



United Nations

Department of
Economic and
Social Affairs

World Family Planning 2022

Meeting the changing needs for
family planning: Contraceptive
use by age and method



Department of Economic and Social Affairs
Population Division

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Contraceptive use by age and method**



United Nations
New York, 2022

United Nations Department of Economic and Social Affairs, Population Division

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Notes on regions, development groups, countries or areas

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

The designation of “more developed” and “less developed”, or “developed” and “developing”, is intended for statistical purposes and does not express a judgment about the stage in the development process reached by a particular country or area. More developed regions comprise all countries and areas of Europe and Northern America, plus Australia, New Zealand and Japan. Less developed regions comprise all countries and areas of Africa, Asia (excluding Japan), Latin America and the Caribbean, and Oceania (excluding Australia and New Zealand).

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

The group of landlocked developing countries (LLDCs) includes 32 countries or territories, located in sub-Saharan Africa (16), Northern Africa and Western Asia (2), Central and Southern Asia (8), Eastern and South-Eastern Asia (2), Latin America and the Caribbean (2), and Europe and Northern America (2). Further information is available at <http://unohrlls.org/about-lldc/>.

The group of small island developing States (SIDS) includes 58 countries or territories, located in the Caribbean (29), the Pacific (20), and the Atlantic, Indian Ocean, Mediterranean and South China Sea (AIMS) (9). Further information is available at <http://unohrlls.org/about-sids/>.

The classification of countries and areas by income level is based on gross national income (GNI) per capita as reported by the World Bank (2022). These income groups are not available for all countries and areas. Further information is available at: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>



**"Family Planning in Pakistan: A class in family training given by Dr. Nishat Masaud"
UN Photo/B. Wolff**

Key messages

1. Sexual and reproductive health and reproductive rights are key to making reproductive choices.

Patterns of contraceptive use and needs disaggregated by marital status, age and type of method reveal that there are sub-populations of women whose needs for family planning are not being met to the same degree as others. The needs of these groups must be addressed to advance progress towards ensuring universal access to sexual and reproductive health-care services, including for family planning, information, and education (SDG target 3.7), and to ensure that no one is left behind.

2. Globally, 966 million women of reproductive age are using some method of contraception.

Among 1.9 billion women of reproductive age (15-49 years), an estimated 874 million women use a modern contraceptive method and 92 million, a traditional contraceptive method. The number of modern contraceptive users has nearly doubled worldwide since 1990 (from 467 million). Yet, there are still 164 million women who want to delay or avoid pregnancy and are not using any contraceptive method, and thus are considered to have an unmet need for family planning.

3. Progress in meeting the global need for family planning with modern methods has continued.

The proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) is 77 per cent globally, a 10-percentage point increase since 1990 (67 per cent). This progress occurred in spite of the fact that the number of women with a need for family planning has increased from 0.7 billion in 1990 to 1.1 billion today.

4. Use of modern contraceptive methods in sub-Saharan Africa remains lower than in other regions.

In sub-Saharan Africa, the proportion of women who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) continues to be among the lowest in the world at 56 per cent. Nevertheless, it also increased faster than in any other region of the world, having more than doubled since 1990, when this proportion was only 24 per cent.

5. In sub-Saharan Africa, national experiences vary greatly in meeting the need for family planning.

Among 10 countries that witnessed the largest increase in the use of modern methods among women with need for family planning (SDG indicator 3.7.1) from 1990 to 2021, 8 are in sub-Saharan Africa, including Ethiopia, Eswatini, Guinea-Bissau, Madagascar, Malawi, Rwanda, Uganda, and Zambia. Yet, among 41 countries where still less than half of women who want to avoid pregnancy are using modern methods, 22 countries are in sub-Saharan Africa.

6. Generally, contraceptive use is highest among women in ages between 25 and 44 years.

At the global level as well as regionally, the proportion of women who want to avoid pregnancy and the proportion of women using any contraceptive method are highest among women aged 25 to 44 years and lowest among women below age 25.

7. Largest gaps in meeting the need for family planning are among young women and adolescents.

Globally, the greatest increase since 2000 in the proportion of women who have their need for family planning satisfied with modern methods is amongst those aged 15 to 24 years. It increased for adolescents (15-19 years) from 45 per cent in 2000 to 61 per cent in 2020 and for young women aged 20 to 24 from 57 per cent to 66 per cent over the same period. Despite these increases, the proportion of women who have their need for family planning satisfied with modern methods remains low compared to other ages – for women above age 30, it is more than 75 per cent.

8. Contraceptive methods used by married women differ from those used by unmarried women.

Of the 820 million users who are married or in a cohabiting union, 48 per cent use permanent or long-acting reversible contraceptives and 41 per cent use short-acting methods. By contrast, of the 146 million users who are unmarried and not in a cohabiting union, most of whom are young, only 20 per cent use permanent or long-acting methods and 69 per cent use short-acting methods.

9. Most-used contraceptive methods differ significantly between regions.

Short-acting methods are the most used methods in five of the eight regions: Australia and New Zealand, Latin America and the Caribbean, Northern Africa and Western Asia, Europe and Northern America, and sub-Saharan Africa. Permanent or long-acting reversible methods are the most-used method in Central and Southern Asia, Eastern and South-eastern Asia, and Oceania excluding Australia and New Zealand. There is no region in which traditional methods are the most commonly used.

10. Injectables play a prominent role in recent increases in the use of modern contraceptive methods.

Among 10 countries that made the greatest progress in meeting the needs for family planning with modern methods since 1990 (SDG indicator 3.7.1.), the increase was driven by use of injectables in 5 countries, by implants and male condoms in 2 countries each, and by the pill in one country.

Introduction

The Programme of Action of the International Conference on Population and Development (ICPD), adopted by 179 Governments in Cairo and reaffirmed by the 2030 Agenda for Sustainable Development, emphasizes equality in access to “reproductive health care, including family planning and sexual health that would allow all couples and individuals to have the basic right to decide freely and responsibly the number and spacing of their children”. This inherently implies that it is “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice” (United Nations, 1994). It was reaffirmed by the 2030 Agenda for Sustainable Development in target 3.7, “by 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes”. Progress towards achieving this target is monitored by indicator 3.7.1, “the proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods of contraception”. The Population Division of the United Nations Department of Economic and Social Affairs is the custodian agency for the global monitoring of this indicator.

A recent report on the topic of family planning analyzed trends in contraceptive use and their relationship to fertility trends (United Nations, 2020a). The report showed that there is generally an inverse relationship between fertility and contraceptive use within countries, but that the relationship between the two can vary depending on the mix of contraceptive methods women use, the incidence of abortion, patterns of marriage and sexual activity, as well as various economic and social influences. Another recent report reviewed the progress towards the achievement of target 3.7. with special attention to the increase in the numbers of women of reproductive age in low and lower-middle-income countries that will require expansion of sexual and reproductive health services, including family planning (United Nations, 2020b). That report showed that nearly half of the growth in the number of modern contraceptive users worldwide between 2000 and 2020 was caused by population growth in the number of women of reproductive age, while the remainder was due to increasing rates of contraceptive use. Furthermore, nearly two-thirds of the projected growth in the number of users by 2030 is expected to be the result of greater uptake of modern contraceptives and a smaller share due to population growth. This report builds on that previous work and provides a comprehensive understanding of the patterns of contraceptive use by women’s age and by the type of contraceptive method used.

The report is organized into three parts. Part one describes the trends in contraceptive use over the past three decades, including trends in SDG indicator 3.7.1. Part two discusses patterns of contraceptive use by women’s age. Part three provides trends in contraceptive use by type of method, including regional variation in the use of specific methods.



**Reproductive Health in Burkina Faso; Aminata Bangaé taking a contraceptive pill
in the CSPA Health and Social Promotion Center of Moaga**

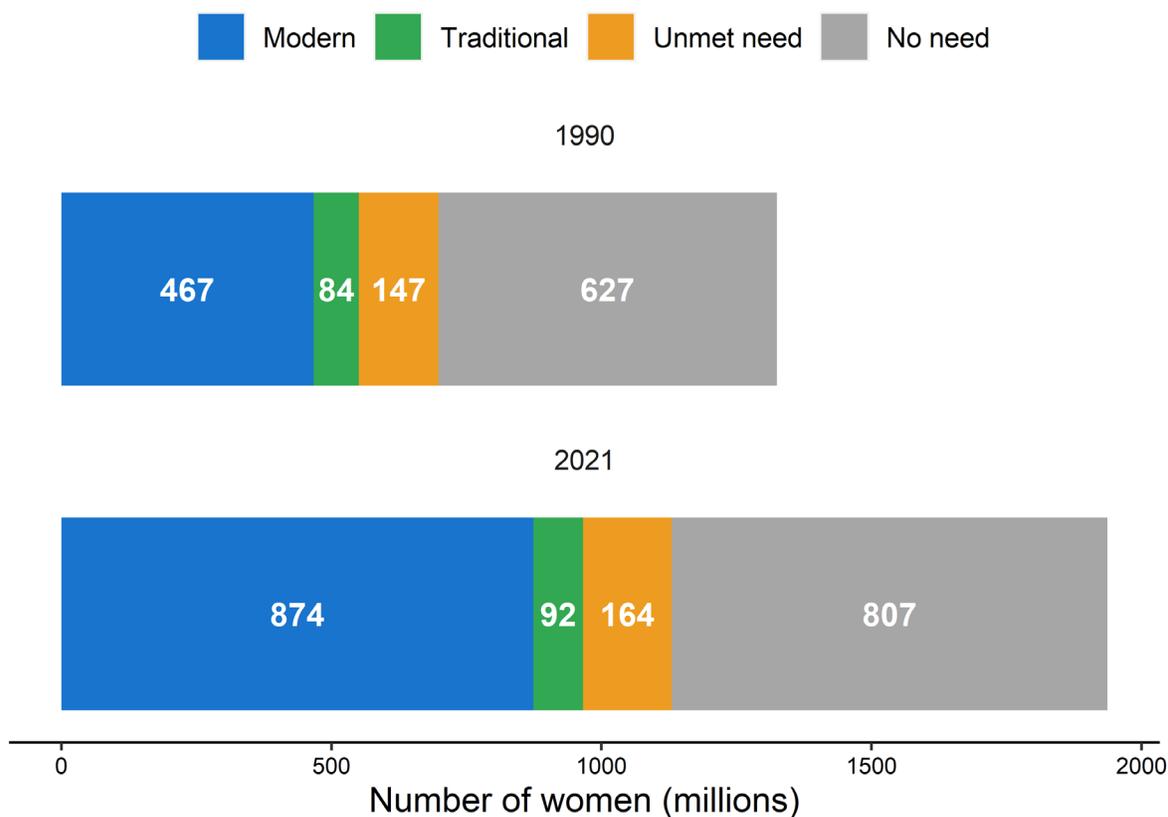
Trends in contraceptive use

More women are using effective methods of contraception

Globally, the number of women of reproductive age (aged 15-49 years) rose from 1.3 billion in 1990 to 1.9 billion in 2021, an increase of 46 per cent (United Nations, 2022a). There was an even larger increase in the number of women of reproductive age who have a need for family planning – that is, they are married or in a union, or are unmarried and sexually active, they are fecund and they intend to delay or avoid childbearing (box 1). Specifically, the number of women with a need for family planning rose from 0.7 billion in 1990 to 1.1 billion in 2021, an increase of 62 per cent (figure 1). This need is increasingly satisfied by the use of modern contraceptive methods. At the same time, total fertility declined globally from 3.3 births per woman in 1990 to 2.3 births per woman in 2021 (United Nations, 2022a). On average, women today live longer periods of their reproductive lives wanting to delay or avoid childbearing.

