Changes in Contraceptive Method Mix In Developing Countries

CONTEXT: *Understanding shifts in contraceptive method mix is key to helping policymakers, program managers and donor agencies meet current contraceptive demand and estimate future needs in developing countries.*

METHODS: *Data from Demographic and Health Surveys, Reproductive Health Surveys and other nationally representative surveys were analyzed to describe trends and shifts in method mix among married women of reproductive age from 1980 to 2005. The analysis included 310 surveys from 104 developing countries.*

RESULTS: *Contraceptive use among married women of reproductive age increased in all regions of the developing world, reaching 66% in Asia and 73% in Latin America and the Caribbean in 2000–2005, though only 22% in Sub-Saharan Africa. The proportion of married contraceptive users relying on the IUD declined from 24% to 20%, and the proportion using the pill fell from 16% to 12%. The share of method mix for injectables rose from 2% to 8%, and climbed from 8% to 26% in Sub-Saharan Africa, while the share for condoms was 5–7%. The overall proportion of users relying on female sterilization ranged from 29% to 39%, reaching 42–43% in Asia and in Latin America and the Caribbean in 2000–2005; on average, the share of all method use accounted for by male sterilization remained below 3% for all periods. Use of traditional methods declined in all regions; the sharpest drop—from 56% to 31% of users—occurred in Sub-Saharan Africa.*

CONCLUSIONS: *To meet the rising demand for modern methods, it is critical that future programmatic efforts provide methods that are both accessible and acceptable to users.*

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Contraceptive prevalence—generally defined as the proportion of women of reproductive age using a contraceptive method—is one yardstick by which countries evaluate their family planning programs. Prevalence among married women has risen steadily in most developing countries over the past four decades. In developing countries overall, it climbed from 9% in the early 1960s to 60% by the late 1990s.[1]

Contraceptive preferences and the promotion of different methods vary by region and country; therefore, so does the contraceptive method mix, or the share of use represented by each method. For example, female sterilization is the most widely employed method in developing countries, followed by the IUD, the pill and injectables.[2] However, female sterilization is little used in the Near East, North Africa or Sub-Saharan Africa.[1] One-third of developing countries have a very skewed method mix, in which a single method accounts for more than half of contraceptive use.[3] Mature family planning programs, such as that of Paraguay, have a more balanced distribution of methods.[4]

Earlier studies have examined trends in contraceptive prevalence[5] and method mix.[6] This study updates information on trends in method mix, using nationally representative survey data collected between 1980 and 2005. It also looks at trends in condom use among married women in developing countries in which HIV and AIDS are most prevalent. In addition, this study considers explanations for the observed changes in method mix over time and explores the potential public health impact and programmatic implications of these trends.

METHODS

The data in this article are from the Demographic and Health Survey series, directed by Macro International; the Reproductive Health Survey series, conducted by the U.S. Centers for Disease Control and Prevention; and other nationally representative surveys.

We identified 104 countries that have had at least one nationally representative survey measuring contraceptive use among married women of reproductive age; overall, data from 310 surveys were included in the analyses (Appendix Table 1, page 123). Seventy-two countries have had at least two surveys since 1980, including 28 from Sub-Saharan Africa, 17 from Latin America or the Caribbean, 15 from East, South or Southeast Asia (hereafter referred to as Asia), and 12 from other regions (North Africa, Europe, or Western or Central Asia).

We originally classified contraceptive methods into eight types: IUD, pill, injectable, condom, male sterilization, female sterilization, traditional methods and other (primarily vaginal methods). The lactational amenorrhea method appeared as a separate method beginning in 1999, and was

classified as a traditional method. The implant was listed separately in a few surveys, and was included in the "other" category. Because the "other" category accounted for only 1% of contraceptive use in all surveys combined, we omitted it from analysis. We classified the remaining seven methods into three categories: reversible modern methods (IUD, pill, injectable and condom), permanent methods (male and female sterilization) and traditional methods (rhythm, withdrawal and folk methods).

