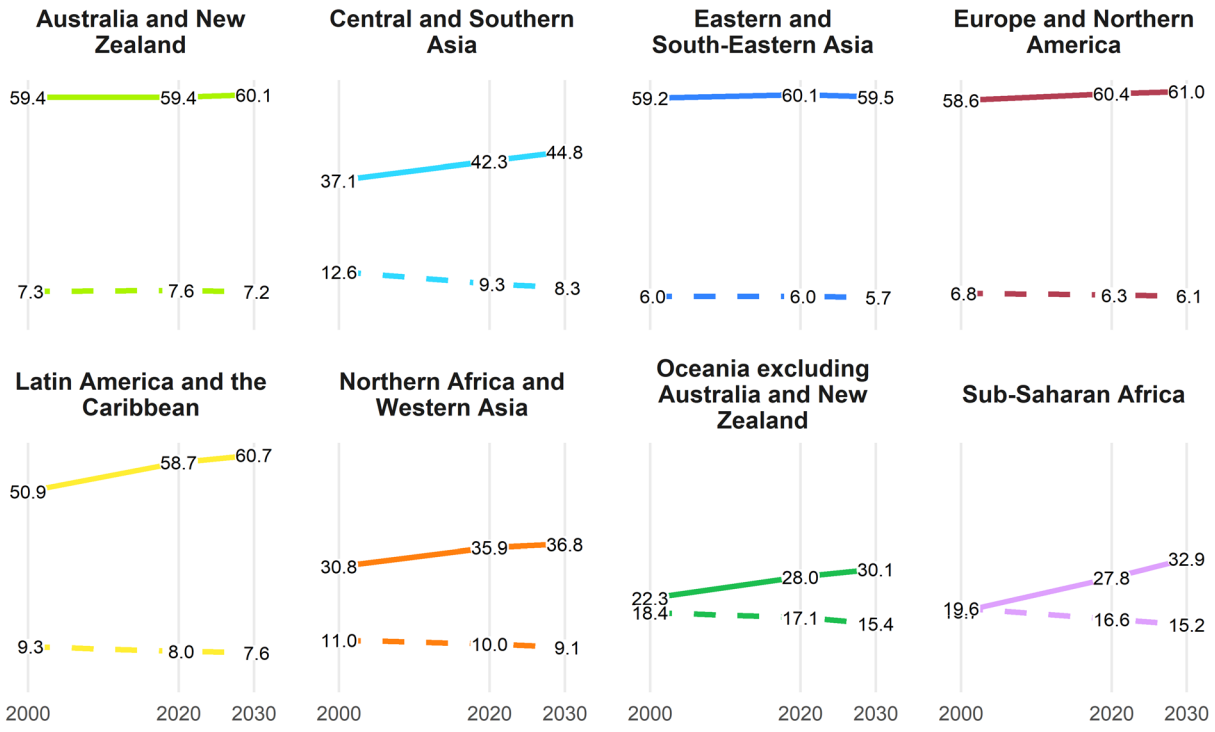
Contraceptive use is increasing in every region and unmet need is declining

The proportion of women of reproductive age who use some method of contraception has increased in all regions since 2000, especially in regions where only a small proportion of women used contraception in the past (figure 2). Significant increases in the use of contraception have occurred in Latin America and the Caribbean, Central and Southern Asia, Oceania excluding Australia and New Zealand, sub-Saharan Africa, and Northern Africa and Western Asia. Between now and 2030, sub-Saharan Africa is projected to experience the largest increase in contraceptive use among major regions of the world.

The proportion of women with an unmet need for family planning has declined in most regions since 2000, although less so in regions where rates of contraceptive use were high already. Central and Southern Asia has seen the largest decline in the number of women with unmet need since 2000. Significant declines have also occurred in Latin America and the Caribbean, sub-Saharan Africa and Oceania excluding Australia and New Zealand. The latter two regions continue to have the highest proportions of women with an unmet need for family planning in the world; moreover, despite projected declines in the coming decade, they are expected to continue to do so by 2030.

Figure 2.

Estimates and projections of the percentage of women aged 15-49 years who use contraception or who have an unmet need for family planning, by region, 2000-2030



Source: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020*.

Note: The solid lines refer to the percentage of women of reproductive age currently using any form of contraception (modern or traditional). The dashed lines refer to the percentage of women of reproductive age with an unmet need for family planning.

The specific contraceptive methods in use vary across regions

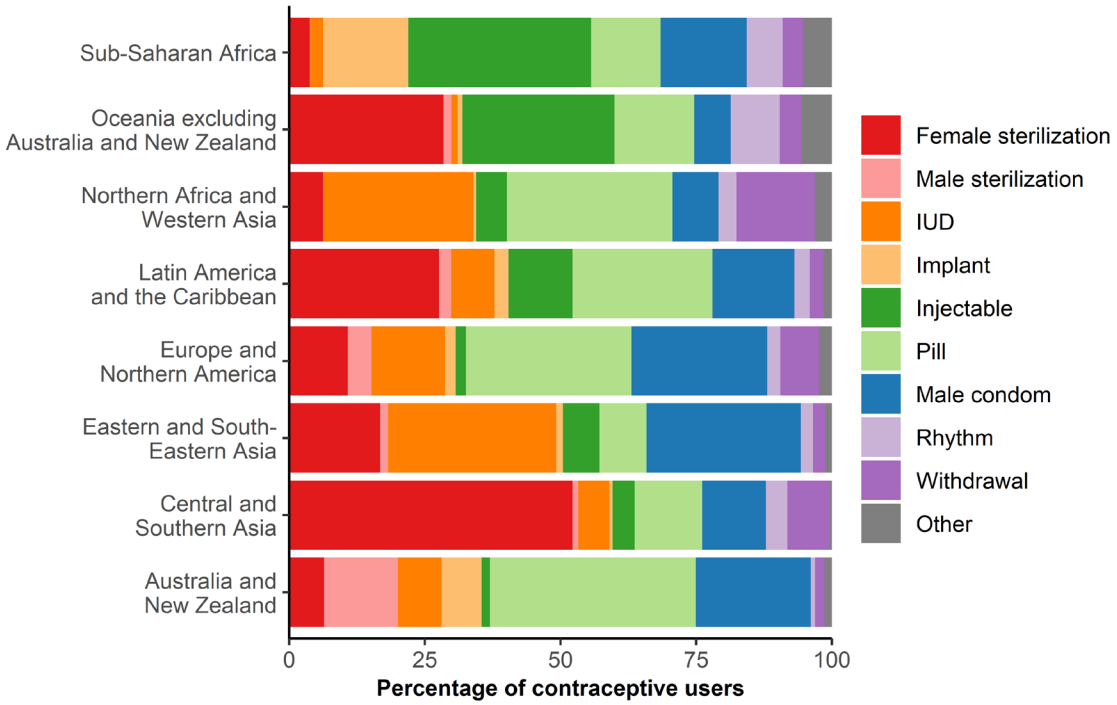
In all regions of the world, the majority of women who use contraception are using modern methods. In 2020, the percentage of contraceptive users who used modern methods was near or above 90 per cent, except in Northern Africa and Western Asia, and in Oceania excluding Australia and New Zealand.

The specific types of modern methods used vary across regions (figure 3). Short-acting contraceptives, such as the oral contraceptive pill or condoms, are commonly used methods in most regions. The pill, for instance, is the most popular method in Australia and New Zealand, Europe and Northern America, Northern Africa and Western Asia and Latin America and the Caribbean. Male condoms are popular in most regions of the world, but their use is most extensive in Eastern and South-Eastern Asia and in Europe and Northern America. Injectables, on the other hand, are not widely used globally but are the most commonly used method in sub-Saharan Africa and in Oceania excluding Australia and New Zealand.

Permanent and long-acting reversible methods account for a substantial share of contraceptive use in some regions. IUDs are the most common method in Eastern and South-Eastern Asia and are also widely used in Northern Africa and Western Asia. Female sterilization is used extensively in Central and Southern Asia, Oceania excluding Australia and New Zealand, and Latin America and the Caribbean, and to a lesser extent in Eastern and South-Eastern Asia and Europe and Northern America. Male sterilization, in contrast, is seldom used except in Australia and New Zealand.

Figure 3.

Distributions of contraceptive use by method, by region, 2019



Source: United Nations, Department of Economic and Social Affairs, Population Division. (2019). *Contraceptive Use by Method 2019.*

Note: "Other" includes less used modern methods, such as lactational amenorrhea method (LAM), vaginal barrier methods, emergency contraception, patches and vaginal rings as well as traditional methods, including douching, prolonged abstinence, gris-gris, incantation, medicinal plants, abdominal massage and other local methods.

The number of contraceptive users is projected to continue to grow globally, with varying regional trajectories

Changes in the number of contraceptive users are related to changes in the number of women of reproductive age. All regions of the world are projected to see increases in the number of contraceptive users except for Europe and Northern America and Eastern and South-Eastern Asia, where low population growth is projected to lead to a reduction in the number of women of reproductive age (table 1). Sub-Saharan Africa is projected to add 86 million women of reproductive age and 40 million contraceptive users, between 2020 and 2030. By contrast, regions that are projected to experience a decreasing number of women of reproductive age are projected to have a smaller number of contraceptive users. For instance, Eastern and South-Eastern Asia is projected to have 30 million fewer women of reproductive age and 20 million fewer contraceptive users in 2030 compared to 2020.

In 2020, there are 20 million more women with unmet need for family planning worldwide than there were in 2000. By 2030, this figure is projected to increase by another five million women. Globally, the absolute growth in the number of women with unmet need for family planning is projected to be almost exclusively driven by increases in sub-Saharan Africa. Based on current projections, 30 per cent of the world's women with unmet need for family planning will live in sub-Saharan Africa in 2030 (table 1).

Table 1.
Numbers of women aged 15-49 years, modern contraceptive users and women with an unmet need for family planning, by region, 2000-2030

	Number of women aged 15-49 years (in thousands)			*Number of women using modern contraception (in thousands)*			*Number of women with an unmet need for family planning (in thousands)*		
SDG Region	**2000**	**2020**	**2030**	**2000**	**2020**	**2030**	**2000**	**2020**	**2030**
Australia and New Zealand	5,821	7,020	7,482	3,282	4,012	4,327	426	537	538
Central and Southern Asia	372,756	524,989	573,286	119,564	194,074	227,022	47,007	48,923	47,817
Eastern and South-Eastern Asia	558,922	569,231	539,689	309,450	320,686	302,290	33,349	33,529	30,314
Latin America and the Caribbean	138,903	173,228	178,933	63,469	95,570	102,641	12,839	13,763	13,551
Europe and Northern America	262,559	248,090	240,860	126,114	133,205	133,311	17,880	15,689	14,663
Oceania excluding Australia and New Zealand	2,120	3,098	3,669	334	679	887	356	493	534
Sub-Saharan Africa	148,176	262,960	348,832	20,333	64,864	105,359	29,041	43,742	53,172
Western Asia and Northern Africa	89,412	131,869	150,585	20,451	37,928	45,784	9,801	13,201	13,597
World	1,578,667	1,920,485	2,043,334	663,169	851,151	922,107	151,883	171,904	177,194

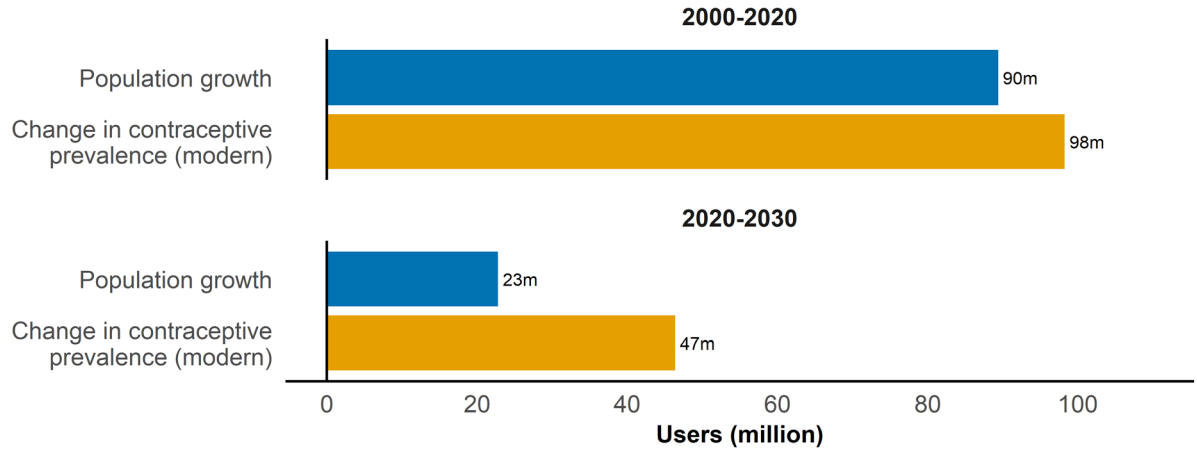
Source: United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019*; United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

Increasing numbers of women of reproductive age lead to more contraceptive users

Population growth will have implications for the growth in the number of contraceptive users (figure 4). Of the 188 million users of modern contraceptive methods who were added globally between 2000 and 2020, the rise in contraceptive prevalence accounted for 98 million additional users. The remaining 90 million additional users are the result of growth in the population of women aged 15-49 years. Similarly, between 2020 and 2030, projected increases in modern contraceptive prevalence rates as well as continued population growth are expected to lead to further increases in the number of modern contraceptive users.