Figure 1

Global number of women of reproductive age (15-49 years) who use modern and traditional contraceptive methods and who have unmet need or no need for family planning, 1990 and 2021 (millions)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Use of modern contraceptive methods is one of the most effective ways to reduce the risk of unintended pregnancies, enabling women and couples to plan how many children they have and when to have them. The number of women using modern contraception nearly doubled from 467 million in 1990 to 874 million in 2021. While in 1990, 35 per cent of women used a modern method of contraception, this proportion

increased to 45 per cent in 2021. The number of women of reproductive age using traditional contraceptive methods increased from 84 million in 1990 to 92 million in 2021, even as the proportion declined from 6 to 5 per cent. Similarly, the number of women of reproductive age having an unmet need for family planning increased from 147 million in 1990 to 164 million in 2021, even though their proportion among women of reproductive age declined from 11 to 8 per cent over the same period.

Box 1

Definition of indicators and contraceptive methods

Contraceptive prevalence: Proportion of women of reproductive age (15-49 years) who are currently using or whose sexual partner is currently using at least one method of contraception.¹ Generally, in surveys, if a woman reports using more than one method, only the most effective method is used to calculate contraceptive prevalence; therefore, the overall use of methods frequently used in combination with another method (such as the male condom, rhythm or withdrawal) might be underestimated.

For analytical purposes, contraceptive methods are often classified as either modern or traditional. In this report, modern methods of contraception include female and male sterilization, intra-uterine devices (IUD), implants, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method (LAM), emergency contraception and other modern methods. Traditional methods of contraception include rhythm (e.g., fertility awareness-based methods, periodic abstinence), withdrawal and other traditional methods.

The married category pertains to women who are married (defined in relation to the marriage laws or customs of a country) and to women in a union (referring to women living with their partner in the same household, i.e., cohabiting unions, consensual unions, unmarried unions, or “living together”). The unmarried category pertains to women who are not married and not in a union.

Unmet need for family planning: The percentage of women who are fecund and sexually active, who wish to stop or delay childbearing, but who are not using any form of contraception. A woman is also considered to have an unmet need if she was pregnant at the time of data collection, but reported that the pregnancy was unwanted or mistimed, or if a woman was postpartum amenorrhoeic, not using family planning and her most recent birth was unwanted or mistimed (Bradley and others, 2012; United Nations, 2022b). This indicator measures, at the population level, the gap between women’s reproductive intentions and their contraceptive behaviour.

Demand for family planning satisfied with modern methods: The proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1) is calculated as follows: the number of women who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method, as a proportion of the number of women of reproductive age who express a demand for family planning either by using any method of contraception or by having an unmet need for family planning as defined above. It is one of two indicators used for the global monitoring of progress towards ensuring, by 2030, universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (SDG target 3.7).

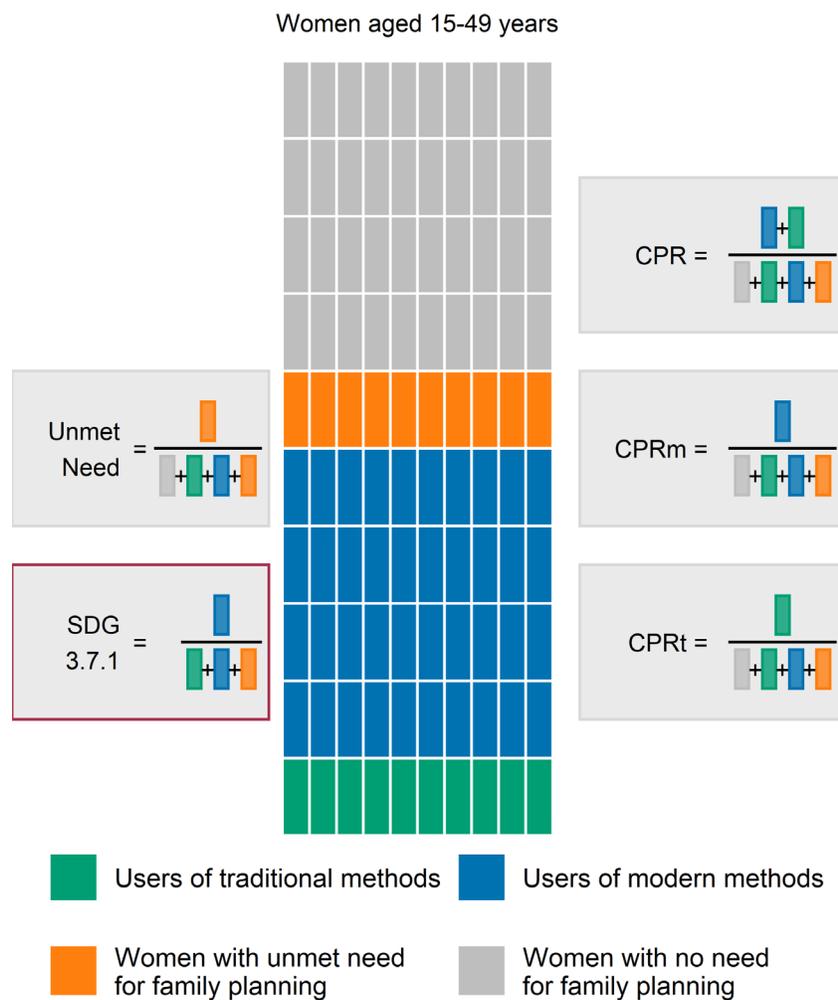
¹A detailed explanation of contraceptive methods is provided in World Health Organization and Johns Hopkins Bloomberg School of Public Health, 2022.

Box continued

Figure I provides a stylised representation of the key indicators. The population of women of reproductive age may be considered as belonging to one of four categories: users of modern contraceptive methods (blue), users of traditional contraceptive methods (green), women with an unmet need for family planning (orange) and women with no need for family planning (grey).² Each rectangle represents 1 per cent of the women of reproductive age. As indicated in the figure, contraceptive prevalence (total, modern or traditional) and unmet need for family planning are expressed as a proportion of all women of reproductive age. The sum of all contraceptive users and women with an unmet need for family planning represents the total demand for family planning – the population of women of reproductive age wanting to avoid pregnancy. The ratio of modern contraceptive users to the total demand for family planning is the SDG indicator 3.7.1 – the proportion of the demand for family planning satisfied with modern methods.

Figure I

Stylised representation of population of women of reproductive age according to contraceptive use and needs



² This color code will be used to represent these indicators throughout the text.

In 41 countries, fewer than half of all women of reproductive age who want to avoid pregnancy use modern methods of contraception

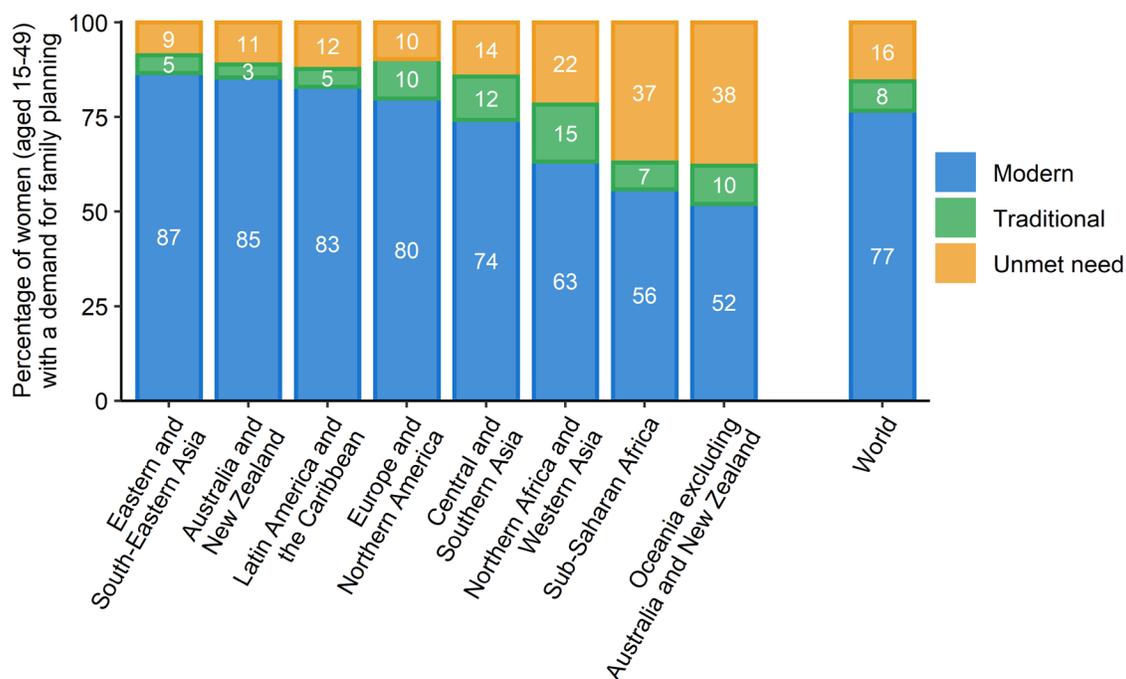
Globally, among women who want to avoid pregnancy, 77 per cent used modern contraceptive methods in 2021 (figure 2). Regions with the highest proportions of modern contraceptive use among women who want to avoid pregnancy are Eastern and South-Eastern Asia (87 per cent), Australia and New Zealand (85 per cent), Latin America and the Caribbean (83 per cent), and Europe and Northern America (80 per cent). In these regions, among women who want to avoid pregnancy, the proportion of women using no contraceptive method ranges from 9 per cent to 12 per cent, and the proportion of women using traditional methods ranges from 3 per cent to 10 per cent. The relatively higher use of traditional methods in Europe and Northern America (10 per cent) compared to the other three regions is due to a higher proportion of women relying on traditional contraceptive methods in some countries of Southern and Eastern Europe.