One challenge in designing this analysis stemmed from the varying frequency of contraceptive prevalence surveys. The median interval between surveys was five years. However, 32 countries had had only a single survey over the 26-year period, whereas one country (Egypt) had had 11 surveys. Another complication was that no nationally representative surveys were available for the former Eastern bloc countries until the entry of Western donors in the early 1990s. These variations are problematic for developing country estimates, because the resulting assessments depend on the available data for a particular period. For annual analyses of contraceptive prevalence, both the United Nations Population Fund and the Population Reference Bureau use the most recent data from each country. We used a variation of this technique for our analysis of changes over time.

We compiled average values for each country for five time periods: 1980–1984, 1985–1989, 1990–1994, 1995–1999 and 2000–2005. Periods without a survey were assigned the value of the previous period; for countries with only one survey in 26 years, all periods were assigned the same value. Exclusion of countries without recent surveys or with a single survey would have introduced volatility into the regional estimates that was attributable only to changes in survey frequency. Such volatility would have been most pronounced for the former Eastern bloc countries, as surveys in these countries were first conducted well into the 26-year study period. Applying these values to earlier periods prevents jumps in the regional and overall estimates caused solely by the addition of such countries to the trend analysis.

The 104 countries included represent 80% of the world's population.[7] We weighted the data on the basis of the population of women of reproductive age, so that the contraceptive prevalence trends are representative for the developing world (excluding countries with no data).

Countries with an active family planning program are more likely than others to conduct contraceptive prevalence studies or Demographic and Health Surveys, and this difference biases prevalence estimates upward. Thus, contraceptive prevalence was 47% for 1980–1984 for countries included in our analysis, compared with 38% for developing countries as of 1980.[1] However, because we focus on shifts over time rather than absolute prevalence levels, this upward bias does not affect the analysis of trends.

With the spread of the HIV and AIDS epidemic, many government agencies promote the use of condoms, even among married couples, for both pregnancy and disease prevention. However, condoms were not a popular contraceptive method among married couples in developing countries before the AIDS epidemic, and many married men continue to object to using them—especially with their wives. To examine whether condom use has increased among married couples in countries with a generalized AIDS epidemic, we asked married women about their condom use. Because awareness of the AIDS epidemic was not widespread in the 1980s, we limited this part of the analysis to countries that had an HIV prevalence among adults of at least 5% in 2003 and that had had two contraceptive prevalence surveys since 1990 (South Africa is the exception).

TABLE 1. Percentage of married women of reproductive age living in developing countries who reported use of any contraceptive method, by survey period and region

Period	All	Latin America/ Caribbean	Sub-Saharan Africa	Asia	Other
1980–1984	47.2	54.1	13.7	50.8	46.7
1985–1989	51.6	57.6	14.1	56.5	49.3
1990–1994	55.0	58.7	15.4	61.1	51.0
1995–1999	58.6	69.5	19.7	64.2	52.4
2000–2005	60.0	72.7	21.8	65.5	54.3

RESULTS

Contraceptive prevalence among married women has increased gradually in all regions of the developing world since 1980, rising to 60% for the period 2000–2005 (Table 1). Prevalence is currently highest in Latin America and the Caribbean (73%) and Asia (66%); these rates are followed distantly by that of Sub-Saharan Africa (22%). However, this pattern masks dramatic variations by country within regions.

Of the 72 countries with at least two surveys since 1980, nearly all showed a monotonic increase in prevalence over time. Only three of these countries (4%) experienced a period of "backsliding"—that is, a decrease of more than three percentage points between surveys (this cut-point was used because smaller differences could be attributable to sampling error). Rates dropped by four points in India between 1988 and 1993, by seven points in the Philippines between 1986 and 1988, and by eight points in Rwanda between 1992 and 2000 (not shown).

Even if a particular method's absolute prevalence increases, its share of the method mix may decline. The following analyses focus on shifts in method mix, and thus are based on married women using contraceptives, rather than on all married women.

The proportion of all use accounted for by the IUD decreased from 24% to 20% over the 26-year period (Table 2). This decline was particularly marked in Asia during the 1980s, whereas the IUD's share of use increased steadily in countries categorized as "other" (Table 3). Similarly, the pill's share of the method mix dropped from 16% to 12% over the entire period. Overall, the proportion of all users relying on the pill fell in all regions, but the most dramatic decline—from 31% to 18%—occurred in Latin America and the Caribbean, most notably between the periods 1980–1984 and 1990–1994.

