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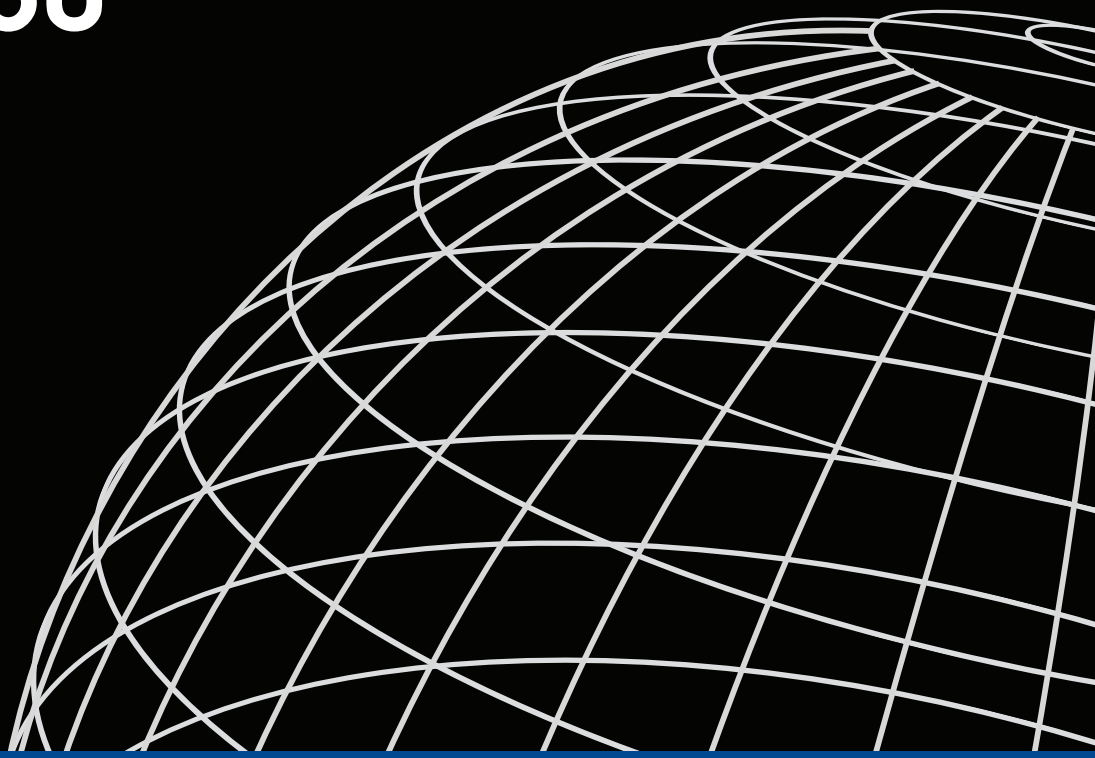
CONTRACEPTION NEEDED TO AVOID HIGH-FERTILITY-RISK BIRTHS, AND MATERNAL AND CHILD DEATHS THAT WOULD BE AVERTED

DHS ANALYTICAL STUDIES 50



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Contraception Needed to Avoid High-Fertility-Risk Births, and Maternal and Child Deaths That Would Be Averted

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Preface

The Demographic and Health Surveys (DHS) Program is one of the principal sources of international data on fertility, family planning, maternal and child health, nutrition, mortality, environmental health, HIV/AIDS, malaria, and provision of health services.

One of the objectives of The DHS Program is to analyze DHS data and provide findings that will be useful to policymakers and program managers in low- and middle-income countries. DHS Analytical Studies serve this objective by providing in-depth research on a wide range of topics, typically including several countries and applying multivariate statistical tools and models. These reports are also intended to illustrate research methods and applications of DHS data that may build the capacity of other researchers.

The topics in the DHS Analytical Studies series are selected by The DHS Program in consultation with the U.S. Agency for International Development.

It is hoped that the DHS Analytical Studies will be useful to researchers, policymakers, and survey specialists, particularly those engaged in work in low- and middle-income countries.

Sunita Kishor
Director, The DHS Program

Abstract

This report estimates the number of maternal and child deaths that could be averted by satisfying the unmet need for contraception based on four high-risk fertility behavior categories, i.e., having a birth at too young an age, too old an age, with inadequate spacing, and at high parity. The data come from 45 Demographic and Health Surveys conducted between 2006 and 2012 with 691,362 non-pregnant women. Twenty-one percent of non-pregnant women have an unmet need for contraception due to their desires or their fertility risk, 5 percent for an unmet spacing method, and 16 percent for a limiting method. Another 20 percent are using a spacing method but have a need for a long-acting, permanent method of family planning. In total, 41 percent of women have a need for focused efforts by family planning programs. By satisfying the risk-based unmet need for contraception, over half of infant and under-five deaths could be averted, with 3.2 million deaths averted out of the 5.6 million deaths projected for 2015. Even more spectacular is the number of maternal deaths that could be averted, i.e., 109,000 out of the 155,000 projected, for a reduction of 70 percent. Only two of five women who need focused efforts and who visited a health facility in the preceding year were informed about family planning. It is thus incumbent upon national and private health programs and donors to serve the women with unmet needs, to cost-effectively avert maternal and child deaths, and to reach the Sustainable Development Targets 3.1 and 3.2.

Executive Summary

Millennium Development Goal (MDG) 4 calls for a reduction in child mortality and MDG 5 for an improvement in maternal health to reduce the maternal mortality ratio (MMRatio). Sustainable Development Goal (SDG) targets call for reducing neonatal mortality to 12 or fewer deaths per 1,000 live births, the under-five mortality to 25 or fewer deaths per 1,000 live births, and the global maternal mortality to less than 70 deaths per 100,000 live births. It has been generally accepted that fertility behavior affects both the mother's and the child's health and survival. Three characteristics and five risks have been identified: age of the mother at the birth of her child (too young or too old), parity at birth (too many), and the interval between pregnancies and birth (too short or sometimes, too long).

The conventional measure of unmet need relies on women's stated preference to space and/or limit births. This report calculates an alternate measure of unmet need that considers a woman who falls in a high-risk fertility behavior category to be in need of family planning. The report estimates the number of maternal and child deaths that could be averted if this alternative risk-based unmet need were satisfied.

Data and Methods

This study defines high-risk fertility behaviors as giving birth at less than 18 years of age and at 40 or more years of age as the age risk, becoming pregnant again at less than 27 months after a preceding birth as the pregnancy spacing risk, and having 4 or more births as the parity risk.

The data come from 45 Demographic and Health Surveys (DHS) conducted between 2006 and 2012 with 691,362 non-pregnant women. Data from the United Nations World Population Prospects were also used.

The number of child deaths that could be averted by satisfying unmet risk-based need and need for a long-acting and permanent method of family planning (LAPM) is calculated using both the reduction in the number of births and the reduction in the risk of dying due to avoiding births in high-risk fertility behavior categories. The probabilities of dying for children in a risk category are drawn from a recent study by Rutstein and Winter (2014).

Reduced age-specific maternal mortality rates (MMRate) are calculated with maternal deaths excluded from the numerator if the mother was less than 18 years of age, 40 years or older, or the birth was of order 4 or higher. The age-specific rates are combined for the MMRatio, weighting by the age-distribution of respondent women.

Results

Overall, 29 percent of women have a short birth-to-pregnancy interval risk, 43 percent have a high parity risk, and 32 percent have a risk because of age. The sum of the percents exceeds 100 because women face multiple risks. Among the 69 percent of women who face at least one fertility-related risk, 28 percent of women have one risk, 39 percent have double risks, and 2 percent face all three possible risks.

Two-thirds of non-pregnant fecund women have a need to use contraception based on their fertility risk status. Nearly half the non-pregnant women (46 percent) have a need for a limiting method because they have had 3 children already or are 40 years of age or over. Among these women, those not currently using contraception have an unmet need.

The overall level of unmet need is estimated by combining unmet need from desires with unmet need from fertility risk. Twenty-one percent of non-pregnant women have an unmet need for contraception because

of their desires or their risk, 5 percent for an unmet spacing method, and 16 percent for a limiting method. Another 20 percent are using a spacing method but have a need for a LAPM. In total, 41 percent of women have a need for focused efforts by family planning programs. Only two out of five women who need focused efforts and who visited a health facility in the preceding year were informed about family planning or contraceptive methods.

If women were to satisfy their unmet risk-based needs for contraception or were to obtain more effective methods of family planning, substantial numbers of under-five deaths and maternal deaths could be averted. According to our calculations, over half of infant and under-five deaths could be averted, with 3.2 million deaths averted out of the 5.6 million deaths projected for 2015. Even more spectacular is the number of maternal deaths that could be averted, 109,000 out of the 155,000, which represents a reduction of 70 percent. It is unrealistic to assume that risk-based unmet need can be eliminated completely, because of conflicts with fertility desires and rejection of use of contraception by some women, their husbands or partners, families, or religions. However, satisfying half of the unmet risk-based need would be a highly effective, cost-effective intervention. For many women, risk-based needs and desire-based needs coincide, and a substantial portion of risk-based unmet needs will be satisfied if women can achieve their preferred number and spacing of births.

Conclusions and Policy Implications

Avoiding high fertility behavior risk could avert substantial numbers of young child and maternal deaths. Many women with unmet needs are not being well-served by health systems. These women need to be informed of the fertility risks and their contraceptive choices, and provided with timely, effective, and high quality services. It is incumbent upon national health programs, international health donors, and private for-profit and not-for-profit health programs to serve the women with unmet needs for contraception in order to cost-effectively avert maternal and child deaths and to reach the Sustainable Development Targets 3.1 and 3.2.

1. Introduction and Rationale

The Millennium Development Goal (MDG) 4 calls for a reduction in child mortality, with a target of reducing the under-five mortality rate; MDG 5 calls for an improvement in maternal health, with a target of reducing the maternal mortality ratio (MMRatio). The follow-on Sustainable Development Goals (SDG) include Targets 3.1 and 3.2, which respectively call for reducing the global maternal mortality to less than 70 deaths per 100,000 live births and reducing neonatal mortality to 12 or fewer deaths per 1,000 live births and under-five mortality to 25 or fewer deaths per 1,000 live births. It has been generally accepted that fertility behavior affects both the mother's and the child's health and survival. Three characteristics and five risks have been identified: age of the mother at the birth of her child (too young or too old), parity at birth (too many), and the interval between pregnancies and birth (too short or sometimes, too long). A recent study (Rutstein and Winter 2014) with data from Demographic and Health Surveys (DHS) in 45 countries estimated the values and prevalence of these risks, both individually and in combination. While the conventional measure of unmet need relies on women's stated preference to space and/or limit births, this report calculates an alternate measure of unmet need that considers a woman who falls in a high-fertility risk category to be in need of family planning, regardless of her stated desire for spacing or limiting the number of births. Carrying forward the findings of Rutstein and Winter (2014), this report estimates the number of maternal and child deaths that could be averted if this alternative risk-based unmet need were satisfied.

Chapter 1 provides a brief overview of the literature on the effects of women's fertility risks on child and maternal survival, and the potential for family planning to avert child and maternal deaths. Chapter 2 describes the data and the methodology of the study, and defines all variables. Chapter 3 has four sections that describe results. First, the study describes the population of non-pregnant women in 45 countries, with data from DHS surveys conducted between 2006 and 2012. The study presents the distribution of these women across fertility risk categories, across categories of fertility-risk-based need, women's desire for children, and current contraceptive use. Second, among non-pregnant currently married or in union women, the study examines the levels of the conventional desire-based need and the fertility-risk-based need as well as levels of a combined measure of desire- and risk- based need. Third, the study focuses specifically on the population of women in need of focused family planning efforts: those with either a risk- or desire-based unmet need. Finally, the study estimates the number of deaths in 2015 to children under-five and the number of pregnancy-related deaths to women in the 45 study countries that could be averted if women would have only those births with optimal birth spacing (36 months or more between births), age at birth (18 to 39 years), and parity (less than 4). These potential reductions in mortality (i.e., deaths averted) are due to a lower number of births and the lower mortality rates. Chapter 4 provides interpretation of key findings, overall conclusions, and policy implications.

1.1. Literature Review

As summarized below, the effects of the length of the preceding interval from birth to pregnancy, maternal age at the child's birth, and the child's birth order on child survival and adverse maternal outcomes are well-established.

1.1.1. High fertility risk: The Length of the preceding birth interval

The effect of short intervals has been shown repeatedly to be one of the most important factors that affect the mortality of infants and children under age five years. Early studies identified a U-shaped pattern between infant mortality and the length of the preceding birth interval (Hughes, Hunter, and Woodbury 1923; Woodbury 1925). Subsequent studies demonstrated that after adjusting for a variety of confounding factors, the effect of birth interval on the mortality of young children persists (Alam 1995; Alam and David

1998; Bhalotra and Soest 2006; Conde-Agudelo, Rosas-Bermúdez, and Kafury-Goeta 2006; DaVanzo et al. 2008; Koenig et al. 1990; Miller et al. 1992; Mozumder et al. 1998; Zenger 1993). The harmful effects of a non-optimal preceding birth interval for the child are concentrated in early infancy (Koenig et al. 1990); this suggests that prenatal conditions may explain the effect of birth interval (Boerma and Bicego 1992). However, studies have also found that the effect of a short-preceding birth interval on child mortality are stronger if the preceding child is still alive; this suggests that sibling completion also plays a role (DaVanzo et al. 2008). In recent years, multi-country studies have sought to identify the birth-to-pregnancy interval that is optimal for child survival. Rutstein (2005 and 2008) and Rutstein and Winter (2014) found that for neonatal mortality and infant mortality, the risk of dying was lowest for children with a preceding birth-to-birth interval of 36-47 months, while for child mortality, risk continued to decrease with increasing length of the preceding birth interval. For a more in-depth discussion of the literature on this relationship, see previous studies by Rutstein (Rutstein 2005; Rutstein 2008).

The effects of the length of the preceding birth-to-pregnancy interval on adverse maternal outcomes are also well established (Conde-Agudelo and Belizán 2000; Conde-Agudelo, Rosas-Bermúdez, and Kafury-Goeta 2007; Conde-Agudelo et al. 2012). Long preceding birth intervals are associated with an increased risk of preeclampsia, while short preceding intervals are associated with increased risk of premature membrane rupture, uteroplacental bleeding disorders, and uterine rupture if a vaginal delivery follows a Cesarean delivery (Conde-Agudelo, Rosas-Bermúdez, and Kafury-Goeta 2007). The adverse effects associated with short intervals could be due to maternal nutritional depletion, since insufficient recovery time between pregnancies can worsen the mother's nutritional status. The adverse outcomes associated with a long preceding interval may result in the gradual decline of the mother's physiological ability to carry a pregnancy back to the state that existed before the first pregnancy (i.e., women's physiological regression) (Conde-Agudelo et al. 2012).

1.1.2. High fertility risk: Maternal age

The effects of maternal age on infant and early child survival and health have been studied extensively. Children born to very young women and older women have higher levels of mortality (Hobcraft, McDonald, and Rutstein 1985; Nortman 1974; Rutstein and Winter 2014). While some authors have used data from the United States to provide evidence that this association can be explained by young women's social disadvantage and other confounding factors (Geronimus 1987; Reichman and Pagnini 1997), most studies find that the observed maternal-age effect persists after adjusting for socio-demographic factors (Finlay, Özaltin, and Canning 2011; Fraser, Brockert, and Ward 1995; Ikamari 2013; Kumar et al. 2013; Rutstein and Winter 2014; Van der Klaauw and Wang 2004). This suggests a biological effect. Van der Klaauw and Wang (2011) report that the expected U-shaped relationship between maternal age and neonatal, post-neonatal, and child (years one to four) mortality persists after adjusting for an array of sociodemographic characteristics among children in rural India. In contrast, Ikamari (2013) reports that the risk of neonatal and post–neonatal mortality increases incrementally with age, with the lowest risk found in the under 20 age group, higher risk found in the 20–34 group, and the highest risk in the 35 and older group. However, this single contrasting study uses data from Kenya only, whereas the other studies use data from many countries. Older maternal age at the child's birth (age 35–39, and 40 or older) has also been associated with stillbirth and preterm birth (Lisonkova et al. 2010).

Several plausible biological factors could explain the excess mortality observed among young and older mothers. The biological influences of aging in older women are believed to influence their reproductive health and children's survival. The bodies of young teenage mothers have not yet reached full physiological and reproductive maturity, and this may increase the mother's risk of complications during pregnancy and birth, and the likelihood of inadequate weight gain during pregnancy. Young mothers who are still growing may also compete for nutrients with the fetus (Fraser, Brockert, and Ward 1995), while psychological

immaturity may also affect the child's care. Some of the observed association could also be explained by social factors or collinearity between maternal age and birth order.

The elevated J-shaped curve of maternal mortality with higher risks among women who are either too young or too old has been documented since the early 1970s (Nortman 1974; Stover and Ross 2010). Nortman (1974) found the risk of maternal mortality to be lowest among women ages 22-23 years (regardless of parity), with slightly elevated risk at young ages and a steep increase in risk at older ages. The risk of both hemorrhage and sepsis increased rapidly with increasing age (Nortman 1974).

1.1.3. High fertility risk: Birth order

The association between birth order and child mortality is often described as U-shaped, with higher mortality levels among first births and high-order births. Two of three recent studies found that the association between birth order and child mortality persists after controlling for potential confounders (Handa, Koch, and Ng 2010; Rutstein and Winter 2014). In the third study, birth order was not a significant determinant of child mortality in adjusted models (Saha and van Soest 2013). See Rutstein and Winter (2014) for a more detailed discussion of the literature on maternal age, birth order, and child survival.

Women are also at higher risk for adverse maternal outcomes during their first birth and high parity births. Specifically, the MMRatio tends to be elevated at parity 1, lower for parities 2 and 3, and then steadily increases at higher parities (Chen et al. 1974; Cleland et al. 2012; Stover and Ross 2010). At high parity, women's health may be compromised from the cumulative experience of childbirth and lactation, while the first birth may be riskier because the woman's body is undergoing childbirth for the first time (Trussell and Pebley 1984).

1.1.4. Potential deaths averted by contraception

Beyond the literature that examines the risk associated with specific high-risk fertility behaviors, a variety of studies since the 1980s have described and assessed the overall effects of contraceptive use on the health and survival of women (Ahmed et al. 2012; Cleland et al. 2012; Fortney 1987; Ross and Blanc 2012; Stover and Ross 2010; Trussell and Pebley 1984; Winikoff and Sullivan 1987) and to a lesser extent, children (Hobcraft 1987; Trussell and Pebley 1984). These studies have employed different analytic approaches to quantifying the potential for increases in contraceptive use to avert maternal and child deaths.

The overall effects of contraceptive use on the health and survival of women and children are expected to work in two ways: first, through reducing the number of births, and second, through reducing the percentage of births that fall in high-risk behavior categories, thus leading to overall reductions in fertility risk. One recent study, which examined the effects of the first pathway only, used simulations to estimate the expected reduction in maternal deaths in 167 countries if all unmet need for contraception was fulfilled (Ahmed et al. 2012). The analysis used MMEIG (WHO) MMRatio estimates, which were held constant, to quantify the effect of changes in fertility levels. The study estimated that in 2008, contraceptive use averted 43-44 percent of maternal deaths. In a separate study, Cleland and colleagues (2012) extended Ahmed and colleagues' results to quantify the effect of changes in the MMRatio from reductions in the percentage of births in high-risk behavior categories. They found that in 2008, the reduction in obstetric risk associated with contraceptive use averted an additional 3.7 percent of maternal deaths, beyond the reduction from lowered fertility.

Other studies have quantified both pathways through which contraceptive use affects maternal and child health. In a study with a methodology similar to the current study, Stover and colleagues (2010) estimated the contributions of increasing contraceptive use to reducing maternal mortality between 1990 and 2005. In this analysis**,** the authors used age- and parity-specific estimates of MMRatio to estimate potential

changes in the overall MMRatio if increasing contraceptive use modified the distribution of births by age and parity. They estimated that over one million maternal deaths were averted during this period directly due to declines in the fertility rate from increased contraceptive use in developing countries, and that additional maternal deaths were averted indirectly, through the reduction in the share of high-risk births that resulted from increased contraceptive use (Stover and Ross 2010).

With a different approach, Ross and Blanc (2012) decomposed the reduction in maternal deaths between 1990 and 2008 to isolate the effects of increases in the female population, decreases in fertility, and declines in the MMRatio. They reported that while the population of women of reproductive age increased by 42 percent, the number of births remained constant because of lower fertility rates. They estimated that on average in developing countries, the contributions of fertility decline and decline in the MMRatio to the reduction in maternal deaths were roughly equal. However, in this study, the declines in MMRatio were not limited to those that resulted from changes in the fertility-risk profile of childbearing women. Instead, the MMRatio declines could also have resulted from general development, improvements in maternal care and health system strengthening, or other factors.

Finally, one of the few studies that has examined the impact of contraceptive use on both maternal and child death focused on the reduction in the percentage of births that fall in high-risk behavior categories, and then lead to overall reductions in fertility risk (for both the mother and child) (Trussell and Pebley 1984). Using published estimates of the association between women's fertility-risk and maternal, infant, and child mortality from other studies, Trussell and Pebley (1984) estimated that if childbearing were limited to women aged 20-34, the infant and child mortality rates would fall by roughly 5 percent. Limiting childbearing to women aged 20-39 would reduce the MMRatio by roughly 11 percent, and eliminating births at parity 4 or higher would reduce infant and child mortality by 8 percent, and the MMRatio by 4 percent. According to this study, changing the birth spacing patterns to make all non-first births at least 2 years after the preceding birth would reduce infant mortality by 10 percent and child mortality by 21 percent.

While most previous studies have extracted estimates of fertility risk from other sources, the current study uses recent DHS survey data to directly calculate estimates of mortality risk and fertility rates. Furthermore, while previous studies have most often presented global or regional estimates for the number of deaths averted by contraceptive use, this study provides country-specific and regional estimates which we hope will be useful for programmatic and planning purposes. The study examines the potential impact of eliminating fertility risk-based need on mortality among mothers and children, considering the effects of both the reduction in the number of births and the reduction in the percentage of births in high-risk behavior categories.

1.1.5. Risk-based unmet need for contraception

An earlier study that used high-risk fertility as the basis for calculating unmet need for contraception was carried out by Govindasamy et al. (1993). Govindasamy et al. used data from 28 DHS surveys between 1985 and 1990 to examine the potential mortality reductions which could be achieved through increased use of family planning and wider access to maternity care. First, the study examined differentials in the coverage and utilization of maternity care. Next, the study explored fertility-related factors that place women and their children at high risk. Data on women who fall into high-risk categories were then used to calculate a new measure of unmet need for family planning with the goal of avoiding high-risk births. The report concluded that the prevention of maternal mortality includes, in part, the prevention of high-risk pregnancies with a broadened definition of unmet need for family planning that considers the known mortality risks associated with maternal age, parity, and birth spacing. This study carries forward this broadened definition of unmet need.

1.1.6. Definition of high risk fertility behavior

This study defines high-risk fertility behaviors as births at too young an age, too old an age, becoming pregnant too soon after a previous birth, and having too many births. Giving birth at less than 18 years of age and at 40 or more years of age constitute the age risk. While women 35-39 years of age have been shown to have a higher risk of child mortality, we have conservatively included only women who would be 40 or more. Becoming pregnant again at less than 27 months after a preceding birth represents the pregnancy spacing risk. Although too long an interval between pregnancies (72 or more months) has also been shown to increase mortality and morbidity risks, the avoidance of this risk cannot be accomplished by use of contraception and does not affect unmet need for contraception. First births and births of order four or higher demonstrate increased risk for mortality and morbidity. However, first births are an unavoidable risk if there are to be any children and are not included in calculations of unmet need for contraception.

2. Methodology and Data

2.1. Data Sources

The data for calculating the fertility risk-based unmet need for contraception come from 45 DHS conducted between 2006 and 2012[1]. These nationally representative surveys were also included in the Rutstein and Winter (2014) report. The calculations in this report are based on non-pregnant women between the ages of 15 and 49 years. For each survey, Table 1 provides the number of women interviewed and their pregnancy status at the time of interview. The total number of women in the 45 surveys is 743,420, of whom 52,058 (7 percent) reported being pregnant at the time of interview, leaving 691,362 for the analysis. In the tables below, the number of respondents in each survey are weighted to adjust for variation in sampling rates and non-response, which is the standard procedure in DHS final reports.

In addition, the calculation of the number of averted child and maternal deaths used the United Nations World Population Prospects (United Nations, Department of Economics and Social Affairs, Population Division 2013).

2.2. Methods

2.2.1. Calculation of fertility-behavior-based risks among non-pregnant women

2.2.1.1. The three main fertility risk parameters are considered to be:

The mother's age at next birth if she were to become pregnant right after the survey, is calculated by adding nine months to the mother's current age.

The mother's birth parity is calculated by adding one to her number of children ever born at the time of the survey. Women who would be at risk due to parity include those who have had 3 or more births. Note that although having a first birth is riskier than second or third births, it is an unavoidable risk if there are to be any children.

The interval of time between a woman's last birth prior to the survey and her next pregnancy if she were to become pregnant right after the survey. Among women who have had a live birth, those in the high-risk zone have a time interval since last birth of less than 15 months and women in the moderate zone an interval of 15 to 26 months. While it has been found that women with long birth intervals are also at increased fertility risk, contraception cannot be used to avoid this risk. Women who did not have any live births at the time of the survey do not have an interval risk.

2.2.1.2. Combining risks:

An indicator of combined risk was created to summarize the total number of risks faced by each woman. The indicator uses a maternal age of 40 years or higher, a preceding birth-to-pregnancy interval of less than 27 months, and a parity of 4 or more as the criteria for higher risk (Table 3). Having a long birth interval (72 months or more) is not included in this indicator.

[1] The data sets for several country DHS surveys with fieldwork in 2012 were not available at the time the Rutstein and Winter (2014) report was written. Instead, earlier DHS surveys for those countries were used if they took place within the period.

2.2.2. Total and unmet need for contraception

In this study, the need for contraception is categorized into two types: need for contraception that arises from satisfying a woman's desires to postpone or avoid a birth, and the need for contraception to reduce the mortality and morbidity risks of fertility behavior. The former, commonly called need and unmet need for contraception, is calculated for DHS main reports. Here, it is termed desire-based need for contraception. The need for contraception to reduce mortality risks is termed fertility-risk-based need. The study also examines a third measure of unmet need which combines the desire- and fertility-risk-based need. The calculation of these three measures is described below.

Desire-based need for contraception: Desire-based need for contraception is the proportion of two numbers. The denominator is the number of women who are currently married or are in a consensual union. The numerator is the number of women who are fecund and who do not want another child (need for limiting) or want to delay the birth of another child for two or more years (need for spacing). Women who are infecund or who want a child within two years are excluded from the numerator. The term need for contraception includes all women with a met or unmet need. Met need for contraception includes women who have a need and are currently using contraception. Unmet need includes women with a need who are not currently using contraception. Met need and unmet need have the same denominator and therefore add to total need. Details of the calculation, the definition of fecund, and the treatment of currently married and postpartum amenorrheic women are described in Bradley et al. (2012).

Fertility-risk-based need for contraception: The calculation of fertility-risk-based need for contraception in this study is analogous to desire-based need. The denominator is the same as that for desire-based need (i.e., all women aged 15-49 years who are currently married or in a consensual union). For the numerator, women can be classified into those whose risk categories would indicate a need for not having any more births, those who should delay the next conception, and those who need not delay the next conception. The first (limiting) category includes women whose next birth would be her fourth or higher parity or who would be age 40 or more at the next birth. The second (spacing) category includes women whose next birth would be at age less than 18 or whose birth-to-pregnancy interval would be shorter than 27 months. Infecund women and women who would not have a fertility-risk based need to limit or space their next birth are omitted. As in the definition of desire-based need, unmet fertility-risk based need includes women who are not currently using contraception. Pregnant women are not considered to have a current need for contraception, and amenorrheic women are treated the same as non-amenorrheic women.

Combined need for contraception using both definitions: Need for contraception from either desires or fertility risk is combined into a single indicator for non-pregnant women who are married or in union; this is called combined need. A woman is categorized as having no need if both definitions indicate that there is no need for contraception. If there is a need for spacing from both desires and risk, there is combined need for spacing. If either desires or risk indicate a need for limiting, women are placed in the combined limiting need category. Women with a need for contraception but who are not using have an unmet need for either spacing or limiting, according to their category of need.

Non-pregnant, currently-married women in the combined need category who need a more effective method of contraception are in two groups: those who are using contraception for spacing based on their desires but have a limiting need based on risk, and those who are using contraception for limiting but are not using a long-acting or permanent method (LAPM)[2]. Women with an unmet need and women with a need for a more effective long-term method constitute the group who require focused family planning efforts.

[2] LAPM methods include female and male sterilization, intrauterine devices (IUD), and contraceptive implants (e.g. Norplant, Inplanon, Nexplanon,).

Figure 1 presents diagrammatically the combinations of desire-based and risk-based need which result in the combined need for contraception indicator. Green shading indicates that there was no need for contraception at the time of the survey. Also without a need were women who either declared themselves infecund or who are inferred to be infecund because they had no pregnancy during five or more years of marriage without using contraception (not shown in diagram). Women in the cells shaded in red had an unmet need for contraception and women in cells shaded in yellow had a need for a LAPM although they were using a method. The area with the red border indicates women in need of focused efforts of family planning programs.

Figure 1. Combined need for contraception indicator

	Not using contraception					Using non-LAPM contraception					Using LAPM contraception-				
	Age 18 to 39,3	Risk-based need				Age 18 to 39,3	Risk-based need				Age 18 to 39,3	Risk-based need			
Desire-based need	months; has had 3 or fewer births, no birth or last birth occurred 28 or more months ago	Less than 18 years of age	Last birth occurred less than 27 months ago	Age 39, 3 months or more	Has had 3 or more births	months; has had 3 or fewer births, no birth or last birth occurred 28 or more months ago	Less than 18 years of age	Last birth occurred less than 27 months ago	Age 39, 3 months or more	Has had 3 or more births	months; has had 3 or fewer births, no birth or last birth occurred 28 or more months ago	Less than 18 years of age	Last birth occurred less than 27 months ago	Age 39, 3 months or more	Has had 3 or more births
Wants within 24 months	No need	Unmet spacing need	Unmet spacing need	Unmet limiting need	Unmet limiting need	No need	Met spacing need	Met spacing need	Unmet need for LAPM	Unmet need for LAPM	No need	Met spacing need	Met spacing need	Met limiting need	Met limiting need
Wants after 24 months or unsure if wants	Unmet spacing need	Unmet spacing need	Unmet spacing need	Unmet limiting need	Unmet limiting need	Met spacing need	Met spacing need	Met spacing need	Unmet need for LAPM	Unmet need for LAPM	Met spacing need	Met spacing need	Met spacing need	Met limiting need	Met limiting need
Does not want any more	Unmet limiting need	Unmet limiting need	Unmet limiting need	Unmet limiting need	Unmet limiting need	Unmet need for LAPM	Unmet need for LAPM	Unmet need for LAPM	Unmet need for LAPM	Unmet need for LAPM	Met limiting need	Met limiting need	Met limiting need	Met limiting need	Met limiting need

Indicates need for focused family planning efforts

Indicates using a non-LAPM method but needs LAPM method

Indicates no need or met need for contraception

Indicates unmet need for contraception

2.2.3. Child deaths averted

To calculate the number of child deaths that could be averted in 2015 if women were to satisfy their unmet risk-based need for contraception or their need for a LAPM, we consider two elements: the reduction in the number of births that would occur and the reduction in the risk of dying after children are born.

Calculation of the reduction in number of births:

The reduction in the number of births that would occur is estimated by first calculating two total fertility rates (TFR): the standard TFR which includes births to all women, and an alternate, hypothetical TFR that assumes that all births to women with risk-based unmet need have been eliminated if they could not be shifted into the non-risk category. In the denominator of the alternate TFR, assuming no risk-based unmet need, all women contribute women-years of exposure by five-year age groups in the three years preceding the survey.[3] In the numerator, starting with the number of births that occurred in the three years preceding the survey, births with these characteristics were excluded:

- Births of order 4 or higher.
- Births to women age 40 years or more if by shifting those births to age less than 40 the resulting birth-to-pregnancy interval would be less than 27 months.

[3] If the survey included individual interviews with ever-married women, then exposure is calculated using "all-women factors". See *Guide to DHS Statistics* (Rutstein and Rojas 2006).

- Births with a birth-to-pregnancy interval of less than 27 months if by shifting the births to an interval of 27 months, mother's age at birth would be 40 or more.

It is assumed that births to women under age 18 years can be shifted into age 18 or higher, and are therefore not excluded. The age-specific fertility rates and the TFR are then calculated.

The projected number of births in each country is taken from United Nations, Department of Economic and Social Affairs, Population Division (2013). The projected number of births for 2015 is the geometric mean of the 2010-14 and 2015-19 periods divided by 5[4].

The reduced number of births is the product of the projected number of births and the ratio of the no risk-based unmet need TFR to the all births TFR.[5]

Calculation of the reduction in risk:

The reduced risk of infant and under-five mortality is obtained from a lifetable calculation for three categories: any avoidable fertility risk, no avoidable risk, and first births (unavoidable risk) for children born in the five years preceding the survey, adjusted for confounding factors[6]. The risks are calculated separately for each of the 45 countries and each geographic region. An unweighted combined average rate is also calculated. The reduced risk mortality rate (RRMR) is then calculated by

$$RRMR=[NARMR*(B-FB)+FBMR*FB]/B$$

In this calculation, RRMR is the reduced risk mortality rate, NARMR is the mortality rate for no avoidable risk, B is the total number of births, FB is the number of first births, and FBMR is the mortality rate for first births.

Calculation of child deaths averted:

The number of infant and under-five deaths averted is calculated with the following formulas:

Current number of infant or under-five deaths:

$$Dc=B*MRc$$

Where Dc is the number of projected deaths in 2015, B is the projected number of births in 2015, using the UN projections as given above, and MRc is the current mortality rate[7].

Deaths averted due to reduced risk:

$$DArr=Dc-B*RRMR$$

[4] The geometric mean more closely interpolates population growth, which is continuous, than does an arithmetic mean which assumes a linear growth.

[5] The TFRs are for the three years preceding each survey. No adjustment has been made for changes that could have occurred between the date of the survey and 2015.

[6] Using the Cox Regression command in IBM SPSS Statistics, version 22, the regression models controlled for urban/rural residence, wealth index quintile, type of water supply, type of toilet, whether the household has a refrigerator, sex of the child, maternal education, and death of the preceding child. Imputed intervals and multiple births are excluded.

[7] Infant and under-five mortality rates. The term rate is commonly used but they are probabilities of surviving from birth to age 12 months and to age 60 months, respectively.

Where DArr is the number deaths averted due to avoiding fertility-related risks.

Deaths averted due to reduced fertility:

DArf=Dc-B*(TFRrr/TFRc)*MRc

Where DArf is the number of deaths averted through the reduced fertility rate, TFRrr is the reduced risk total fertility rate and TFRc is the current fertility rate.

Deaths averted due to both reduced risk and reduced fertility:

DAt=Dc-B*(TFRrr/TFRc)*RRMR

Where DAt is the number of deaths averted due to the joint effects of avoiding high-risk fertility behavior.

2.2.4. Maternal deaths averted

To calculate the number of maternal deaths that could be averted in 2015 if women were to satisfy their risk-based unmet need for contraception or their need for a LAPM, we consider the same two elements described above: the reduction in the number of births that would occur and the reduction in the risk of pregnancy-related death to the mother.

Calculation of the reduction in number of births:

The calculation of the reduction in number of births is the same as described above for child deaths averted.

Calculation of the reduction in risk:

For the calculation of reduced maternal mortality rates and ratios, only mother's age at birth and parity are considered since the DHS data do not provide information on the relationship between birth or pregnancy spacing and the risks of maternal death.[8]

The calculation of maternal mortality rates, maternal mortality ratios, and the lifetime risk of maternal death follows the standard protocol used to calculate DHS mortality rates for the seven years preceding the survey (Rutstein and Rojas 2006). First, reduced age-specific maternal mortality rates are calculated with maternal deaths excluded from the numerator if the mother was less than 18 years of age, 40 years or older, or the birth was of order 4 or higher[9]. The age-specific rates are combined for the total reduced risk maternal mortality rate weighting by the age-distribution of respondent women. A reduced risk MMratio is calculated with the following formula:

RRMMRatio=RRMMRate/RRGFR

Where RRMMRatio is the reduced risk maternal mortality ratio, RRMMRate is the reduced risk maternal mortality rate and the RRGFR is the reduced risk general fertility rate for the seven years preceding the survey. The RRGFR is calculated as the standard GFR, eliminating births to women

[8] The estimation of maternal mortality is based on the sibling history of the DHS, in which respondents are asked about their sisters' survival after a birth. In this history, no information is obtained on the interval between births.

[9] These reduced rates are directly calculated avoiding high-risk births. They are not adjusted for confounders since there is no information in the DHS to do so (there is no information on the values of residence, wealth, education, etc. for the sisters of the respondents in the sibling history of the DHS).

under age 18 at the time of birth, 40 or over, or birth order 4 or higher. The reduced risk lifetime risk of maternal death is calculated by:

$$RRLTRMM = 1 - (1\text{-}RRMMRatio)^{RRTFR}$$

Where RRTFR is the reduced risk total fertility rate for the seven year period prior to the survey, eliminating births to women under age 18 at the time of birth, 40 or over, or birth order 4 or higher.

Calculation of maternal deaths averted:

The number of maternal deaths averted is estimated similarly to infant and under-five deaths:

Current number of maternal deaths

$$MDc = B * MMRatioc$$

Where MDc is the number of projected maternal deaths in 2015, B is the projected number of births in 2015, using the UN projections as given above, and MMRatioc is the current maternal mortality ratio.

Maternal deaths averted due to reduced risk for maternal death:

$$MDArr = MDc - B * RRMMRatio$$

Where MDArr is the number maternal deaths averted due to avoiding fertility-related risks.

Maternal deaths averted due to reduced fertility:

$$MDArf = MDc - B * (RRTFR/TFRc) * MMRatioc$$

Where MDArf is the number of deaths averted through the reduced fertility rate, RRTFR is the reduced risk total fertility rate and TFRc is the current fertility rate. Note that the TFRs are calculated for the 7-year period that precedes the survey.

Maternal deaths averted due to both reduced maternal mortality risk and reduced fertility:

$$MDAt = MDc - B * (TFRrr/TFRc) * RRMMRatio$$

Where MDAt is the number of maternal deaths averted due to both effects of avoiding high-risk fertility behavior.

3. Results

3.1. Percentage of Women Pregnant

Among the 743,420 women surveyed in the 45 DHS surveys between 2006 and 2012, 8 percent were pregnant at the time of the survey. These women were removed from the analysis data set, leaving 691,362 women who said they were not pregnant or were unsure whether they were pregnant (Table 1). The percentage pregnant varies by world region and by country. The regions with the highest percentages pregnant were the Middle East/North Africa (11 percent) and West and Central Africa (10 percent). The region with the lowest percentage is Eastern Europe/NIS (3 percent). Niger had the highest percentage of women pregnant at the time of the survey (15 percent), while Albania had the lowest (2 percent).