Figure 4.

Increase in the number of women aged 15-49 years who use modern contraceptives, with components attributable to population growth or to an increased prevalence of modern contraceptive use, the world, 2000-2020 and 2020-2030

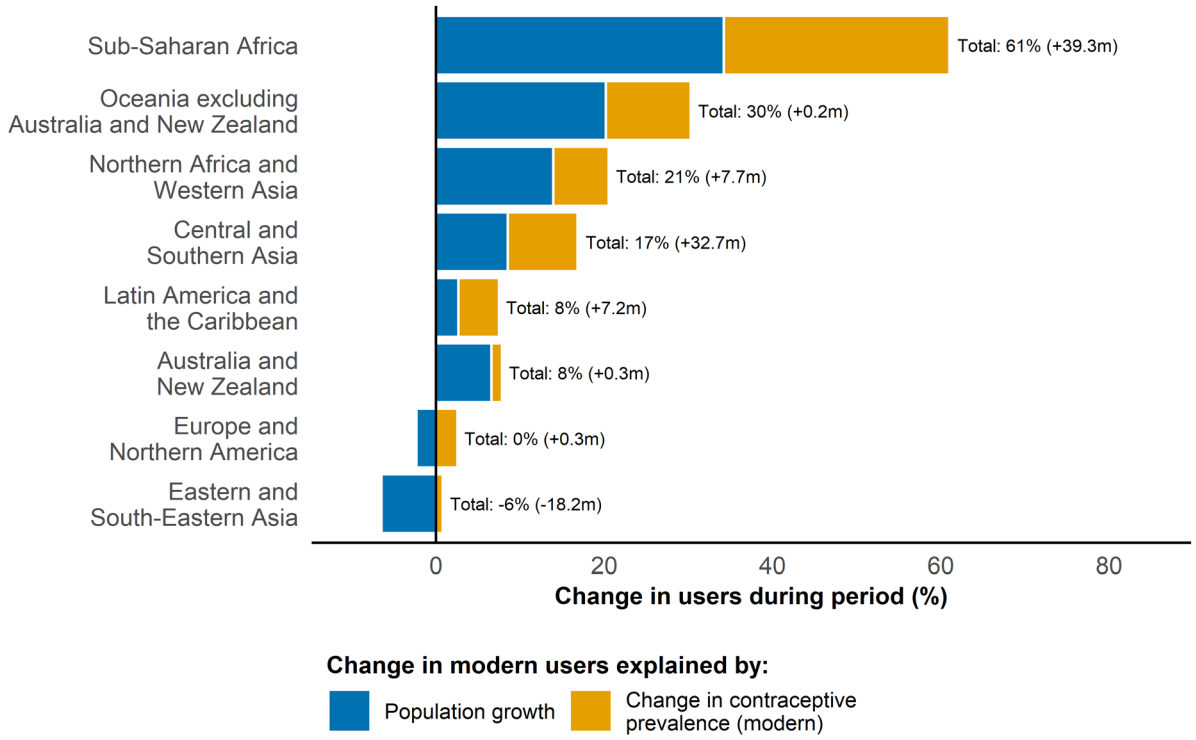


Source: United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019*; United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

Regional differences in population growth are likewise projected to have disparate effects on the growth of the number of contraceptive users between 2020 and 2030 (figure 5). In sub-Saharan Africa, population growth, the primary driver of the increase in users of modern contraception, is projected to add 39 million new users. In Central and Southern Asia, population growth is expected to account for nearly half of the total increase of 32 million users. Conversely, the projected decline in the female population aged 15-49 years in Eastern and South-Eastern Asia is expected to reduce the number of users of modern contraception by 21 million women, which will more than offset the increase in the number of users due to higher contraceptive prevalence.

Figure 5.

Change in the number of women aged 15-49 years who use modern contraceptives, with components attributable to changing population size or to changes in the prevalence of modern contraceptive use, by region, 2020-2030



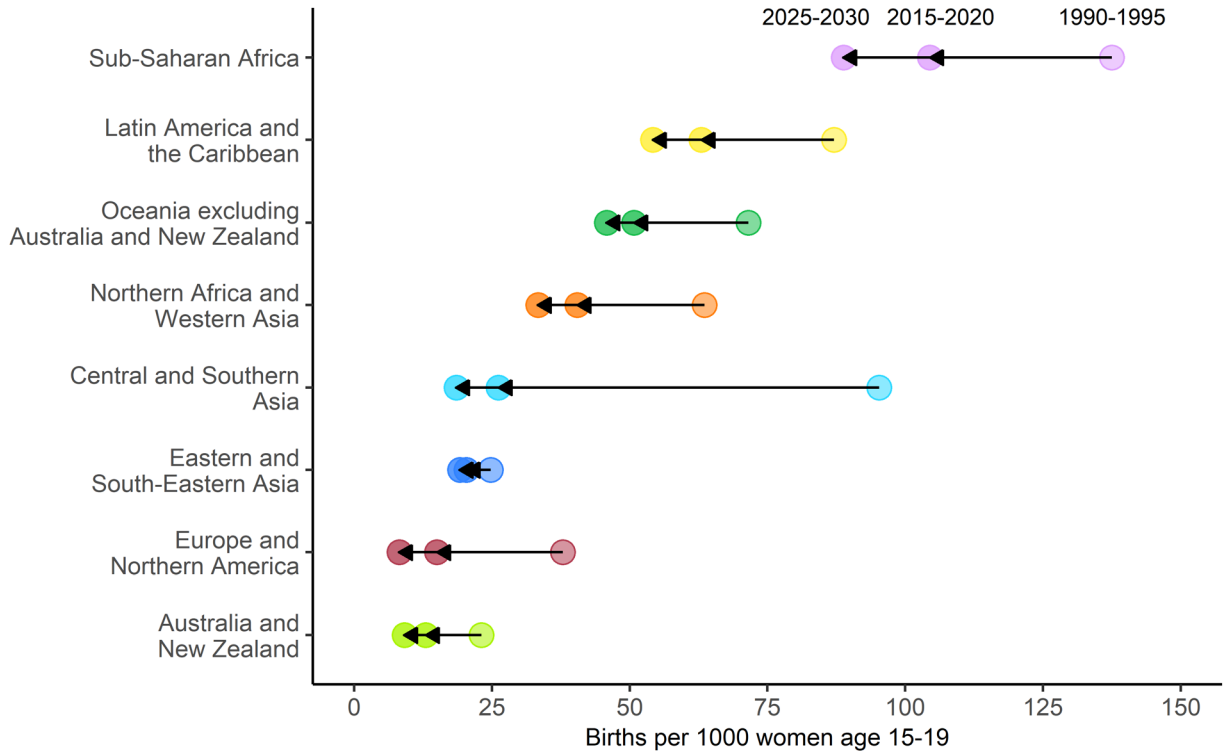
Source: United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019*; United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

Millions of adolescent girls are at risk of childbearing

Pregnancy and childbirth in adolescence can have long-lasting impact on the social and economic well-being and are among the leading causes of death among women aged 15-19 years (World Health Organization, 2018). Compared to other age groups, women aged 15-19 years have experienced the largest relative decrease in birth rates since 1990. Globally, birth rates among women aged 15-19 declined from 64.8 births per 1,000 women during 1990-1995 to 42.5 per 1,000 women during 2015-2020 (figure 6). Adolescent birth rates have declined in all regions of the world during this period, with the largest absolute decreases occurring in sub-Saharan Africa. Despite these significant reductions, the adolescent birth rate in sub-Saharan Africa is more than twice as high as in other world regions. Some countries of Central and Southern Asia and Latin America and the Caribbean also continue to have relatively high levels of adolescent fertility, despite experiencing substantial declines in total fertility. Fertility rates among adolescent women are projected to continue to decline, both globally and regionally. Data on the fertility of girls younger than age 15 are not widely collected or published, in part because births at these ages are uncommon in many countries. The limited data available suggests that fertility rates in this age group are relatively high in parts of sub-Saharan Africa and in Bangladesh, exceeding 10 births per 1,000 girls aged 10 to14 years (United Nations, 2020d).

Figure 6.

Estimates and projections of the reduction in the birth rate for adolescent women aged 15-19 years, by region, 1990-2030