The share of method mix accounted for by use of in-

TABLE 2. Percentage of married female contraceptive users who reported use of selected reversible methods, by survey period

Period	IUD	Pill	Injectable	Condom
1980–1984	23.5	16.0	1.8	5.7
1985–1989	21.1	13.8	2.9	6.0
1990–1994	20.7	12.8	3.9	5.1
1995–1999	20.8	12.6	5.6	6.2
2000–2005	20.1	12.3	7.6	6.9

jectables rose from 2% to 8% over the study period, with small increases in Asia and in Latin America and the Caribbean. Notably, the share in Sub-Saharan Africa grew from 8% to 26% over this period. The proportion of users relying on injectables climbed steadily in all but three countries in this region, and overtook the proportion using the pill in 14 of the 28 countries with multiple surveys (not shown).

TABLE 3. Percentage of married female contraceptive users, by method and survey period, according to region

Method and period	Latin America/ Caribbean	Sub-Saharan Africa	Asia	Other
IUD				
1980–1984	9.2	5.1	27.9	22.9
1985–1989	10.9	4.7	24.0	26.1
1990–1994	10.7	7.0	22.8	29.0
1995–1999	11.0	5.7	22.9	30.0
2000–2005	9.9	2.9	22.8	29.3
Pill				
1980–1984	31.4	19.3	11.8	27.8
1985–1989	27.6	19.3	9.3	25.7
1990–1994	19.5	23.7	8.2	25.2
1995–1999	19.5	22.3	8.0	25.2
2000–2005	18.1	18.6	8.2	25.8
Injectable				
1980–1984	3.5	8.1	0.9	0.6
1985–1989	2.7	9.4	2.4	0.6
1990–1994	2.8	12.2	3.3	0.6
1995–1999	3.9	16.8	4.8	1.3
2000–2005	6.3	25.7	5.8	2.2
Condom				
1980–1984	2.6	3.2	6.0	8.0
1985–1989	3.2	2.8	6.5	8.3
1990–1994	4.0	4.9	4.9	7.6
1995–1999	6.1	6.2	5.9	7.8
2000–2005	7.0	8.3	6.5	7.7
Male sterilization				
1980–1984	0.9	<0.1	5.4	0.2
1985–1989	1.1	0.3	6.5	0.2
1990–1994	0.3	0.3	8.6	0.2
1995–1999	2.1	0.4	5.8	0.2
2000–2005	2.2	0.3	5.1	0.2
Female sterilization				
1980–1984	32.9	7.0	34.3	5.4
1985–1989	35.8	7.1	42.5	5.6
1990–1994	47.8	7.9	43.4	5.8
1995–1999	43.4	7.9	43.1	6.1
2000–2005	43.4	6.5	42.1	6.0
Traditional methods				
1980–1984	17.5	56.4	13.2	33.1
1985–1989	17.5	55.4	8.6	32.0
1990–1994	14.3	42.5	8.1	30.0
1995–1999	13.4	39.4	8.3	27.8
2000–2005	12.3	30.6	8.6	26.8

The proportion of married female contraceptive users relying on condoms rose from 6% to 7% over the study period. In Latin America and the Caribbean, as well as in Sub-Saharan Africa, this proportion increased from 3% in the early 1980s to 7–8% in 2000–2005.

Women's reliance on male sterilization for contraception was low in all periods, with this method's share of use remaining below 3% for all periods. In Asia, however, the proportion of users relying on vasectomies rose to 9% in 1990–1994, before dropping back to 5% in 2000–2005. Three Asian countries reported periods of relatively high vasectomy use (not shown), but reliance on vasectomy declined as a proportion of method mix—from 9% to 4% in India (1993 to 1999), from 19% to 16% in Nepal (1996 to 2001) and from 8% to 6% in Sri Lanka (1987 to 1993).