Table 1. Distribution of women by pregnancy status at time of survey, 45 DHS country surveys 2006-2012

			Percentage pregnant			Number pregnant		
Country	Survey date	Total number of respondents	No or unsure	Yes	Total	No or unsure	Yes	Total
West and Central Africa								
Benin	2006	17,794	89.1	10.9	100	15,850	1,945	17,794
Burkina Faso	2010	17,087	89.9	10.1	100	15,357	1,730	17,087
Cameroon	2011	15,426	90.2	9.8	100	13,914	1,512	15,426
DR Congo	2007	9,995	88.8	11.2	100	8,872	1,124	9,995
Ghana	2008	4,916	92.7	7.3	100	4,556	360	4,916
Liberia	2007	7,092	89.3	10.7	100	6,331	761	7,092
Mali	2006	14,583	87.2	12.8	100	12,721	1,862	14,583
Niger	2006	9,223	85.3	14.7	100	7,871	1,352	9,223
Nigeria	2008	33,385	89.5	10.5	100	29,891	3,494	33,385
Sao Tome & Principe	2008-09	2,615	91.5	8.5	100	2,394	221	2,615
Senegal	2010-11	15,688	92.3	7.7	100	14,480	1,208	15,688
Sierra Leone	2008	7,374	91.9	8.1	100	6,776	598	7,374
East and Southern Africa								
Burundi	2010	9,389	89.6	10.4	100	8,408	981	9,389
Ethiopia	2011	16,515	92.7	7.3	100	15,310	1,205	16,515
Kenya	2008-09	8,444	93.0	7.0	100	7,851	593	8,444
Lesotho	2009	7,624	95.8	4.2	100	7,303	321	7,624
Madagascar	2008-09	17,375	91.7	8.3	100	15,938	1,437	17,375
Malawi	2010	23,020	91.0	9.0	100	20,948	2,072	23,020
Mozambique	2011	13,745	89.0	11.0	100	12,229	1,516	13,745
Namibia	2006-07	9,804	94.6	5.4	100	9,277	528	9,804
Rwanda	2010	13,671	93.0	7.0	100	12,715	956	13,671
Swaziland	2006-07	4,987	94.4	5.6	100	4,708	279	4,987
Tanzania	2010	10,139	90.4	9.6	100	9,170	969	10,139
Uganda	2011	8,674	88.3	11.7	100	7,663	1,011	8,674
Zambia	2007	7,146	89.3	10.7	100	6,384	762	7,146
Zimbabwe	2010-11	9,171	91.7	8.3	100	8,413	758	9,171
Middle East/North Africa								
Egypt	2008	16,527	90.6	9.4	100	14,972	1,555	16,527
Jordan	2007	10,876	87.9	12.1	100	9,561	1,315	10,876
Eastern Europe/NIS								
Albania	2008-09	7,584	98.0	2.0	100	7,434	150	7,584
Armenia	2010	5,922	97.0	3.0	100	5,744	178	5,922
Azerbaijan	2006	8,444	96.5	3.5	100	8,147	297	8,444
Ukraine	2007	6,841	97.2	2.8	100	6,650	191	6,841

(Continued)

Table 1. – *Continued*

Country	Survey date	Total number of respondents	Percentage pregnant			Number pregnant		
			No or unsure	Yes	Total	No or unsure	Yes	Total
Asia								
Bangladesh	2011	17,749	94.0	6.0	100	16,681	1,069	17,749
Cambodia	2010	18,754	95.0	5.0	100	17,821	933	18,754
India	2005-06	124,385	94.8	5.2	100	117,956	6,429	124,385
Indonesia	2007	32,895	94.9	5.1	100	31,232	1,664	32,895
Nepal	2011	12,674	95.1	4.9	100	12,053	621	12,674
Pakistan	2012-13	13,558	89.2	10.8	100	12,097	1,461	13,558
Philippines	2008	13,594	94.8	5.2	100	12,889	705	13,594
Timor-Leste	2009	13,137	93.2	6.8	100	12,238	899	13,137
Latin America and Caribbean								
Bolivia	2008	16,939	94.5	5.5	100	16,001	938	16,939
Colombia	2010	53,521	96.7	3.3	100	51,729	1,792	53,521
Dominican Rep.	2007	27,195	95.6	4.4	100	25,996	1,199	27,195
Guyana	2009	4,996	95.7	4.3	100	4,782	214	4,996
Peru	2012	22,947	96.1	3.9	100	22,055	893	22,947
			Unweighted Average					
West and Central Africa		155,178	89.8	10.2	100	139,012	16,166	155,178
East and Southern Africa		159,704	91.8	8.3	100	146,315	13,389	159,704
Middle East/North Africa		27,403	89.3	10.8	100	24,533	2,870	27,403
Eastern Europe/NIS		28,791	97.2	2.8	100	27,974	817	28,791
Asia		246,746	93.9	6.1	100	232,966	13,780	246,746
Latin America and Caribbean		125,598	95.7	4.3	100	120,562	5,036	125,598
Total		**743,420**	**92.4**	**7.6**	**100**	**691,362**	**52,058**	**743,420**

3.2. Fertility-related Risks of Non-pregnant Women

Table 2 shows the distribution of non-pregnant women by age at next birth, by birth order of next birth, and by birth interval from last birth to next pregnancy if they were to become pregnant within the month after the survey. A total of 29 percent of women have a short birth-to-pregnancy interval risk (less than 27 months), 43 percent have a high parity risk (4 or more births), and 32 percent have a risk because of their age (9 percent less than 18 years and 23 percent 40 years old or older). The African and Middle East/North African regions have the highest spacing interval risks (33 to 36 percent). The Middle East/North Africa region has the greatest parity risk (63 percent). Age at birth related risk does not vary substantially by region but is concentrated in the under eighteens in sub-Saharan Africa, and Latin America and the Caribbean.

Table 2. Percent distribution of non-pregnant women by birth interval from last birth to next pregnancy, by birth order of next birth, and by age at next birth if became pregnant right away, 45 DHS country surveys 2006-2012

			Birth interval to next pregnancy					Next birth order			Age at next birth			
Country	Survey date	Number of respon-dents	Less than 15 months	15 to 26 months	27 to 62 months	63 or more months	First birth	First	Second or third	Fourth or higher	Less than 18 years	18 to 34 years	35 to 39 years	40 or more years
West and Central Africa														
Benin	2006	15,850	26.3	15.5	16.2	18.5	23.5	23.5	23.5	52.9	8.8	59.2	12.7	19.4
Burkina Faso	2010	15,357	25.1	16.6	18.8	16.5	22.9	22.9	23.0	54.1	9.6	58.1	12.2	20.1
Cameroon	2011	13,914	21.5	12.6	14.0	21.4	30.4	30.4	26.4	43.2	11.2	59.7	11.1	18.0
DR Congo	2007	8,872	25.6	13.5	13.9	17.8	29.2	29.2	23.9	47.0	9.9	59.4	11.2	19.5
Ghana	2008	4,556	16.8	10.3	15.2	23.4	34.3	34.3	25.8	39.9	9.7	56.5	13.4	20.4
Liberia	2007	6,331	21.4	12.7	21.1	25.3	19.5	19.5	30.1	50.4	9.4	55.1	13.3	22.2
Mali	2006	12,721	29.1	15.7	15.8	17.8	21.7	21.7	23.1	55.2	11.4	56.8	11.7	20.1
Niger	2006	7,871	33.6	17.4	16.0	14.1	19.0	19.0	20.7	60.4	10.1	57.9	12.9	19.1
Nigeria	2008	29,891	25.0	12.6	13.7	17.8	30.9	30.9	20.4	48.7	9.8	58.1	12.1	19.9
Sao Tome & Principe	2008-09	2,394	19.6	12.5	21.1	21.2	25.7	25.7	26.5	47.9	9.4	59.0	10.0	21.7
Senegal	2010-11	14,480	20.7	12.2	15.0	16.1	36.0	36.0	24.2	39.8	9.6	61.5	12.1	16.8
Sierra Leone	2008	6,776	25.7	13.4	17.4	24.4	19.0	19.0	30.5	50.5	7.3	59.1	15.7	18.0
East and Southern Africa														
Burundi	2010	8,408	22.6	15.2	13.8	11.2	37.2	37.2	19.5	43.3	13.0	58.3	10.8	17.9
Ethiopia	2011	15,310	19.6	10.3	17.0	18.0	35.1	35.1	20.9	44.0	13.0	58.4	12.3	16.3
Kenya	2008-09	7,851	18.1	11.3	17.3	25.5	27.9	27.9	27.8	44.4	10.7	59.1	10.8	19.3
Lesotho	2009	7,303	14.2	9.6	16.6	27.4	32.2	32.2	38.4	29.4	10.7	59.7	10.6	19.1
Madagascar	2008-09	15,938	19.5	11.4	18.9	25.4	24.7	24.7	28.3	47.0	10.8	54.8	12.7	21.7
Malawi	2010	20,948	22.5	16.2	20.8	18.4	22.1	22.1	26.0	52.0	12.1	59.7	11.5	16.7
Mozambique	2011	12,229	25.6	15.0	16.3	21.5	21.5	21.5	29.7	48.8	11.5	56.4	12.3	19.7
Namibia	2006-07	9,277	14.6	8.8	16.7	25.6	34.3	34.3	34.9	30.8	10.8	58.9	11.6	18.7
Rwanda	2010	12,715	15.4	11.1	19.9	15.4	38.1	38.1	22.0	39.9	11.4	58.6	11.2	18.8
Swaziland	2006-07	4,708	16.2	9.7	17.3	26.9	30.0	30.0	33.8	36.2	11.8	59.0	10.6	18.6
Tanzania	2010	9,170	22.7	13.3	18.0	20.5	25.5	25.5	26.8	47.7	11.2	56.3	13.0	19.5
Uganda	2011	7,663	25.7	13.4	16.6	17.7	26.5	26.5	20.6	52.9	12.4	57.5	12.0	18.0
Zambia	2007	6,384	26.0	15.7	15.2	18.2	24.9	24.9	26.2	48.9	11.6	60.1	11.2	17.0
Zimbabwe	2010-11	8,413	20.4	10.5	17.8	24.8	26.5	26.5	37.5	36.0	10.4	60.3	12.4	16.9
Middle East/North Africa														
Egypt	2008	14,972	18.8	11.7	18.2	43.9	7.3	7.3	36.3	56.5	0.4	49.3	16.6	33.7
Jordan	2007	9,561	24.0	13.2	22.6	32.6	7.7	7.7	23.2	69.1	0.2	45.1	19.8	34.9
Eastern Europe/NIS														
Albania	2008-09	7,434	4.6	3.2	9.9	46.3	36.1	36.1	35.0	29.0	10.0	42.4	13.9	33.7
Armenia	2010	5,744	6.3	5.0	8.2	43.3	37.2	37.2	43.6	19.3	5.6	53.5	11.5	29.4
Azerbaijan	2006	8,147	6.9	4.5	8.4	43.1	37.1	37.1	35.0	27.9	8.0	47.9	13.7	30.5
Ukraine	2007	6,650	3.8	3.2	9.2	53.7	30.0	30.0	63.8	6.2	5.4	46.5	15.2	32.9
Asia														
Bangladesh	2011	16,680	12.9	8.1	22.1	48.8	8.1	8.1	45.6	46.3	2.7	58.2	13.5	25.7
Cambodia	2010	17,821	11.1	7.8	15.8	29.4	35.8	35.8	29.0	35.2	9.9	53.5	10.4	26.2
India	2005-06	117,956	11.0	7.0	13.3	40.4	28.4	28.4	31.0	40.7	9.2	56.2	13.7	20.9
Indonesia	2007	31,231	13.6	9.0	22.1	49.2	6.1	6.1	53.3	40.6	0.4	46.1	19.0	34.5
Nepal	2011	12,053	10.6	6.8	15.5	38.0	29.1	29.1	32.8	38.1	9.9	56.9	12.5	20.6
Pakistan	2012-13	12,097	23.4	11.7	19.6	34.3	11.1	11.1	25.4	63.5	0.5	52.5	17.8	29.2
Philippines	2008	12,889	11.6	7.8	14.2	28.7	37.6	37.6	27.8	34.6	10.0	52.5	12.9	24.6
Timor-Leste	2009	12,238	19.4	10.4	14.4	15.3	40.6	40.6	14.8	44.5	12.1	52.7	12.9	22.3
Latin America and Caribbean														
Bolivia	2008	16,001	13.2	8.9	16.2	30.5	31.2	31.2	30.2	38.7	9.8	54.5	12.7	23.0
Colombia	2010	51,729	7.2	5.5	12.7	39.2	35.5	35.5	39.5	25.0	15.0	47.0	11.9	26.1
Dominican Rep.	2007	25,996	8.8	6.7	15.1	40.3	29.1	29.1	31.6	39.2	9.8	52.3	14.0	24.0
Guyana	2009	4,782	10.1	6.0	12.4	40.0	31.6	31.6	33.4	35.0	9.5	49.2	14.1	27.2
Peru	2012	22,055	8.8	7.3	15.6	35.2	33.0	33.0	36.2	30.8	9.4	50.4	14.2	26.1
Unweighted Averages														
West and Central Africa		139,013	24.2	13.8	16.5	19.5	26.0	26.0	24.8	49.2	9.7	58.4	12.4	19.6
East and Southern Africa		146,317	20.2	12.3	17.3	21.2	29.0	29.0	28.0	43.0	11.5	58.4	11.6	18.4
Middle East/North Africa		24,533	21.4	12.5	20.4	38.3	7.5	7.5	29.8	62.8	0.3	47.2	18.2	34.3
Eastern Europe/NIS		27,975	5.4	4.0	8.9	46.6	35.1	35.1	44.4	20.6	7.3	47.6	13.6	31.6
Asia		232,965	14.2	8.6	17.1	35.5	24.6	24.6	32.5	42.9	6.8	53.6	14.1	25.5
Latin America and Caribbean		120,563	9.6	6.9	14.4	37.0	32.1	32.1	34.2	33.7	10.7	50.7	13.4	25.3
Total		**691,366**	**17.8**	**10.7**	**16.1**	**28.1**	**27.4**	**27.4**	**30.2**	**42.5**	**9.2**	**55.2**	**12.9**	**22.6**

Women can be subject to more than one fertility-related risk. Table 3 presents the distribution of non-pregnant women by specific combinations of risk factors and a summary of the number of risk factors to which they are exposed. Overall, 13 percent of non-pregnant women have no fertility-related risk and another 18 percent face the unavoidable risk of having their first pregnancy (with no other fertility-related risk). The other 69 percent of women face at least one fertility-related risk; 28 percent have one risk, 39 percent have double risks, and 2 percent face all three possible risks. See findings in Rutstein and Winter (2014) for a description of how the accumulation of risks raises infant and child mortality. In six countries, more than half of non-pregnant women face double or triple avoidable fertility risks: Benin, Burkina Faso, Mali, Niger, Uganda, and Zambia. In several other countries, more than 49 percent of non-pregnant women face double or triple fertility risks: the Democratic Republic of the Congo, Nigeria, Burundi, Mozambique, and Timor-Leste.

Table 3. Distribution of non-pregnant women by multiple fertility risk categories, 45 DHS country surveys 2006-2012

			Extra risk due to fertility pattern																Single, double and 3-way risk combinations				
Country	Survey date	Number of respondents	No extra risk	Unavoid-able first birth risk	Single spacing risk <15 months	Single spacing risk 15-26 months	Single age risk <18 years	Single age risk 40+ years	Single risk order 4+	Double risk spacing <15, order 4+	Double risk spacing 15-26, order 4+	Double risk first birth age <18	Double risk first birth age 40+	Double risk order 4+, age 40+	Double risk spacing <15, age <18	Other double risk[1]	3 way risk spacing 15-26, age <18, order 4+	3 way risk spacing 15-26, age 40+, order 4+	No extra risk	Unavoidable first birth risk	Any single risk	Any double risk	Any 3 way risk
West and Central Africa																							
Benin	2006	15,850	7.1	14.8	9.3	5.6	0.0	1.2	11.4	15.2	8.5	8.4	0.3	15.0	0.3	0.1	1.5	1.3	7.1	14.8	27.5	47.8	2.8
Burkina Faso	2010	15,357	7.3	13.4	8.7	5.8	0.0	1.0	11.7	14.3	9.1	9.3	0.2	15.4	0.2	0.1	1.9	1.6	7.3	13.4	27.1	48.6	3.6
Cameroon	2011	13,914	10.1	19.4	8.3	4.9	0.1	2.2	10.0	11.5	6.5	10.4	0.6	13.1	0.6	0.2	1.1	1.0	10.1	19.4	25.5	42.9	2.1
DR Congo	2007	8,872	7.7	19.1	9.6	4.5	0.0	1.5	8.7	13.9	7.1	9.4	0.7	13.8	0.5	0.1	1.6	1.8	7.7	19.1	24.2	45.5	3.5
Ghana	2008	4,556	11.1	24.3	7.1	4.8	0.0	2.6	9.8	8.3	4.5	9.6	0.4	15.1	0.1	0.0	1.3	0.9	11.1	24.3	24.4	38.1	2.1
Liberia	2007	6,331	13.8	10.7	8.7	5.0	0.1	1.7	13.6	10.4	6.1	8.5	0.2	17.2	0.7	0.1	1.6	1.5	13.8	10.7	29.1	43.3	3.1
Mali	2006	12,721	7.1	11.1	8.5	4.9	0.0	1.3	10.3	17.7	8.9	10.1	0.5	14.8	1.0	0.2	1.9	1.5	7.1	11.1	25.0	53.3	3.5
Niger	2006	7,871	5.0	9.8	9.0	4.6	0.1	0.7	11.2	20.8	10.5	8.7	0.5	13.1	1.1	0.2	2.7	2.0	5.0	9.8	25.6	54.9	4.7
Nigeria	2008	29,891	5.8	21.1	8.6	3.9	0.0	1.3	9.9	13.8	7.1	9.2	0.7	14.4	0.4	0.2	2.1	1.4	5.8	21.1	23.8	45.9	3.4
Sao Tome & Principe	2008-09	2,394	12.8	16.7	7.2	4.4	0.0	1.4	11.7	9.7	6.5	8.8	0.2	16.4	0.5	0.2	2.0	1.5	12.8	16.7	24.7	42.3	3.5
Senegal	2010-11	14,480	8.9	25.9	8.3	4.6	0.0	1.8	9.0	11.0	6.0	9.1	1.0	11.5	0.3	0.3	1.1	1.3	8.9	25.9	23.7	39.2	2.3
Sierra Leone	2008	6,776	13.2	12.3	9.3	4.8	0.1	2.1	14.0	13.9	7.3	6.2	0.4	12.5	0.7	0.3	1.8	1.1	13.2	12.3	30.3	41.4	2.8
East and Southern Africa																							
Burundi	2010	8,408	4.3	23.8	8.7	5.5	0.0	0.8	7.0	12.0	7.8	12.8	0.6	12.9	0.1	0.0	1.8	1.8	4.3	23.8	22.0	46.3	3.6
Ethiopia	2011	15,310	9.2	21.9	6.6	3.5	0.0	1.2	12.2	11.4	5.8	12.8	0.4	12.3	0.2	0.0	1.3	0.9	9.2	21.9	23.6	43.0	2.3
Kenya	2008-09	7,851	12.9	17.3	7.1	5.1	0.0	2.1	12.7	9.5	5.3	10.2	0.3	15.1	0.4	0.1	1.0	0.7	12.9	17.3	27.0	41.0	1.8
Lesotho	2009	7,303	19.0	21.2	8.9	5.8	0.0	4.2	8.0	4.3	3.0	10.2	0.8	12.8	0.4	0.1	0.6	0.7	19.0	21.2	27.0	31.6	1.2
Madagascar	2008-09	15,938	12.2	14.0	7.4	4.4	0.1	3.1	14.0	9.9	5.5	9.7	1.0	15.0	0.8	0.3	1.3	1.3	12.2	14.0	29.0	42.0	2.8
Malawi	2010	20,948	9.7	10.3	8.7	5.9	0.0	1.1	15.8	11.9	8.9	11.5	0.3	12.6	0.5	0.1	1.4	1.3	9.7	10.3	31.4	45.8	2.8
Mozambique	2011	12,229	10.6	10.4	9.2	6.1	0.1	2.6	11.5	13.7	7.2	10.2	0.8	13.0	1.0	0.2	1.7	1.5	10.6	10.4	29.5	46.3	3.2
Namibia	2006-07	9,277	17.7	23.1	8.1	4.9	0.0	3.7	8.4	5.4	3.0	10.4	0.8	12.5	0.3	0.3	0.8	0.8	17.7	23.1	25.0	32.6	1.6
Rwanda	2010	12,715	8.3	26.1	7.3	4.9	0.0	1.4	11.5	6.9	4.8	11.3	0.6	14.1	0.0	0.0	1.2	1.4	8.3	26.1	25.1	38.0	2.5
Swaziland	2006-07	4,708	16.6	18.0	8.8	5.2	0.0	2.5	10.8	6.2	4.0	11.2	0.8	14.2	0.6	0.0	0.6	0.4	16.6	18.0	27.4	36.9	1.1
Tanzania	2010	9,170	11.0	14.4	8.5	4.8	0.0	1.9	11.3	12.2	7.1	10.6	0.5	14.4	0.5	0.1	1.5	1.3	11.0	14.4	26.5	45.4	2.7
Uganda	2011	7,663	6.5	14.1	8.5	4.2	0.0	1.0	12.9	15.4	7.9	12.0	0.4	13.9	0.4	0.0	1.4	1.3	6.5	14.1	26.5	50.1	2.8
Zambia	2007	6,384	9.6	13.6	8.7	5.4	0.0	1.6	10.3	15.2	8.6	10.8	0.5	11.9	0.7	0.1	1.5	1.5	9.6	13.6	26.0	47.8	3.0
Zimbabwe	2010-11	8,413	16.9	16.2	11.3	6.1	0.0	2.7	10.6	8.0	3.6	9.8	0.5	12.5	0.4	0.1	0.6	0.7	16.9	16.2	30.8	34.9	1.2
Middle East/North Africa																							
Egypt	2008	14,972	13.5	5.6	11.1	6.4	0.0	5.0	17.5	7.1	4.7	0.3	1.3	26.1	0.1	0.0	0.5	0.6	13.5	5.6	40.0	39.7	1.2
Jordan	2007	9,561	7.1	6.0	9.7	4.0	0.0	2.3	17.9	12.4	7.9	0.1	1.5	27.9	0.1	0.1	1.7	1.3	7.1	6.0	33.8	50.2	2.9
Eastern Europe/NIS																							
Albania	2008-09	7,434	15.7	24.8	3.2	2.1	0.0	14.0	8.3	1.3	0.9	10.0	1.2	18.3	0.0	0.0	0.0	0.1	15.7	24.8	27.6	31.8	0.1
Armenia	2010	5,744	19.0	29.3	5.2	4.3	0.0	15.0	5.6	1.0	0.6	5.6	2.2	11.9	0.0	0.1	0.0	0.1	19.0	29.3	30.1	21.5	0.1
Azerbaijan	2006	8,147	15.7	26.2	5.1	3.1	0.0	11.0	8.6	1.7	1.2	7.9	3.0	16.2	0.0	0.1	0.1	0.1	15.7	26.2	27.8	30.1	0.2
Ukraine	2007	6,650	30.2	23.0	3.4	2.8	0.0	27.3	1.6	0.3	0.3	5.4	1.6	3.8	0.0	0.0	0.1	0.0	30.2	23.0	35.1	11.5	0.2

(Continued)

Table 3. – *Continued*

			Extra risk due to fertility pattern																Single, double and 3-way risk combinations				
Country	Survey date	Number of respondents	No extra risk	Unavoid-able first birth risk	Single spacing risk <15 months	Single spacing risk 15-26 months	Single age risk <18 years	Single age risk 40+ years	Single risk order 4+	Double risk spacing <15, order 4+	Double risk spacing15 -26, order 4+	Double risk first birth age <18	Double risk first birth age 40+	Double risk order 4+, age 40+	Double risk spacing <15, age <18	Other double risk[1]	3 way risk spacing 15-26, age <18, order 4+	3 way risk spacing 15-26, age 40+, order 4+	No extra risk	Unavoidable first birth risk	Any single risk	Any double risk	Any 3 way risk
Asia																							
Bangladesh	2011	16,680	26.8	6.0	7.5	5.2	0.1	5.0	19.3	4.3	2.6	1.6	0.5	19.8	0.9	0.1	0.2	0.2	26.8	6.0	37.1	29.8	0.3
Cambodia	2010	17,821	12.9	23.9	6.8	4.7	0.0	4.5	9.5	3.7	2.5	9.8	2.1	18.4	0.1	0.1	0.5	0.6	12.9	23.9	25.4	36.7	1.1
India	2005-06	117,956	15.6	18.7	6.4	3.8	0.0	4.8	18.1	4.3	2.9	9.0	0.7	15.1	0.2	0.0	0.2	0.2	15.6	18.7	33.2	32.2	0.3
Indonesia	2007	31,231	28.4	4.9	8.7	5.5	0.0	10.4	10.9	4.0	2.7	0.3	1.0	21.5	0.1	0.2	0.8	0.7	28.4	4.9	35.5	29.8	1.4
Nepal	2011	12,053	18.4	18.6	6.8	4.0	0.0	3.4	15.8	3.5	2.4	9.8	0.7	15.9	0.1	0.0	0.2	0.3	18.4	18.6	30.0	32.4	0.6
Pakistan	2012-13	12,097	8.4	9.5	10.2	4.3	0.0	2.4	19.2	12.2	6.5	0.4	1.2	23.9	0.1	0.0	0.9	0.8	8.4	9.5	36.1	44.3	1.7
Philippines	2008	12,889	12.4	25.7	5.9	3.8	0.0	5.2	9.6	4.7	3.2	9.8	2.1	15.6	0.2	0.2	0.7	0.7	12.4	25.7	24.6	35.9	1.4
Timor-Leste	2009	12,238	3.9	27.1	6.1	2.9	0.0	1.7	9.3	10.8	5.5	12.0	1.5	14.7	0.1	0.1	2.3	1.9	3.9	27.1	20.0	44.7	4.3
Latin America and Caribbean																							
Bolivia	2008	16,001	14.8	20.9	6.4	4.2	0.0	4.0	11.6	5.5	3.7	9.3	1.0	16.2	0.4	0.3	0.8	0.8	14.8	20.9	26.3	36.3	1.7
Colombia	2010	51,729	20.0	19.1	4.7	3.7	0.0	10.5	8.3	1.8	1.4	14.6	1.8	13.1	0.3	0.3	0.2	0.2	20.0	19.1	27.1	33.3	0.5
Dominican Rep.	2007	25,996	16.1	18.8	5.1	3.7	0.0	6.2	16.7	3.2	2.7	9.2	1.1	16.3	0.4	0.1	0.2	0.2	16.1	18.8	31.6	33.1	0.3
Guyana	2009	4,782	16.7	20.4	5.5	3.2	0.0	7.6	11.5	3.7	2.4	9.2	2.0	16.7	0.3	0.3	0.5	0.2	16.7	20.4	27.8	34.5	0.6
Peru	2012	22,055	18.8	22.4	5.1	4.1	0.0	7.6	8.9	2.9	2.4	9.1	1.6	15.5	0.2	0.4	0.5	0.6	18.8	22.4	25.7	31.9	1.2
Unweighted Averages																							
West and Central Africa		139,013	9.2	16.6	8.6	4.8	0.0	1.6	10.9	13.4	7.3	9.0	0.5	14.4	0.5	0.2	1.7	1.4	9.2	16.6	25.9	45.3	3.1
East and Southern Africa		146,317	11.8	17.5	8.4	5.1	0.0	2.1	11.2	10.1	5.9	11.0	0.6	13.4	0.5	0.1	1.2	1.1	11.8	17.5	26.9	41.6	2.3
Middle East/North Africa		24,533	10.3	5.8	10.4	5.2	0.0	3.7	17.7	9.8	6.3	0.2	1.4	27.0	0.1	0.1	1.1	1.0	10.3	5.8	36.9	45.0	2.1
Eastern Europe/NIS		27,975	20.2	25.8	4.2	3.1	0.0	16.8	6.0	1.1	0.8	7.2	2.0	12.6	0.0	0.1	0.1	0.1	20.2	25.8	30.2	23.7	0.1
Asia		232,965	15.9	16.8	7.3	4.3	0.0	4.7	14.0	5.9	3.5	6.6	1.2	18.1	0.2	0.1	0.7	0.7	15.9	16.8	30.2	35.7	1.4
Latin America and Caribbean		120,563	17.3	20.3	5.4	3.8	0.0	7.2	11.4	3.4	2.5	10.3	1.5	15.6	0.3	0.3	0.4	0.4	17.3	20.3	27.7	33.8	0.9
Total		**691,366**	**13.1**	**17.6**	**7.6**	**4.6**	**0.0**	**4.4**	**11.5**	**8.7**	**5.0**	**8.8**	**0.9**	**15.3**	**0.4**	**0.1**	**1.1**	**0.9**	**13.1**	**17.6**	**28.1**	**39.2**	**2.0**

[1] Includes double risks: order 4+ and age <18; spacing 15-26 and age <18; spacing <15 and age 40+; spacing 15-26 and age 40+

3.2.1. Need for contraception based on fertility-related risks

Table 4 reveals that two-thirds of non-pregnant fecund women have a need to use contraception based on their fertility risk status. The table shows the distribution of non-pregnant women across three categories (with the percentages in each row adding to 100). The column "no need for contraception" includes women between the ages of 18 and 39 who have had less than 3 births and whose last birth (if any) occurred 27 or more months ago. The column "spacing method need" includes women under age 18 and/or whose last birth occurred less than 27 months ago. The column "need for a long-acting or permanent method (LAPM)" includes women who are age 40 or over and/or who have had 3 or more births. This table indicates that overall slightly more than one in five non-pregnant women have a need for a spacing method due to being less than 18 years of age or having had a birth within the last 27 months. Nearly half the non-pregnant women (46 percent) have a need for a limiting method due to having had 3 children already or being 40 years of age or over.

The need for a spacing method is highest in the two sub-Saharan African regions, and the need for a limiting method is highest in the Middle East/North Africa region (Note: the Middle East/North Africa region is based on only two country surveys). In eight countries in East and Southern Africa, at least 25 percent of non-pregnant women have a spacing need. In eleven countries, the limiting need exceeds 50 percent, 5 in West and Central Africa, 2 in East and Southern Africa, in both countries in Middle East/North Africa, and 2 in Asia.

Table 4. Percent distribution of non-pregnant women by need for contraception based on fertility risk, 45 DHS country surveys 2006-2012

			Need for contraception based on fertility risk		
Country	Survey date	Number of respondents	No need for contra-ception	Spacing method need	Need for LAPM
West and Central Africa					
Benin	2006	15,850	27.1	23.1	49.8
Burkina Faso	2010	15,357	23.2	24.0	52.7
Cameroon	2011	13,914	32.2	24.4	43.4
DR Congo	2007	8,872	34.5	21.9	43.6
Ghana	2008	4,556	36.4	21.6	41.9
Liberia	2007	6,331	26.2	23.1	50.7
Mali	2006	12,721	22.5	24.6	52.9
Niger	2006	7,871	18.9	23.4	57.8
Nigeria	2008	29,891	29.3	22.1	48.7
Sao Tome & Principe	2008-09	2,394	31.2	19.8	49.0
Senegal	2010-11	14,480	36.7	22.5	40.8
Sierra Leone	2008	6,776	28.8	20.7	50.5
East and Southern Africa					
Burundi	2010	8,408	30.2	26.9	42.9
Ethiopia	2011	15,310	33.0	23.2	43.9
Kenya	2008-09	7,851	31.7	22.6	45.7
Lesotho	2009	7,303	40.1	25.3	34.6
Madagascar	2008-09	15,938	27.6	22.6	49.9
Malawi	2010	20,948	21.4	26.4	52.2
Mozambique	2011	12,229	25.8	26.3	47.9
Namibia	2006-07	9,277	41.8	23.4	34.8
Rwanda	2010	12,715	35.2	23.5	41.3
Swaziland	2006-07	4,708	36.1	25.8	38.1
Tanzania	2010	9,170	27.1	24.6	48.3
Uganda	2011	7,663	22.4	25.0	52.6
Zambia	2007	6,384	24.5	25.6	49.9
Zimbabwe	2010-11	8,413	34.0	27.8	38.3

(Continued)

Table 4. – *Continued*

Country	Survey date	Number of respondents	Need for contraception based on fertility risk		
			No need for contra-ception	Spacing method need	Need for LAPM
Middle East/North Africa					
Egypt	2008	14,972	21.4	18.0	60.6
Jordan	2007	9,561	14.5	13.9	71.7
Eastern Europe/NIS					
Albania	2008-09	7,434	42.2	15.2	42.6
Armenia	2010	5,744	52.9	15.1	32.0
Azerbaijan	2006	8,147	44.7	16.0	39.3
Ukraine	2007	6,650	56.1	11.6	32.3
Asia					
Bangladesh	2011	16,680	34.8	15.8	49.4
Cambodia	2010	17,821	40.5	20.8	38.7
India	2005-06	117,956	36.9	19.3	43.7
Indonesia	2007	31,231	34.4	14.6	51.0
Nepal	2011	12,053	39.1	20.6	40.2
Pakistan	2012-13	12,097	18.9	14.9	66.3
Philippines	2008	12,889	39.2	19.7	41.1
Timor-Leste	2009	12,238	32.4	20.8	46.8
Latin America and Caribbean					
Bolivia	2010	51,729	40.7	23.4	35.9
Colombia	2008	16,001	38.4	20.3	41.3
Dominican Rep.	2007	25,996	36.4	18.4	45.2
Guyana	2009	4,782	38.1	18.1	43.8
Peru	2012	22,055	44.0	18.5	37.5
Unweighted Averages					
West and Central Africa		139,013	28.9	22.6	48.5
East and Southern Africa		146,317	30.8	24.9	44.3
Middle East/North Africa		24,533	18.0	16.0	66.2
Eastern Europe/NIS		27,975	49.0	14.5	36.6
Asia		232,965	34.5	18.3	47.2
Latin America and Caribbean		68,834	39.2	18.8	42.0
Total		**691,366**	**33.0**	**21.2**	**45.8**

Note: Need for contraception based on fertility risk is categorized as follows:

- No need for contraception includes women between the ages of 18 and 39 who have had less than 3 births and whose last birth (if any) occurred 27 or more months ago. Also includes women who have declared themselves to be infecund or who have had a hysterectomy.
- Spacing method need includes women under age 18 and/or whose last birth occurred less than 27 months ago.
- Need for LAPM includes women age 40 or over and/or have had 3 or more births.

LAPM: Long Acting and Permanent Methods--intrauterine devices (IUDs), implants, female and male sterilization

3.2.2. Fertility desires of non-pregnant women

Many non-pregnant women face a fertility-related risk, but also want to either delay or avoid a/another birth as do women without a fertility-related risk. An examination of non-pregnant women's desires for future fertility is provided in Table 5. Just over half of non-pregnant women want to have a future birth, and about one in three do not. If sterilized women or women with sterilized husbands are included, the percentage reaches 38 percent who do not want a future birth. The remaining 11 percent were either undecided (5 percent), infecund (3 percent), had missing responses, or were not asked due to never having had sex or not being currently in a marital union (3 percent)[10]. By region, West and Central Africa have the highest percentage of non-pregnant women who want a future birth (68 percent) and the Middle East/North Africa the lowest (34 percent). By individual country, the highest percentage of women who want a/another birth is in Niger (84 percent) and the lowest is in Egypt and Bangladesh (28 and 29 percent, respectively). Table 5 also shows that although slightly more than half of non-pregnant women want a future birth, only one in seven want that birth within 2 years of the survey. Only in Pakistan, Egypt and India do more than half of those who want a future birth want that birth to occur within two years.

Table 5. Percent distribution of all[1] non-pregnant women by desires for more children, 45 DHS country surveys 2006-2012

			Desire for more children									
			Have another									
Country	Survey date	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Sterilized (respon-dent or partner)	Declared infecund	Missing	Not asked[1]	Total
West and Central Africa												
Benin	2006	15,850	21.0	34.9	11.9	2.5	23.1	0.3	5.7	0.5	0.0	100.0
Burkina Faso	2010	15,357	18.0	37.2	5.5	1.5	20.9	0.2	2.7	0.2	13.8	100.0
Cameroon	2011	13,914	22.5	32.4	17.9	2.4	20.9	0.4	3.1	0.4	0.0	100.0
DR Congo	2007	8,872	20.8	25.2	21.6	5.0	16.9	0.6	9.6	0.3	0.0	100.0
Ghana	2008	4,556	15.1	29.5	21.9	6.5	24.4	1.1	1.3	0.2	0.0	100.0
Liberia	2007	6,331	17.6	33.0	11.5	9.7	24.5	0.5	2.1	1.1	0.0	100.0
Mali	2006	12,721	28.0	24.2	22.0	2.5	17.8	0.3	4.6	0.6	0.0	100.0
Niger	2006	7,871	33.9	35.4	14.5	1.8	9.3	0.3	4.4	0.4	0.0	100.0
Nigeria	2008	29,891	23.0	22.7	21.7	12.3	16.4	0.3	2.9	0.6	0.0	100.0
Sao Tome & Principe	2008-09	2,394	8.7	35.8	6.7	5.6	38.8	1.0	2.7	0.7	0.0	100.0
Senegal	2010-11	14,480	21.6	24.9	33.4	2.1	15.5	0.2	2.3	0.0	0.0	100.0
Sierra Leone	2008	6,776	24.6	21.4	11.5	9.4	26.9	0.0	4.3	1.9	0.0	100.0
East and Southern Africa												
Burundi	2010	8,408	9.9	33.6	26.7	2.3	24.8	0.4	2.2	0.2	0.0	100.0
Ethiopia	2011	15,310	13.1	38.6	11.0	3.9	30.9	0.4	1.9	0.2	0.0	100.0
Kenya	2008-09	7,851	10.7	28.8	13.7	3.3	38.3	3.4	1.6	0.1	0.0	100.0
Lesotho	2009	7,303	12.1	26.9	3.7	0.0	52.6	1.8	0.3	0.0	2.6	100.0
Madagascar	2008-09	15,938	15.4	32.4	9.5	2.8	37.4	1.0	1.5	0.1	0.0	100.0
Malawi	2010	20,948	11.4	35.3	8.1	2.6	32.6	8.3	1.5	0.1	0.0	100.0
Mozambique	2011	12,229	25.9	25.2	8.8	6.0	28.5	0.2	5.5	0.0	0.0	100.0
Namibia	2006-07	9,277	9.1	22.7	13.5	6.8	40.0	5.4	1.6	0.7	0.0	100.0
Rwanda	2010	12,715	5.4	19.4	5.3	1.1	35.2	0.5	0.8	0.1	32.2	100.0
Swaziland	2006-07	4,708	7.4	19.7	14.0	1.8	52.0	3.2	1.8	0.1	0.0	100.0
Tanzania	2010	9,170	17.7	31.9	5.7	1.1	23.2	2.8	2.0	0.2	15.3	100.0
Uganda	2011	7,663	13.0	39.3	8.0	3.1	32.0	2.5	1.9	0.1	0.0	100.0
Zambia	2007	6,384	12.4	31.8	15.3	7.9	29.3	1.6	1.7	0.2	0.0	100.0
Zimbabwe	2010-11	8,413	15.7	32.8	7.2	6.3	35.8	1.0	1.2	0.0	0.0	100.0
Middle East/North Africa												
Egypt*	2008	14,972	14.3	12.7	0.5	2.1	59.4	1.1	2.5	0.0	7.5	100.0
Jordan*	2007	9,561	18.4	21.4	1.0	2.2	45.7	4.1	1.8	0.0	5.3	100.0

(Continued)

[10] Table 5 is for all non-pregnant women. However, in a few countries, never married and not currently married women were not asked the questions.

Table 5. – *Continued*

Country	Survey date	Number of respon-dents	Desire for more children: Have another: Wants within 2 years	Have another: Wants after 2+ years	Have another: Wants, unsure timing	Un-decided	Wants no more	Sterilized (respon-dent or partner)	Declared infecund	Missing	Not asked[1]	Total
Eastern Europe/NIS												
Albania	2008-09	7,434	6.9	9.2	25.2	4.6	49.5	2.2	2.4	0.0	0.0	100.0
Armenia	2010	5,744	6.4	8.0	20.1	16.9	40.9	0.2	7.4	0.1	0.0	100.0
Azerbaijan	2006	8,147	6.3	3.2	29.1	5.8	50.6	0.3	4.2	0.5	0.0	100.0
Ukraine	2007	6,650	6.8	7.5	21.2	10.1	47.5	0.5	5.9	0.5	0.0	100.0
Asia												
Bangladesh*	2011	16,680	10.8	17.4	0.5	1.1	54.9	6.2	2.3	6.8	0.0	100.0
Cambodia	2010	17,821	7.6	16.6	20.0	11.0	37.9	1.6	5.2	0.0	0.0	100.0
India	2005-06	117,956	9.8	7.7	1.0	0.7	24.5	32.0	3.2	0.1	20.9	100.0
Indonesia*	2007	31,231	13.5	21.3	3.0	3.3	47.9	3.4	1.2	0.2	6.1	100.0
Nepal	2011	12,053	6.7	13.2	13.9	6.4	38.8	18.8	2.3	0.0	0.0	100.0
Pakistan*	2012-13	12,097	23.7	14.8	1.2	2.6	41.3	9.5	1.5	0.2	5.1	100.0
Philippines	2008	12,889	9.3	26.6	12.3	6.9	37.4	6.3	1.2	0.0	0.0	100.0
Timor-Leste	2009	12,238	5.3	19.1	4.0	43.4	25.5	0.5	2.2	0.0	0.0	100.0
Latin America and Caribbean												
Bolivia	2008	16,001	8.3	32.0	2.8	1.4	47.9	4.6	2.9	0.0	0.0	100.0
Colombia	2010	51,729	8.7	32.6	3.0	2.0	26.5	25.2	2.0	0.0	0.0	100.0
Dominican Rep.	2007	25,996	12.0	30.9	4.1	1.0	14.5	35.5	1.7	0.3	0.0	100.0
Guyana	2009	4,782	12.0	25.5	9.9	5.3	41.5	3.9	1.6	0.4	0.0	100.0
Peru	2012	22,055	9.1	40.2	0.7	0.7	39.6	6.6	3.1	0.0	0.0	100.0
Unweighted Averages												
West and Central Africa		139,013	21.2	29.7	16.7	5.1	21.3	0.4	3.8	0.6	1.2	100.0
East and Southern Africa		146,317	12.8	29.9	10.8	3.5	35.2	2.3	1.8	0.2	3.6	100.0
Middle East/North Africa		24,533	16.4	17.1	0.8	2.2	52.6	2.6	2.2	-	6.4	100.0
Eastern Europe/NIS		27,975	6.6	7.0	23.9	9.4	47.1	0.8	5.0	0.3	-	100.0
Asia		232,965	10.8	17.1	7.0	9.4	38.5	9.8	2.4	0.9	4.0	100.0
Latin America and Caribbean		120,563	10.0	32.2	4.1	2.1	34.0	15.2	2.3	0.1	-	100.0
Total		**691,366**	**14.0**	**25.2**	**11.6**	**5.3**	**33.8**	**4.4**	**2.8**	**0.4**	**2.4**	**100.0**

* Ever-married samples
[1]Not asked of women who were not currently married or who never had sexual relations, depending on survey.

3.2.3. Fertility desires versus risk-based need for contraception

Women have varying desires for future births and varying fertility-based needs to delay or avoid a future birth. Table 6 shows the interaction of the two concepts. Among non-pregnant women with no risk-based need, less than one in four want another birth within two years. Two out of three non-pregnant women with a risk-based need to space their births also want to delay the next birth or are unsure about the timing of the next birth. About two of three non-pregnant women with a risk-based need to limit their births either express that they do not want a future birth or are using sterilization as a method. Only 11 percent want another child in the near future. However, not all non-pregnant women's desires coincide with their risk-based need to limit births. For three countries (Mali, Niger, and Nigeria), less than one third of non-pregnant women with a risk-based limiting need want no more children or are using sterilization, and in seven other countries in West and Central Africa, fewer than half of these women want no more children. The only other country with such a low percentage is Tanzania.