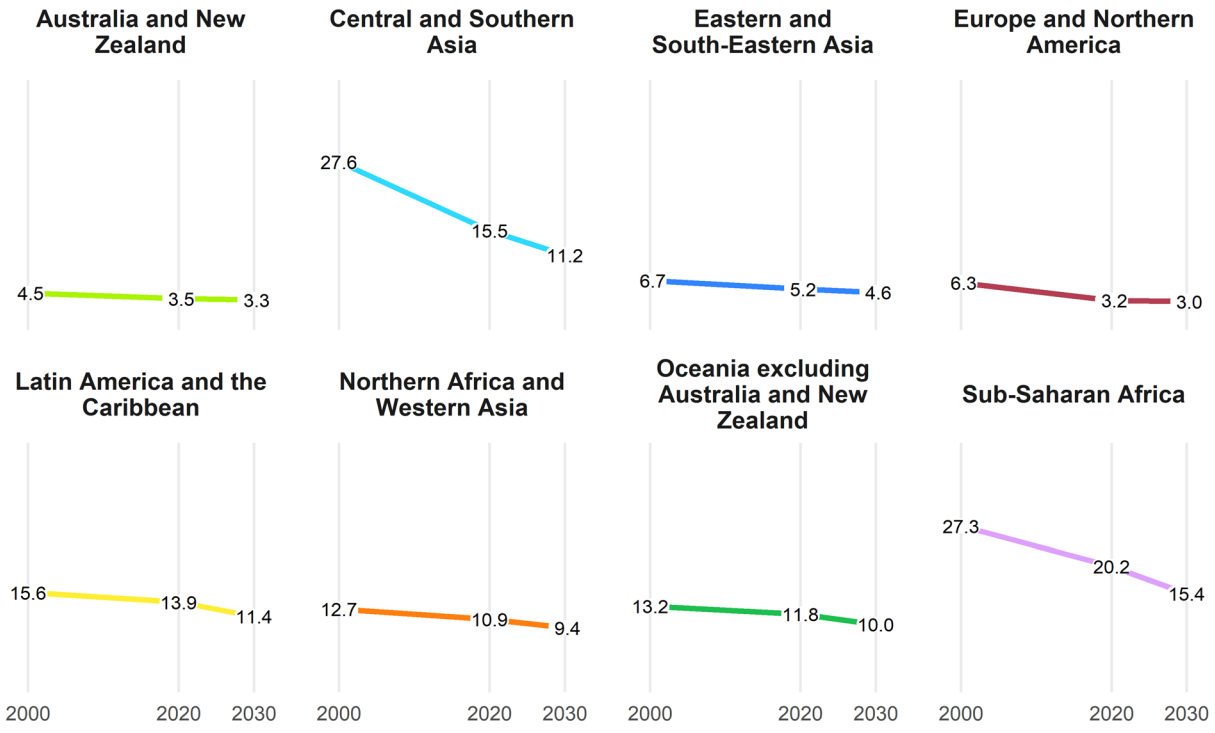


Source: United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019.*

Adolescent birth rates are influenced by trends in marriage and union patterns, sexual activity, contraceptive use and rates of induced abortions (United Nations, 2013). Over the last few decades, declining adolescent fertility has been accompanied by decreases in the proportion of adolescents aged 15-19 years who are married (figure 7). The most rapid changes in the percentage of women aged 15-19 years who are married occurred in Central and Southern Asia and sub-Saharan Africa. In both regions, the percentage of women aged 15-19 who are married is expected to continue to decline through to 2030. Still, in 2020 large numbers of adolescents in these regions – 10 million in Central and Southern Asia and 11 million in sub-Saharan Africa – are married or in a union. In other regions, where child and early marriage is less common, the shares of married adolescents have also declined during the same period, but to a lesser degree, and are projected to continue to do so in the coming decade. Globally, the number of adolescents aged 15-19 years that are married or in a union declined from 46 million in 1990 to 36 million in 2020 and is projected to decline further in coming decade.

Figure 7.

Estimates and projections of the percentage of adolescent women aged 15-19 years who are married or in a union, by region, 1990-2030

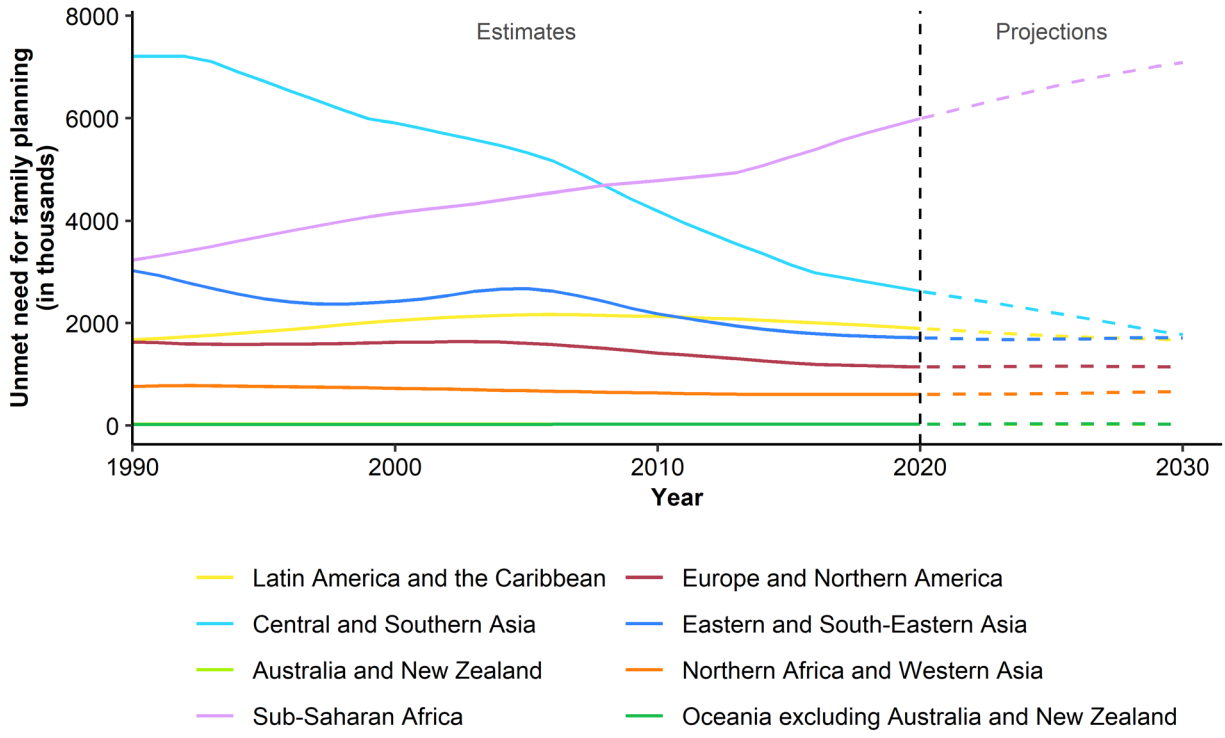


Source: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Women of Reproductive Age Who are Married or in a Union.*

Globally, the number of women aged 15-19 years who had unmet need for family planning decreased from 17 million in 2000 to 14 million in 2020 (figure 8). The large decline in unmet need among adolescent girls and young women in Central and Southern Asia from over 6 million women in 2000 to 2.6 million in 2020 was the primary reason for the decrease at the global level. Significant decreases also occurred, however, in Eastern and South-Eastern Asia and Europe and Northern America. During the same period, the numbers of adolescent women with unmet need for family planning increased in sub-Saharan Africa and Latin America and the Caribbean. The increases observed in these regions were primarily caused by continued population growth, as both saw reductions in the percentage of adolescents with unmet need for family planning between 2000 and 2020. By 2030, the number of women worldwide aged 15-19 years with unmet need for family planning is projected to remain constant at 14 million, but will become increasingly concentrated in sub-Saharan Africa, where more than half of them are projected to live.

Figure 8.

Estimates and projections of the number of women aged 15-19 with an unmet need for family planning, by region, 1990-2030



Source: Model-based estimates using data from: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *World Contraceptive Use 2020.*

"Myanmar/Burma: Securing health care for the most vulnerable populations in Rakhine State" by Mallika Panorat/European Union/ECHO 2016.

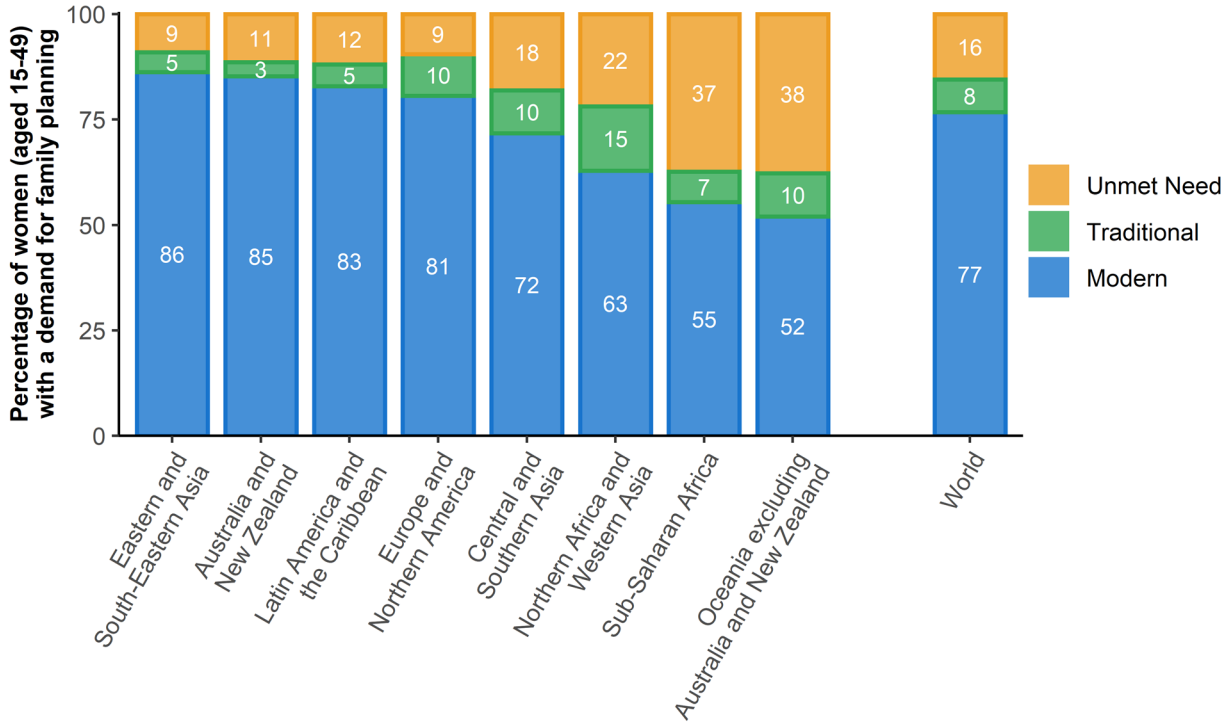
Assessing progress made in meeting the need for family planning

The use of modern contraceptives among women who want to avoid pregnancy continues to increase

Among women who want to avoid pregnancy, 77 per cent use a modern method of contraception (figure 9). Relatively high proportions of demand satisfied by modern methods are found in Eastern and South-Eastern Asia, Australia and New Zealand, Latin America and the Caribbean and Europe and Northern America. These regions are characterized by low levels of unmet need for family planning and high levels of modern contraceptive use, whereas, the use of traditional methods in these regions varies. The comparatively high use of traditional methods in Europe and Northern America – particularly in Southern and Eastern Europe – has led to a lower proportion of the demand satisfied by modern methods compared to these other regions.

Figure 9.

Contraceptive use (modern and traditional) and unmet need for family planning among women with need for family planning, by region, 1990-2030



Source: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

The proportion of women whose demand for family planning is satisfied by modern methods is particularly low in Oceania excluding Australia and New Zealand, in sub-Saharan Africa and in Western Asia and Northern Africa. Sub-Saharan Africa and Oceania excluding Australia and New Zealand have the largest proportions of women with an unmet need for family planning, yet rather small proportions of women relying on traditional contraceptive methods. In Western Asia and Northern Africa, 15 per cent of women who want to avoid pregnancy rely on traditional methods, the highest proportion of any region, resulting in a relatively low proportion of the demand for family planning satisfied by modern methods (63 per cent).

Since 2000, women of reproductive age in all regions have increasingly satisfied their need for family planning by using modern contraceptive methods. Women in sub-Saharan Africa, in particular, have become increasingly more likely to satisfy their need for family planning with modern methods: this proportion grew from 35.8 per cent in 2000 to 55.5 per cent in 2020.

Progress in meeting the need for family planning has been uneven

Whereas some countries with large gaps in meeting the need for family planning have experienced rapid gains, others have lagged behind. Of the 75 countries where, in 2000, less than half of the women with a demand for family planning were using modern methods, 39 were located in sub-Saharan Africa. In 29 of the 75 countries, less than a quarter of women with a demand for family planning used modern methods. In 2020, 38 countries, including 21 in sub-Saharan Africa, still have levels of demand satisfied by modern methods below 50 per cent. Three of these sub-Saharan African countries have levels below 25 per cent (Chad, Somalia and South Sudan).

Some countries in sub-Saharan Africa have experienced the largest observed increases in SDG indicator 3.7.1 between 2000 and 2020 (table 2). The indicator rose more than 30 percentage points in Rwanda, Ethiopia, Burkina Faso, Malawi, Madagascar, Kenya and Sierra Leone (in declining order).