Female sterilization was the most widely used method of contraception in developing countries, and its share of the method mix ranged from 29% to 39% across the time periods (not shown). However, this pattern masks sharp regional variations. For the past 26 years, female sterilization has accounted for at least one-third of all contraceptive use in Asia and in Latin America and the Caribbean. Indeed, its share in the latter region peaked at 48% in 1990–1994, before declining slightly over the next decade. In Asia, the share of use accounted for by female sterilization rose from 34% in 1980–1984 to plateau at 42–43% from 1985 to 2005. Because these values are weighted by population size, China and India—with large populations and high levels of female sterilization—exert a strong influence on these trends. In contrast, the share of female sterilization in the method mix remained fairly level at 5–8% in Sub-Saharan Africa and in "other" countries.

The proportion of use accounted for by traditional methods varied widely by region. This proportion changed markedly over time in Sub-Saharan Africa. In surveys conducted in 1980–1984, 56% of users in this region reported employing traditional methods; subsequently, however, the proportion declined to 31%. Traditional methods represented a much smaller proportion of the method mix in Asia and in Latin America and the Caribbean, where it decreased from 13% to 9% and from 18% to 12%, respectively.

Eleven of the 12 countries with high HIV prevalence among adults are in Sub-Saharan Africa (Table 4, page 120). No more than 8% of married women in any country reported using condoms at the latest survey. Moreover, the proportion using condoms increased substantially in only two countries: In Cameroon, it rose from 2% in 1998 to 8% in 2004 (an average annual change of 0.9%), and in Namibia, it rose from 0.3% in 1992 to 5% in 2000 (an average annual change of 0.6%). Even though HIV prevalence among adults in the other countries ranged from 5% to 25%, the level of condom use in these countries remained below 4%.

DISCUSSION

While the overall increase in contraceptive prevalence and the replacement of traditional methods by more effective modern methods in developing countries are welcome

TABLE 4. Condom use in the era of HIV in 12 countries with high HIV prevalence among adults

Country	% of adults with HIV, 2003	% of married women reporting condom use		
		Earliest*	Most recent	Average annual % change
Cameroon	6.9	2.1 (1998)	7.6 (2004)	0.9
Côte d'Ivoire	7.0	0.7 (1994)	1.8 (1999)	0.2
Haiti	5.6	2.6 (1995)	2.9 (2000)	0.1
Kenya	6.7	0.8 (1993)	1.2 (2003)	<0.1
Malawi	14.2	1.6 (1992)	1.8 (2004)	<0.1
Namibia	21.3	0.3 (1992)	5.2 (2000)	0.6
Nigeria	5.4	1.2 (1999)	1.9 (2003)	0.2
Rwanda	5.1	0.2 (1992)	0.4 (2000)	<0.1
South Africa	21.5	0.7 (1987)	1.7 (1998)	<0.1
Tanzania	8.8	1.7 (1994)	2.0 (2005)	<0.1
Zambia	16.5	3.5 (1996)	3.8 (2002)	0.1
Zimbabwe	24.6	2.3 (1994)	1.8 (1999)	–0.1

*Surveys conducted before 1990 were excluded because awareness of the AIDS epidemic was not widespread in the 1980s. South Africa's 1987 survey was the exception and was included because it was the closest survey to 1990. *Note:* HIV prevalence of 5% or more was considered high.

trends, the relatively low use of condoms and the increasing popularity of injectables present unique challenges for family planning efforts and may have significant programmatic and public health implications in years to come, especially in Sub-Saharan Africa.

Reduced Reliance on Traditional Methods

One encouraging trend in developing countries is the increase in contraceptive prevalence concurrent with the decrease in the share of all use accounted for by traditional methods. Greater reliance on modern contraceptives carries well-known benefits for women, their families and society—lower levels of unintended pregnancy, unsafe abortion, and maternal and child morbidity and mortality, as well as a slowing of population growth.

The rising use of modern methods suggests that family planning programs have made significant progress in offering contraceptives that are both acceptable and accessible to users in developing countries. Improved access to contraceptives can strongly increase their uptake, as Ross et al. demonstrated in analyses based on data from the family planning program effort index and contraceptive prevalence surveys.[5] Studies in Turkey[8] and rural Kenya[9] have shown that family planning programs that improve the availability of contraceptives lead to increases in the use of modern methods at the expense of traditional methods. To meet the rising demand for modern methods, program managers, donors and policymakers will need to work together to ensure an adequate stream of contraceptive supplies as the number of women of reproductive age continues to grow.