Table 6. Percent distribution of all[1] non-pregnant women by desires for more children according to risk-based need for contraception, 45 DHS country surveys 2006-2012

		Need for contraception based on fertility risk																							
		No risk-based need for contraception									Risk-based need for a spacing method								Risk-based need for a long acting or permanent method (LAPM)							
Country	Survey date	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	De-clared infe-cund	Not asked or missing[1]	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	Not asked or missing[1]	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	Not asked or missing[1]
West and Central Africa																									
Benin	2006	4,299	28.7	25.7	19.6	1.7	2.5	0.1	21.2	0.4	3,659	13.5	60.0	21.2	2.0	2.5	0.0	0.7	7,892	20.3	28.3	3.3	3.2	43.8	0.5	0.5
Burkina Faso	2010	3,566	31.3	15.2	15.2	0.5	1.3	0.0	11.5	24.9	3,691	9.0	51.2	4.9	0.3	0.9	0.0	33.6	8,100	16.3	40.4	1.5	2.6	38.7	0.3	0.3
Cameroon	2011	4,475	29.0	30.0	28.6	0.7	1.9	0.0	9.5	0.2	3,403	13.9	51.7	29.4	1.4	3.2	0.0	0.3	6,036	22.6	23.4	3.4	4.2	45.0	0.9	0.5
DR Congo	2007	3,052	21.2	8.7	34.9	3.9	2.7	0.2	27.8	0.6	1,961	13.6	44.2	30.9	6.2	5.1	0.0	0.1	3,858	24.3	28.6	6.3	5.2	34.1	1.3	0.2
Ghana	2008	1,655	22.8	25.3	39.0	6.8	2.4	0.0	3.5	0.2	987	3.0	53.3	30.5	8.0	5.1	0.0	0.1	1,914	14.6	20.8	2.6	5.5	53.4	2.7	0.3
Liberia	2007	1,665	27.9	30.8	17.8	12.1	2.9	0.1	8.0	0.5	1,460	8.6	50.4	21.4	14.0	4.0	0.0	1.6	3,206	16.4	26.2	3.7	6.5	45.0	0.8	1.2
Mali	2006	2,855	36.5	4.3	35.7	1.6	1.3	0.0	20.3	0.3	3,121	18.6	32.1	43.6	2.6	2.3	0.0	0.7	6,745	28.8	28.9	6.2	2.9	31.9	0.5	0.7
Niger	2006	1,467	37.6	4.8	30.5	1.3	1.3	0.3	23.7	0.4	1,836	28.0	44.9	24.5	1.6	0.8	0.0	0.2	4,567	35.1	41.4	5.3	2.0	15.2	0.4	0.5
Nigeria	2008	8,747	23.1	10.5	41.7	13.1	1.2	0.0	9.9	0.5	6,594	20.8	35.2	31.6	10.7	1.1	0.0	0.6	14,551	23.9	24.5	5.3	12.6	32.5	0.6	0.6
Sao Tome & Principe	2008-09	750	18.2	44.9	12.6	7.1	7.6	0.1	8.8	0.8	477	2.6	63.6	8.1	8.8	14.9	0.0	1.9	1,167	5.1	18.6	2.3	3.3	68.6	1.9	0.2
Senegal	2010-11	5,335	27.4	7.0	57.1	1.3	1.0	0.0	6.2	0.0	3,247	12.0	42.8	41.4	1.6	2.3	0.0	0.0	5,898	21.6	31.3	7.6	3.1	36.0	0.4	0.0
Sierra Leone	2008	1,949	37.6	13.8	18.5	8.8	4.6	0.0	15.0	1.7	1,395	18.5	39.5	23.4	11.4	5.5	0.0	1.6	3,432	19.8	18.3	2.7	8.8	48.2	0.1	2.1
East and Southern Africa																									
Burundi	2010	2,529	14.9	18.5	54.3	2.1	2.9	0.0	7.2	0.1	2,268	5.4	55.3	34.8	1.6	2.7	0.0	0.2	3,611	9.1	30.6	2.2	2.9	54.0	0.9	0.3
Ethiopia	2011	5,045	17.9	43.2	18.0	3.4	11.3	0.2	5.9	0.1	3,548	6.2	56.7	18.2	4.8	13.9	0.0	0.1	6,717	13.2	25.5	1.9	3.8	54.6	0.7	0.3
Kenya	2008-09	2,481	19.8	36.5	21.7	3.2	13.6	0.1	5.0	0.2	1,789	5.2	51.5	25.4	4.3	13.6	0.0	0.0	3,581	7.2	12.2	2.4	2.9	67.9	7.4	0.1
Lesotho	2009	2,946	22.5	36.4	5.8	0.0	31.0	0.4	0.7	3.1	1,847	3.3	42.1	5.2	0.0	45.1	0.1	4.2	2,510	6.3	4.5	0.2	0.0	83.6	4.6	0.8
Madagascar	2008-09	4,388	29.6	35.9	15.2	2.7	10.8	0.2	5.5	0.0	3,596	8.0	61.9	18.7	3.0	8.3	0.0	0.1	7,953	10.8	17.1	2.2	2.7	65.3	1.9	0.1
Malawi	2010	4,461	26.3	39.1	14.5	2.2	10.1	0.8	6.9	0.1	5,530	7.5	58.5	16.6	4.3	12.8	0.1	0.1	10,956	7.3	22.1	1.2	1.9	51.8	15.5	0.2
Mozambique	2011	3,156	40.2	18.1	10.3	3.4	6.7	0.0	21.4	0.0	3,231	20.0	44.7	18.1	7.7	9.5	0.0	0.0	5,843	21.4	18.2	2.8	6.4	50.8	0.4	0.0
Namibia	2006-07	3,885	13.0	30.9	19.9	7.3	23.0	1.0	3.9	0.9	2,160	4.1	30.4	19.1	9.7	35.7	0.2	0.6	3,231	7.9	7.7	2.1	4.1	63.3	14.3	0.6
Rwanda	2010	4,471	8.5	12.8	9.7	0.6	5.2	0.0	2.3	61.0	2,990	2.4	38.4	6.4	0.6	7.1	0.0	45.0	5,253	4.4	14.1	0.9	1.9	76.7	1.3	0.8
Swaziland	2006-07	1,697	13.1	27.8	20.6	2.3	30.8	0.3	5.0	0.1	1,213	2.0	30.3	24.3	2.3	40.9	0.1	0.1	1,797	5.6	4.8	0.9	1.1	79.6	7.9	0.1
Tanzania	2010	2,489	30.2	20.4	12.6	0.6	3.9	0.1	7.4	24.8	2,250	8.1	45.0	6.5	0.7	4.8	0.0	34.9	4,431	15.5	31.8	1.5	1.6	43.5	5.7	0.5
Uganda	2011	1,719	25.4	43.3	15.2	2.4	4.8	0.2	8.7	0.0	1,921	8.0	65.7	16.2	4.3	5.7	0.0	0.2	4,024	10.2	25.0	1.0	2.8	56.2	4.7	0.1
Zambia	2007	1,564	23.1	26.1	28.5	8.3	6.8	0.3	6.8	0.2	1,635	6.7	47.7	26.9	10.9	7.3	0.2	0.2	3,184	10.0	26.4	2.9	6.1	51.6	2.9	0.1
Zimbabwe	2010-11	2,855	29.9	31.9	12.7	6.2	15.5	0.1	3.6	0.0	2,337	6.7	60.7	9.2	8.1	15.3	0.0	0.0	3,222	9.5	13.4	0.9	5.2	68.6	2.4	0.0
Middle East/North Africa																									
Egypt*	2008	3,213	40.7	8.1	0.6	2.9	27.8	0.1	11.5	8.4	2,688	16.5	52.5	1.2	3.3	25.1	0.0	1.4	9,070	4.2	2.6	0.2	1.4	80.8	1.8	9.0
Jordan*	2007	1,378	52.8	10.4	1.2	1.2	9.7	0.0	12.2	12.6	1,326	21.8	65.9	0.9	2.4	8.1	0.0	0.8	6,857	10.9	15.1	1.0	2.3	60.3	5.7	4.7
Eastern Europe/NIS																									
Albania	2008-09	3,136	12.7	12.3	40.6	5.8	22.5	0.3	5.8	0.0	1,142	4.0	24.0	51.5	8.1	12.3	0.1	0.0	3,155	2.1	0.9	0.5	2.1	89.8	4.7	0
Armenia	2010	3,048	8.4	5.6	30.3	22.0	19.6	0.0	13.9	0.1	856	7.6	31.5	23.6	23.6	13.5	0.0	0.1	1,841	2.3	1.0	1.7	5.4	88.7	0.6	0.2
Azerbaijan	2006	3,652	9.0	2.2	46.7	7.1	25.2	0.0	9.4	0.5	1,301	9.5	12.8	44.5	10.8	21.1	0.0	1.4	3,193	1.8	0.5	2.8	2.2	91.8	0.7	0.2
Ukraine	2007	3,731	10.3	8.3	29.2	13.0	27.6	0.4	10.4	0.7	768	4.4	24.4	37.9	16.2	16.6	0.3	0.2	2,150	1.6	0.2	1.5	2.8	92.9	0.8	0.2

(Continued)

Table 6. – *Continued*

Country	Survey date	Need for contraception based on fertility risk																							
		No risk-based need for contraception									Risk-based need for a spacing method								Risk-based need for a long acting or permanent method (LAPM)							
		Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	De-clared infe-cund	Not asked or missing[1]	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	Not asked or missing[1]	Number of respon-dents	Wants within 2 years	Wants after 2+ years	Wants, unsure timing	Un-decided	Wants no more	Steril-ized (respon-dent or partner)	Not asked or missing[1]
Asia																									
Bangladesh*	2011	5,811	23.3	23.4	0.8	1.4	36.0	2.0	6.5	6.6	2,560	8.1	53.3	0.8	2.0	33.7	0.8	1.3	8,310	2.9	2.2	0.1	0.5	74.7	10.8	8.8
Cambodia	2010	7,228	11.7	15.6	33.8	15.1	10.5	0.4	12.8	0.0	3,694	3.4	39.5	26.6	16.2	14.0	0.2	0.0	6,899	5.5	5.5	2.0	3.9	79.3	3.7	0.1
India	2005-06	43,537	17.7	4.7	1.2	0.8	14.2	18.0	8.7	34.7	22,814	10.6	25.4	2.2	0.9	14.3	5.3	41.2	51,605	2.8	2.4	0.4	0.5	37.8	55.6	0.4
Indonesia*	2007	10,742	28.9	28.3	4.7	2.7	25.5	0.5	3.6	5.8	4,553	4.1	58.4	3.7	5.2	25.8	0.3	2.5	15,937	5.8	6.0	1.6	3.3	69.4	6.1	7.7
Nepal	2011	4,713	12.3	16.1	20.9	8.8	27.7	8.3	5.9	0.0	2,491	5.0	30.1	26.5	13.1	24.3	1.0	0.0	4,848	2.1	1.6	0.6	0.7	57.0	38.1	0.0
Pakistan*	2012-13	2,281	66.3	5.7	1.7	1.8	8.3	0.8	8.2	7.2	1,800	29.3	54.2	2.3	4.0	8.6	0.1	1.5	8,016	10.4	8.6	0.8	2.5	58.0	14.1	5.6
Philippines	2008	5,046	16.3	38.6	20.3	8.3	12.9	0.6	3.1	0.0	2,544	2.1	47.3	19.2	11.4	19.3	0.7	0.0	5,299	6.2	5.2	1.3	3.4	69.4	14.5	0.0
Timor-Leste	2009	3,960	5.0	5.3	7.7	70.0	5.0	0.1	6.9	0.0	2,554	4.1	29.1	5.1	58.4	3.2	0.0	0.0	5,723	6.1	24.2	0.8	18.3	49.6	1.1	0.0
Latin America and Caribbean																									
Bolivia	2008	6,143	14.2	50.1	4.0	1.7	22.0	0.4	7.6	0.0	3,264	2.1	53.7	4.9	2.7	36.3	0.2	0.0	6,594	5.8	4.4	0.6	0.6	77.9	10.8	0.0
Colombia	2010	21,059	15.9	41.8	3.3	2.5	19.9	11.8	4.8	0.0	12,099	1.8	64.1	6.6	2.9	19.6	5.0	0.0	18,571	5.1	1.7	0.4	0.9	38.4	53.5	0.0
Dominican Rep.	2007	9,447	24.8	45.4	6.7	1.1	9.3	7.5	4.7	0.3	4,789	5.3	70.3	8.0	1.6	11.8	2.6	0.4	11,760	4.3	3.3	0.4	0.6	19.8	71.4	0.3
Guyana	2009	1,834	22.2	34.6	15.7	6.2	16.5	0.4	4.1	0.4	866	4.6	56.3	16.5	7.9	14.6	0.0	0.1	2,082	6.2	4.6	2.0	3.3	74.8	8.6	0.6
Peru	2012	9,697	13.9	56.5	1.0	1.0	20.0	0.6	7.0	0.0	4,090	1.7	70.8	0.7	0.8	25.3	0.6	0.0	8,268	7.2	6.0	0.5	0.3	69.6	16.5	0.0
Unweighted Averages																									
West and Central Africa		39,815	28.4	18.4	29.3	4.9	2.6	0.1	13.8	2.5	31,831	13.5	47.4	25.9	5.7	4.0	-	3.5	67,366	20.7	27.6	4.2	5.0	41.0	0.9	0.6
East and Southern Africa		43,686	22.5	30.1	18.5	3.2	12.6	0.3	6.5	6.5	36,315	6.7	49.2	17.5	4.5	15.9	0.1	6.1	66,313	9.9	18.1	1.7	3.1	62.0	5.0	0.3
Middle East/North Africa		4,591	46.8	9.3	0.9	2.1	18.8	0.1	11.9	10.5	4,014	19.2	59.2	1.1	2.9	16.6	-	1.1	15,927	7.6	8.9	0.6	1.9	70.6	3.8	6.9
Eastern Europe/NIS		13,567	10.1	7.1	36.7	12.0	23.7	0.2	9.9	0.3	4,067	6.4	23.2	39.4	14.7	15.9	0.1	0.4	10,339	2.0	0.7	1.6	3.1	90.8	1.7	0.2
Asia		83,318	22.7	17.2	11.4	13.6	17.5	3.8	7.0	6.8	43,010	8.3	42.2	10.8	13.9	17.9	1.1	5.8	106,637	5.2	7.0	1.0	4.1	61.9	18.0	2.8
Latin America and Caribbean		48,180	18.2	45.7	6.1	2.5	17.5	4.1	5.6	0.1	25,108	3.1	63.0	7.3	3.2	21.5	1.7	0.1	47,275	5.7	4.0	0.8	1.1	56.1	32.2	0.2
Total		**233,157**	**23.6**	**23.4**	**19.6**	**6.2**	**12.6**	**1.3**	**9.0**	**4.4**	**144,345**	**8.9**	**47.1**	**18.6**	**7.2**	**13.7**	**0.4**	**4.0**	**313,857**	**10.7**	**15.1**	**2.1**	**3.5**	**58.7**	**8.9**	**1.1**

* Ever-married samples

[1]Not asked of women who were not currently married or who never had sexual relations, depending on survey.

Note: Need for contraception based on fertility risk is categorized as follows:

No need for contraception includes women between the ages of 18 and 39 who have had less than 3 births and whose last birth (if any) occurred 27 or more months ago. Also includes women who have declared themselves to be infecund or who have had a hysterectomy.

Spacing method need includes women under age 18 and/or whose last birth occurred less than 27 months ago.

Need for LAPM includes women age 40 or over and/or have had 3 or more births.

LAPM: Long Acting and Permanent Methods--intrauterine devices (IUDs), implants, female and male sterilization

3.2.4. Use of contraception

Long-acting and permanent methods (LAPM) are appropriate for women who do not want a future birth or who have a risk-based need to avoid a future birth. These methods provide the greatest protection from a future birth. Long-acting and permanent methods include the intrauterine device (IUD) and the progestogen implant, as well as female and male sterilization. The use of LAPM and other methods by non-pregnant women is shown in Table 7. Only 8 percent of non-pregnant women use LAPM, while 26 percent use a non-LAPM and two-thirds use no method. The use of LAPM is particularly low in the sub-Saharan African regions. The Middle East/North Africa countries Egypt and Jordan have high rates of use of LAPM, 39 and 28 percent, respectively. Other countries with high rates are India (33 percent), Colombia (33 percent) and the Dominican Republic (38 percent).

Table 7. Percent distribution of all non-pregnant women by whether using a LAPM contraceptive method, 45 DHS country surveys 2006-2012

			Whether using a long acting or permanent method		
Country	Survey date	Number of respondents	Not using any method	Using LAPM: IUD, sterilization, implant	Using non-LAPM
West and Central Africa					
Benin	2006	15,850	80.7	1.4	17.9
Burkina Faso	2010	15,357	83.0	3.6	13.4
Cameroon	2011	13,914	73.7	1.2	25.1
DR Congo	2007	8,872	77.4	0.8	21.8
Ghana	2008	4,556	79.1	2.0	18.9
Liberia	2007	6,331	85.1	0.7	14.2
Mali	2006	12,721	91.4	0.5	8.1
Niger	2006	7,871	88.3	0.4	11.3
Nigeria	2008	29,891	82.8	1.2	16.0
Sao Tome & Principe	2008-09	2,394	66.4	1.3	32.3
Senegal	2010-11	14,480	89.6	1.6	8.8
Sierra Leone	2008	6,776	88.9	0.4	10.7
East and Southern Africa					
Burundi	2010	8,408	85.0	2.7	12.3
Ethiopia	2011	15,310	78.9	3.1	18.0
Kenya	2008-09	7,851	65.5	5.9	28.5
Lesotho	2009	7,303	62.5	3.2	34.4
Madagascar	2008-09	15,938	65.5	2.6	31.9
Malawi	2010	20,948	61.1	9.7	29.2
Mozambique	2011	12,229	86.1	0.4	13.5
Namibia	2006-07	9,277	50.8	6.1	43.1
Rwanda	2010	12,715	69.2	4.6	26.1
Swaziland	2006-07	4,708	59.9	4.2	36.0
Tanzania	2010	9,170	68.2	5.3	26.5
Uganda	2011	7,663	73.3	5.1	21.7
Zambia	2007	6,384	66.5	2.0	31.5
Zimbabwe	2010-11	8,413	55.0	3.5	41.5
Middle East/North Africa					
Egypt*	2008	14,972	37.9	38.7	23.4
Jordan*	2007	9,561	38.0	28.4	33.6
Eastern Europe/NIS					
Albania	2008-09	7,434	51.1	2.8	46.1
Armenia	2010	5,744	65.1	6.3	28.6
Azerbaijan	2006	8,147	66.9	6.3	26.9
Ukraine	2007	6,650	47.6	13.0	39.4

(Continued)

Table 7. – *Continued*

Country	Survey date	Number of respondents	Whether using a long acting or permanent method		
			Not using any method	Using LAPM: IUD, sterilization, implant	Using non-LAPM
Asia					
Bangladesh*	2011	16,680	39.0	8.1	53.0
Cambodia	2010	17,821	66.9	3.9	29.1
India	2005-06	117,956	53.8	33.4	12.9
Indonesia*	2007	31,231	39.0	11.0	50.0
Nepal	2011	12,053	59.9	20.8	19.4
Pakistan*	2012-13	12,097	62.1	12.1	25.8
Philippines	2008	12,889	65.7	8.8	25.5
Timor-Leste	2009	12,238	85.4	1.9	12.6
Latin America and Caribbean					
Bolivia	2008	16,001	56.1	10.6	33.3
Colombia	2010	51,729	40.9	33.4	25.7
Dominican Rep.	2007	25,996	43.5	37.6	18.9
Guyana	2009	4,782	63.8	9.0	27.1
Peru	2012	22,055	47.8	8.9	43.3
Unweighted Averages					
West and Central Africa		139,013	82.2	1.3	16.5
East and Southern Africa		146,317	67.7	4.2	28.2
Middle East/North Africa		24,533	38.0	33.6	28.5
Eastern Europe/NIS		27,975	57.7	7.1	35.3
Asia		232,965	59.0	12.5	28.5
Latin America and Caribbean		120,563	50.4	19.9	29.7
Total		**691,366**	**65.9**	**8.2**	**25.9**

* Ever-married samples

The spacing method with the shortest duration of use is the lactational amenorrheic method (LAM), which can be used for a maximum of 6 months after the birth of a living child. To be successfully used, a woman must be postpartum amenorrheic, breastfeeding her child exclusively or predominantly, and be within six months of giving birth. Table 8 shows that among non-pregnant women, almost none say they use LAM, with even fewer using and meeting the LAM criteria. Only in Niger and Zambia do more than 4 percent of non-pregnant women use LAM.

Table 8. Percent distribution of non-pregnant women by current use of the lactational amenorrhea method (LAM), 45 DHS country surveys 2006-2012

Country	Survey date	Number of respondents*	Not using LAM	Using LAM correctly	Using LAM incorrectly
West and Central Africa					
Benin	2006	15,850	99.8	0.1	0.1
Burkina Faso	2010	15,357	99.9	0.0	0.0
Cameroon	2011	13,914	99.8	0.0	0.2
DR Congo	2007	8,872	100.0	0.0	0.0
Ghana	2008	4,556	100.0	0.0	0.0
Liberia	2007	6,331	100.0	0.0	0.0
Mali	2006	12,721	99.5	0.2	0.3
Niger	2006	7,871	95.2	1.0	3.7
Nigeria	2008	29,891	98.7	0.1	1.1
Sao Tome & Principe	2008-09	2,394	100	0.1	0.3
Senegal	2010-11	14,480	99.9	0.0	0.1
Sierra Leone	2008	6,776	99.3	0.1	0.6
East and Southern Africa					
Burundi	2010	8,408	100.0	0.0	0.0
Ethiopia	2011	15,310	100.0	0.0	0.0
Kenya	2008-09	7,851	99.6	0.2	0.3
Lesotho	2009	7,303	100.0	0.0	0.0
Madagascar	2008-09	15,938	99.2	0.5	0.4
Malawi	2010	20,948	100.0	0.0	0.0
Mozambique	2011	12,229	99.9	0.0	0.1
Namibia	2006-07	9,277	100.0	0.0	0.0
Rwanda	2010	12,715	99.7	0.1	0.2
Swaziland	2006-07	4,708	99.2	0.0	0.8
Tanzania	2010	9,170	98.9	0.1	1.0
Uganda	2011	7,663	99.9	0.0	0.1
Zambia	2007	6,384	95.4	0.9	3.8
Zimbabwe	2010-11	8,413	99.9	0.0	0.1
Middle East/North Africa					
Egypt*	2008	14,972	100.0	0.0	0.0
Jordan*	2007	9,561	98.5	0.6	0.9
Eastern Europe/NIS					
Albania	2008-09	7,434	99.7	0.1	0.1
Armenia	2010	5,744	99.5	0.1	0.4
Azerbaijan	2006	8,147	99.3	0.2	0.6
Ukraine	2007	6,650	100.0	0.0	0.0
Asia					
Bangladesh*	2011	16,680	100.0	0.0	0.0
Cambodia	2010	17,821	100.0	0.0	0.0
India	2005-06	117,956	100.0	0.0	0.0
Indonesia*	2007	31,231	100.0	0.0	0.0
Nepal	2011	12,053	100.0	0.0	0.0
Pakistan*	2012-13	12,097	98.4	0.3	1.4
Philippines	2008	12,889	99.8	0.1	0.2
Timor-Leste	2009	12,238	100.0	0.0	0.0
Latin America and Caribbean					
Bolivia	2008	16,001	99.5	0.2	0.3
Colombia	2010	51,729	99.9	0.0	0.1
Dominican Rep.	2007	25,996	99.7	0.0	0.3
Guyana	2009	4,782	99.9	0.0	0.1
Peru	2012	22,055	99.9	0.1	0.0
Unweighted Averages					
West and Central Africa		139,013	99.3	0.1	0.5
East and Southern Africa		146,317	99.4	0.1	0.5
Middle East/North Africa		24,533	99.3	0.3	0.5
Eastern Europe/NIS		27,975	99.6	0.1	0.3
Asia		232,965	99.8	0.1	0.2
Latin America and Caribbean		120,563	99.8	0.1	0.2
Total		**691,366**	**99.5**	**0.1**	**0.4**

* Ever-married samples

Table 9 illustrates the range of contraceptive methods used by non-pregnant women. The most commonly used method is contraceptive injections (7 percent), followed by pill (6 percent), condom (5 percent) and female sterilization (4 percent). A traditional method, withdrawal, also has almost 4 percent using and has particularly high use in the Eastern Europe/NIS region.

Table 9. Distribution of non-pregnant women by type of current contraceptive method, 45 DHS country surveys 2006-2012

Country	Survey date	Number of respondents	Not using	Pill	IUD	Injections	Dia-phragm	Condom	Female sterili-zation	Male sterili-zation	Implant	Lactational Amenor-rheic Method (LAM)	Female condom	Foam or jelly	Other modern method	Periodic abstinence	Abstinence (not postpartum)	Withdrawal	Other method (including country-specific method)
West and Central Africa																			
Benin	2006	15,850	80.7	1.5	0.6	1.7	0.0	2.9	0.3	0.0	0.5	0.2	0.0	0.0	0.0	8.1	0.0	3.2	0.3
Burkina Faso	2010	15,357	83.0	3.1	0.3	5.6	0.0	3.4	0.2	0.0	3.2	0.1	0.0	0.0	0.0	1.0	0.0	0.1	0.1
Cameroon	2011	13,914	73.7	1.8	0.2	2.6	0.0	12.0	0.4	0.0	0.6	0.2	0.2	0.0	0.0	6.5	0.0	1.4	0.5
DR Congo	2007	8,872	77.4	0.9	0.2	0.4	0.0	5.4	0.6	0.0	0.0	0.0	0.0	0.0	0.0	11.7	0.0	2.6	0.8
Ghana	2008	4,556	79.1	3.9	0.2	4.5	0.0	3.8	1.1	0.0	0.7	0.0	0.2	0.0	0.0	4.3	0.0	1.4	0.6
Liberia	2007	6,331	85.1	4.3	0.2	4.2	0.0	3.9	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.4	0.0	0.3	0.0
Mali	2006	12,721	91.4	3.0	0.1	2.6	0.0	0.5	0.3	0.0	0.1	0.5	0.0	0.0	0.0	0.8	0.0	0.1	0.6
Niger	2006	7,871	88.3	3.2	0.1	1.6	0.0	0.1	0.3	0.0	0.0	4.8	0.0	0.0	0.0	0.1	0.0	0.0	1.5
Nigeria	2008	29,891	82.8	1.7	0.8	2.2	0.0	5.3	0.3	0.0	0.0	1.3	0.0	0.0	0.0	2.3	0.0	2.0	1.2
Sao Tome & Principe	2008-09	2,394	66.4	11.5	0.3	9.0	0.0	7.7	1.0	0.0	0.0	0.4	0.0	0.0	0.0	2.2	0.0	0.9	0.5
Senegal	2010-11	14,480	89.6	3.2	0.5	4.0	0.0	0.7	0.2	0.0	1.0	0.1	0.0	0.0	0.0	0.3	0.0	0.2	0.4
Sierra Leone	2008	6,776	88.9	3.2	0.4	3.4	0.0	1.2	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.6	0.0	0.2	1.4
East and Southern Africa																			
Burundi	2010	8,408	85.0	1.6	1.9	7.1	0.0	0.9	0.4	0.0	0.4	0.0	0.0	0.0	0.0	1.2	0.0	1.5	0.0
Ethiopia	2011	15,310	78.9	1.6	0.2	15.1	0.0	0.3	0.4	0.0	2.5	0.0	0.0	0.0	0.0	0.7	0.0	0.2	0.0
Kenya	2008-09	7,851	65.5	5.1	1.1	15.9	0.0	2.8	3.4	0.0	1.4	0.4	0.0	0.0	0.0	3.5	0.0	0.5	0.5
Lesotho	2009	7,303	62.5	8.1	1.3	14.0	0.0	10.9	1.8	0.0	0.1	0.0	0.2	0.0	0.0	0.1	0.0	0.5	0.5
Madagascar	2008-09	15,938	65.5	5.2	0.3	15.4	0.0	1.0	1.0	0.1	1.3	0.8	0.0	0.0	0.0	8.6	0.0	0.7	0.2
Malawi	2010	20,948	61.1	2.1	0.2	21.1	0.0	2.9	8.3	0.0	1.2	0.0	0.1	0.0	0.0	0.7	0.0	1.4	1.0
Mozambique	2011	12,229	86.1	4.8	0.2	4.8	0.0	3.3	0.2	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.1
Namibia	2006-07	9,277	50.8	5.7	0.6	18.1	0.1	17.9	5.3	0.2	0.1	0.0	0.3	0.0	0.0	0.3	0.0	0.1	0.6
Rwanda	2010	12,715	69.2	4.2	0.3	15.7	0.0	2.0	0.5	0.0	3.9	0.3	0.0	0.0	0.0	1.7	0.0	1.9	0.4
Swaziland	2006-07	4,708	59.9	6.2	0.9	12.7	0.0	14.4	3.1	0.1	0.1	0.8	0.1	0.0	0.0	0.2	0.0	1.2	0.3
Tanzania	2010	9,170	68.2	5.7	0.5	9.4	0.0	4.7	2.8	0.0	2.0	1.1	0.0	0.0	0.0	2.9	0.0	2.1	0.8
Uganda	2011	7,663	73.3	2.4	0.4	12.1	0.0	3.7	2.5	0.1	2.1	0.1	0.0	0.0	0.0	1.2	0.0	1.7	0.4
Zambia	2007	6,384	66.5	8.3	0.1	6.9	0.0	5.7	1.6	0.0	0.3	4.6	0.1	0.0	0.0	1.0	0.0	4.0	1.0
Zimbabwe	2010-11	8,413	55.0	29.8	0.2	6.6	0.0	3.8	1.0	0.0	2.4	0.1	0.3	0.0	0.0	0.1	0.0	0.7	0.1
Middle East/North Africa																			
Egypt*	2008	14,972	37.9	12.2	37.1	7.6	0.0	0.7	1.1	0.0	0.5	0.0	0.0	0.0	0.0	0.5	0.0	0.2	2.0
Jordan*	2007	9,561	38.0	9.1	24.1	0.8	0.0	5.7	4.1	0.0	0.1	1.5	0.0	0.0	0.0	4.5	0.0	11.7	0.3
Eastern Europe/NIS																			0.0
Albania	2008-09	7,434	51.1	1.2	0.6	0.5	0.0	3.3	2.1	0.0	0.0	0.3	0.0	0.0	0.0	0.6	0.0	40.3	0.0
Armenia	2010	5,744	65.1	1.0	6.1	0.0	0.0	9.4	0.2	0.0	0.0	0.5	0.0	0.1	0.0	1.5	0.0	15.4	0.8
Azerbaijan	2006	8,147	66.9	0.7	6.0	0.0	0.0	1.4	0.3	0.0	0.0	0.7	0.0	0.1	0.0	2.6	0.0	21.0	0.2
Ukraine	2007	6,650	47.6	3.9	12.5	0.0	0.0	21.9	0.5	0.0	0.0	0.0	0.0	0.6	0.0	4.9	0.0	7.0	1.1
Asia																			
Bangladesh*	2011	16,680	39.0	27.2	0.7	11.2	0.0	5.5	4.9	1.2	1.1	0.0	0.0	0.0	0.0	6.9	0.0	1.9	0.4
Cambodia	2010	17,821	66.9	10.0	2.0	6.8	0.0	1.8	1.6	0.0	0.3	0.0	0.0	0.0	0.0	2.5	0.0	7.6	0.2
India	2005-06	117,956	53.8	2.4	1.4	0.1	0.0	4.1	31.2	0.8	0.0	0.0	0.0	0.3	0.0	3.9	0.0	2.0	0.0
Indonesia*	2007	31,231	39.0	13.1	4.9	31.6	1.3	3.1	0.2	1.5	0.0	0.0	0.0	0.0	0.0	2.1	0.2	0.1	2.8
Nepal	2011	12,053	59.9	3.3	1.0	7.3	0.0	3.5	12.5	6.3	0.9	0.0	0.0	0.0	0.0	0.9	0.0	4.3	0.0
Pakistan*	2012-13	12,097	62.1	1.7	2.5	2.9	0.0	9.4	9.3	0.3	0.1	1.6	0.0	0.0	0.1	0.7	0.0	9.1	0.1
Philippines	2008	12,889	65.7	10.5	2.5	1.7	0.0	1.7	6.3	0.0	0.0	0.2	0.0	0.0	0.0	4.3	0.0	6.7	0.3
Timor-Leste	2009	12,238	85.4	1.1	0.9	10.3	0.0	0.2	0.5	0.0	0.6	0.0	0.0	0.0	0.0	0.4	0.0	0.2	0.5

(Continued)

Table 9. – *Continued*

Country	Survey date	Number of respondents	Not using	Pill	IUD	Injections	Dia-phragm	Condom	Female sterili-zation	Male sterili-zation	Implant	Lactational Amenor-rheic Method (LAM)	Female condom	Foam or jelly	Other modern method	Periodic abstinence	Abstinence (not postpartum)	Withdrawal	Other method (including country-specific method)
Latin America and Caribbean																			
Bolivia	2008	16,001	56.1	2.6	5.9	7.8	0.0	3.8	4.5	0.1	0.0	0.5	0.0	0.1	0.0	14.9	0.0	3.4	0.2
Colombia	2010	51,729	40.9	6.3	5.4	7.7	0.0	7.4	23.4	1.8	2.8	0.1	0.0	0.1	0.0	1.5	0.0	2.4	0.2
Dominican Rep.	2007	25,996	43.5	9.9	1.7	3.3	0.0	3.1	35.5	0.0	0.4	0.3	0.0	0.0	0.0	0.9	0.0	1.1	0.1
Guyana	2009	4,782	63.8	6.2	5.0	3.4	0.0	15.1	3.9	0.0	0.1	0.1	0.0	0.0	0.0	0.6	0.0	1.0	0.6
Peru	2012	22,055	47.8	5.8	2.3	11.8	0.0	9.2	6.3	0.3	0.1	0.1	0.0	0.2	0.0	10.6	0.0	4.9	0.6
Unweighted Averages																			
West and Central Africa		139,013	82.2	3.4	0.3	3.5	0.0	3.9	0.4	0.0	0.5	0.7	0.0	0.0	0.0	3.3	0.0	1.0	0.7
East and Southern Africa		146,317	67.7	6.5	0.6	12.5	0.0	5.3	2.3	0.0	1.3	0.6	0.1	0.0	0.0	1.6	0.0	1.2	0.4
Middle East/North Africa		24,533	38.0	10.7	30.6	4.2	0.0	3.2	2.6	0.0	0.3	0.8	0.0	0.0	0.0	2.5	0.0	6.0	1.2
Eastern Europe/NIS		27,975	57.7	1.7	6.3	0.1	0.0	9.0	0.8	0.0	0.0	0.4	0.0	0.2	0.0	2.4	0.0	20.9	0.5
Asia		232,965	59.0	8.7	2.0	9.0	0.2	3.7	8.3	1.3	0.4	0.2	0.0	0.0	0.0	2.7	0.0	4.0	0.5
Latin America and Caribbean		120,563	50.4	6.2	4.1	6.8	0.0	7.7	14.7	0.4	0.7	0.2	0.0	0.1	0.0	5.7	0.0	2.6	0.3
Total		**691,366**	**65.9**	**5.8**	**3.0**	**7.4**	**0.0**	**5.1**	**4.1**	**0.3**	**0.7**	**0.5**	**0.0**	**0.0**	**0.0**	**2.8**	**0.0**	**3.8**	**0.5**

* Ever-married samples

3.3. Marital Status of Non-pregnant Women

Women who are not currently in a marital union (formally or informally married) are presumed to not have regular sexual relations, and they are less likely to be in need of a contraceptive method for fertility risk. The distribution of non-pregnant women by marital status is shown in Table 10. In this table for the five ever-married samples, the percentages never in union were calculated by using data from the household schedule of the DHS, assuming that women never in union are all not pregnant. Table 10 shows that 62 percent of non-pregnant women are either currently formally married or are living with a partner. West and Central Africa and Asia are the regions with the highest percentage of women in a marital union, 67 and 69 percent, respectively. Two countries, Mali and Niger, have more than 80 percent of non-pregnant women in a marital union and three others, Bangladesh, Indonesia and Nepal, have between 70 and 79 percent in a marital union. In four countries, less than half of non-pregnant women are in a marital union, Namibia (34 percent), Swaziland (40 percent), Dominican Republic and Swaziland (both 48 percent).

Table 10. Distribution of non-pregnant women by marital status, 45 DHS country surveys 2006-2012

			Current marital status					
Country	Survey date	Number of respondents	Never in union	Married	Living with partner	Widowed	Divorced	No longer living together/ separated
West and Central Africa								
Benin	2006	15,850	22.0	66.4	6.5	2.3	0.7	2.1
Burkina Faso	2010	15,357	19.3	73.6	3.7	1.9	0.3	1.1
Cameroon	2011	13,914	30.3	46.5	14.0	3.2	1.4	4.6
DR Congo	2007	8,872	27.0	54.4	8.4	2.2	2.0	6.0
Ghana	2008	4,556	34.4	43.9	12.1	2.2	3.4	4.1
Liberia	2007	6,331	27.3	40.1	22.1	2.9	1.3	6.4
Mali	2006	12,721	13.5	76.9	5.8	1.6	0.9	1.2
Niger	2006	7,871	11.6	83.6	0.2	1.7	2.5	0.4
Nigeria	2008	29,891	27.8	66.1	1.4	2.5	0.9	1.2
Sao Tome & Principe	2008-09	2,394	24.9	3.9	59.2	0.4	0.1	11.5
Senegal	2010-11	14,480	31.4	62.7	0.7	1.2	3.4	0.6
Sierra Leone	2008	6,776	19.9	63.9	9.7	2.8	0.5	3.1
East and Southern Africa								
Burundi	2010	8,408	36.9	37.3	16.1	4.8	0.5	4.3
Ethiopia	2011	15,310	29.2	55.4	4.0	3.5	5.7	2.1
Kenya	2008-09	7,851	33.0	52.1	4.0	4.6	1.4	5.0
Lesotho	2009	7,303	35.2	51.1	0.8	7.8	0.9	4.3
Madagascar	2008-09	15,938	19.4	58.8	8.6	2.1	1.5	9.5
Malawi	2010	20,948	21.4	56.8	8.2	3.9	5.3	4.5
Mozambique	2011	12,229	19.6	42.8	22.9	4.1	2.3	8.2
Namibia	2006-07	9,277	58.8	19.6	14.4	2.6	1.1	3.3
Rwanda	2010	12,715	40.9	33.8	13.9	5.8	4.7	0.8
Swaziland	2006-07	4,708	50.5	31.4	8.9	5.8	0.4	2.9
Tanzania	2010	9,170	26.8	56.0	5.0	3.1	5.5	3.6
Uganda	2011	7,663	26.9	34.0	24.8	4.2	0.7	9.3
Zambia	2007	6,384	28.0	57.9	0.7	4.7	6.6	2.0
Zimbabwe	2010-11	8,413	25.8	56.7	2.7	6.6	3.9	4.3
Middle East/North Africa								
Egypt*	2008	17,379	32.9	62.1	0.0	3.0	1.5	0.5
Jordan*	2007	13,262	45.8	51.3	0.0	1.3	1.5	0.2
Eastern Europe/NIS								
Albania	2008-09	7,434	31.7	64.0	1.2	1.6	1.3	0.2
Armenia	2010	5,744	33.3	59.5	0.5	2.6	3.8	0.3
Azerbaijan	2006	8,147	32.0	60.8	0.2	2.8	3.5	0.6
Ukraine	2007	6,650	23.2	54.5	4.7	3.5	11.8	2.3

(Continued)

Table 10. – *Continued*

Country	Survey date	Number of respondents	Current marital status					
			Never in union	Married	Living with partner	Widowed	Divorced	No longer living together/ separated
Asia								
Bangladesh*	2011	17,154	15.5	78.8	0.0	3.1	1.1	1.4
Cambodia	2010	17,821	32.4	59.5	0.6	3.2	4.0	0.3
India	2005-06	117,956	21.6	73.5	0.0	3.4	0.3	1.2
Indonesia*	2007	35,519	24.4	70.9	0.0	2.3	2.4	0.0
Nepal	2011	12,053	22.5	74.6	0.0	2.1	0.1	0.7
Pakistan*	2012-13	14,524	35.9	60.9	0.0	2.1	0.6	0.6
Philippines	2008	12,889	35.0	50.1	10.0	1.7	0.1	3.1
Timor-Leste	2009	12,238	38.2	55.3	2.0	2.6	0.7	1.2
Latin America and Caribbean								
Bolivia	2008	16,001	33.1	37.5	20.9	1.4	0.8	6.3
Colombia	2010	51,729	36.8	18.1	30.2	1.5	0.4	13.1
Dominican Rep.	2007	25,996	24.9	14.8	40.6	1.2	17.0	1.5
Guyana	2009	4,782	31.6	33.8	23.7	1.7	1.4	7.9
Peru	2012	22,055	33.5	24.9	30.8	0.5	0.4	9.9
Unweighted Averages								
West and Central Africa		139,013	24.1	56.8	12.0	2.1	1.5	3.5
East and Southern Africa		146,317	32.3	46.0	9.6	4.5	2.9	4.6
Middle East/North Africa		30,641	39.3	56.7	-	2.2	1.5	0.3
Eastern Europe/NIS		27,975	30.1	59.7	1.7	2.6	5.1	0.9
Asia		240,154	28.2	65.5	1.6	2.6	1.2	1.1
Latin America and Caribbean		120,563	32.0	25.8	29.2	1.3	4.0	7.7
Total		**704,663**	**29.5**	**51.8**	**9.9**	**2.9**	**2.5**	**3.5**

* Ever-married samples:
Current marital status is calculated from the household declaration and never-in-union women are assumed to be not pregnant at the time of the survey. Therefore the number of respondents for these surveys will not match those of other tables.