The countries with the highest proportion (greater than 80 per cent) of demand for family planning satisfied by modern methods are in Australia and New Zealand, Eastern and South-Eastern Asia, Europe and Northern America, and Latin America and the Caribbean (figure 3).

Regions with the lowest proportion of use of modern methods among women who want to avoid pregnancy include sub-Saharan Africa (56 per cent) and Oceania excluding Australia and New Zealand (52 per cent). Compared to other regions, larger proportions of women who want to avoid pregnancy do not use any method (37 per cent and 38 per cent respectively). In Northern Africa and Western Asia and in Central and Southern Asia, among women who want to avoid pregnancy, a higher share use traditional methods (15 per cent and 12 per cent, respectively) compared to other regions.

Figure 2

Contraceptive use (modern and traditional) and unmet need for family planning among women with a need for family planning, world and by region, 2021 (percentage)



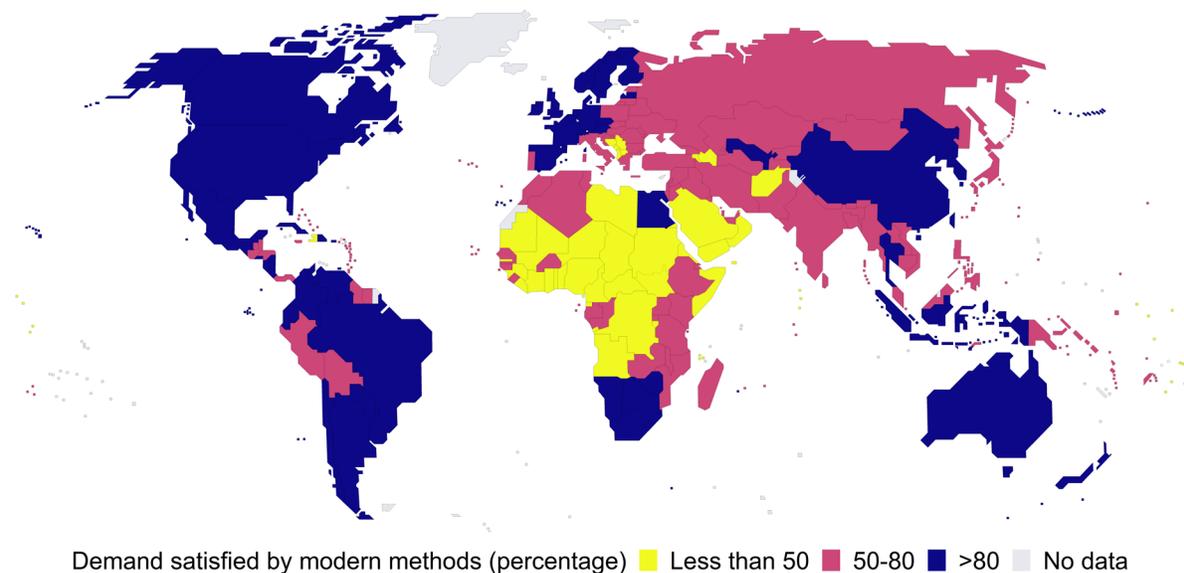
Source: United Nations, Department of Economic and Social Affairs, Population Division. (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Note: Numbers may not add up to 100 due to rounding.

Among the 41 countries where fewer than half of the women with a need for family planning have that need satisfied with modern methods (figure 3), 22 countries are in sub-Saharan Africa. Of the 19 remaining countries, 7 are in Northern Africa and Western Asia, 5 are in Europe and Northern America, 4 are in Oceania excluding Australia and New Zealand, 2 are in Central and Southern Asia, and 1 is in Latin America and the Caribbean.

Figure 3

Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern contraceptive methods (SDG indicator 3.7.1), 2021



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Note: The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined. A dispute exists between the Governments of Argentina and the United Kingdom of Great Britain and Northern Ireland concerning sovereignty over the Falkland Islands (Malvinas).

Box 2

Data and methods

World Family Planning 2022 presents estimates of family planning indicators among women of reproductive age (15-49 years), disaggregated by 5-year age groups (from 15-19 to 45-49), marital status and method of contraceptive use.

The estimates are based on the *World Contraceptive Use 2022* data compilation (United Nations, 2022b), which includes 1,404 nationally representative survey-based observations from 197 countries or areas for the period from 1950 to 2021. Comparable survey-based estimates are not available for all years and all countries or areas. Therefore, model-based estimates and projections of the family planning indicators are calculated for all years from 1990 to 2030 (United Nations, 2022c) using a hierarchical Bayesian model (Alkema and others, 2013; Kantorová and others, 2020). Estimates are calculated for all women of reproductive age and disaggregated by 5-year reproductive age groups and by marital status. Regional and global estimates are calculated as weighted averages where the weights are the population of women of reproductive age derived from *World Population Prospects 2022* (United Nations, 2022a). Estimates of the proportion of women who are married or in a union by 5-year age groups are derived from *Estimates and Projections of Women of Reproductive Age Who Are Married or in a Union 2022* (United Nations, 2022d). Detailed data are available online on the United Nations Population Division Data Portal (<https://population.un.org/dataportal/home>).

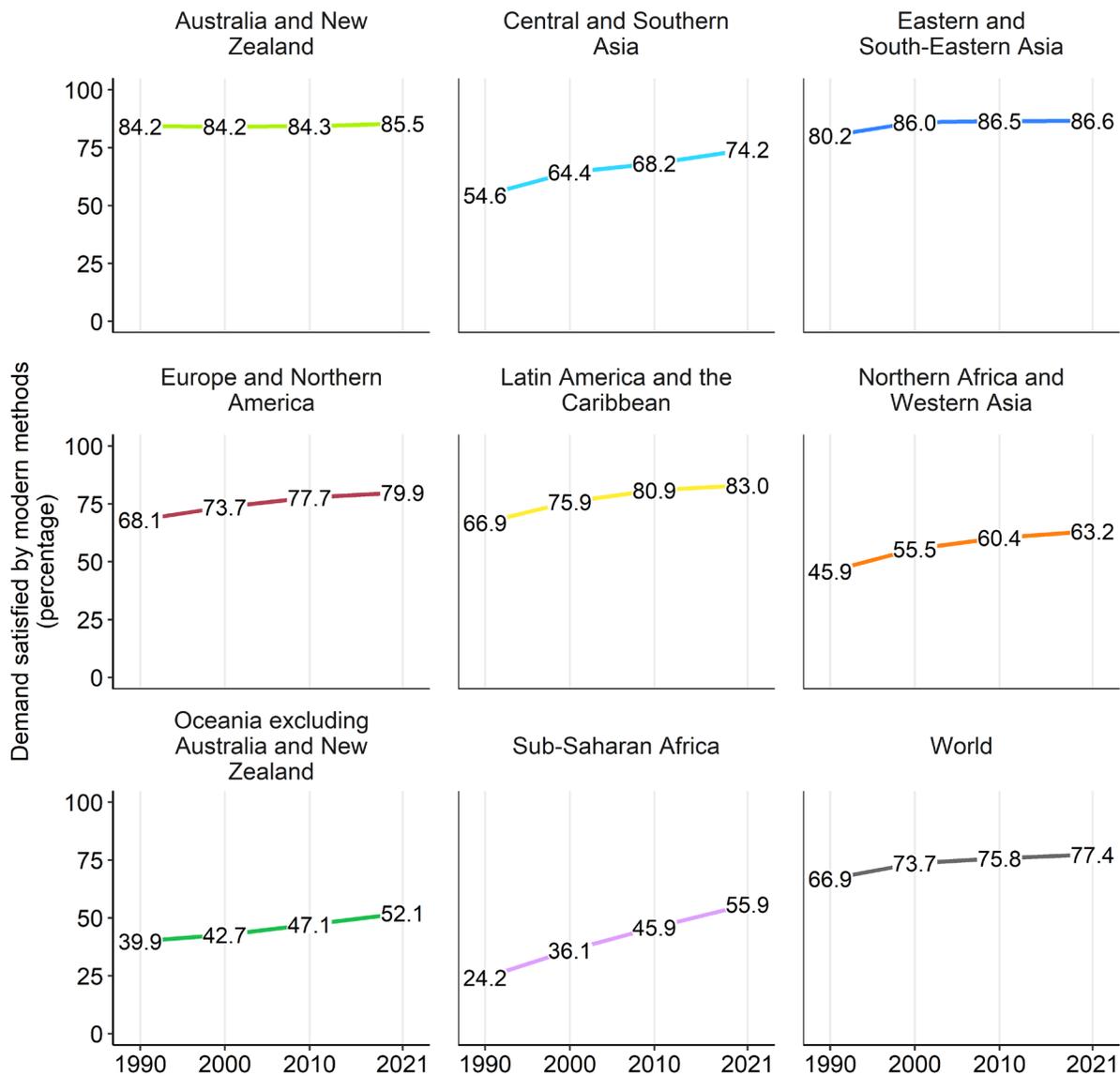
Method-specific estimates are based on the survey estimates compiled in *World Contraceptive Use 2022* and additional tabulations are derived from microdata sets and survey reports. For each of the 197 countries, 2 survey observations are used: a) one closest to the year 1995 for the period 1990 to 1999; and b) one closest to the year 2020 since the year 2010. The distribution of contraceptive methods among all users observed in surveys is applied to the model-based estimates of modern and traditional contraceptive prevalence for the years 1995 and 2020 to estimate the prevalence of individual contraceptive methods among women of reproductive age (15-49 years) by marital status. Combining the survey-based estimates of method-specific use and the model-based estimates of contraceptive prevalence and the number of users allows for calculating method-specific use at the regional and global levels.