The ability to meet women's demand for family planning has often been dampened by transient events, such as armed conflict, natural disasters and epidemics. In Colombia and Uganda, for example, women living in regions that experienced a greater intensity of armed conflict were found to reduce their use of modern contraception (Namasivayam and others, 2017; Svallfors and Billingsley, 2019). The Ebola epidemic in Liberia and Sierra Leone led to a 65 per cent reduction in the distribution of contraceptives (Bietsch and others, 2020). In Indonesia, the 2006 Yogyakarta earthquake reduced the availability of modern contraceptives in affected regions, leading to increases in the number of women relying on traditional methods and greater numbers of unplanned pregnancies (Hapsari and others, 2009). Although such events do not necessarily have persistent effects on women's ability to use contraception, they may have long-lasting consequences for the health and well-being of women and children, particularly in regions with already vulnerable health-care infrastructure.

Within countries, some women who want to avoid pregnancy have been more likely to use modern methods than others. In general, women who are wealthier, living in urban areas and who are older are more likely to have their demand for family planning satisfied by modern methods (Sully and others, 2019). The gap between the poorest and wealthiest groups as well as between women living in rural and urban settings has narrowed over the past two decades, but inequalities persist along these dimensions (Hellwig and others, 2019).

Table 2.
Countries with the largest increases in the proportion of total demand for family planning that is satisfied by modern contraceptive methods, 2000 – 2020

Country	*2000*	*2020*	*Percentage point change*
Rwanda	13.8	67.8	54.0
Ethiopia	15.5	64.9	49.5
Madagascar	26.0	64.4	38.4
Burkina Faso	19.0	56.9	37.9
Sierra Leone	20.8	55.7	34.9
Malawi	42.3	76.7	34.4
Senegal	22.0	55.0	32.9
Congo	17.8	48.3	30.6
Zambia	37.6	67.2	29.6
Kenya	47.8	77.1	29.2

Source: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

Note: Based on countries with data available from at least one survey taken in or after 2015.

Box 2. What makes family planning programmes successful?

Reviews of decades of research on family planning programmes have found that some specific approaches have been more successful than others in increasing the knowledge and use of contraception (Mwaikambo and others, 2011; Weinberger and others, 2019). Successful family planning programmes tend to involve local communities and their leadership to improve the accessibility and availability of contraceptive methods and services. Local communities can help by providing reliable information on family planning and building trust among women who may wish to practice contraception. Community engagement activities, such as group discussions, home visits, local radio programmes, lectures from religious leaders and village gatherings focused on topics relating to family planning, have been found to stimulate the demand for modern methods and to increase modern contraceptive use in a number of settings, including in India, Kenya, Nigeria and Senegal (Speizer and others, 2014; Speizer and others, 2018). Recruiting health workers who understand local cultural norms and can empathize with the concerns of local women has been an effective strategy for communicating information on family planning, distributing contraceptive methods and services and creating a liaison between women and formal health-care institutions in a variety of settings, including in Afghanistan (Huber and others, 2010), Ghana (Debpuur and others, 2003), Madagascar (Stoebenau and Valente, 2003), Malawi (Kalanda, 2010), India (Kambo and others, 1994) and Pakistan (Sultan and others 2002), among others.

By addressing the family planning needs of local populations and playing a supportive role for formal health-care providers, community-based approaches can be effective in meeting the demand for family planning. S approaches have also been scaled-up effectively producing change beyond the local level, as has been done in Kenya, Malawi and Rwanda (Ingabire and others, 2019; Keyonzo and others, 2015; Masiano and others, 2019). Successfully scaling up localized approaches to the regional or national level, however, will depend on the ability of governments to establish sustainable financing strategies through a combination of budget allocation and execution, evidence-based programming, pooled or coordinated purchasing, procuring in bulk, and donor contributions (High Impact Practices in Family Planning, 2018).

Below are some examples of the variety of ways countries have built successful family planning programmes. *Ethiopia:* The success of family planning programmes in Ethiopia is due, in part, to significant investments by the government and international donors in the Ethiopian health-care system as well as in skilled community health workers, women from the local community who are trained to administer health packages and to provide family planning and other health services (Olson and Piller, 2013).

Malawi: Since 2000, the government of Malawi has committed to positioning family planning as an essential part of attaining the health-related Millennium Development Goals, engaging with community and religious leaders to build support for family planning at the local level and heavily subsidizing family planning services (Masiano and others, 2019).

Rwanda: Rwanda has used a number of channels to forge progress, including strong commitment from government officials at the local and national level, the integration of family planning services into immunization and HIV/AIDS programmes, an expansion and decentralization of the health-care system, the creation of community-based health insurance and strengthening logistics systems to avoid shortage in supplies (Muhoza and others, 2016).

Senegal: The Senegalese government has taken a multifaceted approach aimed at stimulating the demand for family planning and to improve the supply and availability of contraception. This included the launch of information campaigns about the effects of frequent pregnancies on health, mass media campaigns that discussed and debated family planning, and decentralized supply chains reducing the incidence of shortages in contraceptive supplies (Hasselback, 2017; Benson and others, 2018).

Improving access to family planning services and information is expected to result in more women using modern contraceptive methods

The vision of the 2030 Agenda is to ensure, by 2030, universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (target 3.7). To achieve this vision, the reproductive rights of individuals should be supported by guaranteeing the accessibility, availability, affordability and convenience of family planning services; comprehensive and factual information on the proper use, effectiveness and side-effects of the various methods; counselling to aid individuals in selecting and effectively using an appropriate method; and a full range of reproductive health-care services, including family planning.

How can the international community monitor the achievement of this ambitious vision? SDG indicator 3.7.1, which measures the proportion of women aged 15-49 years with a need for family planning who use a modern contraceptive method, has no global numerical 'target' value set to be achieved by 2030. Looking at the highest values of the indicator, in 22 countries representing regions such as Europe and Northern America, Latin America and the Caribbean and Eastern and South-Eastern Asia, more than 85 per cent of women who want to avoid pregnancy are using a modern contraceptive method but for no country is this estimate above 91 per cent. Even in these countries, specific sub-populations (for example, adolescents or the poor) can still face barriers to access to family planning information and services. It should also be recognized that reaching 100 per cent may not be a necessary or even desirable outcome with respect to reproductive rights. Some women may prefer to use a traditional method, even while having access to a full range of modern methods and being aware of the typical differences in effectiveness of methods in preventing pregnancies. Other women might have ambivalent preferences regarding their next pregnancy which may influence their contraceptive choice.

What would be ambitious, yet achievable progress in meeting needs for family planning in the coming decade? The trajectories of projections of family planning indicators (United Nations, 2020) are based on past experiences of individual countries and represent a range of possible outcomes that can be achieved, depending on the course of action that countries adopt over the next decade. The median projection represents the most likely outcome for each individual country until 2030 based on experiences of all countries, while the accelerated action projection is based on past trends in countries with faster increases in use of modern methods among women wanting to avoid pregnancy. Some of these countries were given as examples in Box 2 on successful family planning programmes.

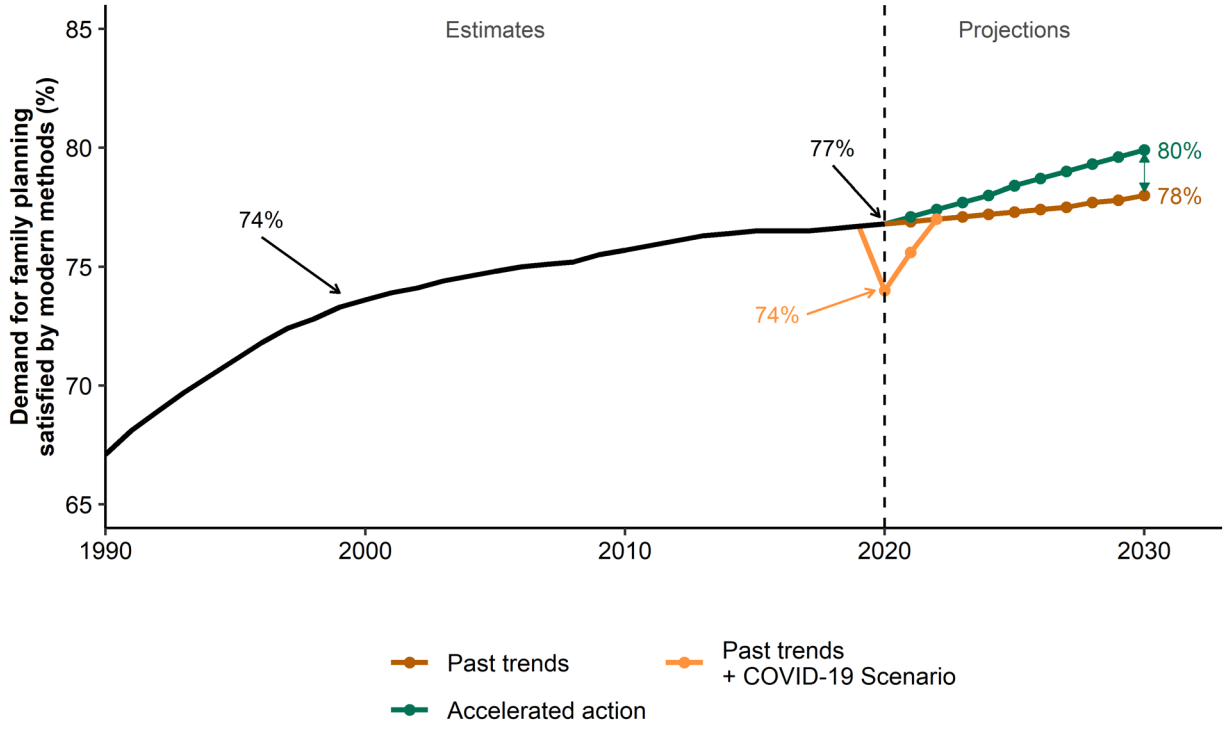
Improved access to family planning services and information is expected to lead to more women using modern methods, with the largest increases occurring in countries with low use of modern contraceptive methods among women who need family planning. Assuming that countries continue on their most probable trajectories until 2030, more than 80 per cent of women who want to avoid pregnancy would use a modern contraceptive method in 66 countries. In 22 countries (of which 13 are in sub-Saharan Africa), less than half would be using a modern contraceptive method by 2030. The largest regional increases are projected for sub-Saharan Africa (to 62.7 per cent in 2030), Oceania excluding Australia and New Zealand (to 56.3 per cent) and Western Asia and Northern Africa (to 66.5 per cent).

If, however, countries progress along the path of accelerated action to improve women's access to reproductive health-care services and contraception, countries with the lowest proportions of demand for family planning satisfied could see as much as a doubling of the proportion of women who use modern methods by 2030. Under this accelerated scenario, only four countries (Albania, Chad, Democratic Republic of Congo, South Sudan) would continue to have a proportion of demand for family planning satisfied by modern methods below 50 per cent. For 109 countries or areas (of 185 countries or areas with data available), accelerated action would lead to more than 80 per cent of women who want to avoid pregnancy using modern methods by 2030. For sub-Saharan Africa, where the proportion of the demand satisfied by modern methods is lowest, accelerated action is projected to increase the share to 66.6 per cent in 2030 as opposed to 62.7 per cent as projected based on average past trends. Achieving accelerated action would reduce inequality in access to sexual and reproductive health-care services, including family planning, across countries and globally.

Despite increases in all countries and regions, only a modest increase is projected at the global level. According to the projections, the global demand for family planning satisfied by modern methods is expected to reach 78 per cent in 2030 based on past trends and 80 per cent if accelerated action were to be achieved (figure 10). In the coming decade, many countries with a low contraceptive prevalence are expected to experience rapid growth in the numbers of women of reproductive age with need for family planning due to a combination of high population growth and changing childbearing intentions. To illustrate the large impact of this differential population growth: if all countries were to maintain the same proportion of the demand for family planning that is satisfied by modern methods in 2030 as they have in 2020, the global value would decline to 75.2 per cent by 2030. Therefore, the progress at the global level is contingent on meeting family planning needs of women in countries with the largest gaps.