3.4. Unmet Need for Contraception Based on Fertility Desires by Need for Contraception Based on Fertility Risk

For many non-pregnant women currently in a marital union, their desires for a future birth are aligned with their need for contraception due to fertility risk. Table 11 shows the coincidence of unmet need based on desires with the total need based on fertility risk. Among the women with no risk-based need (first column panel), about half have either no unmet need based on desires or are infecund or menopausal. Only 11 percent of the women with a risk-based need also have an unmet need based on desires, while 39 percent are using contraception and therefore meeting their needs.

Among the non-pregnant married women with a risk-based need for spacing (second column panel), about one in four have an unmet desire-based need, 44 percent are using contraception to meet their desire-based need, and 30 percent either have no unmet desire-based need, are infecund, or menopausal.

Similarly, among those with a risk-based need for limiting (third column panel), 23 percent have an desire-based need that is unmet, 39 percent are using contraception to meet their desire-based need, and 30 percent either have no unmet desire-based need, are infecund, or menopausal.

Table 11. Among non-pregnant married and in-union women, unmet need for contraception based on fertility desires by need for contraception based on fertility risk, 45 DHS country surveys 2006-2012

		Need for contraception based on fertility risk[1]																				
		No need for contraception							Spacing method need							Need for LAPM						
			Unmet need for contraception based on desires							Unmet need for contraception based on desires							Unmet need for contraception based on desires					
Country	Survey date	Number of respondents	Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal	Number of respondents	Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal	Number of respondents	Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal
West and Central Africa																						
Benin	2006	1,857	6.7	2.0	10.0	3.8	47.3	30.2	2,283	30.4	0.7	21.9	1.2	43.5	2.2	7,407	15.8	20.6	9.3	10.9	37.2	5.9
Burkina Faso	2010	1,869	10.3	0.5	19.2	1.4	35.5	32.8	2,228	30.9	0.4	16.3	0.7	50.9	0.7	7,774	17.7	11.1	9.6	8.7	35.8	16.8
Cameroon	2011	1,686	7.1	0.4	25.7	2.3	31.3	33.1	1,550	25.6	1.4	25.2	1.2	46.1	0.5	5,181	14.1	13.7	12.2	14.9	28.5	16.3
DR Congo	2007	1,140	4.9	2.0	11.4	7.2	11.0	63.6	1,074	30.5	1.3	24.5	1.2	37.2	5.3	3,357	16.8	7.5	14.8	11.4	27.6	21.8
Ghana	2008	490	15.4	1.2	23.9	2.1	33.0	24.5	439	45.0	4.2	21.5	2.6	25.5	1.2	1,622	17.0	19.8	8.7	18.6	17.7	18.1
Liberia	2007	701	20.1	1.6	13.0	1.4	27.7	36.3	558	45.3	2.3	5.8	0.2	44.0	1.9	2,676	20.2	17.3	6.8	7.6	21.8	25.7
Mali	2006	2,007	17.4	0.9	8.1	1.4	48.4	23.7	2,003	33.9	1.4	9.0	0.7	52.8	2.0	6,509	19.1	17.4	5.2	4.6	47.4	6.1
Niger	2006	861	5.6	0.1	4.2	1.4	38.7	50.0	1,373	16.9	0.1	12.6	0.1	65.7	4.6	4,361	13.6	4.4	12.8	2.6	51.8	14.7
Nigeria	2008	2,784	9.2	1.0	10.3	1.5	39.0	38.8	3,893	21.5	0.4	15.1	0.5	59.4	2.9	13,521	14.2	8.2	8.8	9.7	37.9	21.0
Sao Tome & Principe	2008-09	271	22.5	3.1	30.6	7.0	18.3	18.5	237	27.5	8.2	39.9	7.1	13.9	3.4	1,002	11.7	23.2	13.6	31.0	7.7	12.6
Senegal	2010-11	1,934	11.6	0.6	7.2	0.5	44.5	35.6	1,798	38.0	1.3	15.4	0.3	44.5	0.6	5,455	21.2	13.3	8.8	8.2	29.3	19.2
Sierra Leone	2008	1,102	8.9	2.1	6.1	1.4	29.8	51.3	796	28.0	3.9	4.7	0.3	55.7	6.6	3,092	15.5	16.9	4.4	6.3	27.0	29.4
East and Southern Africa																						
Burundi	2010	451	8.3	0.4	13.8	1.0	41.0	35.5	1,028	28.4	0.2	29.2	0.8	39.8	1.5	3,013	19.3	15.0	12.3	14.5	25.4	13.4
Ethiopia	2011	1,722	9.4	1.9	34.6	8.4	18.3	27.4	1,549	24.4	2.2	28.5	5.0	37.8	2.1	5,835	15.4	14.2	11.1	17.8	24.4	17.1
Kenya	2008-09	783	6.7	3.7	37.9	14.8	22.7	14.2	706	21.3	4.8	40.2	9.3	22.7	1.7	2,914	8.9	17.7	9.7	41.1	11.9	10.8
Lesotho	2009	1,156	6.7	4.4	31.1	20.8	24.2	12.4	842	20.0	11.2	27.6	23.8	16.3	0.8	1,787	4.5	19.8	4.5	44.3	4.4	22.2
Madagascar	2008-09	2,376	10.4	1.7	37.5	8.7	20.1	21.5	1,703	21.6	1.6	34.5	4.4	36.5	1.4	6,667	6.8	13.7	12.1	33.6	18.9	14.9
Malawi	2010	1,918	12.9	3.7	27.0	9.3	29.5	17.6	2,723	18.2	3.2	42.4	8.3	26.5	1.3	8,970	9.6	14.7	16.6	40.1	11.0	8.0
Mozambique	2011	1,649	7.2	1.7	7.8	2.8	34.1	46.3	1,690	24.3	2.9	11.9	1.4	58.0	1.4	4,706	13.7	15.2	6.0	8.6	37.0	19.4
Namibia	2006-07	756	6.4	5.3	34.3	26.3	17.9	9.6	456	11.0	8.1	34.7	31.2	14.1	0.9	1,945	7.1	13.2	9.7	49.0	8.9	11.8
Rwanda	2010	835	6.9	0.5	43.9	9.6	21.9	17.0	1,183	13.6	0.8	54.5	6.6	23.9	0.5	4,058	7.5	13.8	13.6	45.2	8.9	10.9
Swaziland	2006-07	430	9.1	6.1	26.5	23.7	20.9	13.6	267	11.4	14.3	29.4	30.5	11.6	2.9	1,198	3.2	19.6	5.9	50.0	7.0	14.3
Tanzania	2010	956	4.0	0.2	28.2	2.4	25.8	39.4	1,008	24.5	1.3	36.1	2.9	34.9	0.3	3,629	13.4	9.2	19.2	22.6	20.2	15.5
Uganda	2011	518	8.0	1.9	21.3	3.2	33.5	32.1	763	32.0	1.4	29.9	3.2	32.8	0.5	3,229	17.0	17.8	14.2	24.4	16.5	10.0
Zambia	2007	489	7.9	1.5	22.9	6.0	35.9	25.7	688	21.0	0.7	49.5	4.3	24.0	0.4	2,564	12.3	13.0	25.0	25.1	15.6	9.1
Zimbabwe	2010-11	1,213	4.3	2.4	40.3	14.5	26.3	12.3	1,294	9.4	1.4	64.3	12.1	12.0	0.8	2,492	4.6	9.3	22.6	45.0	8.3	10.2
Middle East/North Africa																						
Egypt	2008	2,943	2.1	2.1	15.4	27.4	29.8	23.2	2,651	8.3	2.9	48.0	19.7	19.7	1.1	8,250	1.2	8.4	3.7	71.8	3.4	11.2
Jordan	2007	1,204	2.7	3.2	20.6	7.7	36.2	29.6	1,315	11.8	1.3	58.6	5.5	21.4	0.9	6,523	2.8	9.2	19.9	52.6	7.5	7.4
Eastern Europe/NIS																						
Albania	2008-09	1,471	5.2	6.3	28.8	37.2	10.4	12.1	405	16.1	4.8	48.2	19.3	10.7	0.8	2,976	0.7	11.8	2.7	72.0	1.2	11.5
Armenia	2010	1,367	4.1	4.3	22.5	32.4	9.1	27.7	527	18.1	2.2	45.1	17.6	16.7	0.1	1,555	1.3	14.5	3.6	54.9	1.2	24.5
Azerbaijan	2006	1,610	2.7	8.8	11.0	41.1	16.6	19.6	644	10.4	11.4	27.4	24.4	24.1	0.8	2,720	1.1	29.1	1.7	54.3	1.9	11.7
Ukraine	2007	2,003	3.9	2.6	37.7	34.4	4.7	16.5	365	12.1	3.8	44.8	25.4	13.0	0.3	1,564	0.8	12.4	3.6	63.1	1.2	18.8
Asia																						
Bangladesh	2011	5,438	5.0	4.2	27.8	34.6	14.1	14.2	2,529	12.3	4.1	39.0	23.1	20.6	0.9	7,600	1.5	11.6	2.4	66.3	3.5	14.7
Cambodia	2010	2,663	6.9	3.4	35.1	21.0	15.0	18.5	1,988	14.8	4.6	40.1	12.3	27.4	0.4	6,056	2.4	16.4	7.2	48.0	6.5	19.1
India	2005-06	25,424	4.3	3.0	7.5	44.3	17.7	23.2	12,896	20.8	6.6	16.0	20.2	35.0	0.7	48,351	1.8	8.3	1.0	70.5	5.6	12.5
Indonesia	2007	10,127	4.1	2.0	39.8	24.2	15.8	14.0	4,442	8.3	2.5	54.7	20.5	12.6	0.9	14,704	2.1	7.1	8.8	53.4	3.6	24.5
Nepal	2011	2,930	12.2	17.4	10.2	34.4	13.1	12.7	1,410	27.2	13.1	14.4	17.7	26.7	0.9	4,647	1.6	19.8	0.4	64.5	5.2	8.5
Pakistan	2012-13	2,116	5.3	1.8	9.0	7.3	46.8	29.7	1,777	23.8	2.3	29.9	5.3	37.9	0.7	7,585	5.6	16.8	6.2	41.3	10.6	19.3
Philippines	2008	1,867	8.1	5.1	29.7	19.8	19.6	17.7	1,156	22.1	9.6	34.6	19.8	13.5	0.5	4,721	3.6	17.6	6.0	51.6	5.6	15.7
Timor-Leste	2009	712	17.9	0.8	14.0	4.5	18.4	44.2	1,048	40.9	1.6	17.0	0.7	38.1	1.7	5,254	18.5	14.8	13.4	14.2	18.4	20.9

(Continued)

Table 11. – *Continued*

Country	Survey date	Need for contraception based on fertility risk[1]: No need for contraception — Number of respondents	Unmet need for contraception based on desires: Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal	Spacing method need — Number of respondents	Unmet need for contraception based on desires: Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal	Need for LAPM — Number of respondents	Unmet need for contraception based on desires: Unmet need for spacing	Unmet need for limiting	Using for spacing	Using for limiting	No unmet need	Infecund, meno-pausal
Latin America and Caribbean																						
Bolivia	2008	2,276	3.0	3.5	39.7	27.9	8.1	17.9	1,399	13.8	9.4	32.3	29.9	14.2	0.5	5,669	2.0	16.4	7.1	59.1	3.5	11.9
Colombia	2010	8,636	2.4	1.8	33.2	43.3	10.3	8.9	3,232	6.4	2.8	41.4	40.9	6.8	0.4	13,120	0.6	4.9	3.6	83.9	2.1	4.7
Dominican Rep.	2007	3,612	8.2	2.2	33.3	25.4	19.3	11.4	1,793	14.3	2.7	54.8	17.9	10.1	0.2	8,997	1.6	4.9	3.3	83.5	2.3	4.3
Guyana	2009	810	13.1	8.0	22.5	17.3	19.1	20.0	310	21.6	10.3	34.5	13.0	19.5	1.1	1,629	3.9	26.1	4.3	43.0	4.8	17.8
Peru	2012	3,873	2.4	1.9	44.1	29.7	6.8	15.1	1,720	4.8	3.1	47.8	33.6	7.7	0.2	6,684	0.6	5.2	8.6	72.8	2.7	8.7
Unweighted Averages																						
West and Central Africa		16,702	11.6	1.3	14.1	2.6	33.7	36.5	18,232	31.1	2.1	17.7	1.3	44.9	2.7	61,957	16.4	14.5	0.7	11.2	30.8	17.3
East and Southern Africa		15,252	7.7	2.5	29.1	10.8	26.6	23.2	15,900	20.1	3.9	36.6	10.3	27.9	1.2	53,007	10.2	14.7	0.4	33.0	15.6	13.4
Middle East/North Africa		4,147	2.4	2.7	18.0	17.6	33.0	26.4	3,966	10.1	2.1	53.3	12.6	20.6	1.0	14,773	2.0	8.8	1.2	62.2	5.5	9.3
Eastern Europe/NIS		6,451	4.0	5.5	25.0	36.3	10.2	19.0	1,941	14.2	5.6	41.4	21.7	16.1	0.5	8,815	1.0	17.0	0.5	61.1	1.4	16.6
Asia		51,277	8.0	4.7	21.6	23.8	20.1	21.8	27,246	21.3	5.6	30.7	15.0	26.5	0.8	98,918	4.6	14.1	0.5	51.2	7.4	16.9
Latin America and Caribbean		19,207	5.8	3.5	34.6	28.7	12.7	14.7	8,454	12.2	5.7	42.2	27.1	11.7	0.5	36,099	1.7	11.5	0.3	68.5	3.1	9.5
Total		**113,036**	**8.0**	**3.0**	**23.5**	**15.5**	**24.6**	**25.3**	**75,739**	**21.4**	**4.0**	**32.3**	**11.7**	**29.0**	**1.4**	**273,569**	**8.8**	**14.1**	**0.5**	**38.1**	**15.1**	**14.7**

[1] Need for contraception based on fertility risk is categorized as follows: The column "No need for contraception" includes women between the ages of 18 and 39 who have had less than 3 births and whose last birth (if any) occurred 27 or more months ago. The column "Spacing method need" includes women under age 18 and/or whose last birth occurred less than 27 months ago, and the column "Need for a LAPM" includes women who are age 40 or over and/or who have had 3 or more births.

3.4.1. Combining unmet needs by desire and risk

The overall level of unmet need, which is estimated by combining unmet need from desires with unmet need from fertility risk, is shown in Table 12. The unweighted average for the 45 DHS surveys between 2006 and 2012 indicates that 21 percent of non-pregnant women have an unmet need for contraception due to their desires or risk, 5 percent for an unmet spacing method, and 16 percent for a limiting method. Another 20 percent are using a spacing method but have a need for a LAPM. The other 59 percent of women have either no unmet need or are using the appropriate type of contraceptive method, indicating that 41 percent of women have a need for focused efforts by family planning programs.

By both desires and risk, unmet need is highest in West and Central Africa (28 percent) and lowest in the Middle East/North Africa. However, the need for focused efforts (if we assume women to be in need of focused efforts if they have either a desire- or risk-based unmet need, or a need for a more effective method) is high in all the regions, at between 33 and 45 percent of married women. In nine of the forty-five countries, the combined unmet need exceeds 30 percent of married women, 18 countries have a combined unmet need between 20 and 29 percent, 13 countries are between 10 and 29 percent, and 5 countries have a combined unmet need below 10 percent. For focused family planning efforts, there are only six countries in which less than 30 percent of married women need these efforts, and there are six countries where more than half of women need focused efforts.

Table 12. Percent distribution of non-pregnant married and in-union women by unmet combined need for contraception due to either desires or fertility risk and need for focused family planning efforts, 45 DHS country surveys 2006-2012

Country	Survey date	Number of respondents	No unmet need: no need or using appro-priately	Unmet need for a spacing method	Unmet need for a limiting method	Need for a more effective method: spacing method needs limiting	Need for focused family planning efforts[1]
West and Central Africa							
Benin	2006	11,547	57.0	7.1	23.8	11.9	42.8
Burkina Faso	2010	11,871	63.3	7.4	19.0	10.1	36.5
Cameroon	2011	8,417	60.7	6.1	17.4	15.5	39.0
DR Congo	2007	5,572	63.0	6.9	15.3	14.7	36.9
Ghana	2008	2,550	50.3	10.7	24.3	14.6	49.6
Liberia	2007	3,935	54.4	10.0	26.1	9.0	45.1
Mali	2006	10,520	61.3	9.8	23.0	5.6	38.4
Niger	2006	6,595	73.8	4.3	11.9	9.9	26.1
Nigeria	2008	20,198	68.0	5.4	15.2	11.2	31.8
Sao Tome & Principe	2008-09	1,509	38.3	8.3	25.1	28.2	61.6
Senegal	2010-11	9,188	60.5	9.9	20.8	8.8	39.5
Sierra Leone	2008	4,990	65.4	6.4	21.2	6.5	34.1
East and Southern Africa							
Burundi	2010	4,493	53.8	7.3	23.1	15.7	46.1
Ethiopia	2011	9,106	58.2	5.9	19.7	16.1	41.7
Kenya	2008-09	4,404	50.3	4.6	19.0	26.1	49.7
Lesotho	2009	3,784	58.6	6.5	15.3	19.2	41.0
Madagascar	2008-09	10,747	55.1	5.7	13.3	25.8	44.8
Malawi	2010	13,611	51.8	5.5	17.1	25.6	48.2
Mozambique	2011	8,045	67.3	6.6	17.9	8.2	32.7
Namibia	2006-07	3,157	57.4	3.1	14.9	24.3	42.3
Rwanda	2008	7,743	55.8	5.2	15.6	23.4	44.2
Swaziland	2006-07	1,895	50.3	3.7	17.8	28.1	49.6
Tanzania	2010	5,593	58.0	5.1	14.9	22.0	42.0
Uganda	2011	4,510	45.8	6.3	25.4	22.4	54.1
Zambia	2007	3,741	45.4	4.9	17.7	32.0	54.6
Zimbabwe	2010-11	4,999	57.8	3.5	7.9	30.9	42.3
Middle East/North Africa							
Egypt	2008	13,844	73.2	2.0	6.7	17.9	26.6
Jordan	2007	9,042	56.3	2.1	9.3	31.8	43.2
Eastern Europe/NIS							
Albania	2008-09	4,852	44.8	2.9	10.0	42.3	55.2
Armenia	2010	3,449	64.5	4.4	9.2	21.9	35.5
Azerbaijan	2006	4,974	51.1	2.2	20.8	25.4	48.4
Ukraine	2007	3,932	71.6	3.1	6.9	18.2	28.2
Asia							
Bangladesh	2011	15,567	60.9	3.7	8.5	26.8	39.0
Cambodia	2010	10,708	55.9	4.5	12.3	26.9	43.7
India	2005-06	86,671	79.8	4.3	7.4	8.1	19.8
Indonesia	2007	29,272	67.7	2.7	5.7	23.6	32.0
Nepal	2011	8,987	61.1	8.2	18.8	11.9	38.9
Pakistan	2012-13	11,478	60.0	4.7	15.5	19.7	39.9
Philippines	2010	6,075	48.4	3.6	14.5	33.5	51.6
Timor-Leste	2009	7,014	48.3	7.9	25.2	18.6	51.7
Latin America and Caribbean							
Bolivia	2008	9,344	54.3	2.8	13.4	29.4	45.6
Colombia	2010	24,988	82.1	1.7	3.9	12.1	17.7
Dominican Rep.	2007	14,402	83.7	3.8	5.0	7.4	16.2
Guyana	2009	2,749	54.5	6.3	21.3	17.8	45.4
Peru	2012	12,276	60.4	1.4	4.3	32.8	38.5

(Continued)

Table 12. – *Continued*

Country	Survey date	Number of respondents	No unmet need: no need or using appro-priately	Unmet need for a spacing method	Unmet need for a limiting method	Need for a more effective method: spacing method needs limiting	Need for focused family planning efforts[1]
Unweighted Averages							
West and Central Africa		96,892	59.7	7.7	20.3	12.2	40.1
East and Southern Africa		85,828	54.7	5.3	17.1	22.8	45.2
Middle East/North Africa		22,886	64.8	2.1	8.0	24.9	34.9
Eastern Europe/NIS		17,207	58.0	3.2	11.7	27.0	41.8
Asia		175,772	60.3	5.0	13.5	21.1	39.6
Latin America and Caribbean		63,759	67.0	3.2	9.6	19.9	32.7
Total		**462,344**	**59.1**	**5.3**	**15.6**	**19.8**	**40.7**

[1] Includes unmet need for spacing, unmet need for limiting and need for a more effective method
Note: Due to rounding, may not sum to 100.0 exactly

3.5. Background Characteristics of Women with a Need for Focused Family Planning Efforts

Tables 13a, b, and c respectively present the urban-rural residence, level of women's education, and economic status of women with a need for focused family planning efforts to satisfy combined unmet needs for spacing, limiting, and more effective methods. By residence, almost two of three women in need of focused efforts live in rural areas, and there is not a large difference between whether the need is for spacing or limiting (Table 13a and Figure 2). The regional and country patterns of need by residence generally follow the patterns observed for all the countries in total.

Table 13a. Distribution of non-pregnant married and in-union women in need of focused family planning efforts by area of residence, 45 DHS country surveys 2006-2012

Country	Survey date	Unmet need for a spacing method			Unmet need for a limiting method			Need for a more effective method: spacing method needs limiting			Total in need of focused family planning efforts		
		Number of respondents	Urban	Rural	Number of respondents	Urban	Rural	Number of respondents	Urban	Rural	Number of respondents	Urban	Rural
West and Central Africa													
Benin	2006	818	38.6	61.4	2,744	34.5	65.5	1,379	45.5	54.5	4,941	38.2	61.8
Burkina Faso	2010	880	23.9	76.1	2,261	16.6	83.4	1,197	35.4	64.6	4,338	23.3	76.7
Cameroon	2011	516	53.3	46.7	1,468	42.8	57.2	1,306	61.7	38.3	3,290	52.0	48.0
DR Congo	2007	383	44.9	55.1	853	41.3	58.7	821	49.2	50.8	2,057	45.1	54.9
Ghana	2008	273	39.7	60.3	620	38.1	61.9	374	47.3	52.7	1,266	41.1	58.9
Liberia	2007	393	41.1	58.9	1,027	30.3	69.7	355	51.8	48.2	1,776	37.0	63.0
Mali	2006	1,028	50.6	49.4	2,423	24.8	75.2	591	46.7	53.3	4,043	34.6	65.4
Niger	2006	281	24.7	75.3	787	21.2	78.8	652	27.4	72.6	1,719	24.1	75.9
Nigeria	2008	1,093	30.6	69.4	3,079	29.6	70.4	2,257	53.6	46.4	6,430	38.2	61.8
Sao Tome & Principe	2008-09	126	61.8	38.2	378	58.5	41.5	426	42.1	57.9	930	51.4	48.6
Senegal	2010-11	908	51.6	48.4	1,913	37.7	62.3	808	64.4	35.6	3,629	47.1	52.9
Sierra Leone	2008	321	33.7	66.3	1,056	26.9	73.1	325	53.0	47.0	1,702	33.2	66.8
East and Southern Africa													
Burundi	2010	329	7.9	92.1	1,039	5.8	94.2	707	12.3	87.7	2,075	8.3	91.7
Ethiopia	2011	539	12.2	87.8	1,794	10.7	89.3	1,469	24.8	75.2	3,803	16.4	83.6
Kenya	2008-09	203	25.5	74.5	838	16.4	83.6	1,149	15.1	84.9	2,190	16.6	83.4
Lesotho	2009	246	19.3	80.7	579	20.8	79.2	728	28.4	71.6	1,553	24.1	75.9
Madagascar	2008-09	615	21.1	78.9	1,434	11.6	88.4	2,771	15.8	84.2	4,820	15.3	84.7
Malawi	2010	744	17.8	82.2	2,332	17.3	82.7	3,485	15.4	84.6	6,561	16.3	83.7
Mozambique	2011	529	33.6	66.4	1,443	31.0	69.0	657	51.6	48.4	2,628	36.7	63.3
Namibia	2006-07	99	46.5	53.5	471	34.4	65.6	766	50.8	49.2	1,336	44.7	55.3
Rwanda	2010	219	19.1	80.9	879	9.2	90.8	2,036	11.7	88.3	3,134	11.5	88.5
Swaziland	2006-07	70	21.3	78.7	338	22.1	77.9	533	23.2	76.8	941	22.6	77.4
Tanzania	2010	285	23.5	76.5	832	17.9	82.1	1,229	25.7	74.3	2,347	22.7	77.3
Uganda	2011	286	20.7	79.3	1,146	8.9	91.1	1,012	20.3	79.7	2,443	15.0	85.0
Zambia	2007	183	33.4	66.6	661	29.3	70.7	1,197	34.4	65.6	2,042	32.7	67.3
Zimbabwe	2010-11	173	37.0	63.0	394	26.3	73.7	1,544	27.7	72.3	2,111	28.2	71.8
Middle East/North Africa													
Egypt	2008	281	30.1	69.9	930	29.6	70.4	2,478	36.4	63.6	3,689	34.2	65.8
Jordan	2007	188	76.0	24.0	841	83.5	16.5	2,877	85.5	14.5	3,906	84.6	15.4
Eastern Europe/NIS													
Albania	2008-09	142	36.9	63.1	485	31.0	69.0	2,053	42.3	57.7	2,680	40.0	60.0
Armenia	2010	151	49.0	51.0	316	50.6	49.4	754	55.8	44.2	1,222	53.6	46.4
Azerbaijan	2006	111	50.8	49.2	1,035	53.5	46.5	1,265	49.3	50.7	2,412	51.2	48.8
Ukraine	2007	123	60.9	39.1	272	59.8	40.2	716	68.8	31.2	1,111	65.7	34.3

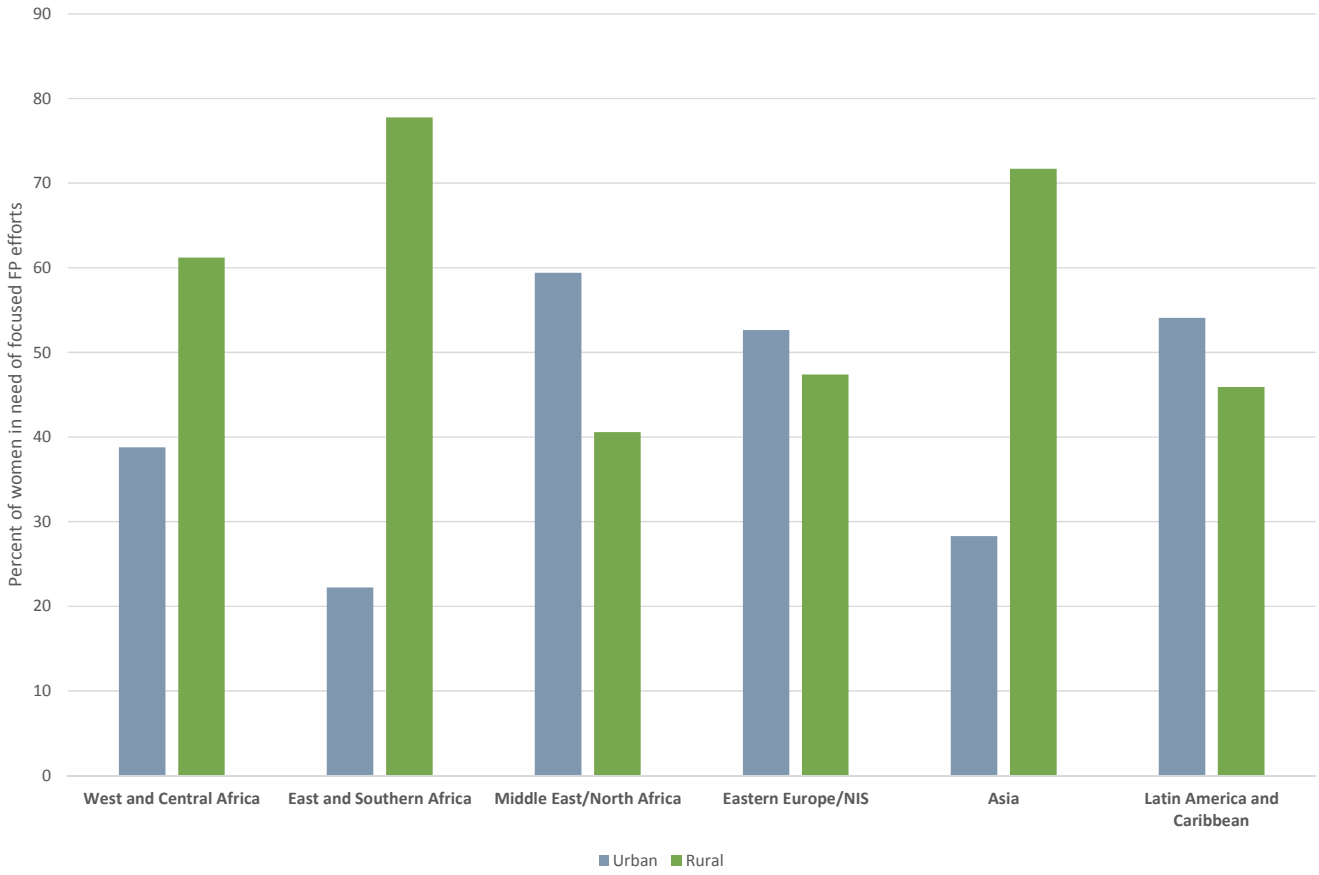
(Continued)

Table 13a. – *Continued*

Country	Survey date	Unmet need for a spacing method			Unmet need for a limiting method			Need for a more effective method: spacing method needs limiting			Total in need of focused family planning efforts		
		Number of respondents	Urban	Rural	Number of respondents	Urban	Rural	Number of respondents	Urban	Rural	Number of respondents	Urban	Rural
Asia													
Bangladesh	2011	583	21.6	78.4	1,321	21.2	78.8	4,171	22.9	77.1	6,075	22.4	77.6
Cambodia	2010	478	13.5	86.5	1,321	12.8	87.2	2,878	15.6	84.4	4,677	14.6	85.4
India	2005-06	3,769	23.0	77.0	6,451	23.0	77.0	7,048	34.6	65.4	17,268	27.7	72.3
Indonesia	2007	787	44.6	55.4	1,677	37.4	62.6	6,916	40.7	59.3	9,379	40.5	59.5
Nepal	2011	740	9.1	90.9	1,691	9.8	90.2	1,069	14.9	85.1	3,500	11.2	88.8
Pakistan	2012-13	536	32.2	67.8	1,777	27.4	72.6	2,260	41.3	58.7	4,573	34.8	65.2
Philippines	2008	405	50.4	49.6	1,206	47.9	52.1	1,813	49.3	50.7	3,425	48.9	51.1
Timor-Leste	2009	556	23.4	76.6	1,768	24.1	75.9	1,303	30.4	69.6	3,627	26.3	73.7
Latin America and Caribbean													
Bolivia	2008	261	62.5	37.5	1,255	43.0	57.0	2,751	54.4	45.6	4,267	51.6	48.4
Colombia	2010	414	73.6	26.4	966	68.3	31.7	3,027	63.9	36.1	4,407	65.8	34.2
Dominican Rep.	2007	553	76.3	23.7	714	66.2	33.8	1,070	69.9	30.1	2,337	70.3	29.7
Guyana	2009	173	21.6	78.4	584	23.5	76.5	490	20.3	79.7	1,247	22.0	78.0
Peru	2012	173	67.5	32.5	522	58.2	41.8	4,023	60.7	39.3	4,719	60.7	39.3
Unweighted Averages													
West and Central Africa		7,020	41.2	58.8	18,609	33.5	66.5	10,491	48.2	51.8	36,121	38.8	61.2
East and Southern Africa		4,520	24.2	75.8	14,180	18.7	81.3	19,283	25.5	74.5	37,984	22.2	77.8
Middle East/North Africa		469	53.1	47.0	1,771	56.6	43.5	5,355	61.0	39.1	7,595	59.4	40.6
Eastern Europe/NIS		527	49.4	50.6	2,108	48.7	51.3	4,788	54.1	46.0	7,425	52.6	47.4
Asia		7,854	27.2	72.8	17,212	25.5	74.6	27,458	31.2	68.8	52,524	28.3	71.7
Latin America and Caribbean		1,574	60.3	39.7	4,041	51.8	48.2	11,361	53.8	46.2	16,977	54.1	45.9
Total		**21,964**	**36.8**	**63.2**	**57,921**	**31.9**	**68.1**	**78,736**	**39.8**	**60.2**	**158,626**	**35.6**	**64.4**

Note: Women with an unmet need (either desire- or fertility-risk based) and women with a need for a more effective method constitute the group who require focused family planning efforts.

Figure 2. Percent distribution of non-pregnant married and in-union women in need of focused family planning efforts by area of residence within region, 45 DHS country surveys 2006-2012



By education, over half of the women with a need for focused family planning efforts have less than a primary complete education; only 10 percent have completed secondary school and 8 percent have higher education (Table 13b). The needs for spacing and for limiting vary by level of education, with fewer less-educated women with a need for spacing and more with a need for limiting. For example, 41 percent of women with less than a primary school education have a need for limiting while 56 percent have a need for spacing. The opposite is true for women with secondary or higher education: 21 percent of these women have a spacing need and 15 percent have a limiting need (Table 13b and Figure 3).

Table 13b. Percent distribution of non-pregnant married and in-union women in need of focused family planning efforts by level of education, 45 DHS country surveys 2006-2012

Country	Survey date	Unmet need for a spacing method: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Unmet need for a limiting method: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Need for a more effective method: Spacing method needs limiting: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Total: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher
West and Central Africa																													
Benin	2006	818	63.3	21.3	3.0	10.6	0.6	1.3	2,744	77.9	15.1	1.7	4.8	0.2	0.2	1,379	62.7	20.3	2.8	12.6	0.9	0.6	4,941	71.3	17.6	2.2	8.0	0.5	0.5
Burkina Faso	2010	880	73.5	13.7	4.2	7.1	0.8	0.7	2,261	88.8	6.6	2.0	2.1	0.1	0.4	1,197	69.8	13.2	4.1	11.3	0.7	0.9	4,338	80.5	9.9	3.0	5.7	0.4	0.6
Cameroon	2011	516	16.7	20.5	14.5	42.5	1.5	4.2	1,468	32.5	28.9	15.3	20.4	0.9	1.9	1,306	6.3	14.7	29.8	40.9	2.6	5.7	3,290	19.6	22.0	20.9	32.0	1.7	3.8
DR Congo	2007	383	16.9	31.8	8.9	36.0	4.4	1.9	853	24.6	30.4	8.1	31.2	5.3	0.3	821	15.6	30.0	9.7	34.3	9.2	1.2	2,057	19.6	30.5	8.9	33.4	6.7	1.0
Ghana	2008	273	19.1	19.0	7.4	42.7	7.5	4.2	620	36.7	21.3	4.6	32.2	3.9	1.3	374	20.5	20.5	8.3	43.4	6.1	1.2	1,266	28.1	20.6	6.3	37.7	5.3	1.9
Liberia	2007	393	28.3	36.3	8.3	18.3	6.2	2.6	1,027	55.0	25.1	4.9	9.5	4.3	1.0	355	42.6	25.1	4.6	17.5	8.1	1.9	1,776	46.6	27.6	5.6	13.1	5.5	1.5
Mali	2006	1,028	63.4	12.5	1.6	20.2	0.9	1.4	2,423	87.1	7.2	1.4	3.8	0.2	0.3	591	67.9	16.5	2.2	12.1	0.6	0.7	4,043	78.3	9.9	1.6	9.2	0.4	0.7
Niger	2006	281	80.9	10.4	1.5	6.6	0.3	0.2	787	87.2	8.2	0.9	3.4	0.3	0.0	652	79.6	11.1	2.1	5.9	0.6	0.7	1,719	83.3	9.6	1.5	4.9	0.4	0.3
Nigeria	2008	1,093	39.3	5.1	12.2	16.4	19.6	7.4	3,079	47.5	7.9	19.4	9.9	10.9	4.3	2,257	13.4	5.8	24.2	15.9	26.8	13.9	6,430	34.1	6.7	19.9	13.1	18.0	8.2
Sao Tome & Principe	2008-09	126	4.0	38.4	11.2	46.4	0.0	0.0	378	9.5	56.9	10.9	21.9	0.9	0.0	426	4.1	63.6	11.8	19.8	0.3	0.4	930	6.3	57.4	11.3	24.3	0.5	0.2
Senegal	2010-11	908	57.6	23.7	4.4	12.9	0.2	1.2	1,913	76.3	14.6	2.8	5.2	0.7	0.5	808	52.0	26.2	7.5	11.6	0.9	1.8	3,629	66.2	19.5	4.2	8.5	0.6	1.0
Sierra Leone	2008	321	67.5	9.9	2.2	14.5	2.2	3.6	1,056	77.9	9.6	2.2	8.2	0.8	1.3	325	61.6	10.0	4.6	18.7	2.0	3.2	1,702	72.8	9.7	2.7	11.4	1.3	2.1
East and Southern Africa																													
Burundi	2010	329	49.2	31.2	12.0	5.6	0.5	1.5	1,039	61.7	22.4	12.4	3.4	0.0	0.1	707	45.7	25.0	19.4	8.9	0.5	0.6	2,075	54.2	24.7	14.7	5.6	0.2	0.5
Ethiopia	2011	539	51.9	38.1	2.9	3.4	1.4	2.4	1,794	75.8	21.3	1.7	0.6	0.3	0.3	1,469	64.4	26.9	2.4	2.3	1.1	2.9	3,803	68.0	25.8	2.1	1.7	0.8	1.6
Kenya	2008-09	203	6.7	30.2	32.7	9.7	16.3	4.5	838	13.0	39.1	29.7	8.6	7.7	1.9	1,149	4.6	31.9	31.4	10.3	16.9	4.9	2,190	8.0	34.5	30.9	9.6	13.3	3.8
Lesotho	2009	246	0.3	23.7	28.6	36.5	8.1	2.8	579	1.8	35.1	33.3	24.8	3.5	1.4	728	1.3	30.6	28.1	28.8	4.7	6.5	1,553	1.3	31.2	30.1	28.5	4.8	4.0
Madagascar	2008-09	615	17.7	41.8	6.9	27.7	3.1	2.8	1,434	23.3	50.6	4.9	18.7	1.0	1.5	2,771	13.0	48.6	6.2	27.2	2.4	2.6	4,820	16.7	48.3	5.9	24.7	2.1	2.3
Malawi	2010	744	7.5	57.5	10.1	15.3	7.9	1.6	2,332	24.1	57.5	8.6	7.0	2.2	0.6	3,485	18.0	61.7	8.5	8.0	3.1	0.6	6,561	19.0	59.8	8.7	8.5	3.3	0.7
Mozambique	2011	529	22.4	40.8	12.0	21.8	2.4	0.7	1,443	37.6	49.3	5.0	6.0	1.2	0.8	657	22.5	47.0	9.4	15.4	4.2	1.6	2,628	30.8	47.0	7.5	11.5	2.2	1.0
Namibia	2006-07	99	8.1	25.0	6.1	42.3	11.8	6.6	471	20.5	29.9	10.2	27.4	6.4	5.5	766	11.4	27.2	6.4	37.5	8.5	9.0	1,336	14.3	28.0	7.7	34.3	8.0	7.6
Rwanda	2010	219	18.6	56.5	15.2	4.9	3.6	1.2	879	28.0	54.4	11.8	4.4	0.7	0.6	2,036	20.0	55.0	15.0	7.7	1.5	0.8	3,134	22.1	55.0	14.1	6.6	1.4	0.8
Swaziland	2006-07	70	7.3	19.4	19.6	43.5	6.7	3.5	338	17.4	25.3	17.1	28.5	8.7	3.0	533	7.4	22.7	13.9	35.6	12.3	8.0	941	11.0	23.4	15.5	33.6	10.6	5.9
Tanzania	2010	285	28.3	11.9	49.9	9.6	0.4	0.0	832	27.9	14.0	54.7	3.2	0.1	0.0	1,229	18.1	11.8	61.6	6.1	2.1	0.4	2,347	22.8	12.6	57.7	5.5	1.2	0.2
Uganda	2011	286	4.9	48.8	16.1	20.6	2.8	6.9	1,146	20.1	56.0	12.0	10.1	0.3	1.5	1,012	11.0	48.9	11.9	22.7	1.0	4.4	2,443	14.6	52.2	12.4	16.6	0.9	3.4
Zambia	2007	183	11.3	38.7	23.2	17.2	7.0	2.6	661	15.7	46.7	21.1	13.6	1.1	1.8	1,197	13.9	40.9	21.5	16.9	3.0	3.9	2,042	14.2	42.6	21.5	15.9	2.8	3.1
Zimbabwe	2010-11	173	0.0	10.9	13.9	72.3	0.7	2.2	394	4.6	18.5	22.4	49.1	1.0	4.4	1,544	3.5	16.3	22.4	54.3	0.3	3.2	2,111	3.4	16.2	21.7	54.8	0.5	3.4
Middle East/North Africa																													
Egypt	2008	281	18.1	5.0	2.0	11.2	45.7	18.1	930	42.8	9.9	4.1	10.8	26.4	5.9	2,478	40.1	10.8	5.8	10.6	26.2	6.5	3,689	39.1	10.2	5.1	10.7	27.7	7.2
Jordan	2007	188	1.3	2.9	1.2	43.6	16.0	35.1	841	6.5	5.7	5.0	45.7	13.7	23.4	2,877	2.9	3.1	2.9	43.5	18.2	29.5	3,906	3.6	3.6	3.2	44.0	17.1	28.4
Eastern Europe/NIS																													
Albania	2008-09	142	1.0	1.7	62.2	4.4	13.3	17.4	485	0.2	2.8	63.3	4.2	22.7	6.8	2,053	0.3	2.3	54.2	4.4	31.0	7.9	2,680	0.3	2.3	56.2	4.4	28.6	8.2
Armenia	2010	151	0.0	0.0	0.0	4.2	46.6	49.2	316	0.0	0.0	0.0	6.0	50.0	44.0	754	0.0	0.0	0.0	4.2	40.2	55.6	1,222	0.0	0.0	0.0	4.7	43.5	51.8
Azerbaijan	2006	111	0.3	1.3	1.1	71.1	14.1	12.1	1,035	1.1	0.6	0.8	45.3	41.7	10.5	1,265	1.0	0.3	0.2	37.1	51.3	10.0	2,412	1.0	0.5	0.5	42.2	45.5	10.3
Ukraine	2007	123	0.0	0.0	0.0	30.2	6.0	63.7	272	0.0	0.0	0.3	36.6	9.0	54.1	716	0.1	0.0	0.2	29.6	7.9	62.1	1,111	0.1	0.0	0.2	31.4	8.0	60.3
Asia																													
Bangladesh	2011	583	7.9	10.9	10.9	53.2	6.3	10.7	1,321	31.5	19.9	10.5	28.3	4.1	5.6	4,171	39.0	23.8	11.5	18.4	3.1	4.1	6,075	34.4	21.7	11.3	23.9	3.6	5.1
Cambodia	2010	478	13.8	44.7	10.7	27.1	1.9	1.7	1,321	22.4	56.1	5.0	14.2	1.6	0.6	2,878	19.8	53.2	6.4	17.9	1.5	1.1	4,677	19.9	53.2	6.5	17.8	1.6	1.0
India	2005-06	3,769	36.8	6.2	9.1	36.7	5.5	5.6	6,451	59.8	6.8	6.3	20.6	2.7	3.8	7,048	48.9	8.3	6.8	25.6	3.5	7.0	17,268	50.3	7.3	7.1	26.2	3.6	5.5
Indonesia	2007	787	2.2	8.7	30.8	27.1	25.4	5.8	1,677	10.9	22.4	30.5	17.4	14.4	4.3	6,916	7.3	20.9	33.8	17.5	14.8	5.6	9,379	7.5	20.2	33.0	18.3	15.6	5.4
Nepal	2011	740	20.6	14.1	5.6	33.8	16.9	9.0	1691.0	47.0	15.8	7.1	18.7	7.1	4.2	1069.0	59.7	15.3	3.9	12.6	4.4	4	3,500	45.3	15.3	5.8	20.0	8.4	5.2
Pakistan	2012-13	536	43.0	8.1	12.0	11.6	13.0	12.3	1,777	68.6	6.8	7.0	6.7	6.4	4.6	2,260	50.3	6.7	12.9	9.2	10.9	9.9	4,573	56.6	6.9	10.5	8.5	9.4	8.1
Philippines	2008	405	1.1	9.1	9.6	13.3	32.1	34.8	1,206	2.6	13.5	15.8	16.2	26.3	25.5	1,813	0.8	10.5	17.0	16.7	30.4	24.7	3,425	1.4	11.4	15.7	16.1	29.1	26.2
Timor-Leste	2009	556	23.7	10.1	9.7	27.2	24.5	4.9	1,768	41.5	15.0	11.8	16.1	13.9	1.7	1,303	29.9	17.5	14.8	19.3	16.1	2.5	3,627	34.6	15.1	12.6	19.0	16.3	2.5