Use of modern contraception among women who want to avoid pregnancy has increased in all regions

In all regions, women who want to avoid pregnancy have increasingly used modern contraceptive methods (figure 4). Sub-Saharan Africa experienced the largest increase in the percentage of demand for family planning satisfied by modern methods, which rose from 24 per cent in 1990 to 56 per cent in 2021. In two regions with similar levels in 2021 – Oceania excluding Australia and New Zealand (52 per cent) and Northern Africa and Western Asia (63 per cent) – the indicator changed little since 1990. Latin America and the Caribbean, with an increase from 67 per cent to 83 per cent over the same period, is now amongst the regions with the highest use of modern methods among women who want to avoid pregnancy. A similar increase occurred in Central and Southern Asia, where the indicator rose from 55 per cent in 1990 to 74 per cent in 2021. An increase from 68 per cent to 80 per cent in Europe and Northern America over the same period was due mainly to a shift from traditional to modern methods of contraception in Eastern Europe. For the two regions that relied the most on modern contraception in 1990, the indicator also continued to increase: from 80 per cent to 87 per cent in Eastern and South-Eastern Asia, and from 84 per cent to 86 per cent in Australia and New Zealand.

Figure 4

Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern contraceptive methods (SDG indicator 3.7.1), world and by region, 1990-2021



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

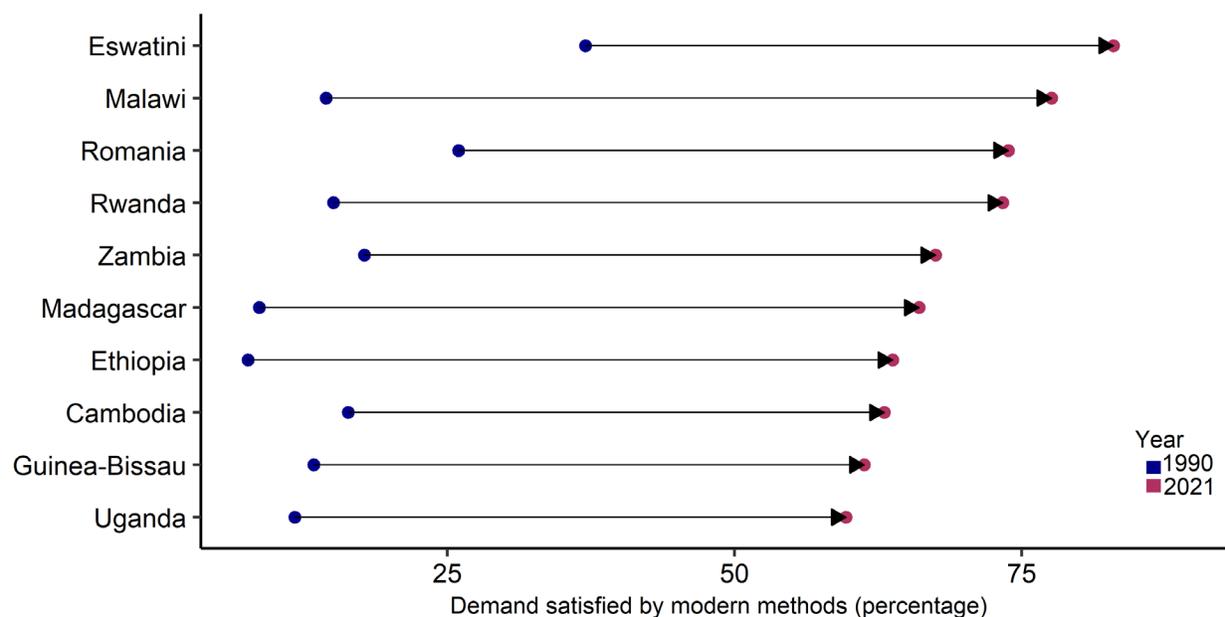
Some countries with previously large gaps in meeting the need for family planning experienced rapid gains while others are lagging behind. Between 1990 and 2021, among the 10 countries that experienced the greatest increase in the proportion of women who have a need of family planning satisfied with modern methods (indicator SDG 3.7.1), 8 were in sub-Saharan Africa (figure 5), including Ethiopia, Eswatini, Guinea-Bissau, Madagascar, Malawi, Rwanda, Uganda and Zambia.

How these countries increased the proportion of demand for family planning satisfied by modern methods varies based on local contexts. In Romania, for instance, modern contraception and family planning programmes were largely prohibited by the socialist government until 1990. Induced abortion (although illegal) and traditional contraceptive methods were the only possibilities to control family size. It was

only after the transition from socialism that the country allowed the establishment of family planning programmes, leading to a rapid increase in the use of modern methods, particularly condoms and the pill (Mureşan and others, 2008). In the eight sub-Saharan countries that witnessed the greatest progress in demand for family planning satisfied by modern methods, governments made strong commitments to include family planning as a component of their development agendas, particularly after 2000. In practice, these commitments led to the integration of family planning into local health systems, reaching rural and other hard-to-reach populations, reducing barriers to young people and expanding contraceptive method mixes, among others (Bongaarts and Hardee, 2019; United Nations, 2020b).

Figure 5

Ten countries with greatest increase in the proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (SDG 3.7.1) from 1990 to 2021 (percentage)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Note: Countries are ordered by value of the indicator in 2021.

It is important to note that even in countries in which the demand for family planning satisfied by modern methods increased more slowly, there were significant increases in the numbers of users over time. In Nigeria, for example, only 40 per cent of the demand for family planning is satisfied by modern methods. Yet since 1990, the number of women using a modern method increased nearly eightfold from 0.8 million to over six million by 2021.

Box 3

The impact of the COVID-19 pandemic on contraceptive use

The impact of the coronavirus disease (COVID-19) pandemic on the availability and use of family planning services and contraception have been varied. Even in cases of severe disruptions to the availability of services and technologies, the effects of the pandemic on the availability of family planning services were generally short-lived (Fuseini and others, 2022; Karp and others, 2021; Wood and others, 2021).

A recent review of studies examining the impact of the COVID-19 pandemic on access to and utilisation of services for sexual and reproductive health (VanBenschoten and others, 2022) shows that there was reduced availability of and access to contraceptive services (especially long-acting reversible contraceptives), safe abortion services, in-person services for survivors of gender-based violence and intimate partner violence, and testing for HIV and sexually transmitted infections. These effects were borne disproportionately by women and girls and may have curtailed progress towards the achievement of certain SDGs.

The pandemic's adverse effects on family planning services have been most severe in low- and middle-income countries and among those who are most vulnerable. In low- and middle-income countries, pandemic-related disruptions often led to increases in the demand for family planning services, reductions in the provision of services and greater barriers to accessing these services, even though its effects varied considerably based on the national context, the health service provided, and the population in question (Polis and others, 2022). While disruptions in family planning services in high-income countries were not as widespread, research has shown that low-income families in such countries have been disproportionately affected by pandemic-related restrictions on reproductive health care and access to contraception and abortion (Bailey and others, 2022).

Although the impact of the COVID-19 pandemic on family planning services has been more modest than initially predicted, the disruptions that did occur could have life-long consequences for the affected individuals. Additional research will be needed to fully understand the pandemic's impact on the demand for, provision of and access to sexual and reproductive health-care services as well as the long-term consequences for those who were unable to obtain needed services.

Use of effective methods of contraception reduces risks of unintended pregnancy

Between 2015 and 2019, there were 121 million unintended pregnancies annually worldwide – 48 per cent of all pregnancies. Despite decreases in the rate of unintended pregnancy in all regions over the past three decades, nearly one in 10 women in sub-Saharan Africa, Western Asia and Northern Africa, and Oceania (excluding Australia and New Zealand) continue to experience an unintended pregnancy every year (Bearak and others, 2020). Unintended pregnancy can have significant adverse impacts on the lives of women, children and families in both the short and long term, including worse socioeconomic outcomes, poor health outcomes and complications from unsafe abortions, among others (Gipson, Koenig and Hindin, 2008; Foster and others, 2019; UNFPA, 2022). Globally, of all unintended pregnancies, 61 per cent end in abortion, that is, 73 million abortions annually. Abortion rates are similar in countries where the procedure is broadly legal (i.e., where it is available on request or on socioeconomic grounds) and those where abortion is restricted – at around 40 abortions per 1,000 women of reproductive age (Bearak and others, 2020). In the latter context, however, most abortions are unsafe, leading to increased risks of health complications and even death. Unsafe abortions cause around 39,000 deaths every year and result in millions more women hospitalized with complications; most of these deaths are concentrated in lower-income countries (World Health Organization, 2022).

A woman may experience an unintended pregnancy as a consequence of not using a contraceptive method despite wanting to avoid pregnancy or as a result of the inefficacy of a contraceptive method being used. There are various reasons why women may not be using contraception even when they do not want to become pregnant, including ambiguous attitudes towards pregnancy, inconsistent method use, switching between methods, or a recent discontinuation of a method due to health or other concerns. Unintended pregnancy may also be caused by contraceptive failure, the risk of which varies widely across methods. The influence of method-specific differences in failure rates on the risk of unintended pregnancy is evident in low- and middle-income countries, where it was found that the risk of unintended pregnancy is nearly three times higher for women who rely on traditional contraceptive methods when compared to those who use a modern method (Bellizzi and others, 2015). Although a majority of unintended births occur when a woman is not using and has not recently used a contraceptive method, a recent study of 36 low- and middle-income countries found that more than 4 out of 10 unintended pregnancies occurred either following the discontinuation of a method or due to a failure of a method (Bellizzi and others, 2020).

Modern contraceptive methods, particularly long-acting reversible methods such as IUDs and implants, are significantly less likely to fail than other methods (Bradley and others, 2019; Polis and others, 2016; Hatcher, 2011). Furthermore, long-acting reversible methods tend to have substantially lower discontinuation rates than short-acting methods in a wide range of contexts (Bradley, Schwandt and Khan, 2009; Barden-O'Fallon and others, 2018; Moreau and others, 2009; Ontiri and others, 2020).

It should be recognized, however, that women and their partners have diverse preferences for and experiences using specific methods and that any method may not be satisfactory for all, even if they are highly effective at reducing the risk of unintended pregnancy. For instance, side effects and health concerns are the most frequently cited reasons given by women who discontinue using or opt not to use hormonal contraception, including long-acting methods (Staveteig, Mallick and Winter, 2015). It is therefore critical to implement policies allowing women and couples to make informed choices about family planning, taking into account their personal circumstances and preferences as well as the potential benefits and risks associated with using or not using specific methods. Improving access to contraceptive methods and information can play a significant role in reducing the risk of unintended pregnancies, averting adverse impacts on the lives of women and families in both the short and long term, including worse socioeconomic outcomes, poor health outcomes and complications from unsafe abortions.