Figure 10.

Proportion of women who have their need for family planning satisfied by modern contraceptive methods (SDG indicator 3.7.1), 1990-2030, with illustrative scenarios



Source: Scenarios calculated using data from: United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020;* United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019.*

Note: Trajectories for projections of family planning indicators (United Nations, 2020) are based on past experiences of individual countries, as well as other countries in the same region and globally. 'Past trends' scenario is based on the median projection (i.e., 50th percentile at each time point of the distribution of probabilistic projection trajectories) and represents the most likely outcome for each country until 2030. 'Accelerated action' scenario equals the 90th percentile of the probabilistic projection trajectories and implies a faster increase in the use of modern contraceptive methods among women with a desire to avoid pregnancy. 'COVID-19 Impact' scenario depicts temporary disruptions in the provision of family planning services as described by Dasgupta and colleagues (2020), with recovery to the 'past trends' scenario in two years.

Box 3. The coronavirus disease (COVID-19) pandemic adds to the uncertainty of achieving universal access to sexual and reproductive health-care services

The coronavirus disease (COVID-19) pandemic has made the path towards achieving universal access to sexual and reproductive health-care services by 2030, including family planning, more uncertain. Beyond its immediate impacts on individual health, it has also had ancillary effects on individual well-being by slowing down economies, virtually halting migration both within and between countries and straining health systems. Women's ability to use contraception has also been impacted by COVID-19 pandemic: it has disrupted the global supply chain, which has led to reduced production, distribution and availability of contraceptive commodities, resulting in shortages (Purdy, 2020); some health-care facilities are reducing services (International Planned Parenthood Federation, 2020; Marie Stopes International, 2020); health-care providers who have been redirected away from providing family planning services towards responding to the COVID-19 pandemic (Santoshini, 2020); and shelter-in-place orders which have limited women's ability to visit health-care facilities (UNFPA, 2020).

In the absence of data that would allow to estimate the global impact, Dasgupta and others (2020) produced a scenario of the potential immediate impact of COVID-19 pandemic on the proportion of women of reproductive age who have their need for family planning satisfied by modern methods (SDG indicator 3.7.1). Assuming that the COVID-19 pandemic would have differential impacts on the use of specific methods, depending on how reliant the use of those methods is on interactions with the health-care system or distribution channels, the greatest impact would be felt in Latin America and the Caribbean and sub-Saharan Africa owing to a relatively greater reliance on short-term methods that need frequent contact with health-care providers, such as injectables and pills. Globally, the proportion of women of reproductive age who have their need for family planning satisfied by modern methods would decline under this scenario to 71 per cent in case of full-year disruptions or 74 per cent for half-year disruptions in 2020. It remains uncertain how long-term trends in access to sexual and reproductive health-care services, including family planning, will be impacted after the immediate disruptions due to COVID-19 pandemic are resolved. A study of the Ebola crisis in Western Africa documented that contraceptive use returned to the pre-disruption situation quite quickly (Bietsch and others, 2020).

For women – and their partners and families – who experienced an unintended pregnancy resulting from the lack of access to contraception during COVID-19 pandemic, the impacts will be long-lasting. Riley and others, 2020, produced a scenario of 10 per cent decline in the use of short- and long-acting reversible contraception in low- and middle-income countries during COVID-19 pandemic, which resulted in an additional 49 million women with unmet need for modern contraception and an additional 15 million unintended pregnancies over the course of the year in low and middle-income countries.


1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS
SUSTAINABLE DEVELOPMENT GOALS

Family planning in the context of the Sustainable Development Goals

The comprehensive nature of the 2030 Agenda naturally led to synergies between its various goals and targets. By meeting women's needs for family planning, progress towards achieving other targets, concerning health and socioeconomic wellbeing, can be facilitated. So too can target 3.7. be influenced by the achievement of other targets of the Sustainable Development Goals.

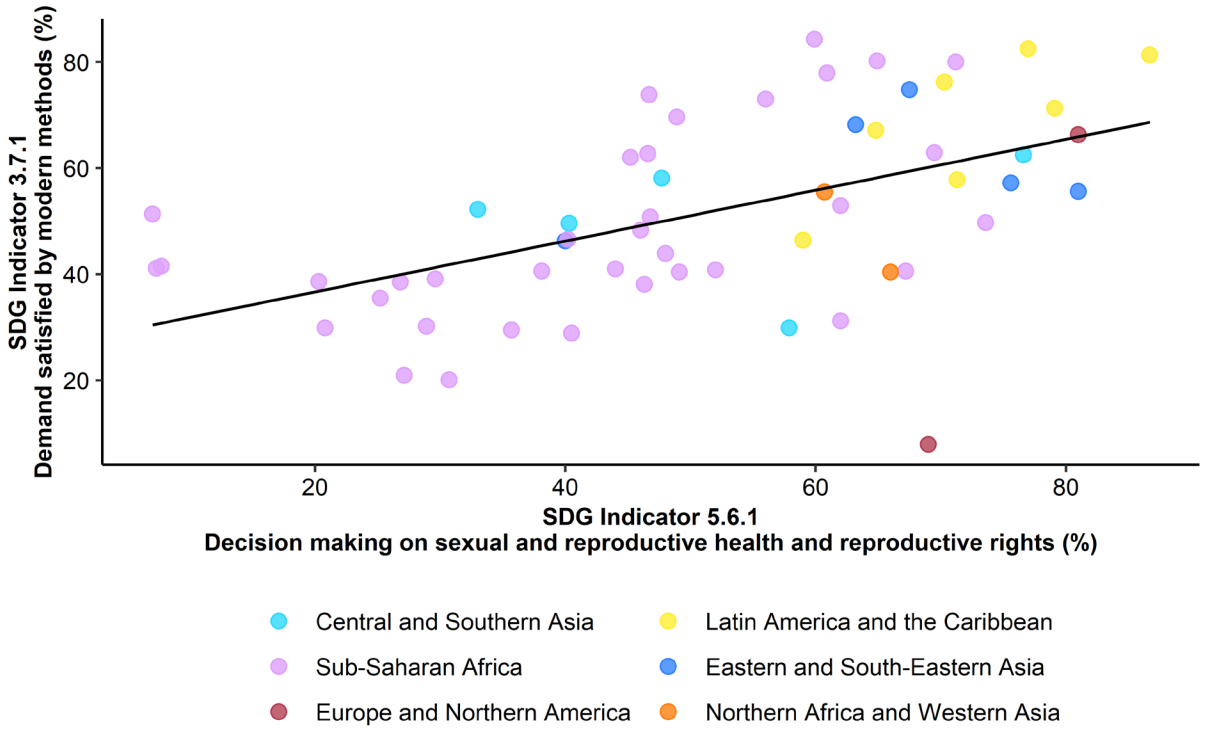
Women who make their own decisions on sexual and reproductive health are more likely to satisfy their need for family planning by using modern contraceptive methods

Target 5.6 of the 2030 Agenda aims to ensure universal access to sexual and reproductive health and reproductive rights in accordance with relevant intergovernmental agreements. A fundamental aspect of attaining universal access is ensuring that all women in the reproductive age range make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

Supporting women's freedom in reproductive and contraceptive decision-making has implications for contraceptive use and the types of methods used. Countries in which more women aged 15-49 years make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1) tend to have higher proportions of the demand for family planning satisfied by the use of modern contraceptive methods (figure 11). Across countries with available data, the average share of women who make their own decisions concerning reproduction and health care is 51.2 per cent. Countries in sub-Saharan Africa typically have the lowest percentage of women who make their own decisions regarding reproduction and health care, while also having the lowest proportions of demand for family planning satisfied by modern methods. Nevertheless, there is wide variation between countries in that region in the percentage of women making their own decisions concerning sexual relations, contraceptive use and reproductive health care, ranging from below 8 per cent in Mali, Niger and Senegal to above 70 per cent in Madagascar and Namibia. Countries in Eastern and South-Eastern Asia and in Latin America and the Caribbean had the highest proportions of women who made their own reproductive health-care decisions and also had the highest use of modern methods among women who want to avoid pregnancy.

Figure 11.

Proportion of women aged 15-49 years whose demand for family planning is satisfied by modern contraceptive methods (SDG indicator 3.7.1) by the proportion who make their own decisions concerning sexual and reproductive health and reproductive rights (SDG indicator 5.6.1), selected countries of areas, 2007 to 2018



Source: United Nations, Department of Economic and Social Affairs, Statistics Division (2020). *Global SDG Indicators Database.*

Note: Data on SDG indicator 5.6.1 are currently available for only 57 countries. Among women aged 15-49 years who are married or in union, the indicator measures the percentage who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. Data on reproductive decision-making come mainly from nationally representative surveys, especially the Demographic and Health Surveys but also the Multiple Indicator Cluster Surveys and the Gender and Generations Surveys.

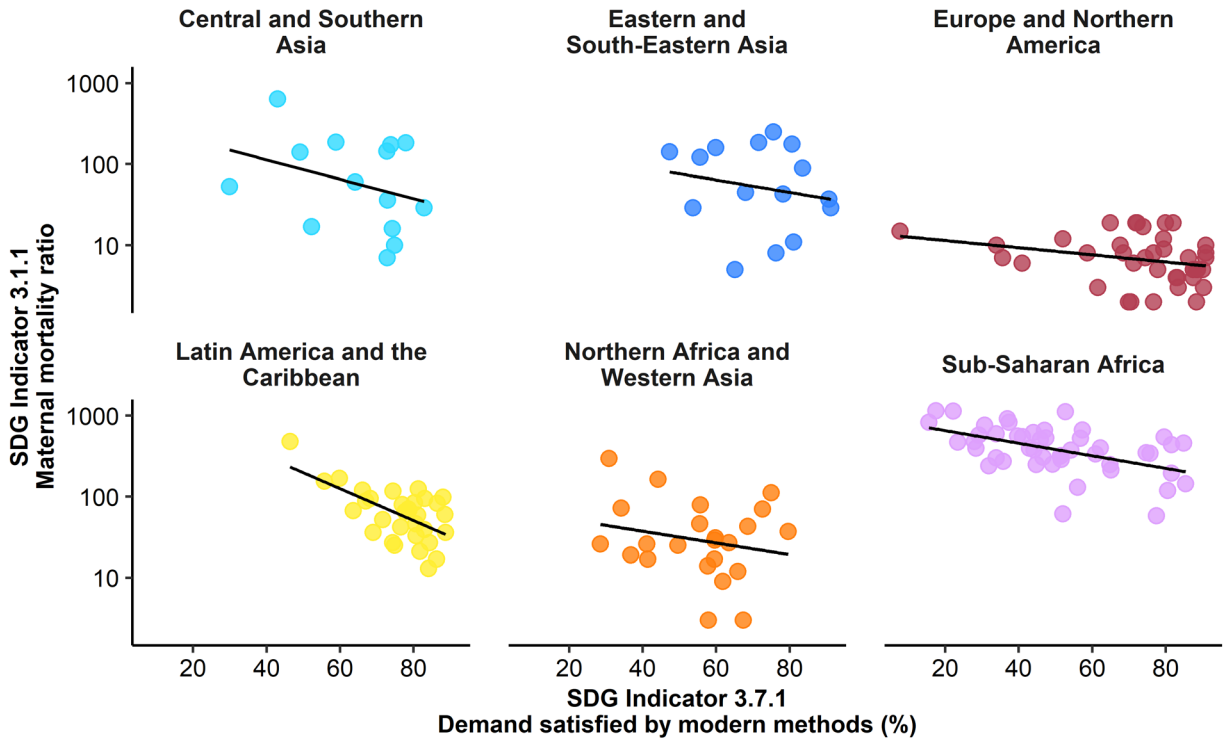
Satisfying the demand for family planning with modern methods can improve health and economic outcomes

Increasing the proportion of demand satisfied by modern methods can lead to progress in achieving other socioeconomic and health goals of the 2030 Agenda by improving women's ability to avoid unwanted, mistimed and high-risk pregnancies. For example, pregnancies occurring following short interbirth intervals or at older ages are known to be associated with higher risks of maternal mortality (Blanc and others, 2013; Conde-Agudelo and Belizán, 2000). In regions with more restrictive abortion legislation, unintended pregnancies are also more likely to be terminated through unsafe abortions, which are associated with a higher risk of maternal mortality (Ganatra and others, 2017). Increasing the proportion of demand satisfied by modern methods can therefore play a pivotal role in supporting progress towards reducing the maternal mortality ratio (SDG indicator 3.1.1) by enabling women to more effectively avoid high-risk pregnancies that disproportionately contribute to maternal mortality (figure 12). Whereas, maternal mortality ratios are highest in sub-Saharan Africa, they vary widely across the region ranging from over 1,100 per 100,000 births in Chad, Sierra Leone and South Sudan to below 100 deaths per 100,000 births in Cabo Verde and Mauritius. A higher proportion of demand satisfied by modern methods tends to be associated with

lower maternal mortality ratios (figure 12). Whereas increasing the proportion of demand satisfied by modern contraceptive methods is, evidently, not sufficient to reduce the maternal mortality ratio on its own, such a change can contribute to a reduction of maternal mortality risks in conjunction with other measures, such as increasing the percentage of births attended by skilled health personnel (SDG indicator 3.1.2), expanding the coverage of essential health services (SDG indicator 3.8.1) and improving the density and distribution of health workers (SDG indicator 3.c.1).