Although the replacement of traditional methods by modern methods is a positive trend, there is cause for concern when government policy primarily promotes the use of permanent and long-acting methods. For example, widespread use of female sterilization in India reflects a legacy of efforts to curb population growth through the use of targets. Despite a 1996 national population policy that eliminated the use of targets and called for the promotion of a wider variety of contraceptive choices, female sterilization continues to dominate India's method mix.[10] Similarly, China's population policy has used incentives and disincentives to achieve demographic objectives, leading to disproportionate use of the IUD and female sterilization.[11,12] In keeping with government policy, women with one child tend to use the IUD, while those with two or more children rely on female sterilization.[12,13]

Consistently Low Use of Condoms

Condom use as a proportion of method mix has remained almost unchanged in developing countries, despite the global AIDS epidemic and efforts to promote the ABC approach (abstinence, being faithful, condom use). The proportion of married female contraceptive users reporting condom use remained constant and low in all regions over the study period. Of the 12 countries with a 2003 HIV prevalence of at least 5%, only Cameroon and Namibia have shown rising condom use among married women.

Worldwide, 80% of HIV infections are transmitted sexually, and another 10% during pregnancy, birth or breastfeeding.[14] Although a joint position statement by the World Health Organization, the Joint United Nations Programme on HIV/AIDS and the United Nations Population Fund[15] promoted the male latex condom as the most effective means of preventing sexual transmission, this study found little evidence that condoms are a popular method among married couples.

Low levels of condom use are cause for concern, particularly in the context of generalized epidemics such as those found in Sub-Saharan Africa. Despite a growing number of studies showing that an increased proportion of HIV infections are transmitted through sex within marriage or with a committed partner,[16] individuals in committed relationships tend to resist condom use, because it is often considered a sign of infidelity.[17] However, evidence from national surveys has shown that condom use is much more prevalent outside of marriage, among both married and unmarried men and women.[18]

In our study, the data may not accurately reflect total condom use among men, since men's use of condoms with extramarital sexual partners would not be picked up by surveys conducted among married women.[19,20] Furthermore, the questions used in the surveys from which our data came did not ask whether condoms were being used for pregnancy or disease prevention, or both. (The question about condom use appeared in the survey section on contraception.)

Our results demonstrating continued low levels of condom use within marriage highlight the need for greater programmatic efforts to procure, promote and distribute condoms. They also point up the need to develop female-controlled methods that can protect women against unplanned pregnancy, HIV and other STIs.

Increased Use of Injectables

Another trend that is likely to have a significant public health impact is the remarkable increase in injectable use in Sub-Saharan Africa and in lower-income Latin American coun-

tries. This dramatic rise signals regional shifts in method mix away from the pill and traditional methods. The injectable, a highly effective, long-lasting and reversible method that meets the needs of women who want to space rather than limit their births, is the leading method in a number of Sub-Saharan African countries.[21]

Injectables offer several benefits, including the reduced likelihood of unplanned pregnancy, unsafe abortion and maternal mortality. The rapid increase in injectable use is largely attributable to its widespread accessibility.[2] Furthermore, women can use this method without others knowing about it; injections are administered periodically (once a month or every three months) and there are no supplies to keep on hand. One study estimated that 6–20% of women in Sub-Saharan Africa used the injectable covertly, a practice that was more common in areas where contraceptive prevalence was low, particularly rural areas.[22] Eventually, injectables may become even more convenient for women as availability increases through community-based distribution and pharmacies.[2]

Conclusions

The low level of condom use and the growing use of injectables in developing countries point to a critical public health issue; providing and supporting use of methods that are acceptable and accessible to women can reduce unintended pregnancy and save lives. Because of women's relative lack of decision-making power in developing countries, it makes sense to provide methods that are female-controlled and can be used covertly. In the future, procurement and distribution of contraceptive supplies will be challenging issues, given rising demand for modern contraceptives, increasing population size and shrinking resources for family planning programs.