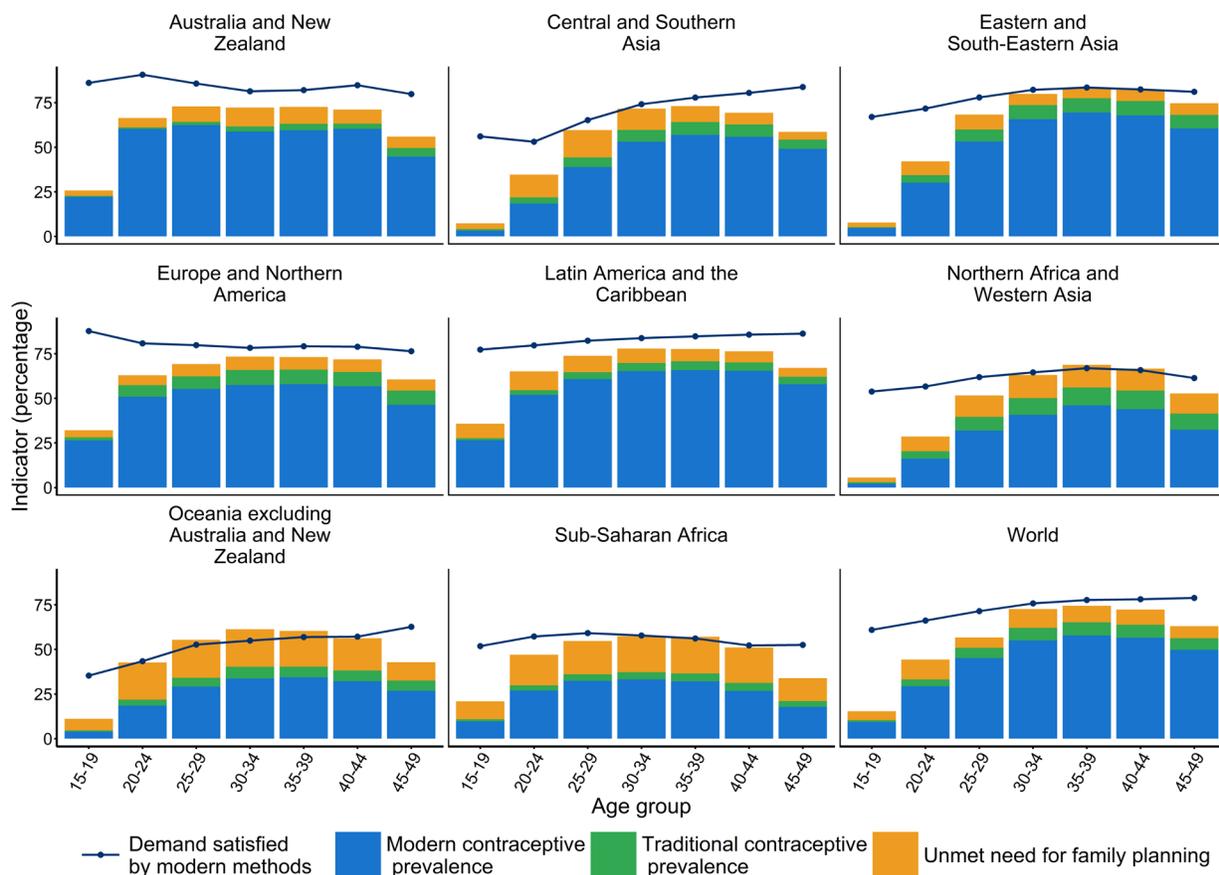
Contraceptive use by women's age

Generally, contraceptive use is highest among women in ages between 25 and 44 years

At the global level, as well as across all regions, the proportion of women who want to avoid pregnancy and the proportion of women using any contraceptive method are highest among women aged 25 to 44 (figure 6). The majority of women at these ages are sexually active, married or in a cohabiting union and in the process of planning or realizing their fertility intentions of how many children to have and when to have them. Australia and New Zealand, Latin America and the Caribbean, Eastern and South-Eastern Asia, and Europe and Northern America stand out as the regions where high proportions of women aged 25 to 44 use any method of contraception. In the latter two regions, the use of traditional methods is higher compared to other regions.

Figure 6

Global and regional estimates of contraceptive prevalence, unmet need for family planning, and the proportion of women of reproductive age who have their need for family planning satisfied with modern methods (SDG 3.7.1), by 5-year age groups, world and by region, 2021



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

In Oceania excluding Australia and New Zealand and in sub-Saharan Africa, the proportion of women using modern contraceptive methods is low in all age groups. High levels of unmet need for family planning -exceeding 20 per cent of women in some age groups- indicate large gaps in meeting needs for family planning for women of all ages.

Adolescents and young women generally have the lowest proportion of modern contraceptive use. In all regions, less than 30 per cent of adolescents and young women aged 15-19 years use contraception. Compared to other regions, contraceptive use is highest among adolescents in Australia and New Zealand, and Europe and Northern America. The vast majority of these young contraceptive users are not married nor in a cohabiting union. In these regions, less than 5 per cent of women aged 15 to 19 are married or in a union (United Nations, 2022d). In contrast, the proportion using any contraceptive method among 15 to 19 years old is less than 5 per cent in Northern Africa and Western Asia and in Central and Southern Asia. Sexual activity in these regions is mostly limited to those who are married. Once married, childbearing soon follows. In Central and Southern Asia, unmet need for family planning is highest among women aged 20 to 29, indicating a large gap between fertility intentions and use of modern methods of contraception among young women.

Young women and adolescents experience the largest gaps between needs for family planning and modern contraceptive use

The proportion of women who have their need for family planning satisfied with modern methods (SDG 3.7.1) indicates potential inequalities in access to and use of modern contraception by women's age.

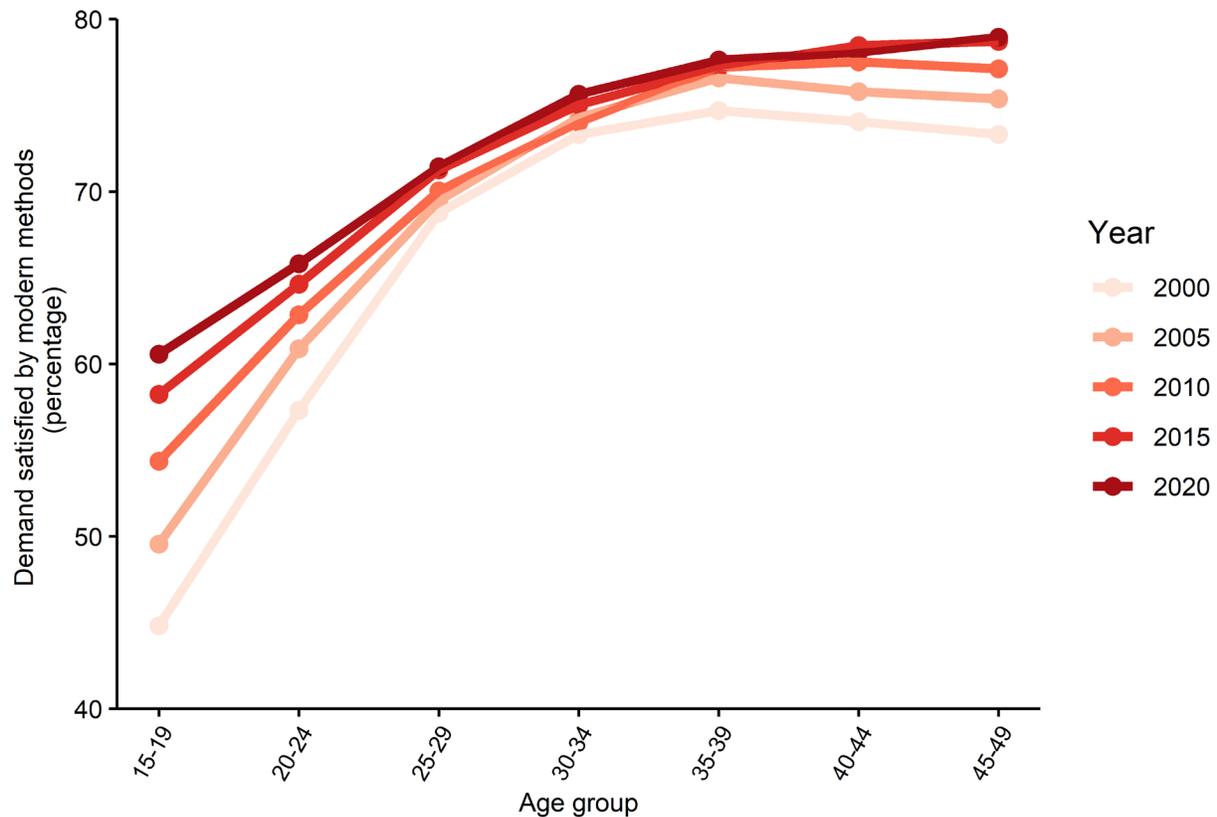
In some regions, the differences across age groups in meeting the needs for family planning are small. In Latin America and the Caribbean, Australia and New Zealand, and Europe and Northern America the proportion of women who have their need for family planning satisfied with modern methods is similar across all ages at more than 75 per cent. In sub-Saharan Africa, another region with relatively small differences in the need for family planning satisfied with modern methods, the indicator is less than 58 per cent in all ages (with just 41 per cent among adolescents), indicating large gaps in meeting needs for family planning across all ages.

Other regions have more pronounced age-specific patterns, with particularly low proportions of women who have their need for family planning satisfied with modern methods among adolescents and young women. In Central and Southern Asia, only half of the women below age 25 have their need for family planning satisfied with modern methods, while it is above 80 per cent among women in ages above 40. This pattern is connected to the high share of female sterilisation among contraceptive methods used in the region, particularly in India.

Progress in meeting the needs for family planning with modern methods from 2000 to 2020 was most remarkable among women aged 15 to 24 years. Globally, it increased for adolescents aged 15 to 19 from 45 per cent in 2000 to 61 per cent in 2020 and for women aged 20 to 24 from 57 per cent to 66 per cent over the same period (figure 7). Despite this progress, the proportion of young women and adolescents who have their need for family planning satisfied with modern methods remains lower compared to other ages. In comparison, for women above age 30, it is more than 75 per cent.