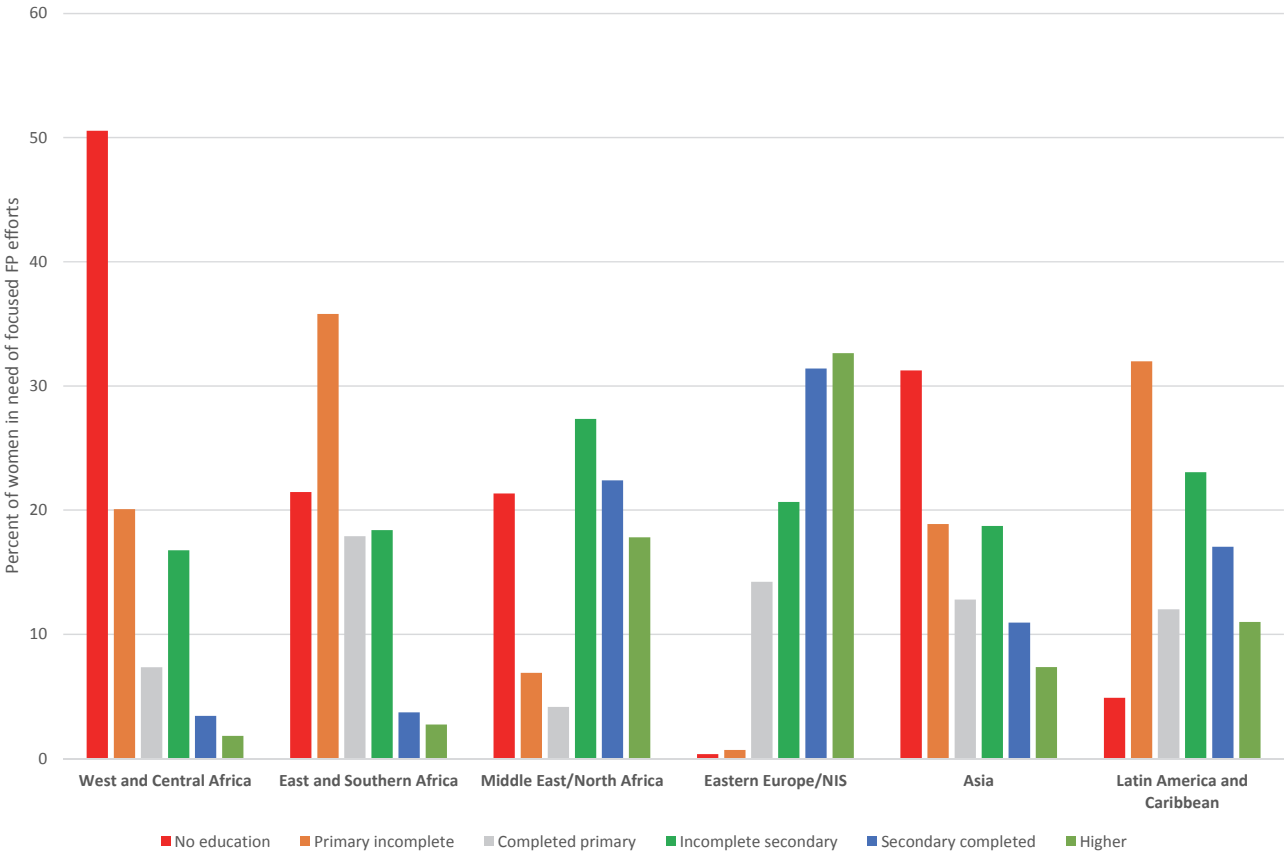
(Continued)

Table 13b. – *Continued*

Country	Survey date	Unmet need for a spacing method: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Unmet need for a limiting method: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Need for a more effective method: Spacing method needs limiting: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher	Total: Number of respondents	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher
Latin America and Caribbean																													
Bolivia	2008	261	2.2	34.1	8.7	18.6	20.2	16.2	1,255	11.7	61.6	5.1	9.4	7.0	5.0	2,751	7.1	56.6	5.9	10.6	10.8	9.0	4,267	8.2	56.7	5.8	10.7	10.2	8.3
Colombia	2010	414	3.2	7.1	11.1	31.3	26.1	21.1	966	5.8	19.4	18.2	21.5	22.2	12.9	3,027	3.6	23.7	19.9	22.7	19.3	10.8	4,407	4.0	21.2	18.7	23.2	20.6	12.2
Dominican Rep.	2007	553	1.0	22.4	9.2	30.7	15.5	21.3	714	7.7	40.4	7.2	23.2	10.1	11.4	1,070	5.2	43.2	9.6	20.4	10.1	11.4	2,337	5.0	37.4	8.8	23.7	11.4	13.8
Guyana	2009	173	0.8	7.1	6.3	36.8	36.1	13.0	584	3.0	17.3	12.8	41.2	21.1	4.7	490	1.7	16.3	13.4	45.6	18.7	4.4	1,247	2.2	15.5	12.1	42.3	22.2	5.7
Peru	2012	173	0.2	12.0	13.4	18.1	41.3	14.9	522	5.5	29.3	14.9	15.2	18.4	16.7	4,023	5.1	29.8	14.7	15.3	20.3	14.7	4,719	5.0	29.1	14.7	15.4	20.9	15.0
Unweighted Averages																													
West and Central Africa		7,020	44.2	20.2	6.6	22.9	3.7	2.4	18,609	58.4	19.3	6.2	12.7	2.4	1.0	10,491	41.3	21.4	9.3	20.3	4.9	2.7	36,121	50.6	20.1	7.3	16.8	3.4	1.8
East and Southern Africa		4,520	16.7	33.9	17.8	23.6	5.2	2.8	14,180	26.5	37.2	17.5	14.7	2.4	1.7	19,283	18.2	35.3	18.4	20.1	4.4	3.5	37,984	21.5	35.8	17.9	18.4	3.7	2.7
Middle East/North Africa		469	9.7	4.0	1.6	27.4	30.9	26.6	1,771	24.7	7.8	4.6	28.3	20.1	14.7	5,355	21.5	7.0	4.4	27.1	22.2	18.0	7,595	21.4	6.9	4.2	27.4	22.4	17.8
Eastern Europe/NIS		527	0.3	0.8	15.8	27.5	20.0	35.6	2,108	0.3	0.9	16.1	23.0	30.9	28.9	4,788	0.4	0.7	13.7	18.8	32.6	33.9	7,425	0.4	0.7	14.2	20.7	31.4	32.7
Asia		7,854	18.6	14.0	12.3	28.8	15.7	10.6	17,212	35.5	19.5	11.8	17.3	9.6	6.3	27,458	32.0	19.5	13.4	17.2	10.6	7.4	52,524	31.3	18.9	12.8	18.7	11.0	7.4
Latin America and Caribbean		1,574	1.5	16.5	9.7	27.1	27.8	17.3	4,041	6.7	33.6	11.6	22.1	15.8	10.1	11,361	4.5	33.9	12.7	22.9	15.8	10.1	16,977	4.9	32.0	12.0	23.1	17.1	11.0
Total		**21,964**	**20.9**	**20.5**	**12.0**	**25.2**	**11.6**	**9.7**	**57,921**	**32.0**	**24.3**	**12.1**	**16.8**	**8.5**	**6.2**	**78,736**	**23.9**	**24.3**	**13.4**	**20.2**	**10.2**	**8.1**	**158,626**	**27.2**	**23.8**	**12.6**	**19.1**	**9.7**	**7.6**

Note: Women with an unmet need (either desire- or fertility-risk based) and women with a need for a more effective method constitute the group who require focused family planning efforts.

Figure 3. Percent distribution of non-pregnant married and in-union women in need of focused family planning efforts by level of education within region, 45 DHS country surveys 2006-2012



The distribution of women in need of focused family planning efforts by their wealth quintile is surprisingly uniform, between 19 and 20 percent in each quintile (Table 13c and Figure 4). The distribution of women in need of a spacing method is also close to uniform. More women with a combined limiting need are in the lower quintiles than in the higher quintiles but the opposite is true for women users with a need for a LAPM. The distribution by quintile within region is shown in Figure 4. Focused efforts needed are quite uniform in the Eastern Europe/NIS and Asia regions, are increasing somewhat with wealth in the sub-Saharan Africa regions, and are decreasing with wealth in the Middle East/North Africa and Latin America and Caribbean regions. A possible explanation for these different patterns is that long periods of postpartum abstinence and higher levels of infecundity occur among the poor than the wealthy in sub-Saharan Africa. In addition, use of contraception is higher among the wealthy than among the poor in the Middle East/North Africa and Latin America and Caribbean regions.

Table 13c. Percent distribution of non-pregnant married and in-union women in need of focused family planning efforts by wealth quintile, 45 DHS country surveys 2006-2012

		Unmet need for a spacing method						Unmet need for a limiting method						Need for a more effective method: Spacing method needs limiting						Total					
Country	Survey date	Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Number of respondents	Poorest	Poorer	Middle	Richer	Richest
West and Central Africa																									
Benin	2006	818	18.0	16.4	21.0	25.9	18.7	2,744	19.8	21.7	21.5	19.8	17.2	1,379	11.3	15.5	17.4	23.6	32.2	4,941	17.1	19.1	20.3	21.9	21.6
Burkina Faso	2010	880	15.0	21.2	22.6	19.5	21.7	2,261	20.8	21.8	22.2	21.2	13.9	1,197	11.3	14.0	15.6	24.5	34.6	4,338	17.0	19.6	20.5	21.8	21.2
Cameroon	2011	516	15.2	15.4	19.3	26.1	24.0	1,468	25.0	21.6	21.1	18.4	13.9	1,306	3.2	15.3	21.3	29.2	31.0	3,290	14.8	18.1	20.9	23.9	22.3
DR Congo	2007	383	22.0	19.5	25.0	17.9	15.6	853	18.6	24.2	22.0	20.9	14.4	821	13.6	17.1	17.8	20.9	30.6	2,057	17.3	20.5	20.9	20.3	21.1
Ghana	2008	273	16.4	23.5	22.0	22.7	15.5	620	23.9	24.6	18.9	19.0	13.6	374	14.0	18.5	17.1	22.4	28.1	1,266	19.3	22.6	19.0	20.8	18.3
Liberia	2007	393	17.6	16.4	23.5	20.8	21.6	1,027	18.6	25.7	21.8	20.5	13.4	355	7.9	12.5	29.7	25.7	24.3	1,776	16.2	21.0	23.7	21.6	17.4
Mali	2006	1,028	12.9	13.3	16.0	17.3	40.5	2,423	21.3	21.8	21.7	19.1	16.2	591	10.5	13.8	13.8	23.3	38.6	4,043	17.6	18.5	19.1	19.2	25.6
Niger	2006	281	18.3	16.0	16.5	20.6	28.6	787	19.7	21.2	19.9	17.0	22.1	652	20.3	15.5	13.7	20.3	30.2	1,719	19.7	18.2	17.0	18.8	26.3
Nigeria	2008	1,093	20.5	19.6	18.0	21.6	20.4	3,079	20.6	22.7	20.5	20.0	16.2	2,257	5.5	8.8	15.6	25.9	44.2	6,430	15.3	17.3	18.3	22.3	26.8
Sao Tome & Principe	2008-09	16	22.1	14.8	21.6	25.5	0.0	21	21.3	21.4	18.8	17.8	0.0	17	20.2	18.1	23.1	21.9	0.0	18	20.9	19.0	21.1	20.7	0.0
Senegal	2010-11	908	16.6	15.8	18.0	25.2	24.4	1,913	22.7	22.6	21.5	19.0	14.2	808	9.2	12.3	23.3	25.0	30.2	3,629	18.2	18.6	21.0	21.9	20.3
Sierra Leone	2008	321	19.7	18.7	19.6	19.4	22.6	1,056	20.5	22.1	22.5	20.6	14.4	325	12.3	10.6	13.3	26.1	37.6	1,702	18.8	19.2	20.2	21.4	20.4
East and Southern Africa																									
Burundi	2010	329	26.7	20.3	19.3	14.9	18.7	1,039	17.6	26.8	19.7	20.1	15.7	707	14.7	17.2	21.6	20.3	26.2	2,075	18.1	22.5	20.3	19.3	19.8
Ethiopia	2011	539	27.3	22.8	18.4	19.5	12.1	1,794	24.6	21.1	23.1	19.8	11.4	1,469	11.0	16.9	20.0	24.5	27.6	3,803	19.7	19.7	21.3	21.6	17.8
Kenya	2008-09	203	16.5	23.1	15.9	20.2	24.3	838	29.3	23.2	16.7	13.3	17.6	1,149	11.0	21.0	25.5	26.1	16.5	2,190	18.5	22.0	21.2	20.6	17.6
Lesotho	2009	246	21.8	23.0	16.8	21.6	16.8	579	27.5	21.1	16.2	21.1	14.1	728	14.5	15.3	19.6	23.8	26.8	1,553	20.5	18.7	17.9	22.4	20.5
Madagascar	2008-09	615	20.1	19.6	14.7	17.2	28.4	1,434	23.2	21.9	19.2	18.5	17.1	2,771	11.3	15.4	22.2	25.0	26.1	4,820	16.0	17.9	20.4	22.1	23.7
Malawi	2010	744	16.9	20.4	21.2	21.3	20.2	2,332	19.1	21.1	20.9	19.7	19.2	3,485	16.6	20.3	21.1	23.1	18.8	6,561	17.5	20.6	21.1	21.7	19.1
Mozambique	2011	529	16.5	19.1	20.6	19.8	24.0	1,443	19.8	20.7	18.7	20.4	20.4	657	5.2	10.6	14.9	25.4	43.9	2,628	15.5	17.9	18.1	21.5	27.0
Namibia	2006-07	99	31.0	8.2	22.1	17.7	21.1	471	27.2	18.8	25.0	17.1	11.9	766	13.9	16.2	20.4	27.4	22.1	1,336	19.9	16.5	22.1	23.1	18.5
Rwanda	2010	219	31.9	19.7	16.6	10.3	21.4	879	25.1	23.6	18.4	18.7	14.2	2,036	16.8	19.4	20.7	23.8	19.3	3,134	20.2	20.6	19.8	21.4	18.0
Swaziland	2006-07	70	25.7	7.1	15.3	30.8	21.0	338	22.8	19.6	19.1	20.1	18.4	533	15.0	18.2	23.4	20.5	22.9	941	18.6	17.9	21.2	21.1	21.2
Tanzania	2010	285	19.7	20.9	21.0	20.1	18.3	832	24.4	22.6	25.3	17.2	10.5	1,229	15.1	17.9	19.7	24.1	23.3	2,347	19.0	19.9	21.8	21.2	18.2
Uganda	2011	286	21.3	19.8	17.4	15.6	26.0	1,146	25.6	23.2	19.5	19.4	12.3	1,012	10.8	16.5	19.7	23.2	29.7	2,443	19.0	20.0	19.3	20.5	21.1
Zambia	2007	183	19.3	24.1	22.1	20.9	13.6	661	20.9	24.5	22.9	19.7	11.9	1,197	25.2	17.7	17.0	21.4	18.7	2,042	23.3	20.5	19.4	20.8	16.0
Zimbabwe	2010-11	173	20.4	19.8	18.3	25.6	15.9	394	26.0	25.3	15.6	18.6	14.5	1,544	20.9	20.5	20.2	21.7	16.7	2,111	21.8	21.3	19.2	21.4	16.2
Middle East/North Africa																									
Egypt	2008	281	20.9	20.4	23.1	21.4	14.1	930	26.2	22.6	20.1	17.1	14.0	2,478	25.2	21.7	20.6	17.6	14.8	3,689	25.2	21.9	20.7	17.7	14.6
Jordan	2007	188	29.8	31.1	22.5	9.3	7.3	841	21.7	19.7	20.2	16.1	22.2	2,877	17.9	19.9	22.8	21.3	18.1	3,906	19.3	20.4	22.2	19.6	18.4
Eastern Europe/NIS																									
Albania	2008-09	142	22.9	16.5	24.3	18.4	18.0	485	24.8	23.1	22.9	17.5	11.8	2,053	20.0	20.2	22.0	18.5	19.3	2,680	21.0	20.5	22.3	18.3	17.8
Armenia	2010	151	20.2	29.4	16.8	21.5	12.1	316	22.3	28.6	23.0	9.3	16.8	754	24.4	20.1	13.5	19.9	22.1	1,222	23.4	23.5	16.4	17.4	19.5
Azerbaijan	2006	111	17.2	28.6	22.8	14.5	16.9	1,035	17.6	21.7	23.1	23.2	14.4	1,265	24.6	20.1	18.8	17.2	19.2	2,412	21.3	21.2	20.8	19.7	17.1
Ukraine	2007	123	14.7	23.9	28.5	18.0	14.9	272	16.9	19.9	20.8	19.9	22.5	716	14.2	21.1	18.2	17.5	29.0	1,111	14.9	21.1	20.0	18.1	25.9
Asia																									
Bangladesh	2011	583	13.4	17.2	21.4	26.7	21.3	1,321	19.4	16.7	19.1	23.2	21.5	4,171	20.8	21.5	20.9	19.1	17.6	6,075	19.8	20.1	20.6	20.8	18.8
Cambodia	2010	478	23.3	22.9	18.6	19.1	16.1	1,321	24.4	23.5	19.3	18.1	14.7	2,878	17.9	20.9	21.1	21.3	18.8	4,677	20.3	21.8	20.3	20.2	17.4
India	2005-06	3,769	21.3	21.4	21.9	20.2	15.1	6,451	30.5	23.1	19.2	14.8	12.4	7,048	19.0	19.8	17.4	19.1	24.6	17,268	23.8	21.4	19.1	17.7	18.0
Indonesia	2007	787	22.8	20.2	20.0	18.3	18.7	1,677	27.9	17.5	20.2	16.5	17.9	6,916	18.4	20.8	20.1	21.5	19.3	9,379	20.4	20.2	20.1	20.3	19.0
Nepal	2011	740	15.9	16.4	27.6	21.2	19.0	1,691	21.4	20.6	19.8	21.1	17.1	1,069	23.3	20.3	19.6	16.7	20.1	3,500	20.8	19.6	21.4	19.8	18.4
Pakistan	2012-13	536	16.2	21.4	21.2	21.0	20.2	1,777	26.0	22.6	18.0	18.6	14.8	2,260	10.8	17.2	23.2	24.2	24.6	4,573	17.4	19.8	20.9	21.6	20.3
Philippines	2008	405	21.4	17.6	17.0	23.9	20.0	1,206	25.8	19.2	19.5	16.6	18.9	1,813	20.4	22.1	23.0	18.5	16.1	3,425	22.4	20.5	21.1	18.5	17.6
Timor-Leste	2009	556	15.5	17.3	25.4	22.7	19.1	1,768	22.9	18.5	20.3	16.8	21.4	1,303	14.4	15.4	17.0	21.8	31.4	3,627	18.7	17.2	19.9	19.5	24.7

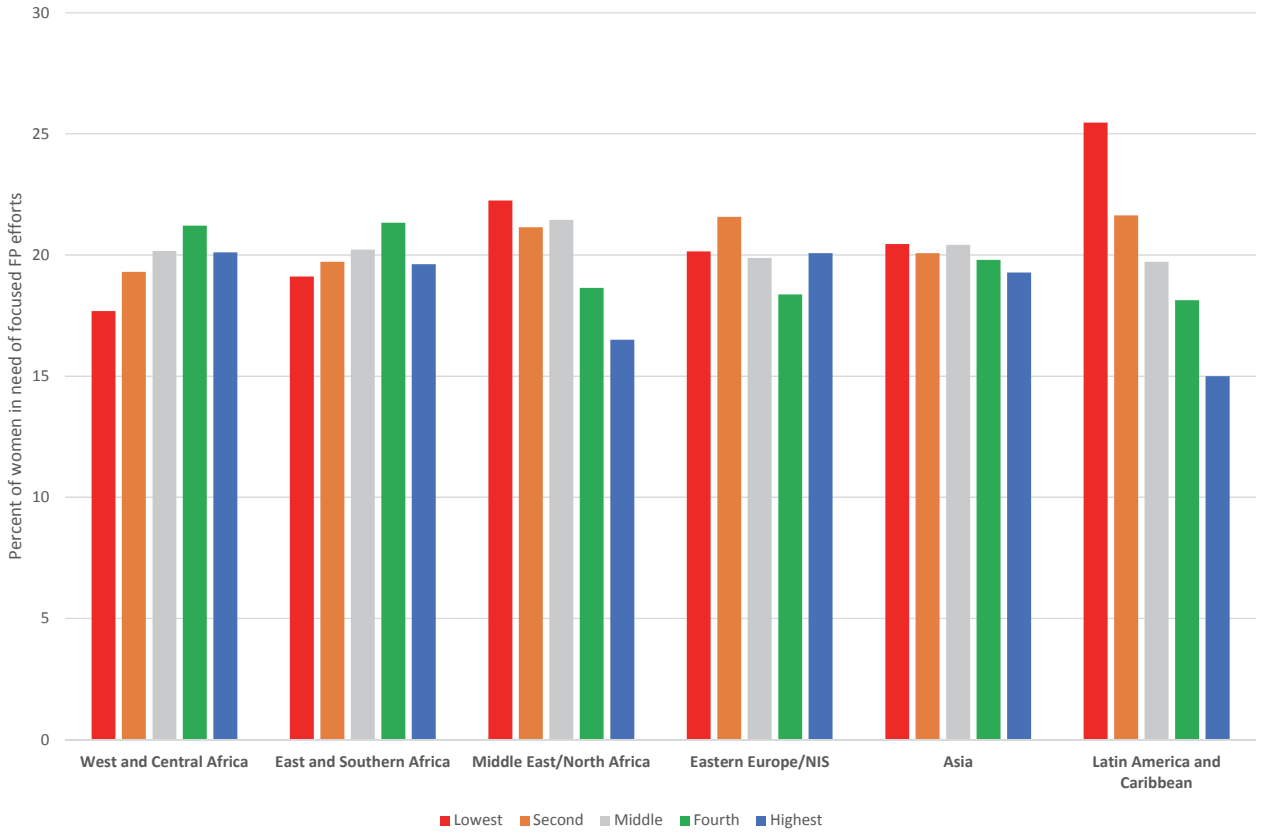
(Continued)

Table 13c. – *Continued*

Country	Survey date	Unmet need for a spacing method: Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Unmet need for a limiting method: Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Need for a more effective method: Spacing method needs limiting: Number of respondents	Poorest	Poorer	Middle	Richer	Richest	Total: Number of respondents	Poorest	Poorer	Middle	Richer	Richest
Latin America and Caribbean																									
Bolivia	2008	261	16.7	20.4	25.8	22.3	14.8	1,255	35.4	24.6	18.7	12.9	8.4	2,751	21.1	22.3	21.5	19.3	15.7	4,267	25.0	22.9	21.0	17.6	13.5
Colombia	2010	414	24.8	23.0	23.6	20.1	8.5	966	29.6	19.5	16.8	18.7	15.5	3,027	29.5	20.5	19.7	16.5	13.8	4,407	29.0	20.5	19.4	17.3	13.7
Dominican Rep.	2007	553	16.7	16.9	20.6	22.3	23.5	714	26.6	21.7	20.4	16.0	15.3	1,070	28.2	22.4	19.4	17.7	12.2	2,337	25.0	20.9	20.0	18.3	15.8
Guyana	2009	173	16.2	16.9	23.1	22.5	21.3	584	26.1	20.8	16.6	19.6	16.9	490	20.3	20.7	18.4	19.7	20.8	1,247	22.5	20.2	18.2	20.0	19.1
Peru	2012	173	20.4	23.5	27.5	17.9	10.7	522	30.3	21.2	21.1	16.8	10.6	4,023	25.5	24.1	19.5	17.6	13.3	4,719	25.8	23.7	20.0	17.5	12.9
Unweighted Averages																									
West and Central Africa		6,910	17.9	17.6	20.3	21.9	21.1	18,252	21.1	22.6	21.0	19.4	14.1	10,082	11.6	14.3	18.5	24.1	30.1	35,209	17.7	19.3	20.2	21.2	20.1
East and Southern Africa		4,520	22.5	19.1	18.6	19.7	20.1	14,180	23.8	22.4	20.0	18.8	14.9	19,283	14.4	17.4	20.4	23.6	24.2	37,984	19.1	19.7	20.2	21.3	19.6
Middle East/North Africa		469	25.4	25.8	22.8	15.4	10.7	1,771	24.0	21.2	20.2	16.6	18.1	5,355	21.6	20.8	21.7	19.5	16.5	7,595	22.3	21.2	21.5	18.7	16.5
Eastern Europe/NIS		527	18.8	24.6	23.1	18.1	15.5	2,108	20.4	23.3	22.5	17.5	16.4	4,788	20.8	20.4	18.1	18.3	22.4	7,425	20.2	21.6	19.9	18.4	20.1
Asia		7,854	18.7	19.3	21.6	21.6	18.7	17,212	24.8	20.2	19.4	18.2	17.3	27,458	18.1	19.8	20.3	20.3	21.6	52,524	20.5	20.1	20.4	19.8	19.3
Latin America and Caribbean		1,574	19.0	20.1	24.1	21.0	15.8	4,041	29.6	21.6	18.7	16.8	13.3	11,361	24.9	22.0	19.7	18.2	15.2	16,977	25.5	21.6	19.7	18.1	15.0
Total		**21,854**	**20.0**	**19.6**	**20.8**	**20.4**	**18.8**	**57,564**	**23.6**	**22.0**	**20.3**	**18.4**	**15.2**	**78,327**	**16.4**	**17.9**	**19.7**	**21.9**	**23.8**	**157,714**	**19.9**	**20.1**	**20.2**	**20.3**	**19.1**

Note: Women with an unmet need (either desire- or fertility-risk based) and women with a need for a more effective method constitute the group who require focused family planning efforts.

Figure 4. Percent distribution of non-pregnant married and in-union women in need of focused family planning efforts by wealth quintile within region, 45 DHS country surveys 2006-2012



3.6. Family Planning Characteristics for Women with a Need for Focused Family Planning Efforts

Program managers who work with women who need special efforts from family planning programs will find it useful to know if the women have used contraception in the past. Table 14 presents the pattern of use for women with a combined unmet need for contraception for spacing and limiting, and for all those with a need for focused efforts. Among women with a combined unmet spacing need, over half (60 percent) have never used contraception. Among women with an unmet combined limiting need, 55 percent have used contraception at some time in the past. When women who are in need of a more effective method are added, about half of those with a need for focused family planning efforts are current users, over a quarter have never used (28 percent), and almost a quarter (23 percent) have used in the past but are not current users. Benin, Niger, São Tomé and Principe, and the Philippines did not collect information on previous contraception use.

Table 14. Pattern of use of contraception among married and in-union women with a need for focused family planning efforts, 41 DHS country surveys 2006-2012

		Unmet need for a spacing method			Unmet need for a limiting method			Need for a more effective method: using spacing method needs limiting method		All with a need for focused family planning efforts			
Country	Survey date	Number of respondents	Used before[1]	Never used	Number of respondents	Used before[1]	Never used	Number of respondents	Currently using	Number of respondents	Currently using	Used before[1]	Never used
West and Central Africa													
Burkina Faso	2010	880	11.3	88.6	2,261	15.0	85.0	1,197	100.0	4,338	27.6	10.2	62.3
Cameroon	2011	516	36.0	64.0	1,468	35.0	65.0	1,306	100.0	3,290	39.7	21.3	39.0
DR Congo	2007	383	46.2	53.8	853	41.6	58.4	821	100.0	2,057	39.9	25.9	34.2
Ghana	2008	273	51.6	48.4	620	55.0	45.0	374	100.0	1,266	29.5	38.1	32.5
Liberia	2007	393	35.6	64.4	1,027	35.0	65.0	355	100.0	1,776	20.0	28.2	51.8
Mali	2006	1,028	15.6	84.4	2,423	19.0	81.0	591	100.0	4,043	14.6	15.4	70.0
Nigeria	2008	1,093	21.0	79.0	3,079	27.1	72.9	2,257	100.0	6,430	35.1	16.5	48.3
Senegal	2010-11	908	20.1	79.9	1,913	28.2	71.8	808	100.0	3,629	22.3	19.8	57.8
Sierra Leone	2008	321	18.9	81.1	1,056	25.4	74.7	325	100.0	1,702	19.1	19.3	61.6
East and Southern Africa													
Burundi	2010	329	9.3	90.7	1,039	14.7	85.3	707	100.0	2,075	34.1	8.8	57.1
Ethiopia	2011	539	21.3	78.6	1,794	29.2	70.8	1,469	100.0	3,803	38.6	16.8	44.6
Kenya	2008-09	203	50.9	49.2	838	64.2	35.7	1,149	100.0	2,190	52.5	29.3	18.2
Lesotho	2009	246	56.1	44.0	579	61.7	38.2	728	100.0	1,553	46.9	31.9	21.2
Madagascar	2008-09	615	30.8	69.2	1,434	45.4	54.7	2,771	100.0	4,820	57.5	17.4	25.1
Malawi	2010	744	54.9	45.1	2,332	74.5	25.6	3,485	100.0	6,561	53.1	32.7	14.2
Mozambique	2011	529	19.1	80.9	1,443	29.0	71.0	657	100.0	2,628	25.0	19.8	55.2
Namibia	2006-07	99	72.8	27.2	471	76.7	23.3	766	100.0	1,336	57.4	32.4	10.2
Rwanda	2010	219	25.6	74.4	879	36.6	63.5	2,036	100.0	3,134	65.0	12.0	23.0
Swaziland	2006-07	70	69.6	30.4	338	88.4	11.6	533	100.0	941	56.7	36.9	6.4
Tanzania	2010	285	15.2	84.7	832	25.3	74.7	1,229	100.0	2,347	52.4	10.8	36.8
Uganda	2011	286	34.2	65.8	1,146	42.4	57.6	1,012	100.0	2,443	41.4	23.9	34.7
Zambia	2007	183	65.6	34.4	661	71.8	28.2	1,197	100.0	2,042	58.6	29.1	12.2
Zimbabwe	2010-11	173	37.8	62.2	394	41.1	58.9	1,544	100.0	2,111	73.1	10.8	16.1
Middle East/North Africa													
Egypt	2008	281	42.4	57.6	930	85.5	14.5	2,478	100.0	3,689	67.2	24.8	8.0
Jordan	2007	188	29.1	70.9	841	83.2	16.8	2,877	100.0	3,906	73.7	19.3	7.0
Eastern Europe/NIS													
Albania	2008-09	142	69.5	30.5	485	91.6	8.4	2,053	100.0	2,680	76.6	20.2	3.1
Armenia	2010	151	12.4	87.6	316	49.5	50.5	754	100.0	1,222	61.7	14.3	23.9
Azerbaijan	2006	111	27.8	72.1	1,035	47.2	52.7	1,265	100.0	2,412	52.5	21.6	26.0
Ukraine	2007	123	60.6	39.4	272	92.8	7.2	716	100.0	1,111	64.4	29.4	6.1
Asia													
Bangladesh	2011	583	60.4	39.5	1,321	85.2	14.8	4,171	100.0	6,075	68.7	24.3	7.0
Cambodia	2010	478	28.5	71.6	1,321	65.2	34.9	2,878	100.0	4,677	61.5	21.3	17.2
India	2005-06	3,769	14.6	85.4	6,451	32.8	67.1	7,048	100.0	17,268	40.8	15.4	43.7
Indonesia	2007	787	58.2	41.8	1,677	72.7	27.3	6,916	100.0	9,379	73.7	17.9	8.4
Nepal	2011	740	34.8	65.2	1,691	72.2	27.8	1,069	100.0	3,500	30.6	42.3	27.2
Pakistan	2012-13	536	14.3	85.7	1,777	57.9	42.1	2,260	100.0	4,573	49.4	24.1	26.4
Timor-Leste	2009	556	4.9	95.1	1,768	16.5	83.5	1,303	100.0	3,627	35.9	8.8	55.3
Latin America and Caribbean													
Bolivia	2008	261	59.8	40.2	1,255	56.9	43.0	2,751	100.0	4,267	64.5	20.4	15.1
Colombia	2010	414	90.5	9.5	966	92.9	7.1	3,027	100.0	4,407	68.7	28.8	2.5
Dominican Rep.	2007	553	78.0	22.0	714	86.4	13.6	1,070	100.0	2,337	45.8	44.9	9.4
Guyana	2009	173	57.4	42.7	584	81.4	18.5	490	100.0	1,247	39.3	46.1	14.6
Peru	2012	173	84.7	15.4	522	87.8	12.2	4,023	100.0	4,719	85.3	12.9	1.9

(Continued)

Table 14. – *Continued*

Country	Survey date	Unmet need for a spacing method			Unmet need for a limiting method			Need for a more effective method: using spacing method needs limiting method		All with a need for focused family planning efforts			
		Number of respondents	Used before[1]	Never used	Number of respondents	Used before[1]	Never used	Number of respondents	Currently using	Number of respondents	Currently using	Used before[1]	Never used
Unweighted Averages													
West and Central Africa		5,795	28.5	71.5	14,700	31.3	68.8	8,034	100.0	28,531	27.5	21.6	50.8
East and Southern Africa		4,520	40.2	59.8	14,180	50.1	49.9	19,283	100.0	37,984	50.9	22.3	26.8
Middle East/North Africa		469	35.8	64.3	1,771	84.4	15.7	5,355	100.0	7,595	70.5	22.1	7.5
Eastern Europe/NIS		527	42.6	57.4	2,108	70.3	29.7	4,788	100.0	7,425	63.8	21.4	14.8
Asia		7,449	30.8	69.2	16,006	57.5	42.5	25,645	100.0	49,099	51.5	22.0	26.5
Latin America and Caribbean		1,574	74.1	26.0	4,041	81.1	18.9	11,361	100.0	16,977	60.7	30.6	8.7
Total		**20,334**	**40.2**	**59.8**	**52,806**	**54.6**	**45.4**	**74,466**	**100.0**	**147,611**	**49.3**	**23.0**	**27.7**

[1]Includes used since last birth and used prior to last birth

Notes: Women with an unmet need (either desire- or fertility-risk based) and women with a need for a more effective method constitute the group who require focused family planning efforts.

Prior use of contraception was not asked in Benin, Niger, Sao Tome & Principe, and the Philippines.

Among women who need focused family planning efforts and who visited a health facility in the preceding 12 months, Table 15 presents the percentage who were told of family planning by the type of combined unmet need for contraception. Only two of five women who need focused efforts and who visited a health facility in the preceding year were told about family planning or contraceptive methods. The percentage is even lower (35 percent) for women with an unmet need for spacing or limiting (as compared to those in need of a more effective method) and is particularly low for women with all three types of need in the Eastern Europe/NIS region.

Table 15. Among married and in-union women with a need for focused family planning efforts and who visited a health facility in the preceding 12 months, the percent who were told of family planning by type of unmet need for contraception, 45 DHS country surveys 2006-2012

		Unmet need for a spacing method		Unmet need for a limiting method		Need for a more effective method: spacing method needs limiting		All with a need for focused family planning efforts	
Country	Survey date	Number of respondents	Percent told	Number of respondents	Percent told	Number of respondents	Percent told	Number of respondents	Percent told
West and Central Africa									
Benin	2006	396	17.1	1,107	25.1	690	28.9	2,193	24.9
Burkina Faso	2010	640	39.7	1,439	42.1	967	64.1	3,046	48.6
Cameroon	2011	334	24.5	862	28.5	949	36.4	2,146	31.4
DR Congo	2007	120	23.2	366	21.1	401	20.8	887	21.2
Ghana	2008	178	40.8	337	38.2	227	38.9	742	39.1
Liberia	2007	270	68.9	666	67.0	295	89.2	1,231	72.7
Mali	2006	218	28.6	527	30.1	281	55.8	1,027	36.8
Niger	2006	122	20.4	378	15.0	397	40.4	896	27.1
Nigeria	2008	267	51.4	743	36.9	892	52.5	1,902	46.3
Sao Tome & Principe	2008-09	71	73.6	193	70.4	245	70.8	509	71.0
Senegal	2010-11	594	16.5	1,267	23.2	630	61.4	2,491	31.2
Sierra Leone	2008	142	36.0	463	47.4	219	60.9	824	49.0
East and Southern Africa									
Burundi	2010	268	40.0	840	38.4	614	38.5	1,721	38.6
Ethiopia	2011	169	16.5	667	22.5	721	34.1	1,557	27.2
Kenya	2008-09	121	25.5	483	28.4	718	33.8	1,322	31.0
Lesotho	2009	107	34.8	259	34.8	389	33.9	755	34.3
Madagascar	2008-09	224	44.4	515	52.6	1,455	65.5	2,194	60.3
Malawi	2010	592	62.0	1,881	64.8	2,975	70.6	5,448	67.7
Mozambique	2011	357	36.9	906	43.5	505	49.9	1,768	44.0
Namibia	2006-07	20	22.2	169	22.1	312	34.3	501	29.7
Rwanda	2010	167	62.7	611	62.7	1,491	68.4	2,268	66.5
Swaziland	2006-07	43	40.8	175	34.9	359	50.7	576	45.2
Tanzania	2010	219	47.2	597	42.3	943	52.4	1,759	48.3
Uganda	2011	217	33.6	860	34.0	747	34.6	1,824	34.2
Zambia	2007	103	37.0	326	55.1	767	63.4	1,197	58.9
Zimbabwe	2010-11	79	44.8	150	48.9	691	53.3	920	51.9
Middle East/North Africa									
Egypt*	2008	113	32.4	241	31.7	973	41.6	1,327	39.0
Jordan*	2007	163	23.8	648	22.9	2,395	30.5	3,206	28.6
Eastern Europe/NIS									
Albania	2008-09	48	35.1	120	23.3	717	33.4	885	32.1
Armenia	2010	112	15.4	126	11.6	280	13.0	519	13.2
Azerbaijan	2006	37	12.7	277	12.6	308	14.2	623	13.4
Ukraine	2007	84	26.7	163	8.4	353	8.9	600	11.3

(Continued)

Table 15. – *Continued*

Country	Survey date	Unmet need for a spacing method		Unmet need for a limiting method		Need for a more effective method: spacing method needs limiting		All with a need for focused family planning efforts	
		Number of respondents	Percent told	Number of respondents	Percent told	Number of respondents	Percent told	Number of respondents	Percent told
Asia									
Bangladesh*	2011	NA	NA	NA	NA	NA	NA	NA	NA
Cambodia	2010	249	44.2	514	48.5	1,175	58.3	1,938	53.9
India	2005-06	NA	NA	NA	NA	NA	NA	NA	NA
Indonesia*	2007	336	22.0	527	25.1	2,953	29.9	3,815	28.5
Nepal	2011	505	10.6	1,149	16.4	732	33.3	2,387	20.4
Pakistan*	2012-13	430	8.5	1,396	9.9	1,879	16.2	3,705	12.9
Philippines	2008	214	46.2	589	49.3	967	55.4	1,771	52.3
Timor-Leste	2009	319	40.5	977	39.0	938	55.8	2,234	46.3
Latin America and Caribbean									
Bolivia	2008	198	35.6	769	42.6	1,721	50.1	2,688	46.8
Colombia	2010	280	34.8	670	32.0	2,296	41.9	3,245	39.2
Dominican Rep.	2007	430	40.5	535	33.4	827	39.5	1,793	37.9
Guyana	2009	104	41.6	312	41.9	283	47.3	699	44.0
Peru	2012	74	53.3	236	41.7	1,850	43.2	2,160	43.4
Unweighted Averages									
West and Central Africa		3,352	36.7	8,348	37.1	6,193	51.7	17,894	41.6
East and Southern Africa		2,686	39.2	8,439	41.8	12,687	48.8	23,810	45.6
Middle East/North Africa		276	28.1	889	27.3	3,368	36.1	4,533	33.8
Eastern Europe/NIS		281	22.5	686	14.0	1,658	17.4	2,627	17.5
Asia		2,053	28.7	5,152	31.4	8,644	41.5	15,850	35.7
Latin America and Caribbean		1,086	41.2	2,522	38.3	6,977	44.4	10,585	42.3
Total		**9,734**	**35.2**	**26,036**	**35.4**	**39,527**	**44.6**	**75,299**	**39.5**

* Ever-married samples
NA Not asked
Note: Women with an unmet need (either desire- or fertility-risk based) and women with a need for a more effective method constitute the group who require focused family planning efforts.