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RESUMEN

Contexto: *Comprender los cambios en la mezcla de métodos anticonceptivos es esencial para ayudar a las personas encargadas de formular las políticas, gerentes de programas y agencias donantes para satisfacer la actual demanda de anticonceptivos y estimar las necesidades futuras en los países en desarrollo.*

Métodos: *Datos de Encuestas Demográficas y de Salud, Encuestas de Salud Reproductiva y otras encuestas representativas a nivel nacional fueron analizados para describir tendencias y cambios en la mezcla de métodos entre las mujeres casadas en edad reproductiva, de 1980 a 2005. Este análisis incluyó 310 encuestas de 104 países en desarrollo.*

Resultados: *El uso de anticonceptivos aumentó en todas las regiones del mundo en desarrollo, llegando a 66% de las mujeres casadas en edad reproductiva en Asia y 73% en América Latina y el Caribe en 2000–2005, aunque solamente llegó a 22% en África subsahariana. La proporción del uso total que corresponde al DIU disminuyó de 24% a 20% con el tiempo, y la proporción que pertenece a la píldora bajó de 16% a 12%. La proporción del uso que se debe a las inyecciones aumentó de 2% a 8% (y escaló de 8% al 26% en África subsahariana).*

A nivel mundial, mientras que la proporción que corresponde a los condones permaneció en 5–7% en todos los períodos, la que corresponde a la esterilización femenina oscilaba entre 29% y 39%, llegando a 42–43% en Asia y América Latina y el Caribe en 2000–2005. En promedio, la proporción que representó la esterilización masculina en el uso de todos los métodos, se mantuvo por debajo del 3% en todos los períodos estudiados. El uso de métodos tradicionales disminuyó a través del tiempo en todas las regiones; la caída más drástica–del 56% del uso total al 31%–ocurrió en África subsahariana.

Conclusiones: *Para satisfacer la creciente demanda de métodos modernos, es crítico que los futuros esfuerzos programáticos proporcionen métodos que sean tanto accesibles como aceptables para las y los usuarios.*

RÉSUMÉ

Contexte: *Pour répondre à la demande contraceptive actuelle et estimer les besoins à venir des pays en développement, les décideurs politiques, gestionnaires de programmes et organismes donateurs doivent impérativement comprendre les variations de la répartition des méthodes contraceptives.*