Figure 7

Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (SDG 3.7.1), by 5-year age groups, world, 2000 to 2020



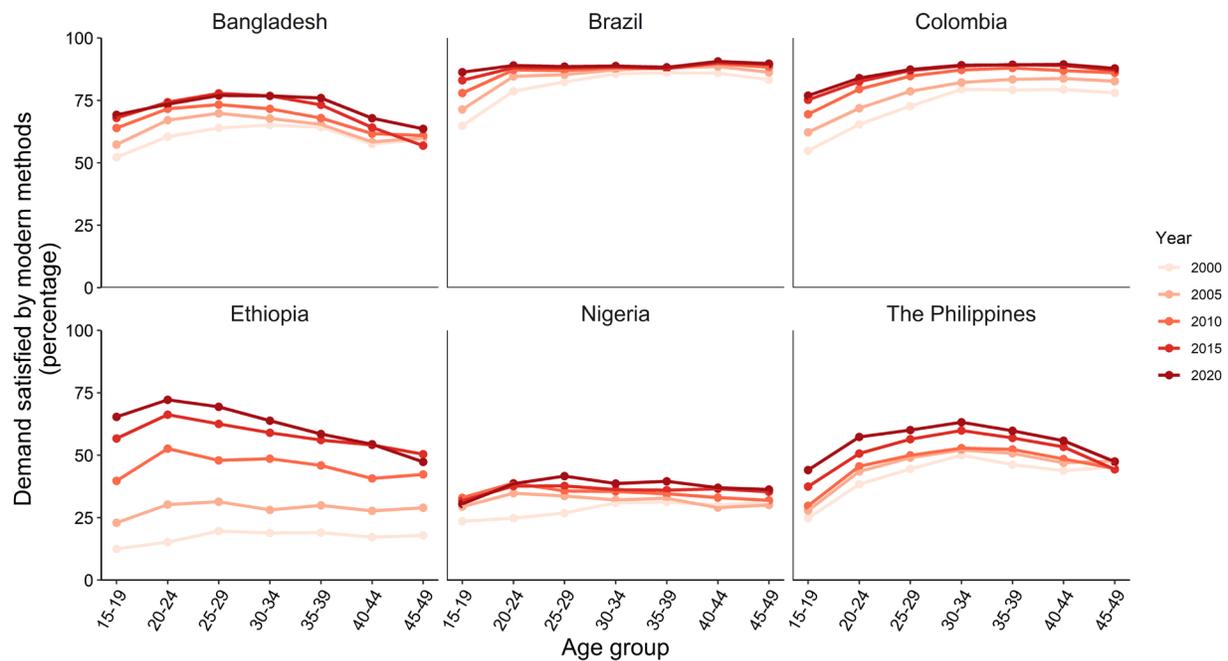
Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Age-specific progress in demand satisfied with modern methods has been uneven across countries

The age pattern of the proportion of demand for family planning satisfied with modern methods developed in diverse ways across countries and over time. A mix of countries was selected based on geographical diversity and distinct patterns of change over time to depict cross-national differences (figure 8). From 2000 to 2020, the increase in the proportion of need for family planning satisfied with modern methods in all of the selected countries was most notable among women aged 15 to 24. In countries like Brazil and Colombia, the larger increase in meeting needs for family planning with modern methods among adolescents and young women since 2000 reduced differences across all ages. Ethiopia and Nigeria both had low modern contraceptive use in 2000. While in Ethiopia the use of modern contraception among women who want to avoid pregnancy increased in all age groups, in Nigeria the progress was slow in all age groups. Bangladesh and the Philippines experienced moderate growth in demand for family planning satisfied with modern methods at all ages in the given period since 2000. Nevertheless, the youngest and oldest age groups have larger gaps in meeting needs for family planning with modern methods compared to other ages.

Figure 8

Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (SDG 3.7.1) by 5-year age group, selected countries, 2000 to 2020



Source: United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

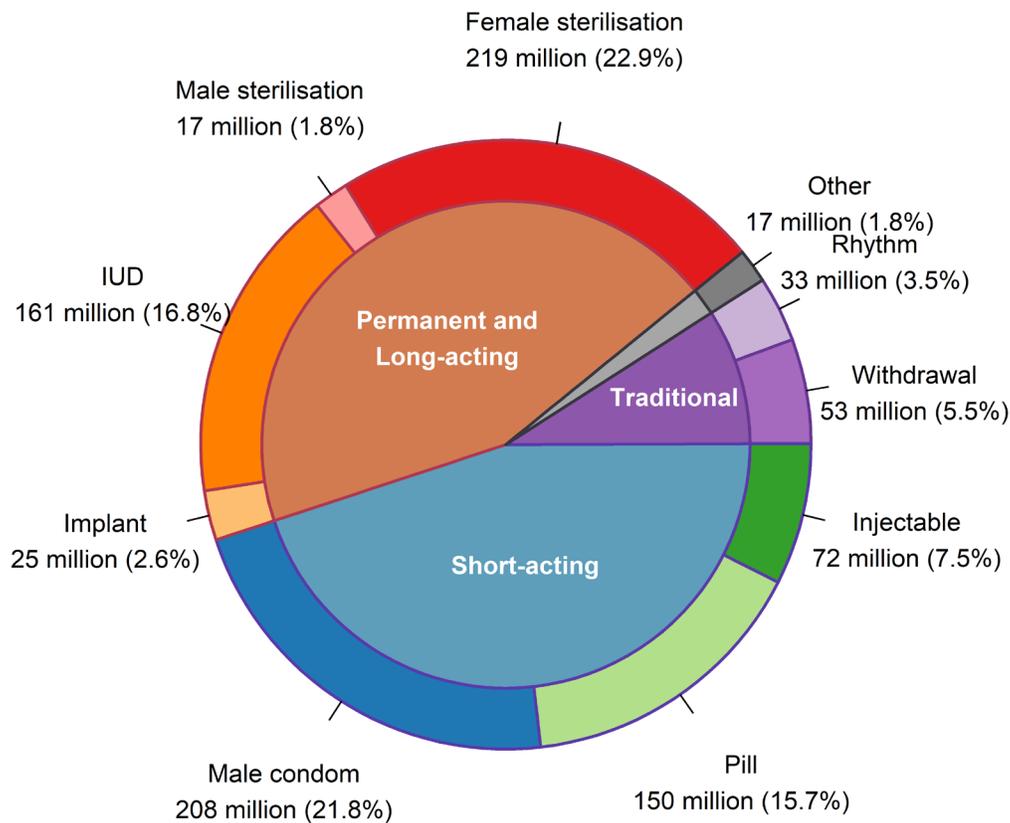
Contraceptive use by method

Female sterilisation and male condoms are the most commonly used methods worldwide

Forty-six percent of the 966 million women of reproductive age who use any method of contraception are using short-acting methods (male condoms, the pill, injectables and other modern methods). With nearly equal share, permanent and long-acting reversible methods (female and male sterilisation, IUDs, implants) represent 44 per cent. Traditional methods (withdrawal, rhythm and other traditional methods) account for a smaller share of use (less than 10 per cent) (figure 9).

Figure 9

Number of women of reproductive age (15-49 years) using various contraceptive methods, world, 2020 (millions and percentage)



Sources: Calculations based on United Nations, Department of Economic and Social Affairs, Population Division (2022). *World Contraceptive Use 2022*; United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Note: Other methods include female condoms, vaginal barrier methods (including diaphragms, cervical caps, and spermicidal foams, jellies, creams and sponges), lactational amenorrhoea method (LAM), emergency contraception, and other modern or traditional methods not presented separately.

Female sterilisation is the most commonly used contraceptive method globally (23 per cent of contraceptive users), followed by male condoms (22 per cent). Each of these methods has more than 200 million users – 219 million for female sterilisation and 208 million for male condoms. The high share of use of female sterilisation globally is largely due to its extensive use in India, which accounts for 48 per cent of the global number of women who use female sterilisation. Female sterilisation would be the fourth most used method and only account for 15 per cent of total use worldwide if India were not included in the calculation. Two other methods have more than 100 million users worldwide, namely IUDs (161 million) and the pill (150 million). Other modern methods have fewer users globally – injectables (72 million), implants (25 million) and male sterilisation (17 million). Among traditional methods, 33 million women rely on rhythm and 53 million on withdrawal.

Box 4

Contraceptive use as a means to fulfilling fertility intentions

Fertility intentions regarding how many children to have and when to have them influence one's decision to use contraception as well as the type of contraception. Intentions to not have any children, delay a first birth, postpone a subsequent birth or stop having children altogether can also influence one's choice of contraceptive method. Among women wanting to delay a first birth or subsequent birth, short-acting methods, such as the pill and injectable, are commonly used as they can be quickly discontinued when women decide they would like to have a child (Pasha and others, 2015; Sedekia and others, 2017). Postpartum women have the option to adopt the lactational amenorrhea method for a period of up to six months following the birth of a child, the effectiveness of which depends on following a strict protocol requiring, among other things, exclusive breastfeeding. Women intending to stop childbearing, on the other hand, are more likely to adopt permanent and long-acting methods, such as IUDs and sterilisation. Yet, the extent to which permanent methods are used by women in this situation varies widely across countries and regions (Olakunde and others, 2020) and in some settings, short-acting methods are used widely by women wishing to limit childbearing (Van Lith, Yahner and Bakamjian, 2013).

In some countries, preference for a son or a daughter may influence the type of contraceptive method used. Research on the contraceptive behaviour of women in societies where many couples prefer having sons over daughters has shown that – compared to women who have at least one son – those who have no son are more likely to use traditional or modern reversible methods of contraception in order to preserve their fecundity to allow them to have a son in the future (Ghosh and Chattopadhyay, 2017; Akhtar and Haque, 2014). After reaching a desired number of sons, women in these societies are substantially more likely to adopt a permanent method of contraception (Channon, 2015; Jayaraman and others, 2009).

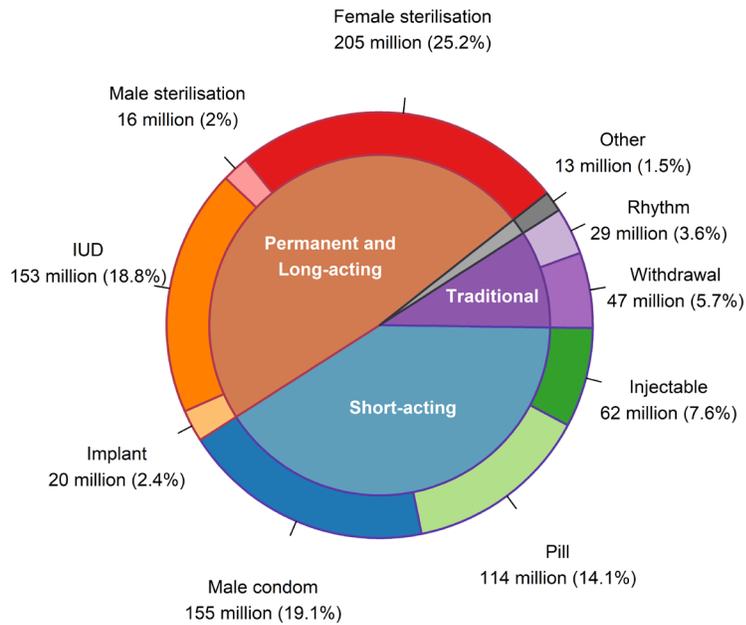
The most common methods used by married women are different from those used by unmarried women

Among the 820 million married women of reproductive age who used any contraception in 2020, nearly half used permanent and long-acting methods (48 per cent), including female sterilisation (25 per cent) and IUDs (19 per cent) (figure 10). Among the 146 million contraceptive users who are unmarried and not in a cohabiting union, and most of whom are young, more than two-thirds use short-acting contraceptives (69 per cent), including male condoms (37 per cent) and the pill (25 per cent). Only, 20 per cent of unmarried users rely on permanent and long-acting methods, and those users are mostly formerly married women.