Figure 12.

Maternal mortality ratios (SDG indicator 3.1.1) by the proportion of women who have their need for family planning satisfied by modern methods (SDG indicator 3.7.1), by region, 2017



Source: United Nations, Department of Economic and Social Affairs, Statistics Division (2020). *Global SDG Indicators Database;* United Nations, Department of Economic and Social Affairs, Population Division. (2020). *Estimates and Projections of Family Planning Indicators 2020.*

Beyond its direct influences on maternal health, increasing the proportion of demand satisfied by modern methods can also support progress towards reaching other targets of the 2030 Agenda. Reducing unplanned pregnancies and having greater control over the timing of pregnancies has the potential to help reduce intimate partner violence (SDG indicator 5.2.1) (Nasir and Hyder, 2003), increase the educational attainment of women and their children (SDG indicator 4.3.1) (Fergusson and others, 2007; Pop-Eleches, 2006), reduce the percentage of women and children who live in poverty (SDG indicator 1.2.1) (Foster and others, 2018), reduce the prevalence of stunting among children under the age of five (SDG indicator 2.2.1) (Shapiro-Mendoza and others, 2005) and reduce neonatal and under-five mortality (SDG indicators 3.2.1 and 3.2.2) (Gipson and others, 2008). In short, ensuring that women who wish to avoid pregnancy have access to a variety of modern contraceptives and agency to use them may have far-reaching implications for other domains of their lives.

Box 4. Estimates of broader development impacts of family planning investments

Family planning is often characterized as a key investment because it provides a lifetime of benefits to users and their families and communities. At the individual level, there are benefits in infant, child and maternal health outcomes (SDG 3), improved educational outcomes (SDG 4), gender equality and women's empowerment (SDG 5) and equal access to the labour market, social protection and the political process (SDGs 5, 8, and 16).

Recent studies have made the economic case for the return on investment of family planning (Canning and Schultz, 2012). Five such studies were assessed and summarised by Family Planning 2020 (2018). These studies vary in terms of timescale for measuring the benefits (short versus long-term), outcomes (health versus other), benefits (US dollars saved versus economic gains), scale (one country versus developing countries), and estimated cost of contraception.

The Guttmacher Institute's *Adding It Up* models estimated the short-term savings of meeting need for family planning. For every additional US dollar invested in meeting the need for contraceptives, the Guttmacher Institute estimates that US$2.20 is saved in maternal and newborn healthcare services, due to a reduction in the number of unintended pregnancies (Singh and others, 2009). This estimate was recently revised upward. Using more recent data, it was found that every additional US dollar investment saved three US dollars (Sully and others, 2020). The Millennium Development Goals (MDG) Scenarios model estimated that for every US dollar invested in contraception between two to six US dollars would be saved in meeting other MDG targets, across the 16 countries studied (Moreland and Talbird, 2006). At the upper bound of the range of estimates, the Copenhagen Consensus project compared the cost-effectiveness of different development interventions and concluded that every US dollar invested in meeting unmet need would yield – in the long-term – US$120 in accrued benefits (Kohler and Behrman, 2015).

The Demographic Dividend model demonstrated that in the long-term, reduced fertility would lead to improved maternal and child health outcomes, as well as to increased labour market productivity resulting in increased GDP per capita (Moreland and others, 2014). This model made the case to policymakers outside the health sector that investments in family planning together with investments in education and the economy would increase per capita GDP. The *Family Planning Sustainable Development Goals* model demonstrated that improvements in socioeconomic status along with investments in family planning maximise long-term progress towards reducing poverty and food insecurity and increasing income.

These analyses have helped to build the economic case for investment in family planning and have shown the relevance of family planning for achieving the Sustainable Development Goals.

Policy implications and recommendations

Although there has been considerable progress in increasing the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied by modern methods (SDG indicator 3.7.1), significant inequalities remain within and between countries and regions. Further progress over the next decade is uncertain because of the large increases in the population of women with need for family planning due to both population growth and changing childbearing preferences. The increase in demand for family planning will be particularly high in sub-Saharan Africa, but also in other regions with large gaps in meeting the needs for family planning, such as Oceania excluding Australia and New Zealand, and Northern Africa and Western Asia. In these regions, population growth will pose significant challenges for meeting the needs of growing numbers of women of reproductive age, requiring rapid expansion of the sexual and reproductive health-care services, including family planning. Countries facing rapid population growth should adopt evidence-based programming strategies and maintain sustainable financing mechanisms by maximising cost-effectiveness of their family planning programmes and to plan for rapid increases in the number of women in need of family planning.

There are multiple reasons for which women do not use modern contraceptive methods even when they wish to avoid pregnancy, including limited choice of methods, limited access to services (particularly among young, poorer and unmarried people), opposition to use of contraception stemming from a woman's or her partner's personal or religious beliefs, fear of side effects, inconvenience, preferences for traditional methods or perceived low pregnancy risk due to infecundity or infrequent sexual activity (Sedgh and Hussain, 2014). In the past two decades, several countries were successful in reducing gaps in meeting the needs for family planning. Whether or not other countries can replicate these successes will depend on a range of factors, in particular the commitment from governments to create legislative and financial mechanisms that can support sustainable family planning programmes and programming that is sensitive to local settings. Investments in developing new contraceptive methods would be beneficial, as many women may be unsatisfied with current modern methods for a number of reasons. Furthermore, there are currently few contraceptive methods intended specifically for use by men.

In the next decade, accelerated action across all countries is needed to live up to the commitments made in the 2030 Agenda to achieve universal access to sexual and reproductive health-care services, information and education by 2030. Nevertheless, the advances made so far and those expected to be made over the next 10 years are not ensured, as the COVID-19 pandemic is leaving significant numbers of women and couples without access to essential sexual and reproductive health-care services and impacting women's lives and reproductive health. It is therefore essential that countries find innovative ways to continue to address the family planning needs of their populations, despite the wide-ranging impact of COVID-19 pandemic on health systems. The disruptions in the provision of contraceptive services have serious and long-lasting impacts for the individuals who experience an unintended pregnancy due to the lack of access to contraceptive methods. Timely action to support the access to sexual and reproductive health-care services, information and education is essential.

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Annex table

Region, development group, country or area	*Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1*						
	2000		*2020*		*Year of latest survey observation*	*Survey estimate*	*Note*
	Median	*95% uncertainty interval*	*Median*	*95% uncertainty interval*			
WORLD	**73.6**	**(71.3-75.3)**	**76.8**	**(74.2-79.0)**	..	..	
Sub-Saharan Africa	35.8	(34.5-37.1)	55.5	(53.4-57.6)	..	..	
Northern Africa and Western Asia	55.0	(51.9-57.8)	62.9	(58.3-67.0)	..	..	
Central and Southern Asia	64.5	(61.3-67.7)	71.7	(64.7-77.7)	..	..	
Eastern and South-Eastern Asia	85.9	(79.8-88.6)	86.2	(80.8-89.5)	..	..	
Latin America and the Caribbean	76.1	(73.5-78.2)	82.9	(79.3-85.6)	..	..	
Oceania (excluding Australia and New Zealand)	42.5	(34.7-50.6)	52.1	(45.0-58.9)	..	..	
Australia and New Zealand	84.5	(71.3-90.0)	85.2	(71.4-91.2)	..	..	
Europe and Northern America	73.6	(69.0-76.7)	80.6	(75.0-84.2)	..	..	
Developed regions	72.8	(68.6-75.9)	79.5	(74.3-82.9)	..	..	
Less developed regions	73.9	(71.2-75.8)	76.3	(73.4-78.8)	..	..	
Less developed regions, excluding least developed countries	77.3	(74.2-79.2)	79.1	(75.8-81.8)	..	..	
Less developed regions, excluding China	63.3	(61.8-64.8)	70.7	(67.8-73.5)	..	..	
Least developed countries	38.6	(37.1-40.0)	58.7	(55.4-61.8)	..	..	
Land-locked Developing Countries (LLDC)	43.6	(42.3-44.9)	62.9	(60.1-65.4)	..	..	
Small island developing States (SIDS)	67.1	(63.9-69.9)	70.5	(66.9-73.6)	..	..	
High-income countries	75.9	(71.3-79.0)	80.2	(75.1-83.5)	..	..	
Middle-income countries	75.5	(72.7-77.4)	78.4	(75.2-81.0)	..	..	
Upper-middle-income countries	84.1	(79.2-86.5)	85.4	(80.9-88.3)	..	..	
Lower-middle-income countries	62.6	(60.2-64.8)	70.6	(65.7-74.9)	..	..	
Low-income countries	33.4	(31.9-35.2)	55.2	(52.7-57.6)	..	..	
AFRICA	**42.7**	**(41.4-43.9)**	**58.5**	**(56.3-60.6)**	..	..	
Eastern Africa	34.6	(33.2-36.0)	64.2	(61.2-67.1)	..	..	
Burundi	19.1	(14.5-24.6)	45.2	(35.8-55.0)	2017	38.0	M
Comoros	28.9	(23.0-35.7)	39.7	(26.6-54.7)	2012	28.8	
Djibouti	18.9	(11.3-32.0)	48.8	(29.6-68.7)	..	..	
Eritrea	18.7	(15.1-22.9)	31.1	(17.0-50.1)	2010	21.0	
Ethiopia	15.5	(13.6-17.7)	64.9	(56.8-72.6)	2018	62.3	M
Kenya	47.8	(42.9-52.7)	77.1	(71.1-82.0)	2017	76.0	