In DHS surveys, women who are not using contraception are asked about their intentions to use at any time in the future. For women with an unmet combined need, only slightly over half said they intended to use contraception in the future, 11 percent were unsure, and 35 percent did not intend to use any contraception (Table 16). In comparisons of women by the type of need, those with a limiting need had a higher percentage who did not intend to use (39 percent), and those with a spacing need had a higher percentage who intended to use later (64 percent). Figure 5 shows the differences by region. In all regions except Eastern Europe/NIS, more women with an unmet need intend to use contraception in the future than do not intend to use. In that region, many women were unsure about future use.

Table 16. Intentions to use contraception in the future among non-pregnant married and in-union women with a combined unmet need for contraception, 45 DHS country surveys 2006-2012

		Unmet need for a spacing method				Unmet need for a limiting method				All with an unmet need			
Country	Survey date	Number of respondents	Use later	Unsure about use	Does not intend	Number of respondents	Use later	Unsure about use	Does not intend	Number of respondents	Use later	Unsure about use	Does not intend
West and Central Africa													
Benin	2006	817	53.5	15.2	31.3	2,730	48.8	13.0	38.2	3,547	49.9	13.5	36.6
Burkina Faso	2010	876	71.3	4.8	23.9	2,247	60.7	3.9	35.3	3,123	63.7	4.2	32.1
Cameroon	2011	514	61.1	9.7	29.2	1,446	52.3	9.2	38.5	1,960	54.6	9.3	36.1
DR Congo	2007	381	36.6	20.0	43.4	849	35.8	14.0	50.2	1,230	36.1	15.9	48.1
Ghana	2008	271	57.2	6.1	36.7	615	54.8	6.6	38.6	886	55.5	6.4	38.1
Liberia	2007	391	48.7	17.4	33.8	1,016	45.0	16.5	38.5	1,407	46.0	16.8	37.2
Mali	2006	1,027	50.1	16.0	33.9	2,412	38.1	10.6	51.3	3,439	41.7	12.2	46.1
Niger	2006	279	36.8	12.0	51.1	786	38.6	8.4	53.0	1,065	38.1	9.3	52.5
Nigeria	2008	1,080	26.6	29.5	43.9	3,033	28.0	21.4	50.6	4,112	27.6	23.5	48.9
Sao Tome & Principe	2008-09	126	51.3	26.0	22.7	375	48.3	18.5	33.2	501	49.0	20.4	30.6
Senegal	2010-11	908	37.7	11.8	50.4	1,913	37.6	6.8	55.5	2,821	37.7	8.5	53.9
Sierra Leone	2008	318	32.1	27.0	40.9	1,051	40.6	19.5	39.8	1,369	38.7	21.3	40.1
East and Southern Africa													
Burundi	2010	328	76.2	3.6	20.2	1,035	63.0	4.6	32.5	1,363	66.1	4.3	29.5
Ethiopia	2011	537	70.4	2.0	27.5	1,787	63.7	3.5	32.8	2,324	65.3	3.1	31.6
Kenya	2008-09	203	71.2	2.3	26.5	836	57.4	6.7	35.9	1,039	60.1	5.8	34.0
Lesotho	2009	246	83.8	5.2	11.0	578	66.8	5.4	27.8	823	71.8	5.4	22.8
Madagascar	2008-09	615	58.3	18.7	23.0	1,427	44.4	13.5	42.1	2,042	48.6	15.1	36.4
Malawi	2010	737	86.5	1.8	11.7	2,314	70.8	2.5	26.7	3,051	74.6	2.3	23.1
Mozambique	2011	529	56.0	8.0	36.0	1,443	53.9	5.2	41.0	1,972	54.4	5.9	39.6
Namibia	2006-07	98	72.1	2.3	25.6	462	60.1	7.4	32.4	560	62.2	6.5	31.2
Rwanda	2010	219	87.9	1.5	10.6	872	71.3	1.3	27.4	1,091	74.6	1.3	24.0
Swaziland	2006-07	70	83.2	3.8	13.0	335	61.0	3.7	35.3	405	64.8	3.7	31.5
Tanzania	2010	280	73.5	5.3	21.2	825	59.0	5.4	35.5	1,106	62.7	5.4	31.9
Uganda	2011	285	73.4	6.8	19.8	1,144	70.6	4.4	24.9	1,429	71.2	4.9	23.9
Zambia	2007	183	79.4	6.3	14.3	658	68.6	4.5	26.9	841	71.0	4.9	24.1
Zimbabwe	2010-11	173	81.2	6.2	12.6	394	59.1	4.8	36.0	567	65.9	5.3	28.9
Middle East/North Africa													
Egypt*	2008	278	81.8	8.9	9.3	919	60.2	7.2	32.6	1,197	65.2	7.6	27.2
Jordan*	2007	188	75.0	3.5	21.5	841	41.0	4.2	54.8	1,029	47.2	4.1	48.7
Eastern Europe/NIS													
Albania	2008-09	142	25.8	26.6	47.5	485	16.7	12.5	70.8	627	18.7	15.7	65.6
Armenia	2010	150	43.8	52.4	3.7	306	26.8	27.9	45.3	456	32.4	35.9	31.6
Azerbaijan	2006	110	38.3	44.1	17.6	1,013	10.8	26.3	62.9	1,123	13.5	28.1	58.4
Ukraine	2007	123	37.3	43.0	19.8	263	13.2	28.4	58.4	386	20.9	33.1	46.1
Asia													
Bangladesh*	2011	580	91.3	3.0	5.6	1,311	68.1	1.6	30.2	1,891	75.2	2.1	22.7
Cambodia	2010	473	72.3	8.0	19.7	1,316	43.9	7.2	48.9	1,789	51.4	7.4	41.2
India	2005-06	3,755	79.5	9.0	11.4	6,422	69.7	5.9	24.4	10,177	73.3	7.0	19.6
Indonesia*	2007	781	68.7	10.2	21.1	1,656	42.4	10.0	47.7	2,437	50.8	10.1	39.2
Nepal	2011	740	95.9	0.7	3.4	1,691	81.9	3.7	14.4	2,431	86.2	2.8	11.0
Pakistan*	2012-13	535	50.6	21.5	27.9	1,772	42.2	13.8	44.0	2,308	44.2	15.6	40.2
Philippines	2008	403	58.2	7.9	33.9	1,203	40.9	4.1	55.0	1,607	45.2	5.0	49.7
Timor-Leste	2009	556	26.5	30.7	42.9	1,768	14.0	27.3	58.6	2,324	17.0	28.1	54.9

(Continued)

Table 16. – *Continued*

Country	Survey date	Unmet need for a spacing method				Unmet need for a limiting method				Total			
		Number of respondents	Use later	Unsure about use	Does not intend	Number of respondents	Use later	Unsure about use	Does not intend	Number of respondents	Use later	Unsure about use	Does not intend
Latin America and Caribbean													
Bolivia	2008	260	82.6	6.4	11.1	1,249	57.8	15.0	27.2	1,509	62.1	13.5	24.4
Colombia	2010	414	90.5	3.2	6.3	966	67.0	5.5	27.5	1,381	74.1	4.8	21.1
Dominican Rep.	2007	546	87.5	3.7	8.8	694	65.5	6.5	28.0	1,240	75.2	5.3	19.5
Guyana	2009	171	63.2	11.4	25.5	581	40.7	12.4	46.8	752	45.8	12.2	42.0
Peru	2012	173	92.1	2.2	5.8	522	82.6	4.5	12.9	696	85.0	3.9	11.1
Unweighted Averages													
West and Central Africa		6,988	46.9	16.3	36.8	18,473	44.1	12.4	43.6	25,460	44.9	13.4	41.7
East and Southern Africa		4,503	75.2	5.3	19.5	14,110	62.1	5.2	32.7	18,613	65.2	5.3	29.5
Middle East/North Africa		466	78.4	6.2	15.4	1,760	50.6	5.7	43.7	2,226	56.2	5.9	38.0
Eastern Europe/NIS		525	36.3	41.5	22.2	2,067	16.9	23.8	59.4	2,592	21.4	28.2	50.4
Asia		7,823	67.9	11.4	20.7	17,139	50.4	9.2	40.4	24,964	55.4	9.8	34.8
Latin America and Caribbean		1,564	83.2	5.4	11.5	4,012	62.7	8.8	28.5	5,578	68.4	7.9	23.6
Total		**21,869**	**63.9**	**12.6**	**23.5**	**57,561**	**50.7**	**9.9**	**39.3**	**79,433**	**54.1**	**10.6**	**35.3**

* Ever-married samples

Figure 5. Distribution of married and in-union women with an unmet need for contraception by intention to use in the future, according to region, 45 DHS country surveys 2006-2012

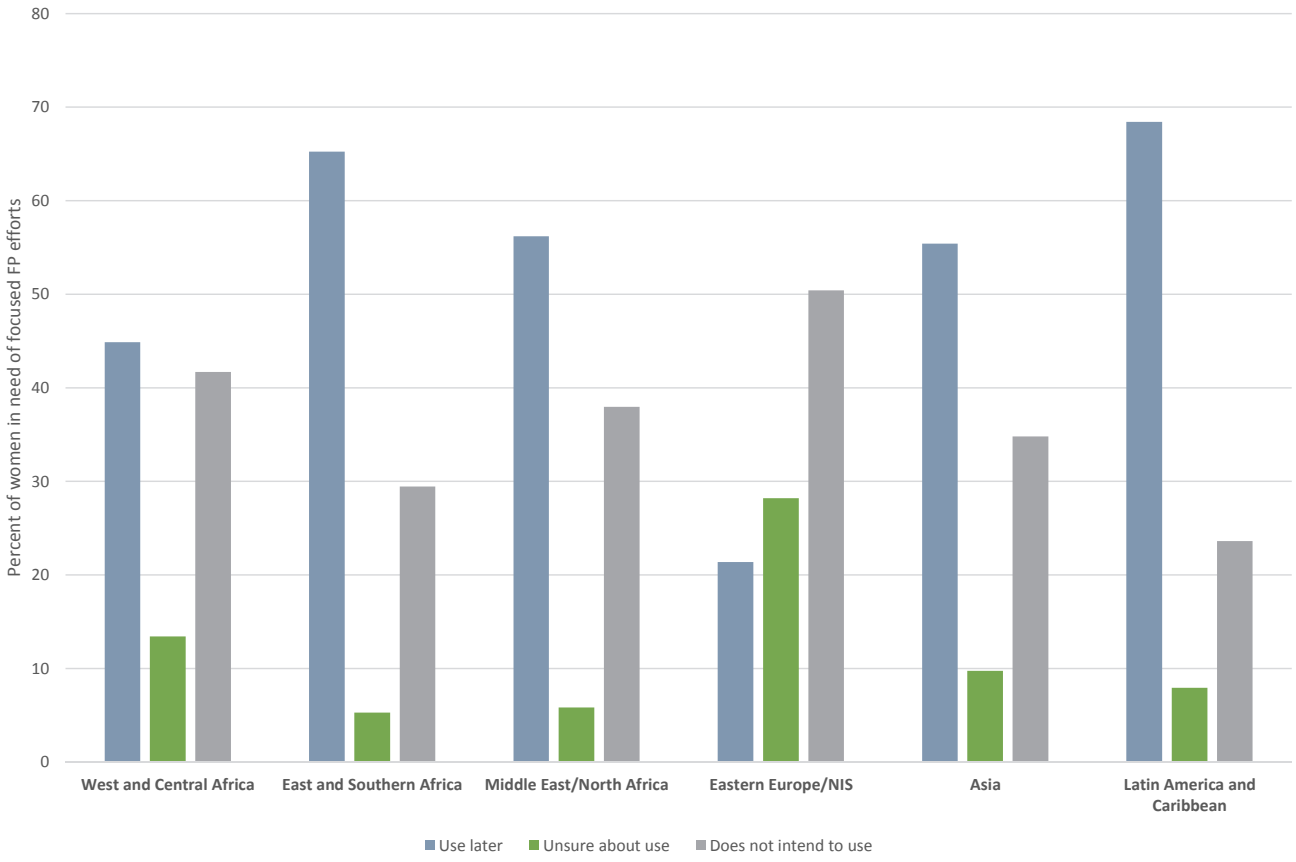


Table 17 shows categories of reasons for not intending to use contraception for non-pregnant married women with an unmet need for either spacing or limiting. Women could offer multiple responses. Almost a third of women indicated that side effects and health concerns were reasons not to use in the future. Opposition by her husband, family or others, as well as religious prohibition were mentioned by over a quarter of women, while 11 percent cited various program-related problems. Program-related reasons included no access or too far, no source, no method known, no method available, preferred method unavailable, inconvenient to use, and/or high costs. About one-fifth of the non-pregnant married women mentioned a lack or infrequency of sexual relations.

By region, no or infrequent sexual relations was cited as a reason most frequently in Latin America and the Caribbean; infecundity or subfecundity was cited most frequently in Eastern Europe/NIS; breastfeeding/postpartum amenorrhea, the opposition of others or religious prohibition, and family planning program problems were mentioned most often in West and Central Africa. Fatalism appeared most often in East and Southern Africa, while side effects and health concerns were cited most often in Asia. The questions on reasons for not intending to use were not asked in the two countries of the Middle East/North Africa region. The individual reasons for not intending to use are given in the Appendix Table A1.

Table 17. Among non-pregnant married women with a combined unmet need for either a spacing or a limiting method of contraception but who do not intend to use in the future, distribution by summary of reasons for not intending to use, 40 DHS country surveys 2006-2012

Country	Survey date	Number of respon-dents	No or infrequent sex	Infecund or subfecund[1]	Breast-feeding or post-partum amenor-rheic	Fatalistic	Husband, family or other opposition or religious prohibition	Side effects or health concerns	Program-related problems[2]
West and Central Africa									
Benin	2006	1,128	28.0	7.4	5.2	2.3	21.1	35.4	15.6
Burkina Faso	2010	907	23.0	2.2	13.0	5.5	35.9	20.4	11.9
Cameroon	2011	565	29.3	2.9	11.3	4.0	28.9	30.6	16.1
DR Congo	2007	444	21.7	2.2	24.8	0.8	29.0	22.2	26.5
Ghana	2008	291	14.8	6.0	3.1	0.2	26.8	46.8	10.5
Liberia	2007	439	12.3	0.0	17.1	0.1	26.3	43.0	22.5
Mali	2006	1,183	10.6	3.3	6.6	3.4	32.8	24.3	15.8
Niger	2006	449	12.8	0.5	10.1	1.7	40.1	19.5	22.4
Nigeria	2008	1,278	12.4	1.2	6.0	0.2	43.3	27.5	12.7
Sao Tome & Principe	2008-09	133	18.1	1.1	1.0	0.0	27.7	44.5	0.0
Senegal	2010-11	1,290	16.2	1.0	20.8	5.7	38.3	14.3	6.4
Sierra Leone	2008	420	7.0	2.5	8.4	0.6	47.1	28.8	23.7
East and Southern Africa									
Burundi	2010	357	9.5	3.7	9.8	24.0	39.7	23.5	2.7
Ethiopia	2011	622	7.4	1.7	15.0	15.4	28.0	34.1	10.3
Kenya	2008-09	313	15.7	3.6	3.1	0.2	22.3	48.6	9.4
Lesotho	2009	184	12.6	20.2	5.1	1.3	22.6	27.9	16.8
Madagascar	2008-09	676	15.8	7.3	2.7	1.5	26.0	44.8	13.1
Malawi	2010	648	14.3	9.4	7.2	2.2	18.4	41.7	2.8
Mozambique	2011	653	22.4	2.9	37.1	19.7	13.9	6.4	10.2
Namibia	2006-07	144	13.2	2.2	5.6	0.0	23.0	27.6	12.9
Rwanda	2010	252	21.4	0.4	5.0	19.3	18.0	34.3	2.7
Swaziland	2006-07	124	11.3	11.2	0.0	1.5	24.3	40.4	14.8
Tanzania	2010	317	13.5	1.4	6.8	2.1	30.4	56.1	3.3
Uganda	2011	315	20.3	8.9	10.6	12.9	26.5	39.3	6.6
Zambia	2007	175	27.6	21.2	5.7	3.4	16.8	34.1	6.1
Zimbabwe	2010-11	149	30.2	8.9	1.0	6.4	37.5	14.6	1.3
Eastern Europe/NIS									
Albania	2008-09	376	18.9	5.5	0.5	0.5	53.3	30.9	7.8
Armenia	2010	138	26.1	36.6	0.0	0.3	27.7	7.6	14.4
Azerbaijan	2006	639	27.3	32.4	0.1	1.2	12.9	25.0	6.5
Ukraine	2007	160	33.2	19.5	1.0	9.1	14.9	19.9	2.0
Asia									
Cambodia	2010	688	37.2	10.6	2.6	12.0	6.4	51.3	7.8
India	2005-06	1,785	27.8	3.7	5.7	13.6	35.2	21.3	15.3
Nepal	2011	255	33.8	7.3	1.5	2.9	13.4	28.2	0.5
Philippines	2008	754	26.1	8.3	2.5	2.1	14.8	51.9	18.7
Timor-Leste	2009	1,029	2.4	0.8	8.1	0.1	69.9	34.2	8.4

(Continued)

Table 17. – *Continued*

Country	Survey date	Number of respon-dents	No or infrequent sex	Infecund or subfecund[1]	Breast-feeding or post-partum amenor-rheic	Fatalistic	Husband, family or other opposition or religious prohibition	Side effects or health concerns	Program-related problems[2]
Latin America and Caribbean									
Bolivia	2008	360	41.6	7.8	5.2	0.0	22.6	33.3	17.2
Colombia	2010	275	22.4	10.9	0.1	0.7	12.2	28.6	16.6
Dominican Rep.	2007	229	18.5	10.8	0.9	5.7	25.6	31.3	9.9
Guyana	2009	293	15.0	4.8	2.5	0.8	14.1	40.7	9.5
Peru	2012	72	45.2	2.3	1.6	0.7	9.1	36.7	0.0
Unweighted Averages									
West and Central Africa		8,527	17.2	2.5	10.6	2.0	33.1	29.8	15.3
East and Southern Africa		4,929	16.8	7.4	8.2	7.9	24.8	33.8	8.1
Eastern Europe/NIS		1,313	26.4	23.5	0.4	2.8	27.2	20.9	7.7
Asia		4,511	25.5	6.1	4.1	6.1	27.9	37.4	10.1
Latin America and Caribbean		1,229	28.5	7.3	2.1	1.6	16.7	34.1	10.6
Total		**20,509**	**20.4**	**7.4**	**6.9**	**4.6**	**26.9**	**31.8**	**10.8**

Note: Reasons for not intending to use were not asked in the ever-married surveys of Bangladesh, Egypt, Indonesia, Jordan, and Pakistan.
[1] Includes hysterectomy and menopause
[2] Program-related problems: No access or too far, no source or method known, no method available, preferred method unavailable, inconvenient to use, costs too much

3.7. Child Deaths Averted

Satisfying fertility-risk based unmet need for contraception has the potential to avert many child and maternal deaths. The number of infant and child deaths that could be averted in 2015 in each of the 45 countries is provided in Table 18. The first panel of this table contains current estimates and projections for fertility rates, number of births, infant and under-five mortality rates, and numbers of infant and under-five deaths. This panel serves as the baseline for calculating the averted number of infant and under-five deaths. In the second panel, the infant and under-five mortality rates that would result from satisfying the unmet risk-based needs are used to calculate the decreased number of deaths, assuming no change in fertility levels. In the third panel, a decreased number of deaths is calculated assuming a decrease in fertility due to satisfying risk-based unmet needs but with no reduction in infant and child mortality rates. The fourth panel presents the decreases in deaths with the two effects combined. The two columns in the fifth panel provide the number of infant and under-five deaths averted through both a fertility reduction and mortality risk reduction if risk-based unmet needs were eliminated.

For the 45 countries together, about 3.2 million under-five deaths would be averted; 2.1 million of these are infant deaths. The deaths averted represent reductions of about 56 percent in both infant and under-five deaths (last panel of Table 18). The reductions are not uniform, and are the greatest in the sub-Saharan African regions, with 68 percent of under-five deaths averted in West and Central Africa and 61 percent in East and Southern Africa, and the least in Eastern Europe/NIS at 23 percent of infant deaths. Eight countries would have more than 70 percent of under-five deaths averted, five of which are in West and Central Africa. Three countries, all in Eastern Europe/NIS, would have less than 10 percent of child deaths averted; this includes the anomalous result of a 33 percent increase. These very low figures may be due to the very low fertility rates and the resulting high concentrations of births in the unavoidable risk category of first births.

Table 18. Infant and under-five child deaths averted due to satisfying risk-based unmet need for contraception, 45 DHS country surveys 2006-2012

		Current						Reduced mortality rate						Reduced fertility rate						Combined effect						Total number of child deaths averted		Percent of deaths that are averted	
Country	Survey	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Under-five deaths	Infant deaths	Under-five deaths	Infant deaths
West and Central Africa																													
Benin	2006	5.74	386.53	99.0	38,254	56.1	21,697	5.74	386.53	81.6	31,522	41.5	16,053	2.68	180.47	99.0	17,861	56.1	10,130	2.68	180.47	81.6	14,718	41.5	7,495	23,537	14,202	61.5	65.5
Burkina Faso	2010	5.99	713.51	107.6	76,766	56.6	40,395	5.99	713.51	69.4	49,484	37.1	26,440	2.62	312.08	107.6	33,577	56.6	17,669	2.62	312.08	69.4	21,644	37.1	11,565	55,122	28,831	71.8	71.4
Cameroon	2011	5.09	850.10	101.6	86,339	51.9	44,134	5.09	850.10	78.6	66,831	43.7	37,157	2.42	404.17	101.6	41,049	51.9	20,983	2.42	404.17	78.6	31,774	43.7	17,666	54,564	26,468	63.2	60.0
DR Congo	2007	6.28	2,983.76	129.7	387,121	82.5	246,073	6.28	2,983.76	113.6	338,947	73.7	219,853	2.58	1,225.81	129.7	159,040	82.5	101,094	2.58	1,225.81	113.6	139,249	73.7	90,322	247,872	155,751	64.0	63.3
Ghana	2008	4.03	805.04	75.2	60,547	51.5	41,435	4.03	805.04	65.1	52,409	44.2	35,622	2.23	445.47	75.2	33,504	51.5	22,928	2.23	445.47	65.1	29,000	44.2	19,711	31,547	21,724	52.1	52.4
Liberia	2007	5.20	155.65	93.0	14,482	62.6	9,751	5.20	155.65	68.0	10,586	43.8	6,813	2.64	79.02	93.0	7,352	62.6	4,951	2.64	79.02	68.0	5,374	43.8	3,459	9,108	6,292	62.9	64.5
Mali	2006	6.58	758.89	156.5	118,747	83.3	63,247	6.58	758.89	116.5	88,429	57.1	43,301	2.54	292.94	156.5	45,839	83.3	24,415	2.54	292.94	116.5	34,135	57.1	16,715	84,612	46,532	71.3	73.6
Niger	2006	7.02	954.78	132.9	126,918	61.3	58,533	7.02	954.78	87.6	83,607	37.4	35,719	2.42	329.14	132.9	43,752	61.3	20,178	2.42	329.14	87.6	28,822	37.4	12,313	98,096	46,220	77.3	79.0
Nigeria	2008	5.72	7,425.49	144.2	1,070,810	71.2	529,047	5.72	7,425.49	98.5	731,061	47.7	353,924	2.46	3,193.48	144.2	460,523	71.2	227,527	2.46	3,193.48	98.5	314,407	47.7	152,212	756,403	376,835	70.6	71.2
Sao Tome & Principe	2008-09	4.90	6.54	52.6	344	34.5	226	4.90	6.54	25.0	164	18.2	119	2.46	3.29	52.6	173	34.5	113	2.46	3.29	25.0	82	18.2	60	262	166	76.1	73.5
Senegal	2010-11	4.98	548.46	63.8	34,995	40.1	22,014	4.98	548.46	51.4	28,179	42.0	23,033	2.34	257.71	63.8	16,444	40.1	10,344	2.34	257.71	51.4	13,241	42.0	10,823	21,755	11,191	62.2	50.8
Sierra Leone	2008	5.12	224.47	126.6	28,418	84.4	18,954	5.12	224.47	83.0	18,639	60.5	13,578	2.50	109.60	126.6	13,876	84.4	9,255	2.50	109.60	83.0	9,101	60.5	6,630	19,317	12,325	68.0	65.0
East and Southern Africa																													
Burundi	2010	6.38	470.58	78.7	37,056	53.4	25,147	6.38	470.58	61.5	28,945	49.3	23,188	2.83	208.74	78.7	16,437	53.4	11,155	2.83	208.74	61.5	12,839	49.3	10,286	24,217	14,861	65.4	59.1
Ethiopia	2011	4.80	3,166.55	90.9	287,730	53.4	169,155	4.80	3,166.55	50.6	160,089	37.1	117,422	1.93	1,273.22	90.9	115,692	53.4	68,014	1.93	1,273.22	50.6	64,369	37.1	47,213	223,361	121,942	77.6	72.1
Kenya	2008-09	4.56	1,578.49	66.7	105,313	47.8	75,457	4.56	1,578.49	66.5	104,960	45.7	72,077	2.36	816.94	66.7	54,504	47.8	39,052	2.36	816.94	66.5	54,321	45.7	37,303	50,992	38,154	48.4	50.6
Lesotho	2009	3.30	57.02	107.2	6,115	80.2	4,575	3.30	57.02	110.4	6,295	80.7	4,599	2.32	40.09	107.2	4,299	80.2	3,217	2.32	40.09	110.4	4,425	80.7	3,233	1,690	1,342	27.6	29.3
Madagascar	2008-09	4.82	829.75	70.7	58,660	44.7	37,097	4.82	829.75	72.8	60,374	29.8	24,760	2.42	416.60	70.7	29,452	44.7	18,626	2.42	416.60	72.8	30,312	29.8	12,432	28,348	24,666	48.3	66.5
Malawi	2010	5.71	677.69	94.1	63,795	55.9	37,908	5.71	677.69	91.1	61,726	48.6	32,961	2.58	306.21	94.1	28,825	55.9	17,128	2.58	306.21	91.1	27,890	48.6	14,893	35,905	23,015	56.3	60.7
Mozambique	2011	5.92	1,032.86	85.2	87,959	55.5	57,314	5.92	1,032.86	65.7	67,867	45.6	47,149	2.73	476.30	85.2	40,562	55.5	26,430	2.73	476.30	65.7	31,297	45.6	21,743	56,662	35,571	64.4	62.1
Namibia	2006-07	3.57	60.82	68.7	4,178	44.6	2,715	3.57	60.82	68.7	4,179	42.5	2,584	2.35	40.03	68.7	2,751	44.6	1,787	2.35	40.03	68.7	2,751	42.5	1,701	1,428	1,014	34.2	37.3
Rwanda	2010	4.56	421.41	61.5	25,896	44.9	18,937	4.56	421.41	70.8	29,849	44.5	18,771	2.28	210.71	61.5	12,948	44.9	9,469	2.28	210.71	70.8	14,925	44.5	9,385	10,971	9,552	42.4	50.4
Swaziland	2006-07	3.85	37.27	109.2	4,070	82.3	3,066	3.85	37.27	117.5	4,378	92.1	3,431	2.33	22.55	109.2	2,463	82.3	1,856	2.33	22.55	117.5	2,650	92.1	2,076	1,421	990	34.9	32.3
Tanzania	2010	5.43	1,998.47	67.4	134,794	46.9	93,796	5.43	1,998.47	59.5	118,885	42.3	84,439	2.58	949.55	67.4	64,046	46.9	44,566	2.58	949.55	59.5	56,487	42.3	40,120	78,307	53,676	58.1	57.2
Uganda	2011	6.20	1,693.60	77.9	131,976	49.7	84,115	6.20	1,693.60	64.6	109,355	41.9	70,882	2.49	680.17	77.9	53,003	49.7	33,782	2.49	680.17	64.6	43,918	41.9	28,467	88,058	55,647	66.7	66.2
Zambia	2007	6.17	657.09	99.9	65,673	62.7	41,192	6.17	657.09	104.6	68,710	68.5	45,038	2.63	280.09	99.9	27,994	62.7	17,558	2.63	280.09	104.6	29,288	68.5	19,198	36,385	21,994	55.4	53.4
Zimbabwe	2010-11	4.10	457.00	76.2	34,820	46.9	21,429	4.10	457.00	73.5	33,579	43.8	20,024	2.81	313.21	76.2	23,865	46.9	14,686	2.81	313.21	73.5	23,014	43.8	13,723	11,806	7,705	33.9	36.0
Middle East/North Africa																													
Egypt	2008	4.40	1,890.06	25.2	47,710	22.3	42,179	4.40	1,890.06	18.5	34,995	13.6	25,676	3.55	1,524.93	25.2	38,493	22.3	34,031	3.55	1,524.93	18.5	28,235	13.6	20,716	19,475	21,464	40.8	50.9
Jordan	2007	6.05	191.10	17.6	3,372	14.7	2,805	6.05	191.10	6.5	1,249	5.5	1,059	4.11	129.82	17.6	2,291	14.7	1,905	4.11	129.82	6.5	849	5.5	719	2,524	2,086	74.8	74.4
Eastern Europe/NIS																													
Albania	2008-09	1.59	41.79	18.0	751	17.2	717	1.59	41.79	13.8	577	9.2	384	1.42	37.32	18.0	671	17.2	641	1.42	37.32	13.8	515	9.2	343	236	374	31.4	52.2
Armenia	2010	1.70	39.18	19.5	764	13.8	541	1.70	39.18	27.3	1,070	7.8	304	1.61	37.10	19.5	723	13.8	513	1.61	37.10	27.3	1,013	7.8	288	(250)	253	-32.7	46.8
Azerbaijan	2006	2.02	161.08	48.6	7,831	41.0	6,602	2.02	161.08	49.6	7,997	33.7	5,429	1.86	148.32	48.6	7,210	41.0	6,079	1.86	148.32	49.6	7,363	33.7	4,999	467	1,603	6.0	24.3
Ukraine	2007	1.17	473.52	18.0	8,506	13.7	6,478	1.17	473.52	18.1	8,567	12.0	5,696	1.11	449.24	18.0	8,070	13.7	6,145	1.11	449.24	18.1	8,128	12.0	5,404	379	1,073	4.5	16.6
Asia																													
Bangladesh	2011	2.77	3,097.68	47.4	146,944	39.9	123,577	2.77	3,097.68	42.7	132,403	31.8	98,654	2.26	2,527.35	47.4	119,889	39.9	100,824	2.26	2,527.35	42.7	108,025	31.8	80,491	38,919	43,086	26.5	34.9
Cambodia	2010	3.04	386.14	53.8	20,760	46.5	17,973	3.04	386.14	39.5	15,255	30.4	11,753	2.24	284.53	53.8	15,297	46.5	13,243	2.24	284.53	39.5	11,241	30.4	8,660	9,520	9,312	45.9	51.8
India	2005-06	2.68	25,378.96	60.1	1,524,582	47.8	1,212,382	2.68	25,378.96	43.4	1,100,566	31.8	806,137	1.90	17,992.54	60.1	1,080,861	47.8	859,525	1.90	17,992.54	43.4	780,252	31.8	571,515	744,330	640,867	48.8	52.9
Indonesia	2007	3.64	4,617.47	45.5	210,011	33.6	155,201	3.64	4,617.47	38.6	178,339	24.8	114,380	3.06	3,881.72	45.5	176,548	33.6	130,471	3.06	3,881.72	38.6	149,923	24.8	96,155	60,088	59,046	28.6	38.0
Nepal	2011	2.60	579.34	48.5	28,105	43.9	25,411	2.60	579.34	36.4	21,067	31.5	18,254	1.93	430.05	48.5	20,863	43.9	18,863	1.93	430.05	36.4	15,638	31.5	13,550	12,467	11,861	44.4	46.7
Pakistan	2012-13	5.34	4,593.80	85.3	391,671	71.1	326,482	5.34	4,593.80	85.4	392,299	73.2	336,158	3.37	2,899.09	85.3	247,178	71.1	206,038	3.37	2,899.09	85.4	247,574	73.2	212,145	144,097	114,337	36.8	35.0
Philippines	2008	3.26	2,443.10	32.0	78,269	23.4	57,193	3.26	2,443.10	21.7	52,969	19.2	46,857	2.13	1,596.26	32.0	51,139	23.4	37,368	2.13	1,596.26	21.7	34,608	19.2	30,615	43,660	26,578	55.8	46.5
Timor-Leste	2009	5.68	42.05	59.0	2,480	42.0	1,766	5.68	42.05	36.2	1,520	31.6	1,331	2.33	17.25	59.0	1,017	42.0	724	2.33	17.25	36.2	624	31.6	546	1,856	1,220	74.9	69.1

(Continued)

Table 18. – *Continued*

		Current						Reduced mortality rate						Reduced fertility rate						Combined effect						Total number of child deaths averted		Percent of deaths that are averted	
Country	Survey	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Total Fertility Rate	Births in 1000s	Under-five mortality rate*	Under-five deaths	Infant mortality rate*	Infant deaths	Under-five deaths	Infant deaths	Under-five deaths	Infant deaths
Latin America and Caribbean																													
Bolivia	2008	3.54	277.78	50.5	14,023	42.8	11,902	3.54	277.78	32.0	8,885	27.0	7,508	2.21	173.41	50.5	8,754	42.8	7,430	2.21	173.41	32.0	5,547	27.0	4,687	8,476	7,215	60.4	60.6
Colombia	2010	2.14	897.60	18.0	16,184	15.2	13,650	2.14	897.60	15.1	13,535	11.6	10,447	1.78	746.60	18.0	13,462	15.2	11,354	1.78	746.60	15.1	11,258	11.6	8,689	4,927	4,961	30.4	36.3
Dominican Rep.	2007	2.43	214.03	30.3	6,492	25.1	5,370	2.43	214.03	24.9	5,324	20.5	4,379	1.92	169.11	30.3	5,129	25.1	4,243	1.92	169.11	24.9	4,206	20.5	3,460	2,285	1,910	35.2	35.6
Guyana	2009	2.78	15.91	34.4	548	30.5	485	2.78	15.91	31.1	495	31.9	508	2.00	11.45	34.4	394	30.5	349	2.00	11.45	31.1	356	31.9	366	192	119	35.0	24.6
Peru	2012	2.53	596.34	19.0	11,353	16.2	9,690	2.53	596.34	14.8	8,802	13.2	7,844	1.89	445.49	19.0	8,481	16.2	7,239	1.89	445.49	14.8	6,575	13.2	5,860	4,778	3,830	42.1	39.5
Unweighted Averages of Rates and Sums of Births and Deaths																													
West and Central Africa		5.55	15,813	106.9	2,043,742	61.4	1,095,508	5.55	15,813	78.2	1,499,857	45.6	811,611	2.49	6,833	106.9	872,990	61.4	469,587	2.49	6,833	78.2	641,548	45.6	348,970	1,402,194	746,537	68.6	68.1
East and Southern Africa		4.96	13,139	82.5	1,048,037	54.9	671,903	4.96	13,139	77.0	859,191	50.9	567,325	2.47	6,034	82.5	476,840	54.9	307,326	2.47	6,034	77.0	398,487	50.9	261,774	649,550	410,129	62.0	61.0
Middle East/North Africa		5.23	2,081	21.4	51,082	18.5	44,984	5.23	2,081	12.5	36,245	9.6	26,734	3.83	1,655	21.4	40,784	18.5	35,936	3.83	1,655	12.5	29,084	9.6	21,435	21,999	23,549	43.1	52.4
Eastern Europe/NIS		1.62	716	26.0	17,852	21.4	14,338	1.62	716	27.2	18,211	15.7	11,814	1.50	672	26.0	16,675	21.4	13,378	1.50	672	27.2	17,020	15.7	11,034	832	3,304	4.7	23.0
Asia		3.63	41,139	53.9	2,402,823	43.5	1,919,984	3.63	41,139	43.0	1,894,418	34.3	1,433,525	2.40	29,629	53.9	1,712,792	43.5	1,367,057	2.40	29,629	43.0	1,347,885	34.3	1,013,677	1,054,938	906,308	43.9	47.2
Latin America and Caribbean		2.68	2,002	30.5	48,600	26.0	41,097	2.68	2,002	23.6	37,040	20.8	30,686	1.96	1,546	30.5	36,221	26.0	30,615	1.96	1,546	23.6	27,943	20.8	23,062	20,657	18,035	42.5	43.9
Total		**4.34**	**74,889**	**70.4**	**5,612,136**	**46.8**	**3,787,814**	**4.34**	**74,889**	**58.0**	**4,344,962**	**38.2**	**2,881,694**	**2.38**	**46,369**	**70.4**	**3,156,302**	**46.8**	**2,223,899**	**2.38**	**46,369**	**58.0**	**2,461,966**	**38.2**	**1,679,952**	**3,150,170**	**2,107,863**	**56.1**	**55.6**

3.8. Maternal Deaths Averted

Among the 45 DHS country surveys included in this report, 28 included information on pregnancy-related maternal deaths that were obtained through the sisterhood module. Maternal deaths averted and the reduction in lifetime risk of a maternal death are calculated by using the same three-step procedure used for infant and under-five deaths: reductions due to reduced risk, reductions due to reduced fertility, and the combination of both reductions due to satisfying age-and parity-risk unmet needs for contraception.[11]

For the 28 countries together, satisfying risk-based unmet need would avert 109,000 maternal deaths in 2015, which is 70 percent of the projected number of maternal deaths. In most of the countries with maternal mortality data, satisfying risk-based unmet need would substantially reduce maternal deaths and the lifetime risk of a maternal death. The number of maternal deaths that would be averted for 2015 varies from 26,513 in Nigeria to 6 in São Tomé and Principe, where only 8 maternal deaths are projected. The percentage of maternal deaths averted varies across countries from 47 to 84 percent. The percentage reductions in lifetime risk of maternal deaths follows closely that of maternal deaths. Due to the reduced number of countries by region, no regional results are shown.

[11] Reductions due to satisfying birth interval-risk unmet need for contraception cannot be calculated because the sisterhood module did not have any information on the pregnancy intervals of the respondents' sisters.