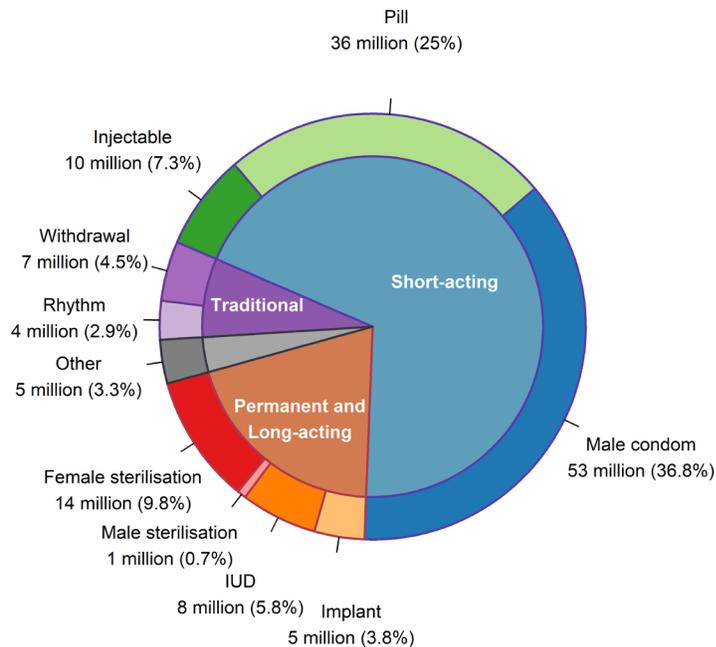
Figure 10

Number of women of reproductive age (15-49 years) using various contraceptive methods, by marital status, world, 2020 (millions and percentage)

Married women
(820 million users)



Unmarried women
(146 million users)



Sources: Calculations based on United Nations, Department of Economic and Social Affairs, Population Division. (2022). *World Contraceptive Use 2022*. Additional tabulations derived from microdata sets and survey reports and estimates of contraceptive prevalence for 2022 from *Estimates and Projections of Family Planning Indicators 2022*.

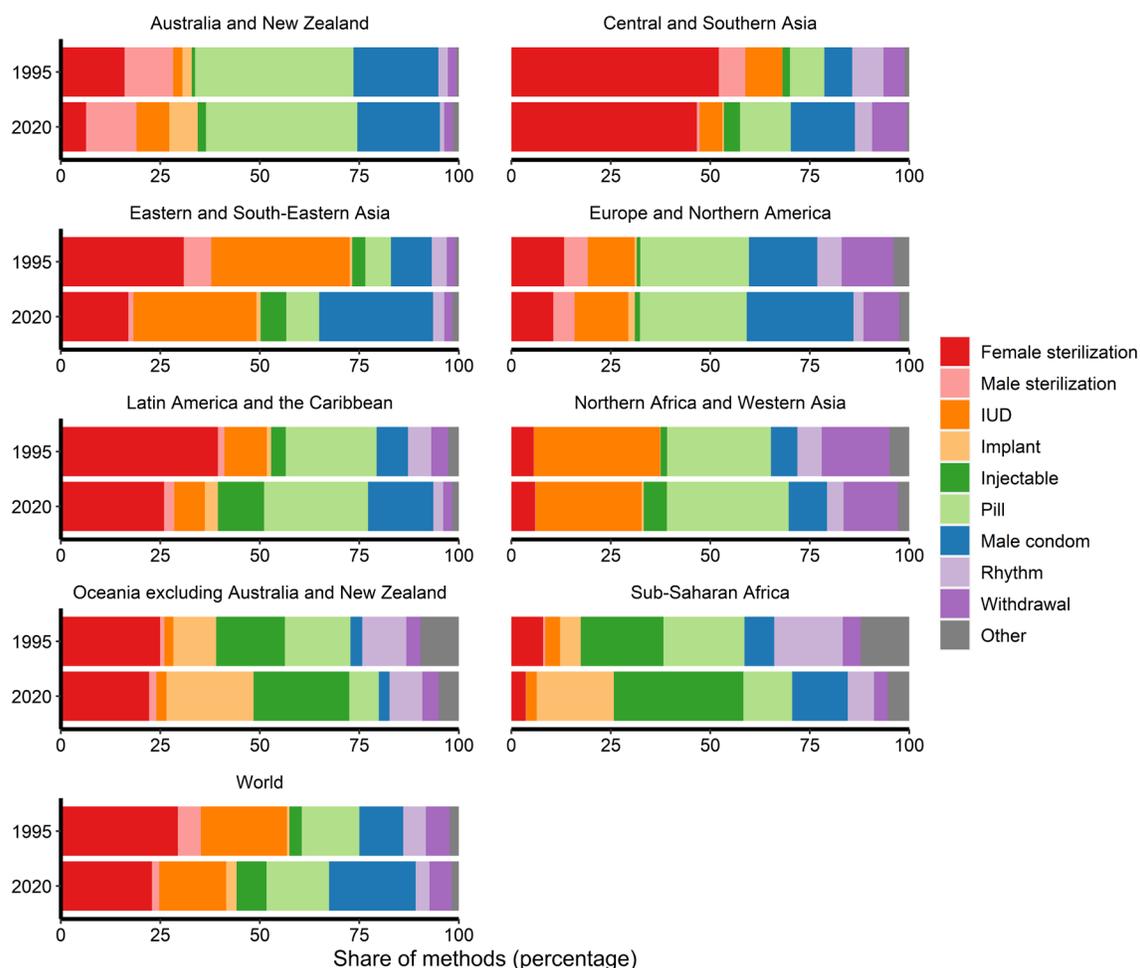
Note: Other methods include modern methods such as female condoms, vaginal barrier methods (including diaphragms, cervical caps and spermicidal foams, jellies, creams and sponges), the lactational amenorrhoea method (LAM), emergency contraception and other modern and traditional methods not presented separately.

Most-used contraceptive methods vary by region

Use of modern contraception exceeds use of traditional methods in all regions of the world (figure 11). Short-acting methods are more commonly used than permanent and long-acting methods in five regions, including sub-Saharan Africa (63 per cent), Australia and New Zealand (61 per cent), Europe and Northern America (57 per cent), Latin America and the Caribbean (55 per cent) and Northern Africa and Western Asia (47 per cent). Within these regions there is some diversity in the type of short-acting method used. The pill is the most widely used method in Australia and New Zealand (38 per cent), Northern Africa and Western Asia (31 per cent) and Latin America and the Caribbean (26 per cent). The pill and male condoms make up approximately 27 per cent of use in Europe and Northern America. Sub-Saharan Africa is the only region in which injectables are the dominant method, accounting for 33 per cent of contraceptive use.

Figure 11

Contraceptive methods used among women of reproductive age (15-49 years), world and by region, 1995 and 2020 (percentage)



Sources: Calculations based on United Nations, Department of Economic and Social Affairs, Population Division (2022). *World Contraceptive Use 2022*; United Nations, Department of Economic and Social Affairs, Population Division (2022). *Estimates and Projections of Family Planning Indicators 2022*.

Note: Other methods include modern methods such as female condoms, vaginal barrier methods (including diaphragms, cervical caps and spermicidal foams, jellies, creams, and sponges), lactational amenorrhoea method (LAM), emergency contraception and other modern and traditional methods not presented separately.

Female sterilisation as a share of total contraceptive decreased in all regions. Between 1995 and 2020, it declined the most in Eastern and South-Eastern Asia (from 31 per cent in 1995 to 17 per cent in 2020), Latin America and the Caribbean (from 39 per cent in 1995 to 26 per cent in 2020), and Australia and New Zealand (from 16 per cent in 1995 to 6 per cent in 2020). In Central and Southern Asia –the region where female sterilisation is used the most among all regions– the decline in the share of female sterilisation was limited, from 52 per cent in 1995 to 47 per cent in 2020. Globally, the share of female sterilisation declined from 29 per cent in 1995 to 23 per cent in 2020. Due to differences in the rates of decline in the use of female sterilisation across regions, Central and Southern Asia had a growing share of the world's women who were sterilised, which led to only a modest reduction in the use of female sterilisation at the global level.

Other methods that declined globally are male sterilisation, IUDs and traditional methods. Male sterilisation as a share of total use declined from 6 per cent in 1995 to less than 2 per cent in 2020 globally, due to declines in Eastern and South-Eastern Asia, and Central and Southern Asia (both from 7 per cent in 1995 to 1 per cent in 2020). From 1995 to 2020, the share of IUDs among contraceptive methods declined from 22 per cent to 17 per cent globally, with Northern Africa and Western Asia experiencing the largest decline. Over the same period, the share of traditional methods declined from 13 per cent to 10 per cent globally. The largest decline, from 13 per cent to 9 per cent, was for withdrawal in Europe and Northern America due to the move towards use of modern methods in Eastern Europe.

The contraceptive method recording the greatest relative increase in use varies across regions. In sub-Saharan Africa, the increase in the shares of implants (from 5 per cent in 1995 to 19 per cent in 2020) and injectables (from 21 per cent in 1995 to 33 per cent in 2020) is notable. The rapid increase of these two methods in sub-Saharan Africa is largely the result of extensive investment by international donors and efforts by local authorities over the past two decades (Tsui, Brown and Li, 2017). In Oceania excluding Australia and New Zealand, the shares of overall contraceptive use increased for implants (from 11 per cent in 1995 to 22 per cent in 2020) and for injectables (from 17 per cent in 1995 to 24 per cent in 2020). In Latin America and the Caribbean, the largest relative increases in contraceptive use were recorded for male condoms (from 8 per cent in 1995 to 16 per cent in 2020) and injectables (from 4 per cent in 1995 to 12 per cent in 2020). Between 1995 and 2020, the share of users relying on male condoms also increased in Eastern and South-Eastern Asia (from 10 per cent to 29 per cent), Central and Southern Asia (from 7 per cent to 16 per cent) and Europe and Northern America (from 17 per cent to 27 per cent). Apart from implants, all methods that experienced an increase in their share of overall contraceptive use were short-acting.