Region, development group, country or area	Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1						
	2000		2020		Year of latest survey observation	Survey estimate	Note
	Median	95% uncertainty interval	Median	95% uncertainty interval			
Madagascar	26.0	(21.4-31.0)	64.4	(54.8-72.8)	2017	60.5	M
Malawi	42.3	(39.2-44.8)	76.7	(68.0-83.5)	2016	73.9	
Mauritius*	51.7	(37.6-65.3)	55.2	(35.9-72.5)	2014	40.8	M
Mozambique	36.4	(30.9-42.3)	54.9	(42.4-67.1)	2015	55.5	
Réunion*	79.4	(66.3-87.9)	82.7	(64.7-93.3)	..	..	
Rwanda	13.8	(12.0-16.1)	67.8	(57.0-77.0)	2015	62.9	M
Somalia	2.8	(0.9-9.0)	20.8	(6.6-47.1)	..	..	
South Sudan	10.2	(5.0-20.4)	19.7	(11.5-33.5)	2010	5.6	M
Uganda	33.2	(29.8-36.6)	58.1	(51.1-64.9)	2018	53.5	M
United Republic of Tanzania*	40.0	(35.4-44.7)	60.0	(49.8-69.3)	2016	54.0	
Zambia	37.6	(32.8-42.5)	67.2	(59.7-73.7)	2014	62.4	
Zimbabwe	72.5	(68.6-76.1)	85.2	(77.7-90.5)	2015	84.8	
Middle Africa	17.4	(14.7-20.6)	33.8	(28.6-39.6)	..	..	
Angola	17.3	(12.1-23.9)	34.3	(26.0-43.7)	2016	29.8	
Cameroon	25.0	(20.0-30.4)	50.0	(40.7-58.9)	2014	47.0	
Central African Republic	21.1	(15.6-27.8)	40.7	(24.5-59.3)	2011	28.7	M
Chad	11.0	(8.3-14.5)	24.2	(16.2-34.7)	2015	20.2	M
Congo	17.8	(10.3-28.6)	48.3	(35.1-62.0)	2015	43.2	
Democratic Republic of the Congo	14.5	(10.3-20.0)	26.6	(17.7-37.4)	2014	18.9	M
Equatorial Guinea	19.5	(12.2-29.7)	36.4	(24.6-49.9)	2011	20.7	M
Gabon	26.6	(22.8-30.7)	52.2	(39.6-64.7)	2012	44.0	
Sao Tome and Principe	41.3	(32.3-50.9)	58.3	(44.5-71.3)	2014	52.2	M
Northern Africa	66.1	(62.1-69.0)	71.3	(64.4-76.7)	..	..	
Algeria	70.3	(59.2-78.5)	75.8	(59.4-86.3)	2013	77.2	M
Egypt	75.8	(72.1-77.8)	80.2	(68.9-88.1)	2014	80.0	M
Libya	36.1	(25.5-47.4)	37.4	(22.8-54.0)	2014	24.0	M
Morocco	67.9	(59.8-74.3)	73.4	(65.1-79.7)	2018	68.6	M
Sudan	17.4	(11.5-26.5)	33.2	(19.5-50.9)	2014	30.1	M
Tunisia	70.4	(61.3-77.5)	68.8	(55.5-79.2)	2012	73.2	M
Southern Africa	79.0	(74.5-82.7)	81.6	(74.1-87.6)	..	..	
Botswana	75.8	(61.3-86.5)	86.0	(72.0-93.8)	..	..	
Eswatini	56.6	(48.2-64.6)	82.7	(72.4-90.1)	2014	82.9	M
Lesotho	51.8	(45.7-57.9)	80.8	(72.8-86.8)	2014	78.9	
Namibia	69.1	(65.1-72.9)	82.8	(72.4-90.4)	2013	80.4	
South Africa	80.8	(75.9-84.8)	81.4	(72.8-88.2)	2016	77.9	M

Region, development group, country or area	*Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1*						
	2000		*2020*		*Year of latest survey observation*	*Survey estimate*	*Note*
	Median	*95% uncertainty interval*	*Median*	*95% uncertainty interval*			
Western Africa	25.7	(23.8-27.8)	44.6	(41.1-48.1)	..	..	
Benin	15.2	(12.4-18.5)	31.9	(25.7-38.5)	2018	25.9	M
Burkina Faso	19.0	(16.0-22.4)	56.9	(49.1-64.6)	2018	56.4	
Cabo Verde	68.3	(56.6-75.7)	78.6	(63.0-88.9)	2005	73.2	M
Côte d'Ivoire	24.3	(19.6-29.6)	47.6	(40.3-55.1)	2018	39.4	M
Gambia	31.9	(24.3-40.9)	37.4	(27.3-49.3)	2013	26.7	M
Ghana	28.2	(24.5-32.2)	50.0	(41.6-58.3)	2017	46.2	M
Guinea	17.7	(14.8-21.0)	32.0	(22.9-42.9)	2016	21.5	M
Guinea-Bissau	27.2	(19.3-37.3)	59.6	(45.6-72.4)	2014	55.7	M
Liberia	26.3	(19.6-34.6)	50.0	(39.1-61.5)	2013	41.4	
Mali	19.3	(16.4-22.6)	43.6	(36.7-51.2)	2015	35.0	M
Mauritania	14.4	(11.4-18.4)	34.3	(21.5-49.7)	2015	30.4	M
Niger	25.4	(20.6-30.9)	48.2	(37.1-59.2)	2018	45.5	M
Nigeria	28.8	(24.9-32.9)	40.2	(33.3-47.1)	2018	42.8	M
Senegal	22.0	(18.4-26.2)	55.0	(45.1-64.5)	2017	50.9	
Sierra Leone	20.8	(15.6-27.7)	55.7	(48.3-63.0)	2017	44.7	M
Togo	23.0	(18.8-27.7)	46.4	(36.3-56.9)	2014	37.4	M
ASIA	**77.4**	**(73.8-79.6)**	**78.9**	**(74.9-82.0)**	**..**	**..**	
Central Asia	73.6	(70.4-76.4)	76.2	(67.1-82.3)	..	..	
Kazakhstan	72.3	(67.3-76.7)	74.9	(66.2-82.0)	2018	79.4	M,S
Kyrgyzstan	70.2	(62.4-76.9)	65.3	(53.3-75.7)	2014	66.2	
Tajikistan	53.2	(41.7-64.4)	53.9	(44.4-63.0)	2017	44.8	M
Turkmenistan	72.7	(68.2-76.2)	73.8	(58.3-85.0)	2016	75.6	M
Uzbekistan	79.1	(73.3-83.7)	83.1	(65.9-92.5)	..	..	
Eastern Asia	89.7	(81.9-93.1)	89.4	(82.2-93.5)	..	..	
China*	92.2	(84.0-95.6)	91.3	(83.6-95.4)	2001	96.6	M
China, Hong Kong SAR*	82.7	(67.3-90.9)	80.3	(64.9-89.9)	..	..	
China, Taiwan Province of China*	80.2	(63.7-88.5)	82.0	(63.9-91.8)	..	..	
Dem. People's Republic of Korea	69.5	(58.9-77.6)	83.7	(72.7-90.3)	2014	89.8	M
Japan	64.3	(51.0-74.5)	67.3	(52.0-79.2)	..	..	
Mongolia	67.8	(60.2-74.0)	69.1	(59.1-77.5)	2013	65.2	M
Republic of Korea	77.5	(60.7-87.3)	81.8	(64.3-91.0)	..	..	
South-Eastern Asia	69.9	(67.8-72.0)	76.3	(72.6-79.7)	..	..	
Cambodia	32.7	(29.9-35.5)	62.2	(47.0-74.9)	2014	56.5	M
Indonesia	77.0	(73.5-80.3)	80.9	(74.2-86.3)	2017	77.6	M
Lao People's Democratic Republic	46.0	(39.1-53.3)	73.5	(65.3-80.2)	2017	71.6	M

Region, development group, country or area	Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1						
	2000		2020		Year of latest survey observation	Survey estimate	Note
	Median	95% uncertainty interval	Median	95% uncertainty interval			
Malaysia*	47.5	(33.0-62.4)	56.1	(39.9-71.0)	..	..	
Myanmar	54.3	(46.6-62.3)	77.7	(68.3-85.2)	2016	74.9	M
Philippines	44.1	(39.5-48.7)	57.6	(46.9-66.9)	2017	52.5	M
Singapore	71.7	(58.6-81.8)	77.0	(57.7-89.6)	..	..	
Thailand	89.7	(85.7-92.5)	90.8	(83.9-94.8)	2016	89.2	M
Timor-Leste	39.9	(33.3-47.0)	51.0	(39.9-61.9)	2016	37.4	
Viet Nam	70.7	(64.8-75.5)	78.9	(68.0-86.6)	2014	69.6	M
Southern Asia	64.2	(60.8-67.4)	71.5	(64.3-77.8)	..	..	
Afghanistan	21.0	(13.6-31.9)	45.7	(35.4-57.0)	2016	42.2	M
Bangladesh	61.6	(57.8-64.9)	74.7	(63.0-83.9)	2014	72.6	M
Bhutan	52.2	(40.1-65.1)	79.3	(62.0-90.2)	2010	84.6	M
India	67.2	(62.8-71.4)	73.7	(63.8-81.9)	2016	67.2	M
Iran (Islamic Republic of)	69.3	(60.8-76.4)	75.1	(57.6-86.9)	2011	68.6	M
Maldives	48.3	(40.5-56.1)	31.8	(23.8-41.1)	2009	42.5	M
Nepal	51.6	(47.0-56.2)	61.7	(51.1-71.3)	2017	56.0	M
Pakistan	36.8	(31.3-43.0)	50.9	(41.9-60.1)	2018	48.5	M,P
Sri Lanka	64.3	(55.5-72.3)	73.4	(61.7-82.2)	2016	74.3	M
Western Asia	45.9	(41.1-50.4)	55.8	(49.8-61.3)	..	..	
Armenia	31.7	(26.6-37.2)	43.1	(29.8-57.1)	2016	36.9	M
Azerbaijan*	24.4	(17.2-33.5)	31.2	(16.8-50.5)	2006	21.5	M
Bahrain	49.2	(30.3-67.3)	58.9	(32.9-80.2)	..	..	
Georgia*	34.2	(23.7-45.3)	51.0	(36.4-64.3)	2010	52.8	M,S
Iraq	45.9	(34.8-57.6)	56.9	(41.9-70.9)	2018	54.6	M
Israel	64.5	(41.7-80.6)	68.3	(41.2-85.6)	..	..	
Jordan	55.3	(47.8-61.8)	55.9	(44.7-66.0)	2018	56.7	M
Kuwait	59.5	(46.0-70.6)	66.6	(42.3-83.9)	..	..	
Lebanon	52.7	(41.7-63.6)	60.6	(40.7-77.6)	..	..	
Oman	36.9	(26.8-49.0)	39.2	(26.0-54.9)	2014	39.6	M
Qatar	55.6	(41.2-69.2)	63.0	(43.7-78.9)	2012	68.9	M
Saudi Arabia	40.1	(26.3-56.4)	43.6	(28.1-61.2)	..	..	
State of Palestine*	53.2	(42.2-63.7)	64.3	(47.4-78.0)	2014	64.6	M
Syrian Arab Republic	51.9	(41.4-62.7)	61.1	(41.4-77.4)	2009	53.3	M
Turkey	50.2	(40.8-58.8)	60.4	(47.5-71.2)	2013	59.7	M
United Arab Emirates	47.0	(28.8-65.9)	59.5	(31.9-81.3)	..	..	
Yemen	22.0	(17.0-28.6)	46.8	(32.6-61.4)	2013	37.7	M