Table 19. Maternal pregnancy-related deaths averted due to satisfying risk-based unmet needs for contraception, 28 DHS country surveys 2006-2012

		Current					Reduced mortality rate					Reduced fertility rate					Combined effect								
Country	Survey	Total Fertility Rate	Births in 1000s	Maternal mortality ratio per 100,000 births	Maternal deaths	Lifetime risk (maternal deaths per 1000 women)	Total Fertility Rate	Births in 1000s	Maternal mortality ratio per 100,000 births	Maternal deaths	Lifetime risk (maternal deaths per 1000 women)	Total Fertility Rate	Births in 1000s	Maternal mortality ratio per 100,000 births	Maternal deaths	Lifetime risk (maternal deaths per 1000 women)	Total Fertility Rate	Births in 1000s	Maternal mortality ratio per 100,000 births	Maternal deaths	Lifetime risk (maternal deaths per 1000 women)	Total maternal deaths averted	Reduction in lifetime risk (maternal deaths per 1000 women)	Percent reduction in maternal deaths	Percent reduction in lifetime risk
West and Central Africa																									
Benin	2006	5.74	386.53	400	1,546	22.7	5.74	386.53	219	846	12.5	2.68	180.47	400	722	10.7	2.68	180.47	219	395	5.9	1,151	16.9	74.4	74.2
Burkina Faso	2010	5.99	713.51	341	2,433	20.3	5.99	713.51	191	1,363	11.4	2.62	312.08	341	1,064	8.9	2.62	312.08	191	596	5.0	1,837	15.3	75.5	75.3
Cameroon	2011	5.09	850.10	782	6,648	39.2	5.09	850.10	495	4,208	24.9	2.42	404.17	782	3,161	18.8	2.42	404.17	495	2,001	11.9	4,647	27.2	69.9	69.5
DR Congo	2007	6.28	2,983.76	543	16,202	33.6	6.28	2,983.76	281	8,384	17.5	2.58	1,225.81	543	6,656	13.9	2.58	1,225.81	281	3,445	7.2	12,757	26.4	78.7	78.5
Liberia	2007	5.20	155.65	994	1,547	50.6	5.20	155.65	525	817	27.0	2.64	79.02	994	785	26.0	2.64	79.02	525	415	13.8	1,132	36.8	73.2	72.7
Mali	2006	6.58	758.89	465	3,529	30.2	6.58	758.89	265	2,011	17.3	2.54	292.94	465	1,362	11.8	2.54	292.94	265	776	6.7	2,753	23.5	78.0	77.8
Niger	2006	7.02	954.78	709	6,769	48.7	7.02	954.78	326	3,113	22.7	2.42	329.14	709	2,334	17.1	2.42	329.14	326	1,073	7.9	5,696	40.9	84.1	83.8
Nigeria	2008	5.72	7,425.49	545	40,469	30.8	5.72	7,425.49	437	32,449	24.7	2.46	3,193.48	545	17,404	13.4	2.46	3,193.48	437	13,956	10.7	26,513	20.1	65.5	65.2
Sao Tome & Principe	2008-09	4.90	6.54	116	8	5.7	4.90	6.54	46	3	2.3	2.46	3.29	116	4	2.9	2.46	3.29	46	2	1.1	6	4.5	80.1	80.1
Senegal	2010-11	4.98	548.46	484	2,655	23.9	4.98	548.46	321	1,761	15.9	2.34	257.71	484	1,247	11.3	2.34	257.71	321	827	7.5	1,827	16.4	68.8	68.6
Sierra Leone	2008	5.12	224.47	857	1,924	43.1	5.12	224.47	556	1,248	28.1	2.50	109.60	857	939	21.3	2.50	109.60	556	609	13.8	1,314	29.3	68.3	67.9
East and Southern Africa																									
Burundi	2010	6.38	470.58	500	2,353	31.5	6.38	470.58	278	1,308	17.6	2.83	208.74	500	1,044	14.1	2.83	208.74	278	580	7.8	1,773	23.6	75.3	75.1
Ethiopia	2011	4.80	3,166.55	676	21,406	32.0	4.80	3,166.55	414	13,110	19.7	1.93	1,273.22	676	8,607	13.0	1.93	1,273.22	414	5,271	8.0	16,135	24.1	75.4	75.1
Kenya	2008-09	4.56	1,578.49	520	8,208	23.5	4.56	1,578.49	364	5,746	16.5	2.36	816.94	520	4,248	12.2	2.36	816.94	364	2,974	8.6	5,234	14.9	63.8	63.5
Lesotho	2009	3.30	57.02	1243	709	40.4	3.30	57.02	910	519	29.7	2.32	40.09	1243	498	28.6	2.32	40.09	910	365	21.0	344	19.5	48.5	48.1
Madagascar	2008-09	4.82	829.75	498	4,132	23.8	4.82	829.75	261	2,166	12.5	2.42	416.60	498	2,075	12.0	2.42	416.60	261	1,087	6.3	3,045	17.5	73.7	73.5
Malawi	2010	5.71	677.69	675	4,574	37.9	5.71	677.69	407	2,758	23.0	2.58	306.21	675	2,067	17.3	2.58	306.21	407	1,246	10.5	3,328	27.5	72.8	72.4
Mozambique	2011	5.92	1,032.86	408	4,214	23.9	5.92	1,032.86	292	3,016	17.2	2.73	476.30	408	1,943	11.1	2.73	476.30	292	1,391	8.0	2,823	16.0	67.0	66.7
Namibia	2006-07	3.57	60.82	508	309	18.0	3.57	60.82	271	165	9.6	2.35	40.03	508	203	11.9	2.35	40.03	271	108	6.4	200	11.7	64.9	64.7
Rwanda	2010	4.56	421.41	487	2,052	22.0	4.56	421.41	313	1,319	14.2	2.28	210.71	487	1,026	11.1	2.28	210.71	313	660	7.1	1,393	14.9	67.9	67.6
Swaziland	2006-07	3.85	37.27	589	219	22.5	3.85	37.27	362	135	13.9	2.33	22.55	589	133	13.7	2.33	22.55	362	82	8.4	138	14.1	62.8	62.6
Tanzania	2010	5.43	1,998.47	494	9,872	26.5	5.43	1,998.47	284	5,676	15.3	2.58	949.55	494	4,691	12.7	2.58	949.55	284	2,697	7.3	7,176	19.2	72.7	72.4
Uganda	2010-11	6.17	457.00	591	2,701	35.9	6.17	457.00	490	2,239	29.9	2.63	194.80	591	1,151	15.5	2.63	194.80	490	955	12.8	1,746	23.1	64.7	64.3
Zambia																									
Zimbabwe	2007	6.20	473.52	432	2,046	26.5	6.20	473.52	224	1,061	13.8	2.49	190.17	432	822	10.7	2.49	190.17	224	426	5.6	1,620	20.9	79.2	79.0
Middle East/North Africa																									
Egypt	2007	3.64	4,617.47	168	7,757	6.1	3.64	4,617.47	107	4,941	3.9	3.06	3,881.72	168	6,521	5.1	3.06	3,881.72	107	4,153	3.3	3,604	2.8	46.5	46.4
Jordan	2009	5.68	42.05	557	234	31.2	5.68	42.05	287	121	16.2	2.33	17.25	557	96	12.9	2.33	17.25	287	50	6.7	185	24.6	78.9	78.6
Eastern Europe/NIS																									
Albania	2008	3.54	277.78	268	744	9.5	3.54	277.78	145	403	5.1	2.21	173.41	268	465	5.9	2.21	173.41	145	251	3.2	493	6.3	66.2	66.1
Armenia	2007	2.43	214.03	172	368	4.2	2.43	214.03	113	242	2.7	1.92	169.11	172	291	3.3	1.92	169.11	113	191	2.2	177	2.0	48.1	48.1
Azerbaijan		**5.11**	**31,421**	**537**	**155,629**	**27.3**	**5.11**	**31,421**	**328**	**101,126**	**16.6**	**2.46**	**15,775**	**537**	**71,560**	**13.1**	**2.46**	**15,775**	**328**	**46,581**	**8.0**	**109,048**	**19.3**	**69.5**	**69.2**

4. Discussion

According to our calculations, if women were to satisfy their unmet risk-based needs for contraception or were to obtain more effective methods of family planning, substantial numbers of under-five deaths and maternal deaths could be averted. When we consider the combined effects of a reduced number of births and lower mortality rates, we find that over half of infant and under-five deaths could be averted, with 3.2 million deaths averted out of the 5.6 million deaths projected for 2015 in the 45 countries included in the analysis. Even more spectacular is the number of maternal deaths that could be averted, with 109,000 out of the 155,000 projected for 2015, a reduction of 70 percent. It is unrealistic to assume that risk-based unmet need can be eliminated completely because of conflicts with fertility desires and rejection of contraception use of by some women and their husbands or partners, families, or religions. However, our calculations indicate that satisfying half of the unmet risk-based need would be a highly effective, cost-effective intervention to avert young child and maternal deaths. For many women, risk-based needs and desire-based needs coincide, and a substantial portion of risk-based unmet need will be satisfied if women can achieve their preferred number and spacing of births.

The numbers of child deaths averted in our analyses are much greater than those predicted by the FamPlan/LiST model tool (Bhutta et al. 2014; Jo et al. 2014). See Walker et al. (2013) for a description of the LiST tool. The differences lie in the different approaches. To estimate the number of deaths averted by increases in contraceptive use, the FamPlan/LiST model considers only those reductions in infant and child deaths that are transmitted through direct causes of death for which there is published evidence that links fertility risks to pregnancy and delivery complications. Reductions in births are also considered. However, published model results represent various scenarios of increases in the contraceptive prevalence rate over a period of years rather than eliminating the unmet need due to fertility risk. By contrast, the approach taken here uses the observed risk of mortality for infant and under-five children that is associated with fertility behavior after controlling for a host of confounding factors. These risk estimates are not limited to transmission through direct causes of death for which there is published evidence. Given the lack of available data for middle and low income countries that link fertility risk behavior to specific causes of death, as well as indirect and underlying causes, we believe that the FamPlan/LiST model severely underestimates the potential impact of contraceptive use on mortality. Thus, there are two main differences between our methodology and the methodology used by the FamPlan/LiST tool. We take into account indirect and/or underlying causes of death, and we estimate reductions in births from satisfying risk-based unmet needs for contraception.

Our estimates of maternal deaths averted by satisfying risk-based unmet needs compare well with those of Stover and Ross (2009), who found that the increase in contraceptive use between 1990 and 2005 averted over 1.2 million maternal deaths. This was due to the decline in the fertility rate and was associated with a reduction in the MMRatio of 450 points from the reduction in high-risk births. Cleland et al. (2012) and Ahmed et al. (2012) calculated that satisfying *demand-based* unmet need could avoid 30 and 29 percent of maternal deaths, respectively. Our estimates are based on *risk-based* unmet needs and needs for more effective contraception and could easily exceed the percentage of maternal deaths averted by satisfying just demand-based unmet need.

Our estimates of infant and under-five mortality reduced by satisfying risk-based unmet needs differ in several ways from those estimated by Trussell and Pebley (1984). First, they estimated the reduction of mortality rates from eliminating each of the fertility risk factors individually rather than eliminating the combination of risk factors. Second, they used a different birth interval range, less than 24 months from birth to birth rather than less than 36 months. Their infant and under-five mortality results are based primarily on data from the World Fertility Surveys, which took place more than three decades ago when there were much higher levels of mortality. They did not estimate the number of deaths averted and did not

take into account changes in fertility levels. Their estimates of the potential change in the MMRatio are based only on data from one location, the Matlab (Thana, Bangladesh) surveillance site, and are also more than four decades old. Trussell and Pebley did not take account of the reduction in fertility from avoiding the maternal mortality risks and did not calculate the number of maternal deaths averted.

Basing the analyses on our 2014 high-risks births report, we find a very high level of unmet need for contraception among non-pregnant women. Many thousands of maternal and child deaths could be averted if risk-based unmet needs were satisfied. In this study of the 45 DHS country surveys with fieldwork between 2006 and 2012, we find that more than two-thirds of non-pregnant women age 15-49 have an avoidable risk for young child and maternal death based on their fertility status. We have included only women who would be age 40 or more at next birth as a conservative approach, although women 35-39 years of age also have been shown to have an increased risk. Moreover, while it has been shown that women with long birth-to-pregnancy intervals are at increased risk for both child mortality and pregnancy complications, the use of contraception will not avert these risks and is not included in the calculation of need for contraception.

Many women seem to appreciate the fertility-based risks that they are facing, since only 9 percent of those faced with a spacing risk (low age at birth, short interval) want another child within two years of the survey, and 68 percent of those women with a limiting risk do not want another child or are using a permanent method. Combining the fertility-risk based unmet need with unmet need based on fertility desires indicates the percent of women with an unmet need for contraception from both concepts. Women who are using a contraceptive method that is not in agreement with their desires, their risks or both are in need a more effective method, and more specifically, a LAPM. Two of five married, non-pregnant women have either an unmet need for contraception or a need to improve their method, and thus have a need for focused attention from family planning programs. Because DHS data was lacking in many countries, the calculations in this report are limited to currently married women, although women who are not currently married can be having sexual relations and may need focused attention as well.

Married, non-pregnant women with an unmet need for contraception or a need for a more effective method live primarily in rural areas, and most have completed less than a primary education. Surprisingly, these women are not concentrated among the poorest. Women with an unmet need are rather evenly distributed across wealth quintiles.

We found that six in ten women with an unmet need for focused family planning efforts were not told about family planning in recent visits to health facilities. Over a third do not intend to use contraception in the future, and one in nine reported that family planning program problems were a reason for not intending to use contraception. This finding suggests that, in many cases, family planning and health programs are not adequately informing women of their risks and are not responding to the unmet need for contraception or for a more effective method of contraception.

This study has several limitations that should be taken into account. For the projected number of deaths averted in 2015, we use the latest DHS estimates of fertility, infant, under-five and maternal mortality rates. We assume that those rates are accurate and have not changed from the periods of measurement (three years before the survey for fertility rates, five years for infant and child mortality, and seven years for maternal mortality rates) to the current year. Population estimates for women are based on UN medium level population projections published in 2013 and projected from 2005-10 data. This study also assumes no change in other interventions to reduce mortality, which may cause fewer deaths averted to be attributable to contraception.

The calculation of the reduction in deaths by satisfying risk-based unmet need for contraception does not take into account married women’s desires for having a future birth. Those desires could raise the number

of births averted, since some women without risk-based unmet need do not wish to have another child, and this would lower the reduced-risk fertility rate. On the other hand, women with an unmet risk-based need may be unwilling to use contraception, which could lower the number of births averted and raise the reduced-risk fertility rate. The calculations also do not take into account the capacity and quality of family planning programs needed to satisfy the unmet needs. The results here apply only to the 45 countries in the analysis (28 for maternal mortality), and regional averages, especially for the Middle East/North Africa, Eastern Europe/North Africa and Latin America/Caribbean regions, are based on very few countries.

The appendix provides brief summaries for each country included in this report.

5. Conclusions and Policy Implications

Avoiding high fertility behavior risk (due to inadequate birth-to-pregnancy spacing, too young or too old age at birth, and high parity) would go a long way toward averting substantial numbers of young child and maternal deaths. Many women have unmet needs for contraception based on their risk status, and in many cases this coincides with their unmet needs based on desires not to have or to delay a future birth. Many of the women with unmet needs are not being well-served by health systems. These women need to be informed of the fertility risks and their contraceptive choices, and to be provided with timely, effective, and high quality services. A majority of the women with risk-based unmet needs live in rural areas and have low levels of education. However, those with unmet needs are not limited to the poor and many women in the higher wealth quintiles also have risk-based unmet needs. It is incumbent upon national health programs, international health donors and private for-profit and not-for-profit health programs to serve the women with unmet needs for contraception in order to cost-effectively avert maternal and child deaths and to reach the Sustainable Development Targets 3.1 and 3.2.

References

Ahmed, S., Q. Li, L. Liu, and A.O. Tsui. 2012. "Maternal Deaths Averted by Contraceptive Use: An Analysis of 172 Countries." *Lancet* 380 (9837):111-25.

Alam, N. 1995. "Birth Spacing and Infant and Early Childhood Mortality in a High Fertility Area of Bangladesh: Age-Dependent and Interactive Effects." *Journal of Biosocial Science* 27:393-393.

Alam, N., and P.H. David. 1998. "Infant and Child Mortality in Bangladesh: Age-Specific Effects of Previous Child's Death." *Journal of Biosocial Science* 30 (03):333-348.

Bhalotra, S., and A.v. Soest. 2006. *Birth Spacing and Neonatal Mortality in India: Dynamics, Frailty and Fecundity*. Paper read at Population Association of America, at Los Angeles, California.

Bhutta, Z.A., J.K. Das, R. Bahl, J.E. Lawn, R.A. Salam, V.K. Paul, M.J. Sankar, H. Blencowe, A. Rizvi, V.B. Chou, and N. Walker. 2014. "Can Available Interventions End Preventable Deaths in Mothers, Newborn Babies, and Stillbirths, and at What Cost?" *Lancet* 384 (9940):347-70.

Boerma, J.T., and G.T. Bicego. 1992. "Preceding Birth Intervals and Child Survival: Searching for Pathways of Influence." *Studies in Family Planning* 23 (4):243-256.

Bradley, S.E.K., T.N. Croft, J.D. Fishel, and C.F. Westoff. 2012. *Revising Unmet Need for Family Planning*. DHS Analytical Studies No. 25. Calverton, Maryland, USA: ICF International. Available at http://dhsprogram.com/pubs/pdf/AS25/AS25.pdf.

Chen, L.C., M.C. Gesche, S. Ahmed, A.I. Chowdhury, and W.H. Mosley. 1974. "Maternal Mortality in Rural Bangladesh." *Stud Fam Plann* 5 (11):334-41.

Cleland, J., A. Conde-Agudelo, H. Peterson, J. Ross, and A. Tsui. 2012. "Contraception and Health." *The Lancet* 380 (9837):149-156.

Conde-Agudelo, A., and J.M. Belizán. 2000. "Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross Sectional Study." *BMJ* 321 (7271):1255-1259.

Conde-Agudelo, A., A. Rosas-Bermúdez, and A.C. Kafury-Goeta. 2006. "Birth Spacing and Risk of Adverse Perinatal Outcomes." *JAMA: the journal of the American Medical Association* 295 (15):1809-1823.

Conde-Agudelo, A., A. Rosas-Bermúdez, and A.C. Kafury-Goeta. 2007. "Effects of Birth Spacing on Maternal Health: A Systematic Review." *American Journal of Obstetrics & Gynecology* 196 (4):297-308.

Conde-Agudelo, A., A. Rosas-Bermudez, F. Castaño, and M.H. Norton. 2012. "Effects of Birth Spacing on Maternal, Perinatal, Infant, and Child Health: A Systematic Review of Causal Mechanisms." *Studies in Family Planning* 43 (2):93-114.

DaVanzo, J., L. Hale, A. Razzaque, and M. Rahman. 2008. "The Effects of Pregnancy Spacing on Infant and Child Mortality in Matlab, Bangladesh: How They Vary by the Type of Pregnancy Outcome that Began the Interval." *Popul Stud (Camb)* 62 (2):131-54.

Finlay, J.E., E. Özaltin, and D. Canning. 2011. "The Association of Maternal Age with Infant Mortality, Child Anthropometric Failure, Diarrhoea and Anaemia for First Births: Evidence from 55 Low- and Middle-income Countries." *BMJ open* 1 (2).

Fortney, J.A. 1987. "The Importance of Family Planning In Reducing Maternal Mortality." *Studies in Family Planning* 18 (2):109-114.

Fraser, A.M., J.E. Brockert, and R.H. Ward. 1995. "Association Of Young Maternal Age with Adverse Reproductive Outcomes." *New England journal of medicine* 332 (17):1113-1118.

Geronimus, A.T. 1987. "On Teenage Childbearing and Neonatal Mortality in the United States." *Population and Development Review*:245-279.

Govindasamy, P., M.K. Stewart, S.O. Rutstein, J.T. Boerma, and A.E. Sommerfelt. 1993. *High-risk Births and Maternity Care*. In *Comparative Studies 8*. Columbia, Maryland, USA: Macro International Inc.

Handa, S., S. Koch, and S.W. Ng. 2010. "Child Mortality in Eastern and Southern Africa." *Population Review* 49 (1).

Hobcraft, J. 1987. *Does Family Planning Save Childrens Lives?* In *International Conference on Better Health for Women and Children through Family Planning - See more at: http://www.popline.org/node/353677#sthash.egnpzdOB.dpuf*. Nairobi, Kenya.

Hobcraft, J.N., J.W. McDonald, and S.O. Rutstein. 1985. "Demographic Determinants of Infant And Early Child Mortality: A Comparative Analysis." *Population Studies* 39 (3):363-385.

Hughes, E.A., E.B. Hunter, and R.M. Woodbury. 1923. *Infant Mortality: Results of a Field Study in Gary, Ind., Based on Births in One Year*: US Department of Labor, Children's Bureau.

Ikamari, L.D. 2013. "Regional Variation in Neonatal and Post-neonatal Mortality in Kenya." *African Population Studies* 27 (1).

Jo, Y., A.B. Labrique, A.E. Lefevre, G. Mehl, T. Pfaff, N. Walker, and I.K. Friberg. 2014. "Using the Lives Saved Tool to Model Mhealth Impact on Neonatal Survival In Resource-limited Settings." *PLoS ONE* 9 (7):e102224.

Koenig, M.A., J.F. Phillips, O.M. Campbell, and S. D'Souza. 1990. "Birth Intervals and Childhood Mortality in Rural Bangladesh." *Demography* 27 (2):251-265.

Kumar, C., P.K. Singh, R.K. Rai, and L. Singh. 2013. "Early Neonatal Mortality in India, 1990–2006." *Journal of Community Health* 38 (1):120-130.

Miller, J.E., J. Trussell, A.R. Pebley, and B. Vaughan. 1992. "Birth Spacing and Child Mortality in Bangladesh and the Philippines." *Demography* 29 (2):305-318.

Mozumder, A.K.A., T.T.K. Barkat-e-Khuda, T.T. Kane, and M.S.I. Khan. 1998. *Determinants of Infant and Child Mortality in Rural Bangladesh*: International Centre for Diarrhoeal Disease Research, Bangladesh.

Nortman, D. 1974. *Parental Age as a Factor in Pregnancy Outcome and Child Development*. Reports on Population/Family Planning. New York: The Population Council.

Reichman, N.E., and D.L. Pagnini. 1997. "Maternal Age and Birth Outcomes: Data from New Jersey." *Family Planning Perspectives*:268-295.

Ross, J.A., and A.K. Blanc. 2012. "Why Aren't There More Maternal Deaths? A Decomposition Analysis." *Maternal and Child Health Journal* 16 (2):456-463.

Rutstein, S.O., and G. Rojas. 2006. *Guide to DHS Statistics*. Calverton, Maryland: ORC Macro. Available at http://www.dhsprogram.com/pubs/pdf/DHSG1/Guide_to_DHS_Statistics_ 29Oct2012_ DHSG1.pdf.

Rutstein, S.O., and R. Winter. 2014. *The Effects of Fertility Behavior on Child Survival and Child Nutritional Status: Evidence from the Demographic and Health Surveys, 2006-2012*. DHS Analytical Studies No. 37. Rockville, Maryland, USA: ICF International. Available at http://dhsprogram.com/pubs/pdf/AS37/AS37.pdf.

Saha, U.R., and A. van Soest. 2013. "Contraceptive Use, Birth Spacing, and Child Survival in Matlab, Bangladesh." *Studies in Family Planning* 44 (1):45-66.

Stover, J., and J. Ross. 2010. "How Increased Contraceptive Use Has Reduced Maternal Mortality." *Maternal AND Child Health Journal* 14 (5):687-695.

Trussell, J., and A.R. Pebley. 1984. "The Potential Impact of Changes in Fertility on Infant, Child and Maternal Mortality." *Studies in Family Planning* 15 (6):267-280.

United Nations, Department of Economics and Social Affairs, and Population Division. 2013. *World Population Prospects: The 2012 Revision, DVD Edition.*

Van der Klaauw, B., and L. Wang. 2004. *Child mortality in Rural India*: World Bank.

Walker, N., Y. Tam, and I.K. Friberg. 2013. "Overview of the Lives Saved Tool (LIST)." *BMC Public Health* 13 Suppl 3:S1.

Winikoff, B., and M. Sullivan. 1987. "Assessing the Role of Family Planning in Reducing Maternal Mortality." *Stud Fam Plann* 18 (3):128-43.

Woodbury, R.M. 1925. *Causal Factors in Infant Mortality: A statistical study based on Investigations in Eight Cities*: US Government Printing Office.

Zenger, E. 1993. "Siblings' Neonatal Mortality Risks and Birth Spacing in Bangladesh." *Demography* 30 (3):477-488.

Appendix A

Table A.1. Among non-pregnant married and in-union women with a combined unmet need for either a spacing or a limiting method of contraception but who do not intend to use in the future, distribution by reasons for not intending to use, 40 DHS country surveys 2006-2012

Country	Survey date	Number of respon-dents	Not having sex	Infrequent sex	Meno-pausal, hyster-ectomy	Subfecund, infecund	Post-partum amenor-rheic	Breast-feeding	Fatalistic	Respondent opposed	Husband, partner opposed	Other opposed	Religious prohibition	Health concerns	Fear of side effects	Interferes with body's processes	Knows no method	Knows no source	Lack of access, too far	Costs too much	Incon-venient to use	Preferred method not available	No method available	Don't know
Albania	2008-09	376	6.4	13.9	0.8	4.7	0	0.5	0.5	41.5	33.8	0.7	0.1	8	22.6	1.5	1.2	2.2	0.5	4.1	0.4	0	0	0.5
Armenia	2010	138	6.6	21.1	0	36.6	0	0	0.3	22.9	8.2	0	0.8	6.1	1.5	0.2	0.7	0	1.4	0	0	13.5	0	1.5
Azerbaijan	2006	639	12.5	17.7	0.1	32.4	0.1	0.1	1.2	7.9	5.1	0.9	1	20.1	4.3	2.7	2.5	1	0.3	2.7	1.5	0	0	0.9
Bangladesh *	2011	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Benin	2006	1,128	12.2	17.2	1.1	6.3	1.6	3.9	2.3	15.5	4.2	0.5	2.5	15	21.8	4.5	6.4	6.7	0.4	3.4	1.2	0	0	2.2
Bolivia	2008	360	13.6	30.8	3.6	4.2	4.9	1	0	13.6	10.9	0.2	1.4	11.5	23.6	3.4	10.7	3.9	1	2.2	2.1	0.7	0	0.6
Burkina Faso	2010	907	7.1	16	0	2.2	1.9	11.6	5.5	15.3	23.7	0.5	4.1	0	19.3	1.5	3.5	1.3	2.9	4.1	1.3	0.3	0	0.6
Burundi	2010	357	2.5	7	0	3.7	4.5	6	24	11.2	11.7	0.1	20.4	0	22.4	1.1	0	0.3	0	0	2.5	0	0	0.9
Cambodia	2010	688	4.6	33	2.9	8.1	0.8	2.1	12	5.2	1.1	0	0.3	50.6	0	0.6	0.4	0	0.4	1.2	4.6	1.2	0.2	0.6
Cameroon	2011	565	12	18.1	0	2.9	2.1	10	4	16.4	9.7	1	7.3	13	18.8	3.5	6.5	5.3	1.2	4.9	3	0	0	0.7
Colombia	2010	275	8.3	13.9	7.2	4.2	0.1	0	0.7	10	1.9	0	0.2	19	8.6	2.9	0.6	0.7	0	0	1.4	0	0	1
Congo DR	2007	444	10.6	12.3	1.1	1.1	2.4	23.6	0.8	13.8	11	0.7	7	6.3	14.1	3.9	15	6	1.1	4.9	3.1	0	0	0.9
Dominican Rep.	2007	229	8.5	8.4	0.8	10	0.3	0.6	5.7	23.7	2.6	0.1	0.1	1.7	0.4	16.5	14	0.1	0	6.1	3.1	1.6	0	0.4
Egypt *	2008	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Ethiopia	2011	622	3.3	4.1	0	1.7	5.8	10.6	15.4	7.4	6.4	2	15.7	0	29.7	6.2	3	1.9	0.7	0.4	5.1	0	0	1.7
Ghana	2008	291	7	7.5	0.4	5.6	0	3.1	0.2	20.4	3.7	0.1	3.6	13	32.1	6.8	3.3	2.7	0	2.4	3.2	0	0	0
Guyana	2009	293	5.5	9.4	1.1	3.7	0	2.5	0.8	8.7	8.3	0.1	0.8	22.1	14.1	9.6	0.1	1.5	1.6	3.3	4.3	0	0	6.9
India	2005-06	1,785	7.7	20.6	0.7	3	1.3	5	13.6	11	16.4	1	14.6	11.1	10.5	2.7	4.2	2.3	0.3	3.1	0.9	6.1	0	0
Indonesia *	2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Jordan *	2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Kenya	2008-09	313	9.2	6.4	0.9	2.7	0.5	2.6	0.2	8.8	8.4	0	7.3	29.1	19.7	10.6	1.9	3.4	2.5	1.7	0.7	0	0	1.6
Lesotho	2009	184	4.2	8.4	4.7	15.6	2.1	3.7	1.3	6	14	2.3	1.5	5	19.7	6.4	1	0	6.8	10.9	2.1	0	0	0
Liberia	2007	439	6.3	5.7	0	0	0.1	17	0.1	9.9	11.4	2.7	6.5	11.6	6.1	5.9	35.3	4.7	1.8	2.2	3.2	0	0	1.8
Madagascar	2008-09	676	4.1	11.4	1.3	5.9	0.6	2.1	1.5	18.5	6.4	0.6	2.4	19.1	25.2	4	6	4.7	0.9	1.7	2.4	0	0	1.5
Malawi	2010	648	6.2	8.3	5.1	4.3	1.7	5.7	2.2	10.6	5.3	0.7	1.7	15.8	23.4	5.5	0.1	0.5	1	0.6	0.6	0	0	1.7
Mali	2006	1,183	3.2	7.3	1.6	1.7	0.3	6.4	3.4	20.2	7.3	0.2	6.9	12.5	6.6	6	8.8	6.7	0.2	0.7	0.7	0	0	5.1
Mozambique	2011	653	7.9	14.6	0	2.9	1.4	35.9	19.7	5.1	7.5	1.2	1.1	0	5.3	1	0.1	0.8	1.8	5.8	0.5	0.9	0.3	0.4
Namibia	2006-07	144	9.6	3	1	1.3	0	5.6	0	11.4	10.8	0	2.6	16.9	6	4.7	7.4	0.4	0.8	4.1	0.6	0	0	8.8
Nepal	2011	255	7.8	26	0	7.3	0.2	1.2	2.9	1.2	7	0.2	5.9	0	24.6	4.1	0	0	0	0.5	0	0	0	0
Niger	2006	449	3.9	8.9	0.1	0.4	1	9.2	1.7	22.7	11.2	1.6	8.2	12.6	5.6	2.5	13.3	8.1	1	1.8	2.6	0	0	2.4
Nigeria	2008	1,278	4.1	8.7	0.5	0.7	0.1	5.9	0.2	23.4	14.4	1.3	8.7	6.6	18	5.5	9.4	2.4	0.4	0.6	2.1	0	0	3
Pakistan *	2012-13	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Peru	2012	72	25.3	21.4	2.1	0.3	1.6	0	0.7	1.4	5.5	0	2.2	7.3	29.4	1.3	0	0	0	0	0	0	0	0
Philippines	2008	754	8.2	19.5	2.9	5.5	1.3	1.2	2.1	7.2	5.4	0.4	3.1	0.5	0.4	35	21.9	0.7	14.8	2.9	2	0	0	0.2
Rwanda	2010	252	9.6	12.2	0.4	0	1.9	3.5	19.3	10.4	5.5	0.5	5.1	0	29.2	7.7	0	0	0	0	2.7	0	0	0.4
Sao Tome & Principe	2008-09	133	4.6	13.6	0.8	0.2	0.2	0.8	0	22.6	7.8	0	0.6	27.7	10.2	9.4	0	0	0	0	0	0	0	3.1
Senegal	2010-11	1,290	6.9	9.6	0	1	3	18.2	5.7	23.6	11.6	0.7	4.7	0	12.5	1.8	2.2	1.5	0.4	1.4	1	0	0	4.2
Sierra Leone	2008	420	3.1	2.1	1.2	1.3	0.2	8.2	0.6	21.5	20.7	1.8	12.6	12.2	17.7	3.4	13.9	2.7	0.7	6.8	1.1	0	0	1.2
Swaziland	2006-07	124	0	11.3	7.3	3.8	0	0	1.5	4.8	16.1	0	3.4	19.4	20.2	5	0	0.5	0	1.6	2.5	3.2	7.1	0
Tanzania	2010	317	5.8	7.7	1.4	0	3	3.8	2.1	15.1	17.1	0.7	1.9	17.4	45	2.6	0.5	0.5	0.6	0.8	1.1	0	0	0.9
Timor-Leste	2009	1,029	0.8	1.9	0.4	0.3	0.1	8.1	0.1	63.8	26.5	0.5	1.3	15.7	16.7	3.9	7.3	0.3	1.3	0	0.2	0	0	0.8
Uganda	2011	315	7.8	13.2	0	8.9	4.7	7.5	12.9	16.7	6.8	4.2	3	0	36.6	5.8	1.2	1.3	0	1.4	3.6	0.4	0	1.4
Ukraine	2007	160	6.8	27.1	1.3	18.6	0.6	0.4	9.1	11.1	6.5	1.2	2.7	16.9	0.9	3.2	0	0	0	0.9	1.1	0	0	0
Zambia	2007	175	9.7	19.5	1	20.2	0.8	4.9	3.4	9.4	5	1.8	3	11.3	24.6	3.4	2.3	1.4	1.3	2.4	0.4	0	0	0.2
Zimbabwe	2010-11	149	14.2	16.7	1.4	7.4	0.3	0.7	6.4	7.4	10.2	1.6	20.9	0	14.6	0.3	0	0	0	1.3	0	0	0	0.4

* Ever-married samples
NA = not asked

Appendix B:
Country Summaries: Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Albania

In 2015, there will be an estimated 751 deaths to under-five children in Albania. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 236 of those under-five deaths (31 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.42 births per woman instead of 1.59, and the under-five mortality rate would be 14 deaths per thousand births instead of 18.

To achieve these levels, 55 percent of non-pregnant married women require focused family planning efforts to reduce the 10 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 3 percent with an unmet need for a spacing method, and the 42 percent who need to shift from non-LAPM to LAPM.

Who are the women in need of focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Forty percent of the married women who have a need for focused family planning efforts live in urban areas, just 2 percent have no education or incomplete primary schooling, and 42 percent live in households in the lowest two wealth quintiles.

Three of four married women who need focused family planning efforts are users in need of a better method (LAPM—77 percent), 3 percent have never used a method, and 20 percent have used a method in the past but are not current users.

Two-thirds (68 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Two of three women (66 percent) said that they did not intend to use contraception in the future, and gave the following reasons for their intentions not to use: Are breastfeeding (1 percent), are fatalistic (1 percent), have infrequent sexual relations (14 percent) or are not having sexual relations (6 percent), fear side effects or have health concerns (31 percent), say that contraception interferes with the body's processes (2 percent), have a husband who is opposed (34 percent) or they are opposed (42 percent), and believe they are subfecund or infecund (6 percent). Eight percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method, or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Armenia

In 2015, there will be an estimated 764 deaths to under-five children in Armenia. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 250 of those under-five deaths (33 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.61 births per woman instead of 1.70. The under-five mortality rate would actually be slightly higher, at 27 deaths per thousand births instead of 19, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 36 percent of non-pregnant married women require focused family planning efforts to reduce the 9 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 22 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over half (54 percent) of the married women who have a need for focused family planning efforts live in urban areas, 100 percent have completed at least primary education, and nearly half (47 percent) live in households in the lowest two wealth quintiles.

About three in five married women with a need for focused family planning efforts are users who need of a better method (LAPM—62 percent), 24 percent have never used a method, and 14 percent have used a method in the past but are not current users.

A vast majority (87 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in three (32 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Have infrequent sexual relations (21 percent) or are not having sexual relations (7 percent), fear side effects or have health concerns (8 percent), have a husband who is opposed (8 percent) or they are opposed (23 percent), believe they are subfecund or infecund (37 percent), and cite a religious prohibition (1 percent). One in seven (14 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Azerbaijan

In 2015, there will be an estimated 7,831 deaths to under-five children in Azerbaijan. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 467 of those under-five deaths (6 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.86 births per woman instead of 2.02. The under-five mortality rate would be actually be slightly higher, at 50 deaths per thousand births instead of 49, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 48 percent of non-pregnant married women require focused family planning efforts to reduce the 21 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 2 percent with an unmet need for a spacing method, and the 25 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

About half (51 percent) of the married women who have a need for focused family planning efforts live in urban areas, 1 percent have no education and another 1 percent have incomplete primary schooling, and 43 percent live in households in the lowest two wealth quintiles.

Over half of the married women who need focused family planning efforts are users who need of a better method (LAPM—52 percent), 26 percent have never used a method, and 22 percent have used a method in the past but are not current users.

A vast majority (87 percent) of the women with a focused family planning need who visited a health facility in the 12 months preceding the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Over half (58 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are fatalistic (1 percent), have infrequent sexual relations (18 percent) or are not having sexual relations (13 percent), fear side effects or have health concerns (25 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (5 percent) or they are opposed (8 percent), believe they are subfecund or infecund (32 percent), and cite a religious prohibition (1 percent). Seven percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Bangladesh

In 2015, there will be an estimated 146,944 deaths to under-five children in Bangladesh. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 38,919 of those under-five deaths (26 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.26 births per woman instead of 2.77 and the under-five mortality rate would be 43 deaths per thousand births instead of 47.

To achieve these levels, 39 percent of non-pregnant married women require focused family planning efforts in order to reduce the 9 percent with an unmet need for limiting births (i.e. using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 27 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

More than one in five (22 percent) of the married women who need focused family planning efforts live in urban areas, 34 percent have no education and another 22 percent have incomplete primary schooling, and 40 percent live in households in the lowest two wealth quintiles.

Two of three married women with a need for focused family planning efforts are users in need of a better method (LAPM—69 percent), 7 percent have never used a method, and 24 percent have used a method in the past but are not current users.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use in the future. Almost one in four (23 percent) said that they did not intend to use contraception in the future, although the survey did not ask women about reasons they did not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Benin

In 2015, there will be an estimated 38,254 deaths to under-five children and 1,546 pregnancy related deaths of mothers in Benin. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 23,537 of those under-five deaths (62 percent) and 1,151 pregnancy-related deaths (74 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.68 births per woman instead of 5.74, the under-five mortality rate would be 82 deaths per thousand births instead of 99, and the maternal mortality ratio would be 219 per hundred thousand births instead of 400.

To achieve these levels, 43 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 24 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 12 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Thirty-eight percent of the married and in-union women who need focused family planning efforts live in urban areas, 71 percent have no education and 18 percent have incomplete primary schooling, and 36 percent live in households in the lowest two wealth quintiles.

About 28 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM).

A large majority (75 percent) of women with a focused family planning need who visited a health facility in the 12 months preceding the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Some 37 percent said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (5 percent), are fatalistic (2 percent), have infrequent sexual relations (17 percent) or are not having sexual relations (12 percent), fear side effects or have health concerns (35 percent), say that contraception interferes with the body's processes (5 percent), have a husband who is opposed (4 percent) or they are opposed (16 percent), believe they are subfecund or infecund (7 percent), and say there is a religious prohibition (3 percent). One in six (16 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Bolivia

In 2015, there will be an estimated 14,023 deaths to under-five children and 744 pregnancy related deaths of mothers in Bolivia. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 8,476 of those under-five deaths (60 percent) and 493 pregnancy-related deaths (66 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.21 births per woman instead of 3.54, the under-five mortality rate would be 32 deaths per thousand births instead of 50, and the maternal mortality ratio would be 145 per hundred thousand births instead of 268.

To achieve these levels, 46 percent of non-pregnant married and in-union women require focused family planning efforts in order to reduce the 13 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 3 percent with an unmet need for a spacing method, and the 29 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over half (52 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 8 percent have no education and another 57 percent have incomplete primary schooling, and nearly half (48 percent) live in households in the lowest two wealth quintiles.

Almost two of three married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—64 percent), 15 percent have never used a method, and 20 percent have used a method in the past but are not current users.

A majority (53 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a quarter (24 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (5 percent), have infrequent sexual relations (31 percent) or are not having sexual relations (14 percent), fear side effects or have health concerns (33 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (11 percent) or they are opposed (14 percent), believe they are subfecund or infecund (8 percent), and cite a religious prohibition (1 percent). One in six (17 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Burkina Faso

In 2015, there will be an estimated 76,766 deaths to under-five children and 2,433 pregnancy related deaths of mothers in Burkina Faso. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 55,122 of those under-five deaths (72 percent) and 1,837 pregnancy-related deaths (76 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.62 births per woman instead of 5.99, the under-five mortality rate would be 69 deaths per thousand births instead of 108, and the maternal mortality ratio would be 191 per hundred thousand births instead of 341.

To achieve these levels, 37 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 19 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 10 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Almost a quarter (23 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 81 percent have no education and another 10 percent have incomplete primary schooling, and 37 percent live in households in the lowest two wealth quintiles.

Some 28 percent of married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 62 percent have never used a method, and 10 percent have used a method in the past but are not current users.

Over half (51 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in three (32 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (13 percent), are fatalistic (6 percent), have infrequent sexual relations (16 percent) or are not having sexual relations (7 percent), fear side effects or have health concerns (20 percent), say that contraception interferes with the body's processes (2 percent), have a husband who is opposed (24 percent) or they are opposed (15 percent), believe they are subfecund or infecund (2 percent), and say there is a religious prohibition (4 percent). Twelve percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Burundi

In 2015, there will be an estimated 37,056 deaths to under-five children and 2,353 pregnancy related deaths of mother in Burundi. If women would have only those births they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 24,217 of those under-five deaths (65 percent) and 1,773 pregnancy-related deaths (75 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.83 births per woman instead of 6.38, the under-five mortality rate would be 62 deaths per thousand births instead of 79, and the maternal mortality ratio would be 278 per hundred thousand births instead of 500.

To achieve these levels, 46 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 23 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 16 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Only eight percent of the married and in-union women who need focused family planning efforts live in urban areas, 54 percent have no education and another 25 percent have incomplete primary schooling, and 41 percent live in households in the lowest two wealth quintiles.

About one in three married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—34 percent), 57 percent have never used a method, and 9 percent have used a method in the past but are not current users.