Méthodes: *Les données des Enquêtes démographiques et de*

APPENDIX TABLE 1. Countries included in the analysis and survey years, by region

Country	Survey years
Latin America/Caribbean	
Belize	1991, 1999
Bolivia	1983, 1989, 1994, 1998, 2003
Brazil	1986, 1991, 1996
Colombia	1980, 1986, 1990, 1995, 2000
Costa Rica	1981, 1986, 1993
Cuba	1987
Dominican Republic	1980, 1983, 1986, 1991, 1996, 1999, 2002
Ecuador	1982, 1987, 1989, 1994, 1999, 2004
El Salvador	1985, 1988, 1993, 1998, 2003
Guatemala	1983, 1987, 1995, 1999, 2002
Haiti	1983, 1987, 1989, 1995, 2000
Honduras	1981, 1984, 1987, 1996, 2001
Jamaica	1983, 1989, 1993, 1997, 2002
Mexico	1982, 1987, 1992, 1995, 1997, 2003
Nicaragua	1981, 1993, 1998, 2001
Panama	1984
Paraguay	1987, 1990, 1996, 1998, 2004
Peru	1981, 1986, 1992, 1996, 2000
Puerto Rico	1982, 1996
Trinidad and Tobago	1987
Sub-Saharan Africa	
Benin	1981, 1996, 2001
Botswana	1984, 1988
Burkina Faso	1993, 1999, 2003
Burundi	1987
Cameroon	1991, 1998, 2004
Cape Verde	1998
Central African Republic	1995
Chad	1997
Comoros	1996
Côte d'Ivoire	1980, 1994, 1999
Eritrea	1995, 2002
Ethiopia	1990, 2000, 2005
Gabon	2000
Ghana	1988, 1993, 1998, 2003
Guinea	1992, 1995, 2005
Kenya	1984, 1989, 1993, 1998, 2003
Lesotho	1992
Liberia	1986
Madagascar	1992, 1997, 2004
Malawi	1984, 1992, 1996, 2000, 2004
Mali	1987, 1996, 2001
Mauritania	1999, 2001
Mauritius	1985, 1991
Mozambique	1997, 2003
Namibia	1989, 1992, 2000
Niger	1992, 1998
Nigeria	1981, 1990, 1999, 2003
Rwanda	1983, 1992, 2000, 2005
Senegal	1986, 1993, 1997, 1999, 2005
South Africa	1981, 1987, 1998
Sudan	1989, 1990, 1993
Swaziland	1988
Tanzania	1992, 1994, 1996, 1999, 2005
Sub-Saharan Africa (continued)	
Togo	1988, 1998
Uganda	1988, 1995, 2001, 2005
Zaire	1991
Zambia	1992, 1996, 2002
Zimbabwe	1984, 1988, 1994, 1999
Asia	
Bangladesh	1989, 1991, 1994, 1997, 2000, 2004
Cambodia	1995, 2000
China	1982, 1985, 1988, 1992, 1997, 2001
Hong Kong	1982, 1987, 1992
India	1980, 1988, 1993, 1999
Indonesia	1980, 1985, 1987, 1991, 1994, 1997, 2003
Malaysia	1984
Myanmar	1991, 1997
Nepal	1981, 1986, 1991, 1996, 2001
Pakistan	1984, 1991
Philippines	1983, 1986, 1988, 1993, 1998, 2003
Singapore	1982
South Korea	1982, 1985, 1988, 1992, 1994
Sri Lanka	1981, 1982, 1987, 1993
Taiwan	1980, 1985, 1991, 1992
Thailand	1980, 1981, 1984, 1987, 1993, 1996
Vietnam	1988, 1994, 1997, 2002
Other	
Albania	2002
Algeria	1986, 1992, 1995
Armenia	2000
Azerbaijan	2001
Bahrain	1995
Czech Republic	1993
Egypt	1980, 1981, 1984, 1988, 1992 , 1995, 1997, 1998, 2000, 2003, 2005
Georgia	1999
Iran	1992, 1994
Iraq	1989
Jordan	1983, 1985, 1990, 1997, 2002
Kazakhstan	1995, 1999
Kuwait	1987, 1996
Kyrgyzstan	1997
Libya	1995
Moldova	1997
Morocco	1980, 1983, 1987, 1992, 1995, 2004
Oman	1988, 1995
Qatar	1998
Romania	1993, 1999
Saudi Arabia	1996
Syria	1993
Tunisia	1983, 1988
Turkey	1983, 1988, 1993, 1998, 2003
Turkmenistan	2000
Ukraine	1999
United Arab Emirates	1995
Uzbekistan	1996
Yemen	1992, 1997

santé, Enquêtes de santé de la reproduction et autres enquêtes nationalement représentatives ont été analysées de manière à décrire les tendances et variations de la ventilation des de méthodes parmi les femmes mariées en âge de procréer, de 1980 à 2005. Les données de 310 enquêtes originaires de 104 pays en développement ont été analysées.

Résultats: *La pratique contraceptive des femmes mariées en âge de procréer s'est accrue dans toutes les régions du monde en développement, atteignant 66% en Asie et 73% en Amérique latine et Caraïbes en 2000–2005, mais seulement 22% en Afrique subsaharienne. La proportion d'utilisatrices mariées ayant recours au stérilet a baissé, de 24% à 20%, de même que celle des utilisatrices de la pilule, passée de 16% à 12%. La part de pratique globale représentée par les injectables s'est quant à elle accrue, de 2% à 8%, passant de 8% à 26% en Afrique subsaharienne, tandis que la part du préservatif était de 5% à 7%. Au total, la proportion d'utilisatrices ayant recours à la stérilisation féminine se situe entre 29% et 39%, atteignant pourtant 42–43% en Asie et en Amérique latine et Caraïbes en 2000–2005. En moyenne, la part de pratique globale représentée par la stérilisation masculine demeure inférieure à 3% sur toutes les périodes. Le recours aux méthodes traditionnelles est en baisse dans toutes les régions, la plus forte chute–de 56% à 31% des utilisatrices–s'étant produite en Afrique subsaharienne.*

Conclusions: *Pour répondre à la demande grandissante de méthodes contraceptives modernes, il est crucial que les efforts programmatiques futurs se concentrent sur l'apport de méthodes à la fois accessibles et acceptables.*

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