Region, development group, country or area	Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1						
	2000		2020		Year of latest survey observation	Survey estimate	Note
	Median	95% uncertainty interval	Median	95% uncertainty interval			
EUROPE	**70.1**	**(66.2-73.1)**	**79.5**	**(75.0-83.0)**	**..**	**..**	
Eastern Europe	60.9	(54.7-66.2)	74.5	(66.5-80.9)	..	..	
Belarus	65.7	(53.7-75.5)	77.9	(67.0-85.7)	2012	74.2	M
Bulgaria	47.8	(36.3-59.2)	70.4	(50.0-85.1)	..	..	
Czechia	72.9	(61.1-81.7)	84.3	(69.9-92.4)	2008	85.7	M,S
Hungary	76.0	(62.5-84.7)	80.2	(63.3-90.3)	..	..	
Poland	53.3	(38.1-68.0)	71.8	(56.8-82.6)	..	..	
Republic of Moldova*	56.6	(46.0-66.4)	66.4	(48.1-80.7)	2012	60.4	M
Romania	48.4	(34.9-62.7)	74.2	(53.5-88.2)	2004	46.5	M,S
Russian Federation	63.9	(52.8-72.9)	74.9	(60.1-85.3)	2011	72.4	M,S
Slovakia	67.0	(47.4-82.2)	79.2	(56.3-92.2)	..	..	
Ukraine*	59.3	(47.1-70.0)	73.6	(58.1-85.1)	2012	68.0	M
Northern Europe	83.1	(75.2-87.1)	85.8	(74.8-91.1)	..	..	
Denmark*	85.7	(69.7-93.7)	87.7	(66.8-95.7)	..	..	
Estonia	73.1	(56.2-83.3)	80.3	(58.7-90.8)	..	..	
Finland*	86.8	(76.1-91.2)	90.4	(80.2-94.5)	..	..	
Ireland	84.7	(71.1-89.7)	87.7	(72.3-93.9)	..	..	
Latvia	74.3	(55.7-85.5)	80.5	(57.3-92.0)	..	..	
Lithuania	58.3	(43.2-70.6)	69.7	(48.9-83.9)	..	..	
Norway*	86.1	(70.4-92.2)	88.6	(70.3-95.4)	..	..	
Sweden	79.8	(62.5-88.9)	83.4	(61.7-93.3)	..	..	
United Kingdom*	84.7	(75.3-89.7)	86.5	(72.0-93.3)	..	..	
Southern Europe	59.2	(51.7-65.7)	72.3	(64.1-78.6)	..	..	
Albania	16.7	(10.7-25.1)	9.3	(5.9-14.9)	2018	4.9	
Bosnia and Herzegovina	22.4	(14.8-32.9)	37.3	(22.0-55.8)	2012	21.9	M
Croatia	39.6	(16.9-71.3)	61.4	(33.0-85.3)	..	..	
Greece	45.0	(31.1-59.9)	63.5	(40.3-82.4)	..	..	
Italy	54.3	(38.1-68.4)	72.0	(55.3-83.6)	..	..	
Malta	59.4	(32.6-77.6)	73.0	(45.0-89.8)	..	..	
Montenegro	38.2	(27.4-49.9)	42.5	(30.6-55.1)	2013	42.8	
North Macedonia	21.8	(11.1-40.2)	38.8	(23.0-58.2)	2011	22.3	M
Portugal	70.3	(47.6-83.3)	77.6	(55.7-89.7)	..	..	
Serbia*	40.8	(30.0-52.3)	54.8	(39.7-68.9)	2014	38.7	M
Slovenia	65.1	(45.3-80.8)	75.8	(52.8-90.0)	..	..	
Spain*	78.2	(69.0-84.0)	83.5	(73.8-89.5)	..	..	

Region, development group, country or area	Proportion of women aged 15-49 who have their need for family planning satisfied by modern contraceptive methods (per cent), SDG indicator 3.7.1						
	2000		2020		Year of latest survey observation	Survey estimate	Note
	Median	95% uncertainty interval	Median	95% uncertainty interval			
Western Europe	86.2	(76.2-90.4)	90.0	(78.6-93.9)	..	..	
Austria	81.2	(66.5-88.8)	88.0	(74.8-93.5)	..	..	
Belgium	86.0	(74.6-91.7)	90.1	(74.8-94.9)	..	..	
France*	88.8	(76.7-92.9)	91.0	(76.6-95.7)	2005	95.5	M
Germany	85.4	(71.6-91.6)	91.0	(74.8-96.2)	..	..	
Netherlands*	87.3	(75.1-92.7)	88.6	(73.8-94.8)	..	..	
Switzerland	87.5	(76.8-92.5)	88.9	(79.6-93.3)	..	..	
LATIN AMERICA AND THE CARIBBEAN	**76.1**	**(73.5-78.2)**	**82.9**	**(79.3-85.6)**	**..**	**..**	
Caribbean	72.1	(68.1-75.3)	75.4	(70.9-79.1)	..	..	
Anguilla*	63.1	(43.1-79.1)	72.9	(51.1-87.6)	..	..	
Antigua and Barbuda	70.6	(50.6-84.8)	77.5	(55.4-90.6)	..	..	
Bahamas	74.7	(54.2-87.4)	79.3	(57.8-91.6)	..	..	
Barbados	71.4	(56.4-82.5)	75.2	(60.1-85.6)	2012	70.0	M
Cuba	83.8	(75.1-90.0)	89.1	(80.3-94.2)	2014	88.8	M
Dominica	72.6	(53.2-86.0)	78.2	(56.3-91.0)	..	..	
Dominican Republic	79.2	(76.3-81.8)	83.5	(74.9-89.3)	2014	81.7	
Grenada	67.9	(48.4-82.6)	75.7	(53.6-89.4)	..	..	
Guadeloupe*	62.0	(39.8-80.0)	72.3	(47.8-87.8)	..	..	
Haiti	34.4	(31.3-37.4)	49.1	(40.6-57.9)	2017	43.1	
Jamaica	76.0	(62.1-83.7)	77.6	(59.7-88.3)	2009	79.2	M
Martinique*	65.3	(43.1-81.8)	74.0	(49.8-88.8)	..	..	
Montserrat*	73.8	(52.3-87.4)	79.2	(56.7-91.7)	..	..	
Puerto Rico*	78.6	(66.8-86.1)	82.1	(66.0-91.4)	..	..	
Saint Kitts and Nevis	67.2	(44.3-83.9)	75.4	(50.6-89.9)	..	..	
Saint Lucia	69.0	(53.2-81.0)	75.4	(59.3-86.2)	2012	72.4	M
Saint Vincent and the Grenadines	74.8	(55.2-87.1)	79.5	(57.5-91.3)	..	..	
Trinidad and Tobago	57.3	(46.0-66.5)	65.1	(49.0-77.9)	2011	58.2	M
United States Virgin Islands*	76.4	(59.8-86.7)	80.7	(62.1-91.2)	..	..	
Central America	74.3	(69.3-78.4)	80.2	(75.3-84.2)	..	..	
Belize	64.6	(54.3-73.5)	70.5	(57.8-80.7)	2016	65.9	M
Costa Rica	81.8	(72.6-87.4)	84.3	(73.3-90.6)	2011	89.1	M
El Salvador	75.8	(67.2-82.4)	81.1	(70.8-88.0)	2014	80.0	M,S
Guatemala	51.2	(44.3-58.3)	69.6	(58.6-78.7)	2015	66.1	M

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	Median	95% uncertainty interval	Median	95% uncertainty interval			
Honduras	65.5	(56.9-73.2)	78.2	(67.4-85.9)	2012	76.0	S
Mexico	76.2	(69.9-81.4)	81.4	(74.9-86.5)	2015	79.8	M
Nicaragua	77.2	(74.4-79.7)	88.1	(79.6-92.8)	2012	92.6	M
Panama	71.7	(59.0-81.4)	72.8	(60.9-82.1)	2013	73.3	
South America	77.1	(73.9-79.8)	84.7	(79.8-88.1)	..	..	
Argentina	76.6	(65.0-83.9)	83.6	(71.4-90.9)	..	..	
Bolivia (Plurinational State of)	37.5	(31.5-43.6)	58.3	(45.6-69.3)	2016	50.3	M
Brazil	82.8	(77.6-86.9)	88.8	(80.3-93.8)	2007	89.0	M
Chile	72.2	(58.0-82.2)	84.8	(74.4-90.9)	..	..	
Colombia	74.4	(70.9-77.4)	86.8	(80.9-91.0)	2016	86.6	
Ecuador	69.1	(60.9-76.1)	81.7	(70.1-89.1)	2012	79.4	M
Guyana	53.6	(44.7-62.5)	62.3	(47.7-74.7)	2014	51.5	
Paraguay	67.2	(58.0-75.1)	81.2	(71.6-88.0)	2016	78.9	S
Peru	57.9	(52.5-62.5)	69.1	(59.9-76.4)	2017	66.6	M
Suriname	65.1	(54.1-75.0)	67.1	(55.5-77.2)	2010	73.2	M
Uruguay	83.5	(72.7-90.1)	86.5	(74.6-93.1)	..	..	
Venezuela (Bolivarian Republic of)	74.4	(65.1-81.1)	82.0	(67.8-90.7)	..	..	
NORTHERN AMERICA	**81.4**	**(69.4-87.7)**	**83.3**	**(70.1-89.8)**	**..**	**..**	
Canada	89.7	(80.9-93.6)	90.9	(77.0-95.9)	..	..	
United States of America*	80.4	(67.6-87.4)	82.5	(68.1-89.6)	2015	77.2	M,S
OCEANIA	**77.4**	**(66.7-82.3)**	**77.9**	**(67.3-83.1)**	**..**	**..**	
Australia and New Zealand	84.5	(71.3-90.0)	85.2	(71.4-91.2)	..	..	
Australia*	84.5	(70.2-90.5)	85.0	(69.9-91.5)	..	..	
New Zealand*	85.7	(71.3-91.9)	87.7	(72.3-93.8)	..	..	
Melanesia	41.5	(33.0-50.4)	51.8	(44.3-59.0)	..	..	
Fiji	58.2	(33.3-79.1)	64.4	(34.5-85.0)	..	..	
Papua New Guinea	37.9	(28.7-48.2)	50.2	(41.9-58.3)	2007	40.6	M
Solomon Islands	53.7	(39.0-66.0)	53.6	(39.1-65.9)	2015	38.0	M
Vanuatu	48.3	(35.5-60.8)	60.2	(44.2-73.6)	2013	50.7	M
Micronesia	62.6	(50.3-71.2)	64.6	(51.0-74.9)	..	..	
Guam*	69.9	(49.8-81.4)	74.4	(50.9-88.0)	..	..	
Kiribati	50.4	(36.6-61.0)	43.5	(26.9-60.2)	2009	35.8	M
Marshall Islands	65.2	(50.1-76.5)	72.2	(52.9-85.4)	2007	80.5	M
Nauru	48.0	(31.3-65.0)	56.6	(35.7-74.7)	2007	42.5	M
Palau	55.8	(36.9-73.8)	64.5	(39.0-82.9)	..	..	

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	2000		2020		Year of latest survey observation	Survey estimate	Note
	Median	95% uncertainty interval	Median	95% uncertainty interval			
Polynesia*	40.3	(32.6-48.4)	45.4	(36.1-55.5)	..	..	
Cook Islands*	72.0	(54.6-81.3)	74.9	(54.0-88.2)	..	..	
Samoa	33.8	(25.1-44.0)	38.2	(25.4-53.1)	2014	39.4	M
Tonga	44.2	(27.8-61.7)	51.3	(36.1-66.3)	2012	47.9	M
Tuvalu	39.5	(25.6-55.0)	47.0	(28.1-67.0)	2007	41.0	M

* For country notes, please refer to https://population.un.org/wpp/Download/Metadata/Documentation

M. The global indicator represents all women of reproductive age. This survey estimate represents women who were married or in a union when the data were collected.

S. Data pertain to a non-standard age or marital status group.

P. Preliminary data.

World Family Planning 2020 Highlights presents regional and global estimates of the contraceptive use and needs for women of reproductive age (15-49 years) between 1990 and 2020 with projections until 2030. This report assesses trends and inequalities in contraceptive use, regional differences in method choice, the contraceptive needs of young women and adolescents age (15-19 years) and the effects of population growth on past and future changes in the number of contraceptive users. It also evaluates the progress made in increasing the proportion of women who use modern contraceptive methods to avoid pregnancy, illustrates how family planning can aid in achieving the Sustainable Development Goals and provides policy recommendations for addressing the reproductive health and family planning needs of women and couples.

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