In 5 of the 10 countries that experienced the greatest increase in the value of SDG indicator 3.7.1 since 1990 (figure 5), the use of injectables played a prominent role. Injectables are now the most common method among users in Ethiopia (57 per cent), Malawi (51 per cent), Zambia (51 per cent), Madagascar (40 per cent) and Uganda (31 per cent). Implants are the most common method among users in Guinea-Bissau (47 per cent) and Rwanda (43 per cent). Male condoms are the most commonly used method in Eswatini (45 per cent) and Romania (36 per cent), while the pill is the most commonly used method in Cambodia (33 per cent).

Box 5

Method mix in the context of family planning programmes

Method mix is the combination of different forms of contraceptive methods used. It is the result of the interaction between the supply (availability, affordability and accessibility of methods) and demand (individual and societal preferences, and cultural influences) for specific contraceptive methods in a country or region (Bertrand and others, 2020). The use of specific contraceptive methods varies widely across countries. Method mix has shifted over time due to changes in related policies, health-care systems, technologies and access to the various methods. Governments at all levels have played a strong and visible role in promoting and legitimizing the provision and use of family planning and reproductive health-care services as well as the use of specific contraceptive methods.

Family planning programmes – typically administered by national authorities or non-governmental organizations, or integrated into maternal and child health programmes (Seltzer, 2002) – can influence the method mix by educating individuals and couples and healthcare professionals about specific methods as well as by distributing and administering contraceptive methods that are acceptable, affordable and accessible to all (Seiber and others, 2007). Prior to 1990, programmes often resulted in shifts towards a particular contraceptive method whereas since 2000, programmes have often led to the adoption of a variety of methods (Boglaeva, 2021). The effects of specific programmes and policies are also reflected in regional differences in method-specific use. In sub-Saharan Africa, for instance, programmatic emphasis since 1990 on the use of long-acting reversible methods has led to increase in implants, a method typically only used by a small percentage of users in other regions.

Modern family planning programmes generally aim to diversify method mix in order to reduce overreliance on one single method. Although a more varied method mix has not been found to be associated with greater overall use (Ross and others, 2015; Bertrand and others, 2020), the overreliance on a single method can leave a population vulnerable to stockouts or shortages and can point to a lack of choice among users or coercion by governments (Seiber and others, 2007). In approximately one-fifth of countries, more than 50 per cent of contraceptive use is accounted for by a single contraceptive method (United Nations, 2019). Nevertheless, programmes in some countries have had limited success in shifting to a more diverse mix of methods. For example, efforts to shift contraceptive prevalence from the pill to IUDs were unsuccessful in Morocco in the 1990s (Bertrand and others, 2014). Similarly, despite efforts to encourage the uptake of vasectomy, its use has fallen sharply where it formerly had a significant share of use (Bertrand and others, 2020). There has been debate about whether family planning programmes should focus on expanding acceptability and accessibility of less popular and newer methods with a purpose to promote method mix or instead focus on making already accepted methods more widely available in given settings (Ross and others, 2015).

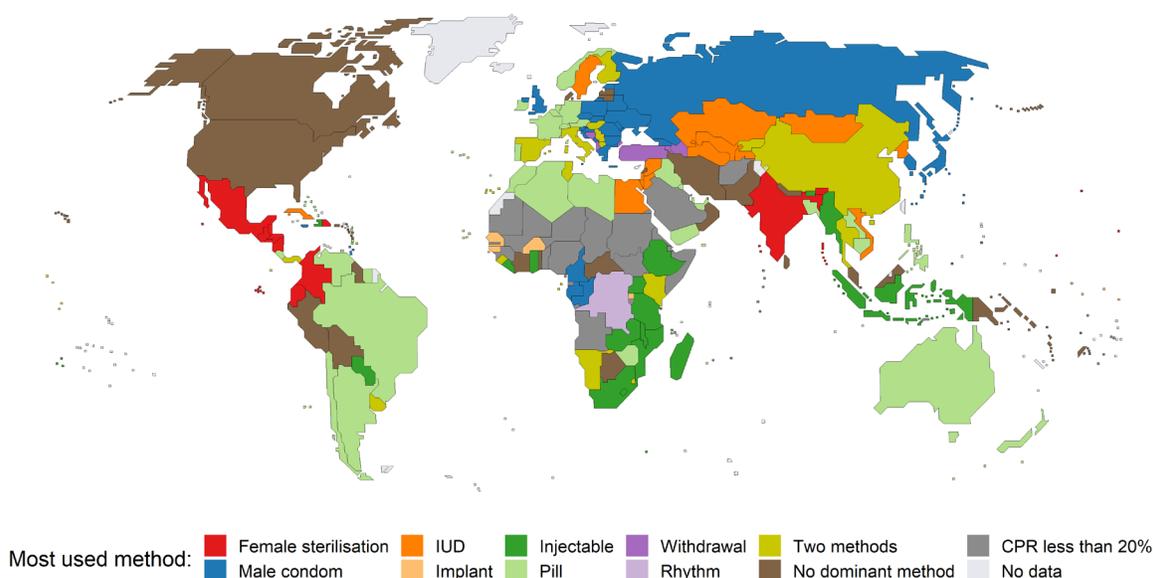
Contraceptive methods are continuously evolving to meet the needs of women and men. The past three decades witnessed the emergence of numerous methods which are acceptable to many users and are cost-effective (e.g., hormonal patches, emergency contraception), and ongoing work seeks to improve the efficacy of existing methods, for example, by lowering the dose of existing hormonal compositions in patches and intravaginal rings and changing the material and shape of condoms, IUDs and diaphragms (Brady and others, 2020; Logie and others, 2022; Haddad and others 2021). There are also substantial investments being made into new contraceptive technology to reduce the barriers associated with repeat clinical visits and methods specifically for men (Haddad and others, 2021). Whether newer methods will significantly influence method mixes in the future will depend on how they are incorporated into national strategies and programmes.

The contraceptive pill and male condom are the most commonly used methods in many countries

In 118 countries, more than 30 per cent of contraceptive use is accounted for by one method (figure 12). The pill accounts for the largest share of contraceptive use in 36 of these countries. Its use is the most extensive in Northern Africa, where it exceeds 70 per cent of total use in Algeria and Morocco. Male condoms account for more than 30 per cent of use in 27 countries; it is most heavily relied upon in Japan (75 per cent), Gabon (61 per cent), Belarus (49 per cent) and Ukraine (47 per cent). Injectables account for the highest share of contraceptive use in 18 countries and cover 50 per cent or more of total use in Ethiopia, Liberia, Malawi, Myanmar, and Zambia. IUDs are the most commonly used method in 14 countries, particularly in Central Asia and Eastern Asia.

Figure 12

Most used contraceptive method among women of reproductive age (15-49 years), 2020



Source: Calculations based on United Nations, Department of Economic and Social Affairs, Population Division (2022). *World Contraceptive Use 2022*.

Note: Contraceptive prevalence rate (CPR) refers to contraceptive prevalence. The most used method was only identified for countries or areas which had an estimate of contraceptive prevalence greater than 20 per cent, as the most used method in countries with low contraceptive prevalence only represents a small share of women of reproductive age. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

In 11 countries, female sterilisation is used by more than 30 per cent of all users of contraceptive methods. Its share among users is greatest in India (59 per cent), El Salvador (53 per cent), Mexico (48 per cent), Dominican Republic (45 per cent) and Nicaragua (40 per cent). Implants are the most commonly used contraceptive method in five countries, all of which are in sub-Saharan Africa. The share of a traditional method exceeds that of other methods in seven countries, primarily in Western Asia.

In 18 countries, two methods account for at least 30 per cent of contraceptive use, while in 36 countries there is no single method which accounts for such a high share. In countries in which two methods are widely used, one of these methods is always either male condoms, the pill or injectables. Male condoms are used in 12 of the 18 countries in which 2 methods account for more than 30 per cent of use, most commonly in conjunction with the pill, but also with IUDs, injectables and withdrawals. There are only two cases in which a permanent method, female sterilisation, accounts for more than 30 per cent of use simultaneously

with another method. In Panama, female sterilisation accounts for 31 per cent of total use and injectables account for 32 per cent of use. In Thailand, female sterilisation accounts for 36 per cent of total use and the pill for 39 per cent.

In many countries, the most commonly used methods have not changed much over time, having been influenced heavily by early efforts to introduce modern methods of contraception by family planning programmes. Early family planning programmes of the 1960s and 1970s, such as those in China, Egypt, and Tunisia, often prioritized IUDs as the preferred reversible method (Brown, 2007; Robinson and El-Zanaty, 2007; Wang, 2012) and they continue to be the most widely used methods in these countries today. In India, female sterilisation was at the core of early family planning efforts and, despite later emphasis on bringing a variety of methods to the population (Harkavy and Roy, 2007), it continues to be used more than any other method in the country. Thailand's National Family Planning Program garnered widespread acceptance of oral contraceptives by allowing auxiliary midwives to distribute them early on (Rosenfield and Min, 2007), leading to a rapid uptake of the pill and its continued high rate of use (nearly 40 per cent of total users among all women in 2020).

Not all countries have continued to follow the path set by early family planning programmes, however. Family planning programmes in Morocco initially emphasized the use of IUDs, similar to neighboring Tunisia (Brown, 2007). Yet eventually it was oral contraceptive pills which became the most used method. In Colombia in the 1970s, the national family planning programme was successful in widely distributing the pill, IUDs and injectables, leading to a significant uptake of these methods (Measham and Lopez-Escobar, 2007). Over time, however, it was female sterilisation which became the most widely used method in this country and remains so today.

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Contraception assists individuals and couples to achieve their reproductive goals and enables them to exercise the right to have children by choice. *World Family Planning 2022* presents the latest trends and patterns in contraceptive use at the global, regional and national level. The report assesses levels and trends in contraceptive use and needs of women of reproductive age between 1990 and 2021, including the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods of contraception (SDG indicator 3.7.1). It presents trends in contraceptive use by type of method, including regional variations in the use of specific methods. The report also examines how contraceptive use and needs vary by women's age and highlights gaps in meeting the need for family planning among adolescents and young women.

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