A majority (61 percent) of the women with a focused family planning need who visited a health facility in the 12 months preceding the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost one in three (30 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (10 percent), are fatalistic (24 percent), have infrequent sexual relations (7 percent) or are not having sexual relations (3 percent), fear side effects or have health concerns (24 percent), say that contraception interferes with the body's processes (1 percent), have a husband who is opposed (12 percent) or they are opposed (11 percent), believe they are subfecund or infecund (4 percent), and say there is a religious prohibition (20 percent). Few (3 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Cambodia

In 2015, there will be an estimated 20,760 deaths to under-five children in Cambodia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 9,520 of those under-five deaths (46 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.24 births per woman instead of 3.04 and the under-five mortality rate would be 40 deaths per thousand births instead of 54.

To achieve these levels, 44 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 12 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 27 percent who need to shift from non-LAPM to LAPM.

Who are the women in need of focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Fifteen percent of the married and in-union women who need focused family planning efforts live in urban areas, 20 percent have no education and another 53 percent have incomplete primary schooling, and 42 percent live in households in the lowest two wealth quintiles.

More than three of five married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—62 percent), 17 percent have never used a method, and 21 percent have used a method in the past but are not current users.

Slightly less than half (46 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Two out of five (41 percent) said that they did not intend to use contraception in the future, and they gave the following reasons for not intending to use: Are breastfeeding (3 percent), are fatalistic (12 percent), have infrequent sexual relations (33 percent) or are not having sexual relations (5 percent), fear side effects or have health concerns (51 percent), say that contraception interferes with the body's processes (1 percent), have a husband who is opposed (1 percent) or they are opposed (5 percent), and believe they are subfecund or infecund (11 percent). Eight percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Cameroon

In 2015, there will be an estimated 86,339 deaths to under-five children and 6,648 pregnancy related deaths of mothers in Cameroon. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 54,564 of those under-five deaths (63 percent) and 4,647 pregnancy-related deaths (70 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.42 births per woman instead of 5.09, the under-five mortality rate would be 79 deaths per thousand births instead of 102, and the maternal mortality ratio would be 495 per hundred thousand births instead of 782.

To achieve these levels, 39 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 17 percent with an unmet need for limiting births (i.e. using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 16 percent who need to shift from non-LAPM to LAPM.

Who are the women in need of focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over half (52 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 20 percent have no education, and another 22 percent have incomplete primary schooling. Surprisingly, only 33 percent live in households in the lowest two wealth quintiles.

Two of five married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—40 percent), 39 percent have never used a method, and 21 percent have used a method in the past but are not current users.

Over two out of three (69 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. More than one in three (36 percent) said that they did not intend to use contraception in the future, and they gave the following reasons for not intending to use: Are breastfeeding (11 percent), are fatalistic (4 percent), have infrequent sexual relations (18 percent) or are not having sexual relations (12 percent), fear side effects or have health concerns (31 percent), say that contraception interferes with the body's processes (4 percent), have a husband who is opposed (10 percent) or they are opposed (16 percent), believe they are subfecund or infecund (3 percent), and say there is a religious prohibition (7 percent). Sixteen percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Colombia

In 2015, there will be an estimated 16,184 deaths to under-five children in Colombia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 4,927 of those under-five deaths (30 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.78 births per woman instead of 2.14 and the under-five mortality rate would be 15 deaths per thousand births instead of 18.

To achieve these levels, 18 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 4 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 2 percent with an unmet need for a spacing method, and the 12 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Two-thirds (66 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 4 percent have no education and another 21 percent have incomplete primary schooling, and half (50 percent) live in households in the lowest two wealth quintiles.

More than two-thirds of married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—68 percent), 3 percent have never used a method, and 29 percent have used a method in the past but are not current users.

A large majority (61 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in five (21 percent) women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are fatalistic (1 percent), have infrequent sexual relations (14 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (29 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (2 percent) or they are opposed (10 percent), and believe they are subfecund or infecund (11 percent). One in six (17 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in the Democratic Republic of the Congo

In 2015, there will be an estimated 387,121 deaths to under-five children and 16,202 pregnancy related deaths of mothers in the Democratic Republic of the Congo. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 247,872 of those under-five deaths (64 percent) and 12,757 pregnancy-related deaths (79 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.58 births per woman instead of 6.28, the under-five mortality rate would be 114 deaths per thousand births instead of 130, and the maternal mortality ratio would be 281 per hundred thousand births instead of 543.

To achieve these levels, 37 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 15 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Forty-five percent of the married and in-union women with a need for focused family planning efforts live in urban areas, 20 percent have no education and another 31 percent have incomplete primary schooling, and 38 percent live in households in the lowest two wealth quintiles.

About 40 percent of married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 34 percent have never used a method, and 26 percent have used a method in the past but are not current users.

More than three quarters (79 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Nearly half (48 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (25 percent), are fatalistic (1 percent), have infrequent sexual relations (12 percent) or are not having sexual relations (11 percent), fear side effects or have health concerns (22 percent), say that contraception interferes with the body's processes (4 percent), have a husband who is opposed (11 percent) or they are opposed (14 percent), believe they are subfecund or infecund (2 percent), and say there is a religious prohibition (7 percent). More than one in four (27 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in the Dominican Republic

In 2015, there will be an estimated 6,492 deaths to under-five children and 368 pregnancy related deaths of mothers in the Dominican Republic. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 2,285 of those under-five deaths (35 percent) and 177 pregnancy-related deaths (48 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.92 births per woman instead of 2.43, the under-five mortality rate would be 25 deaths per thousand births instead of 30, and the maternal mortality ratio would be 113 per hundred thousand births instead of 172.

To achieve these levels, 16 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 5 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 7 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Seven in ten (70 percent) married and in-union women who need focused family planning efforts live in urban areas, 5 percent have no education and another 37 percent have incomplete primary schooling, and 46 percent live in households in the lowest two wealth quintiles.

Some 46 percent of married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 9 percent have never used a method, and 45 percent have used a method in the past but are not current users.

A majority (62 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in five (20 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (1 percent), are fatalistic (6 percent), have infrequent sexual relations (8 percent) or are not having sexual relations (9 percent), fear side effects or have health concerns (31 percent), say that contraception interferes with the body's processes (17 percent), have a husband who is opposed (3 percent) or they are opposed (24 percent), and believe they are subfecund or infecund (11 percent). One in ten (10 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Egypt

In 2015, there will be an estimated 47,710 deaths to under-five children in Egypt. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 19,475 of those under-five deaths (41 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 3.55 births per woman instead of 4.40 and the under-five mortality rate would be 19 deaths per thousand births instead of 25.

To achieve these levels, 27 percent of non-pregnant married women require focused family planning efforts to reduce the 7 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 2 percent with an unmet need for a spacing method, and the 18 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

A third (34 percent) of the married women who need focused family planning efforts live in urban areas, 39 percent have no education and another 10 percent have incomplete primary schooling, and nearly half (47 percent) live in households in the lowest two wealth quintiles.

Two-thirds (67 percent) of the married women with a need for focused family planning efforts are users in need of a better method (LAPM), 8 percent have never used a method, and 25 percent have used a method in the past but are not current users.

A majority (61 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. More than one in four (27 percent) said that they did not intend to use contraception in the future. The survey did not ask the women why they did not intend to use in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Ethiopia

In 2015, there will be an estimated 287,730 deaths to under-five children and 21,406 pregnancy related deaths of mothers in Ethiopia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 223,361 of those under-five deaths (78 percent) and 16,135 pregnancy-related deaths (75 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.93 births per woman instead of 4.80, the under-five mortality rate would be 51 deaths per thousand births instead of 91, and the maternal mortality ratio would be 414 per hundred thousand births instead of 676.

To achieve these levels, 42 percent of non-pregnant married women require focused family planning efforts to reduce the 20 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 16 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

The 16 percent of the married women who need focused family planning efforts live in urban areas, 68 percent have no education and another 26 percent have incomplete primary schooling, and 39 percent live in households in the lowest two wealth quintiles.

The 38 percent of the married women who need focused family planning efforts are users in need of a better method (LAPM), 45 percent have never used a method, and 17 percent have used a method in the past but are not current users.

Almost three quarters (73 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a third (32 percent) said that they did not intend to use contraception in the future, and they gave the following reasons for not intending to use: Are breastfeeding (15 percent), are fatalistic (15 percent), have infrequent sexual relations (4 percent) or are not having sexual relations (3 percent), fear side effects or have health concerns (34 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (6 percent) or they are opposed (7 percent), believe they are subfecund or infecund (2 percent), and say there is a religious prohibition (16 percent). Ten percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Ghana

In 2015, there will be an estimated 60,547 deaths to under-five children in Ghana. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 31,547 of those under-five deaths (52 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.23 births per woman instead of 4.03 and the under-five mortality rate would be 65 deaths per thousand births instead of 75.

To achieve these levels, 50 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 24 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 11 percent with an unmet need for a spacing method, and the 15 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Two out of five (41 percent) of the married and in-union women with a need for focused family planning efforts live in urban areas, 28 percent have no education and another 21 percent have incomplete primary schooling, and 42 percent live in households in the lowest two wealth quintiles.

Some 29 percent of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM), 33 percent have never used a method, and 38 percent have used a method in the past but are not current users.

A majority (61 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost two in five (38 percent) said that they did not intend to use contraception in the future. They gave the following reasons for not intending to use: Are breastfeeding (3 percent), have infrequent sexual relations (8 percent) or are not having sexual relations (7 percent), fear side effects or have health concerns (47 percent), say that contraception interferes with the body's processes (7 percent), have a husband who is opposed (4 percent) or they are opposed (20 percent), believe they are subfecund or infecund (6 percent), and say there is a religious prohibition (4 percent). Eleven percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Guyana

In 2015, there will be an estimated 548 deaths to under-five children in Guyana. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 192 of those under-five deaths (35 percent would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.00 births per woman instead of 2.78 and the under-five mortality rate would be 31 deaths per thousand births instead of 34.

To achieve these levels, 45 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 21 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 18 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Twenty-two percent of the married and in-union women with a need for focused family planning efforts live in urban areas, 2 percent have no education and another 16 percent have incomplete primary schooling, and 43 percent live in households in the lowest two wealth quintiles.

The 29 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 15 percent have never used a method, and 46 percent have used a method in the past but are not current users.

A majority (56 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. More than two in five (42 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (3 percent), are fatalistic (1 percent), have infrequent sexual relations (9 percent) or are not having sexual relations (6 percent), fear side effects or have health concerns (41 percent), say that contraception interferes with the body's processes (10 percent), have a husband who is opposed (8 percent) or they are opposed (9 percent), believe they are subfecund or infecund (5 percent), and say there is a religious prohibition (1 percent). A tenth (10 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in India

In 2015, there will be an estimated 1,524,582 deaths to under-five children In India. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 744,330 of those under-five deaths (49 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.90 births per woman instead of 2.68 and the under-five mortality rate would be 43 deaths per thousand births instead of 60.

To achieve these levels, 20 percent of non-pregnant married women require focused family planning efforts to reduce the 7 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 8 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

More than a quarter (28 percent) of the married women with a need for focused family planning efforts live in urban areas, 50 percent have no education and another 7 percent have incomplete primary schooling, and 45 percent live in households in the lowest two wealth quintiles.

More than two of five married women with a need for focused family planning efforts are users in need of a better method (LAPM—41 percent), 44 percent have never used a method, and 15 percent have used a method in the past but are not current users.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in five (20 percent) women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (6 percent), are fatalistic (14 percent), have infrequent sexual relations (21 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (21 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (16 percent) or they are opposed (11 percent), believe they are subfecund or infecund (4 percent), and say there is a religious prohibition (15 percent). About one in seven (15 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Indonesia

In 2015, there will be an estimated 210,011 deaths to under-five children and 7,757 pregnancy related deaths of mothers in Indonesia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 60,088 of those under-five deaths (29 percent) and 3,604 pregnancy-related deaths (46 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 3.06 births per woman instead of 3.64, the under-five mortality rate would be 39 deaths per thousand births instead of 45, and the maternal mortality ratio would be 107 per hundred thousand births instead of 168.

To achieve these levels, 32 percent of non-pregnant married women require focused family planning efforts to reduce the 6 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 3 percent with an unmet need for a spacing method, and the 24 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Two out of five (41 percent) of the married women who need focused family planning efforts live in urban areas, 8 percent have no education and another 20 percent have incomplete primary schooling, and 41 percent live in households in the lowest two wealth quintiles.

About three quarters of married women who need focused family planning efforts are users in need of a better method (LAPM—74 percent), 8 percent have never used a method, and 18 percent have used a method in the past but are not current users.

A large majority (71 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not informed about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost two in five women said that they did not intend to use contraception in the future. The survey did not ask women about reasons they did not intend to use in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Jordan

In 2015, there will be an estimated 3,372 deaths to under-five children in Jordan. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 2,524 of those under-five deaths (75 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 4.11 births per woman instead of 6.05 and the under-five mortality rate would be 7 deaths per thousand births instead of 18.

To achieve these levels, 43 percent of non-pregnant married women require focused family planning efforts to reduce the 9 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 2 percent with an unmet need for a spacing method, and the 32 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Most (85 percent) of the married women who need focused family planning efforts live in urban areas, 4 percent have no education and another 4 percent have incomplete primary schooling, and 40 percent live in households in the lowest two wealth quintiles.

Close to three in four married women who need focused family planning efforts are users in need of a better method (LAPM—74 percent), 7 percent have never used a method, and 19 percent have used a method in the past but are not current users.

A large majority (71 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use in the future. Almost half (49 percent) said that they did not intend to use in the future. The survey did not ask women about reasons they did not intend to use in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Kenya

In 2015, there will be an estimated 105,313 deaths to under-five children and 8,208 pregnancy related deaths of mothers in Kenya. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 50,992 of those under-five deaths (48 percent) and 5,234 pregnancy-related deaths (64 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.36 births per woman instead of 4.56, the under-five mortality rate would be 66 deaths per thousand births instead of 67, and the maternal mortality ratio would be 364 per hundred thousand births instead of 520.

To achieve these levels, 50 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 19 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 26 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Seventeen percent of the married and in-union women who need focused family planning efforts live in urban areas, 8 percent have no education and another 35 percent have incomplete primary schooling, and 41 percent live in households in the lowest two wealth quintiles.

Over half of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—53 percent), 18 percent have never used a method, and 29 percent have used a method in the past but are not current users.

Two-thirds (69 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. A third (34 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (3 percent), have infrequent sexual relations (6 percent) or are not having sexual relations (9 percent), fear side effects or have health concerns (49 percent), say that contraception interferes with the body's processes (11 percent), have a husband who is opposed (8 percent) or they are opposed (9 percent), believe they are subfecund or infecund (4 percent), and say there is a religious prohibition (7 percent). Nine percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Lesotho

In 2015, there will be an estimated 6,115 deaths to under-five children and 709 pregnancy related deaths of mothers in Lesotho. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 1,690 of those under-five deaths (28 percent) and 344 pregnancy-related deaths (49 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.32 births per woman instead of 3.30 and the maternal mortality ratio would be 910 per hundred thousand births instead of 1243. The under-five mortality rate would actually be slightly higher, at 110 deaths per thousand births instead of 107, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 41 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 19 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

One in four (24 percent) married and in-union women who need focused family planning efforts live in urban areas, 1 percent have no education and another 31 percent have incomplete primary schooling, and 39 percent live in households in the lowest two wealth quintiles.

Close to half of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—47 percent), 21 percent have never used a method, and 32 percent have used a method in the past but are not current users.

Two thirds (66 percent) of women with a focused need for family planning who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a quarter (23 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (5 percent), are fatalistic (1 percent), have infrequent sexual relations (8 percent) or are not having sexual relations (4 percent), fear side effects or have health concerns (28 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (14 percent) or they are opposed (6 percent), believe they are subfecund or infecund (20 percent), and say there is a religious prohibition (2 percent). One in six (17 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Liberia

In 2015, there will be an estimated 14,482 deaths to under-five children and 1,547 pregnancy related deaths of mothers in Liberia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 9,108 of those under-five deaths (63 percent) and 1,132 pregnancy-related deaths (73 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.64 births per woman instead of 5.2, the under-five mortality rate would be 68 deaths per thousand births instead of 93, and the maternal mortality ratio would be 525 per hundred thousand births instead of 994.

To achieve these levels, 45 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 26 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 10 percent with an unmet need for a spacing method, and the 9 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Thirty-seven percent of the married and in-union women who need focused family planning efforts live in urban areas, 47 percent have no education and another 28 percent have incomplete primary schooling, and 37 percent live in households in the lowest two wealth quintiles.

One in five married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—20 percent), 52 percent have never used a method, and 28 percent have used a method in the past but are not current users.

Over a quarter (27 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. More than a third (37 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (17 percent), have infrequent sexual relations (6 percent) or are not having sexual relations (6 percent), fear side effects or have health concerns (43 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (11 percent) or they are opposed (10 percent), and say that there is a religious prohibition (7 percent). Close to a quarter (23 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Madagascar

In 2015, there will be an estimated 58,660 deaths to under-five children and 4,132 pregnancy related deaths of mothers in Madagascar. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 28,348 of those under-five deaths (48 percent) and 3,045 pregnancy-related deaths (74 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.42 births per woman instead of 4.82 and the maternal mortality ratio would be 261 per hundred thousand births instead of 498. The under-five mortality rate would actually be slightly higher, at 73 deaths per thousand births instead of 71, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 45 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 13 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 26 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

One in seven (15 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 17 percent have no education and another 48 percent have incomplete primary schooling, and 34 percent live in households in the lowest two wealth quintiles.

The 58 percent of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM), 25 percent have never used a method, and 17 percent have used a method in the past but are not current users.

Two out of five (40 percent) women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. More than a third (36 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (3 percent), are fatalistic (2 percent), have infrequent sexual relations (11 percent) or are not having sexual relations (4 percent), fear side effects or have health concerns (45 percent), say that contraception interferes with the body's processes (4 percent), have a husband who is opposed (6 percent) or they are opposed (19 percent), believe they are subfecund or infecund (7 percent), and say there is a religious prohibition (2 percent). Thirteen percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Malawi

In 2015, there will be an estimated 63,795 deaths to under-five children and 4,574 pregnancy related deaths of mothers in Malawi. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 35,905 of those under-five deaths (56 percent) and 3,328 pregnancy-related deaths (73 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.58 births per woman instead of 5.71, the under-five mortality rate would be 91 deaths per thousand births instead of 94, and the maternal mortality ratio would be 407 per hundred thousand births instead of 675.

To achieve these levels, 48 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 17 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 26 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

About one in six (16 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 19 percent have no education and another 60 percent have incomplete primary schooling, and 38 percent live in households in the lowest two wealth quintiles.

More than half of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—53 percent), 14 percent have never used a method, and 33 percent have used a method in the past but are not current users.

One in three (32 percent) women with a focused family planning need who visited a health facility in the 12 months before the survey was not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost one in four (23 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (7 percent), are fatalistic (2 percent), have infrequent sexual relations (8 percent) or are not having sexual relations (6 percent), fear side effects or have health concerns (42 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (5 percent) or they are opposed (11 percent), believe they are subfecund or infecund (9 percent), and say there is a religious prohibition (2 percent). Three percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Mali

In 2015, there will be an estimated 118,747 deaths to under-five children and 3,529 pregnancy related deaths of mothers in Mali. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 84,612 of those under-five deaths (71 percent) and 2,753 pregnancy-related deaths (78 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.54 births per woman instead of 6.58, the under-five mortality rate would be 117 deaths per thousand births instead of 156, and the maternal mortality ratio would be 265 per hundred thousand births instead of 465.

To achieve these levels, 38 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 23 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 10 percent with an unmet need for a spacing method, and the 6 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

More than a third (35 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 78 percent have no education and another 10 percent have incomplete primary schooling, and 36 percent live in households in the lowest two wealth quintiles.

While only 15 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 70 percent have never used a method, and 15 percent have used a method in the past but are not current users.

A majority (63 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advises about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Close to half (46 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (7 percent), are fatalistic (3 percent), have infrequent sexual relations (7 percent) or are not having sexual relations (3 percent), fear side effects or have health concerns (24 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (7 percent) or they are opposed (20 percent), believe they are subfecund or infecund (3 percent), and say there is a religious prohibition (7 percent). One in six (16 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Mozambique

In 2015, there will be an estimated 87,959 deaths to under-five children and 4,214 pregnancy related deaths of mothers in Mozambique. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 56,662 of those under-five deaths (64 percent) and 2,823 pregnancy-related deaths (67 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.73 births per woman instead of 5.92, the under-five mortality rate would be 66 deaths per thousand births instead of 85, and the maternal mortality ratio would be 292 per hundred thousand births instead of 408.

To achieve these levels, 33 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 18 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 7 percent with an unmet need for a spacing method, and the 8 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Thirty-seven percent of the married and in-union women who need focused family planning efforts live in urban areas, 31 percent have no education, and another 47 percent have incomplete primary schooling. Surprisingly, only 33 percent live in households in the lowest two wealth quintiles.

A quarter (25 percent) of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 55 percent have never used a method, and 20 percent have used a method in the past but are not current users.

A majority (56 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Two in five (40 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (37 percent), are fatalistic (20 percent), have infrequent sexual relations (15 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (6 percent), say that contraception interferes with the body's processes (1 percent), have a husband who is opposed (8 percent) or they are opposed (5 percent), believe they are subfecund or infecund (3 percent), and say there is a religious prohibition (1 percent). One in ten (10 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Namibia

In 2015, there will be an estimated 4,178 deaths to under-five children and 309 pregnancy related deaths of mothers in Namibia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 1,428 of those under-five deaths (34 percent) and 200 pregnancy-related deaths (65 percent) would be averted. These reductions in mortality are due to lower mortality rates and a lower number of births. Under these conditions, the total fertility rate would be 2.35 births per woman instead of 3.57 and the maternal mortality ratio would be 271 per hundred thousand births instead of 508. The under-five mortality rate would remain the same, at 69 deaths per thousand births, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 42 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 3 percent with an unmet need for a spacing method, and the 24 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Nearly half (45 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 14 percent have no education and another 28 percent have incomplete primary schooling, and 36 percent live in households in the lowest two wealth quintiles.

The 58 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM-24 percent), 10 percent have never used a method, and 32 percent have used a method in the past but are not current users.

A large majority (70 percent) of women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Three in ten (31 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (6 percent), have infrequent sexual relations (3 percent) or are not having sexual relations (10 percent), fear side effects or have health concerns (28 percent), say that contraception interferes with the body's processes (5 percent), have a husband who is opposed (11 percent) or they are opposed (11 percent), believe they are subfecund or infecund (2 percent), and say there is a religious prohibition (3 percent). Thirteen percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Nepal

In 2015, there will be an estimated 28,105 deaths to under-five children in Nepal. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 12,467 of those under-five deaths (44 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.93 births per woman instead of 2.6 and the under-five mortality rate would be 36 deaths per thousand births instead of 49.

To achieve these levels, 39 percent of non-pregnant married women require focused family planning efforts to reduce the 19 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 8 percent with an unmet need for a spacing method, and the 12 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Eleven percent of the married women who need focused family planning efforts live in urban areas, 45 percent have no education and another 15 percent have incomplete primary schooling, and 40 percent live in households in the lowest two wealth quintiles.

About three of ten married women with a need for focused family planning efforts are users in need of a better method (LAPM—31 percent), 27 percent have never used a method, and 42 percent have used a method in the past but are not current users.

Four out of five (80 percent) women with a focused family planning need who visited a health facility in the 12 months preceding the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in nine (11 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (2 percent), are fatalistic (3 percent), have infrequent sexual relations (26 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (28 percent), say that contraception interferes with the body's processes (4 percent), have a husband who is opposed (7 percent) or they are opposed (1 percent), believe they are subfecund or infecund (7 percent), and say there is a religious prohibition (6 percent). One percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Niger

In 2015, there will be an estimated 126,918 deaths to under-five children and 6,769 pregnancy related deaths of mothers in Niger. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 98,096 of those under-five deaths (77 percent) and 5,696 pregnancy-related deaths (84 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.42 births per woman instead of 7.02, the under-five mortality rate would be 88 deaths per thousand births instead of 133, and the maternal mortality ratio would be 326 per hundred thousand births instead of 709.

To achieve these levels, 26 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 12 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 10 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

A quarter (24 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 83 percent have no education and another 10 percent have incomplete primary schooling, and 38 percent live in households in the lowest two wealth quintiles.

Some 38 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM).

A majority (73 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Over half (53 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (10 percent), are fatalistic (2 percent), have infrequent sexual relations (9 percent) or are not having sexual relations (4 percent), fear side effects or have health concerns (20 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (11 percent) or they are opposed (23 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (8 percent). More than one in five (22 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Nigeria

In 2015, there will be an estimated 1,070,810 deaths to under-five children and 40,469 pregnancy related deaths of mothers in Nigeria. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 756,403 of those under-five deaths (71 percent) and 26,513 pregnancy-related deaths (66 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.46 births per woman instead of 5.72, the under-five mortality rate would be 98 deaths per thousand births instead of 144, and the maternal mortality ratio would be 437 per hundred thousand births instead of 545.

To achieve these levels, 32 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 11 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

The 38 percent of the married and in-union women who need focused family planning efforts live in urban areas, 34 percent have no education, and another 7 percent have incomplete primary schooling. Surprisingly, only 33 percent live in households in the lowest two wealth quintiles.

About a third (35 percent) of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 48 percent have never used a method, and 17 percent have used a method in the past but are not current users.

A majority (54 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost half (49 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (6 percent), have infrequent sexual relations (9 percent) or are not having sexual relations (4 percent), fear side effects or have health concerns (28 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (14 percent) or they are opposed (23 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (9 percent). About one in eight (13 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Pakistan

In 2015, there will be an estimated 391,671 deaths to under-five children in Pakistan. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 144,097 of those under-five deaths (37 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 3.37 births per woman instead of 5.34. The under-five mortality rate would actually remain unchanged, at 85 deaths per thousand births, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 40 percent of non-pregnant married women require focused family planning efforts to reduce the 16 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 20 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

The 35 percent of the married women who need focused family planning efforts live in urban areas, 57 percent have no education and another 7 percent have incomplete primary schooling, and 37 percent live in households in the lowest two wealth quintiles.

Half of the married women with a need for focused family planning efforts are users in need of a better method (LAPM—50 percent), 26 percent have never used a method, and 24 percent have used a method in the past but are not current users.

A vast majority (87 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Two in five (40 percent) women said that they did not intend to use contraception in the future. The survey did not ask women about the reasons they did not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Peru

In 2015, there will be an estimated 11,353 deaths to under-five children in Peru. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 4,778 of those under-five deaths (42 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.89 births per woman instead of 2.53 and the under-five mortality rate would be 15 deaths per thousand births instead of 19.

To achieve these levels, 39 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 4 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 1 percent with an unmet need for a spacing method, and the 33 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Three out of five (61 percent) married and in-union women who need focused family planning efforts live in urban areas, 5 percent have no education and another 29 percent have incomplete primary schooling, and 50 percent live in households in the lowest two wealth quintiles.

Most married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—85 percent), 2 percent have never used a method, and 13 percent have used a method in the past but are not current users.

A majority (57 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in nine (11 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (2 percent), are fatalistic (1 percent), have infrequent sexual relations (21 percent) or are not having sexual relations (25 percent), fear side effects or have health concerns (37 percent), say that contraception interferes with the body's processes (1 percent), have a husband who is opposed (6 percent) or they are opposed (1 percent), believe they are subfecund or infecund (2 percent), and say there is a religious prohibition (2 percent). No women cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in the Philippines

In 2015, there will be an estimated 78,269 deaths to under-five children in the Philippines. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 43,660 of those under-five deaths (56 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.13 births per woman instead of 3.26 and the under-five mortality rate would be 22 deaths per thousand births instead of 32.

To achieve these levels, 52 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 34 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Almost half (49 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 1 percent have no education and another 11 percent have incomplete primary schooling, and 43 percent live in households in the lowest two wealth quintiles.

About two-thirds of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—65 percent).

Close to half (48 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Half (50 percent) of the women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (3 percent), are fatalistic (2 percent), have infrequent sexual relations (20 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (52 percent), say that contraception interferes with the body's processes (35 percent), have a husband who is opposed (5 percent) or they are opposed (7 percent), believe they are subfecund or infecund (8 percent), and say there is a religious prohibition (3 percent). One in five (19 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Rwanda

In 2015, there will be an estimated 25,896 deaths to under-five children and 2,052 pregnancy related deaths of mothers in Rwanda. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 10,971 of those under-five deaths (42 percent) and 1,393 pregnancy-related deaths (68 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.28 births per woman instead of 4.56 and the maternal mortality ratio would be 313 per hundred thousand births instead of 487. The under-five mortality rate would actually be higher, at 71 deaths per thousand births instead of 61, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 44 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 16 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 23 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Only 12 percent of the married and in-union women who need focused family planning efforts live in urban areas, 22 percent have no education and another 55 percent have incomplete primary schooling, and 41 percent live in households in the lowest two wealth quintiles.

Almost two out of three (65 percent) married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM), another 23 percent have never used a method, and 12 percent have used a method in the past but are not current users.

A third (34 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a quarter (24 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (5 percent), are fatalistic (19 percent), have infrequent sexual relations (12 percent) or are not having sexual relations (10 percent), fear side effects or have health concerns (34 percent), say that contraception interferes with the body's processes (8 percent), have a husband who is opposed (6 percent) or they are opposed (10 percent), and say there is a religious prohibition (5 percent). Three percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in São Tomé and Principe

In 2015, there will be an estimated 344 deaths to under-five children and 8 pregnancy related deaths of mothers in São Tomé and Principe. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 262 of those under-five deaths (76 percent) and 6 pregnancy-related deaths (80 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.46 births per woman instead of 4.9, the under-five mortality rate would be 25 deaths per thousand births instead of 53, and the maternal mortality ratio would be 46 per hundred thousand births instead of 116.

To achieve these levels, 62 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 25 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 8 percent with an unmet need for a spacing method, and the 28 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over half (51 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 6 percent have no education and another 57 percent have incomplete primary schooling, and 40 percent live in households in the lowest two wealth quintiles.

The 46 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM).

More than a quarter (29 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey was not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a third (31 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (1 percent), have infrequent sexual relations (14 percent) or are not having sexual relations (5 percent), fear side effects or have health concerns (45 percent), say that contraception interferes with the body's processes (9 percent), have a husband who is opposed (8 percent) or they are opposed (23 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (1 percent). No women cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Senegal

In 2015, there will be an estimated 34,995 deaths to under-five children and 2,655 pregnancy related deaths of mothers in Senegal. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 21,755 of those under-five deaths (62 percent) and 1,827 pregnancy-related deaths (69 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.34 births per woman instead of 4.98, the under-five mortality rate would be 51 deaths per thousand births instead of 64, and the maternal mortality ratio would be 321 per hundred thousand births instead of 484.

To achieve these levels, 40 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 21 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 10 percent with an unmet need for a spacing method, and the 9 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Close to half (47 percent) of the married and in-union women who need for focused family planning efforts live in urban areas, 66 percent have no education and another 20 percent have incomplete primary schooling, and 37 percent live in households in the lowest two wealth quintiles.

The 22 percent of married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 58 percent have never used a method, and 20 percent have used a method in the past but are not current users.

More than two-thirds (69 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Over half (54 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (21 percent), are fatalistic (6 percent), have infrequent sexual relations (10 percent) or are not having sexual relations (7 percent), fear side effects or have health concerns (14 percent), say that contraception interferes with the body's processes (2 percent), have a husband who is opposed (12 percent) or they are opposed (24 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (5 percent). Six percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Sierra Leone

In 2015, there will be an estimated 28,418 deaths to under-five children and 1,924 pregnancy related deaths of mothers in Sierra Leone. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 19,317 of those under-five deaths (68 percent) and 1,314 pregnancy-related deaths (68 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.50 births per woman instead of 5.12, the under-five mortality rate would be 83 deaths per thousand births instead of 127, and the maternal mortality ratio would be 556 per hundred thousand births instead of 857.

To achieve these levels, 34 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 21 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 7 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

A third (33 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 73 percent have no education and another 10 percent have incomplete primary schooling, and 38 percent live in households in the lowest two wealth quintiles.

The 19 percent of the married and in-union women who need focused family planning efforts are users in need of a better method (LAPM), 62 percent have never used a method, and 19 percent have used a method in the past but are not current users.

About half (51 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Two out of five (40 percent) women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (8 percent), are fatalistic (1 percent), have infrequent sexual relations (2 percent) or are not having sexual relations (3 percent), fear side effects or have health concerns (29 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (21 percent) or they are opposed (22 percent), believe they are subfecund or infecund (3 percent), and say there is a religious prohibition (13 percent). A quarter (24 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Swaziland

In 2015, there will be an estimated 4,070 deaths to under-five children and 219 pregnancy related deaths of mothers in Swaziland. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 1,421 of those under-five deaths (35 percent) and 138 pregnancy-related deaths (63 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.33 births per woman instead of 3.85 and the maternal mortality ratio would be 362 per hundred thousand births instead of 589. The under-five mortality rate would actually be slightly higher, at 117 deaths per thousand births instead of 109, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 50 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 18 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 28 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Almost a quarter (23 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 11 percent have no education and another 23 percent have incomplete primary schooling, and 37 percent live in households in the lowest two wealth quintiles.

Almost three in five married and in-union women who need focused family planning efforts are users in need of a better method (LAPM—57 percent), 6 percent have never used a method, and 37 percent have used a method in the past but are not current users.

A majority (55 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost a third (32 percent) of the women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are fatalistic (2 percent), fear side effects or have health concerns (40 percent), say that contraception interferes with the body's processes (5 percent), have a husband who is opposed (16 percent) or they are opposed (5 percent), believe they are subfecund or infecund (11 percent), and say there is a religious prohibition (3 percent). One in seven (15 percent) cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Tanzania

In 2015, there will be an estimated 134,794 deaths to under-five children and 9,872 pregnancy related deaths of mothers in Tanzania. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 78,307 of those under-five deaths (58 percent) and 7,176 pregnancy-related deaths (73 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.58 births per woman instead of 5.43, the under-five mortality rate would be 59 deaths per thousand births instead of 67, and the maternal mortality ratio would be 284 per hundred thousand births instead of 494.

To achieve these levels, 42 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 15 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 22 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Almost one in four (23 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 23 percent have no education and another 13 percent have incomplete primary schooling, and 39 percent live in households in the lowest two wealth quintiles.

A little over half of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—52 percent), 37 percent have never used a method, and 11 percent have used a method in the past but are not current users.

A majority (52 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. One in three (32 percent) women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (7 percent), are fatalistic (2 percent), have infrequent sexual relations (8 percent) or are not having sexual relations (6 percent), fear side effects or have health concerns (56 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (17 percent) or they are opposed (15 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (2 percent). Three percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Timor-Leste

In 2015, there will be an estimated 2,480 deaths to under-five children and 234 pregnancy related deaths of mothers in Timor-Leste. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 1,856 of those under-five deaths (75 percent) and 185 pregnancy-related deaths (79 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.33 births per woman instead of 5.68, the under-five mortality rate would be 36 deaths per thousand births instead of 59, and the maternal mortality ratio would be 287 per hundred thousand births instead of 557.

To achieve these levels, 52 percent of non-pregnant married women require focused family planning efforts to reduce the 25 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 8 percent with an unmet need for a spacing method, and the 19 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over one in four (26 percent) of the married women who need focused family planning efforts live in urban areas, 35 percent have no education and another 15 percent have incomplete primary schooling, and 36 percent live in households in the lowest two wealth quintiles.

More than one in three married women who need focused family planning efforts are users in need of a better method (LAPM—36 percent), 55 percent have never used a method, and 9 percent have used a method in the past but are not current users.

A majority (54 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Over half (55 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (8 percent), have infrequent sexual relations (2 percent) or are not having sexual relations (1 percent), fear side effects or have health concerns (34 percent), say that contraception interferes with the body's processes (4 percent), have a husband who is opposed (27 percent) or they are opposed (64 percent), believe they are subfecund or infecund (1 percent), and say there is a religious prohibition (1 percent). Eight percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Uganda

In 2015, there will be an estimated 131,976 deaths to under-five children in Uganda. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 42,311 of those under-five deaths (32 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.96 births per woman instead of 3.61 and the under-five mortality rate would be 65 deaths per thousand births instead of 78.

To achieve these levels, 54 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 25 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 6 percent with an unmet need for a spacing method, and the 22 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Fifteen percent of the married and in-union women who need focused family planning efforts live in urban areas, 15 percent have no education and another 52 percent have incomplete primary schooling, and 39 percent while in households in the lowest two wealth quintiles.

The 41 percent of the married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM), 35 percent have never used a method, and 24 percent have used a method in the past but are not current users.

Two-thirds (66 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. A quarter (24 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (11 percent), are fatalistic (13 percent), have infrequent sexual relations (13 percent) or are not having sexual relations (8 percent), fear side effects or have health concerns (39 percent), say that contraception interferes with the body's processes (6 percent), have a husband who is opposed (7 percent) or they are opposed (17 percent), believe they are subfecund or infecund (9 percent), and say there is a religious prohibition (3 percent). Seven percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Ukraine

In 2015, there will be an estimated 8,506 deaths to under-five children and 2,046 pregnancy related deaths of mothers in Ukraine. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 5,066 of those under-five deaths (60 percent) and 1,620 pregnancy-related deaths (79 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.49 births per woman instead of 6.2 and the maternal mortality ratio would be 224 per hundred thousand births instead of 432. The under-five mortality rate would remain unchanged, at 18 deaths per thousand births, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 28 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 7 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 3 percent with an unmet need for a spacing method, and the 18 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Two-thirds (66 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 100 percent have completed at least primary school, and 36 percent live in households in the lowest two wealth quintiles.

Almost two in three married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—65 percent), 6 percent have never used a method, and 29 percent have used a method in the past but are not current users.

A vast majority (89 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Close to half (46 percent) of the women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (1 percent), are fatalistic (9 percent), have infrequent sexual relations (27 percent) or are not having sexual relations (7 percent), fear side effects or have health concerns (20 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (7 percent) or they are opposed (11 percent), believe they are subfecund or infecund (20 percent), and say there is a religious prohibition (3 percent). Two percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Zambia

In 2015, there will be an estimated 65,673 deaths to under-five children in Zambia. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 487 of those under-five deaths (1 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 1.11 births per woman instead of 1.17. The under-five mortality rate would actually be slightly higher, at 105 deaths per thousand births instead of 100, because the decrease that would otherwise have occurred is counteracted by an increase in the percentage of births that are first-births. First-births are unavoidably at higher risk than later births. However, the *number* of under-five deaths would still be reduced due to the lower number of births.

To achieve these levels, 55 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 18 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 5 percent with an unmet need for a spacing method, and the 32 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

A third (33 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 14 percent have no education and another 43 percent have incomplete primary schooling, and 44 percent live in households in the lowest two wealth quintiles.

About three of five married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—59 percent), 12 percent have never used a method, and 29 percent have used a method in the past but are not current users.

Two out of five (41 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Almost one out of four (24 percent) said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (6 percent), are fatalistic (3 percent), have infrequent sexual relations (20 percent) or are not having sexual relations (10 percent), fear side effects or have health concerns (34 percent), say that contraception interferes with the body's processes (3 percent), have a husband who is opposed (5 percent) or they are opposed (9 percent), believe they are subfecund or infecund (21 percent), and say there is a religious prohibition (3 percent). Six percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.

Reduced Child and Maternal Mortality through Reduced Fertility Risk and Eliminating Unmet Need for Contraception in Zimbabwe

In 2015, there will be an estimated 34,820 deaths to under-five children and 2,701 pregnancy related deaths of mothers in Zimbabwe. If women would have only those births that they desired and with adequate birth spacing (36 months or more), age at birth (18 to 39 years), and parity (less than 4), 20,507 of those under-five deaths (59 percent) and 1,746 pregnancy-related deaths (65 percent) would be averted. These reductions in mortality are due to a lower number of births and lower mortality rates. Under these conditions, the total fertility rate would be 2.63 births per woman instead of 6.17, the under-five mortality rate would be 73 deaths per thousand births instead of 76, and the maternal mortality ratio would be 490 per hundred thousand births instead of 591.

To achieve these levels, 42 percent of non-pregnant married and in-union women require focused family planning efforts to reduce the 8 percent with an unmet need for limiting births (i.e., using a long-acting or permanent contraceptive method—LAPM), the 4 percent with an unmet need for a spacing method, and the 31 percent who need to shift from non-LAPM to LAPM.

Who are the women who need focused family planning efforts, i.e., non-pregnant married and in-union women with a combined unmet need for contraception or a need for a long-term or permanent method of contraception?

Over a quarter (28 percent) of the married and in-union women who need focused family planning efforts live in urban areas, 3 percent have no education and another 16 percent have incomplete primary schooling, and 43 percent live in households in the lowest two wealth quintiles.

Almost three of four married and in-union women with a need for focused family planning efforts are users in need of a better method (LAPM—73 percent), 16 percent have never used a method, and 11 percent have used a method in the past but are not current users.

Almost half (48 percent) of the women with a focused family planning need who visited a health facility in the 12 months before the survey were not advised about family planning.

Married and in-union women with an unmet need for contraception for either desires or risk were asked about their intentions to use contraception in the future. Three in ten (29 percent) women said that they did not intend to use contraception in the future, and gave the following reasons for not intending to use: Are breastfeeding (1 percent), are fatalistic (6 percent), have infrequent sexual relations (17 percent) or are not having sexual relations (14 percent), fear side effects or have health concerns (15 percent), have a husband who is opposed (10 percent) or they are opposed (7 percent), believe they are subfecund or infecund (9 percent), and say there is a religious prohibition (21 percent). Only 1 percent cited family planning program reasons (no method or preferred method not available, inconvenient to use, costs too much, lack of access or too far away, knows no method or knows no source) as the reason they do not intend to use contraception in the future.