

19

DHS COMPARATIVE STUDIES

Contraceptive Knowledge, Use, and Sources



DEMOGRAPHIC
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SURVEYS

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Comparative Studies No. 19**

**Contraceptive Knowledge,
Use, and Sources**

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Preface

One of the most significant contributions of the DHS program is the creation of an internationally comparable body of data on the demographic and health characteristics of populations in developing countries. The *DHS Comparative Studies* series and the *DHS Analytical Reports* series examine these data across countries in a comparative framework, focusing on specific topics.

The objectives of DHS comparative research are: to describe similarities and differences between countries and regions, to highlight subgroups with specific needs, to provide information for policy formulation at the international level, and to examine individual country results in an international context. While *Comparative Studies* are primarily descriptive, *Analytical Reports* utilizes a more analytical approach.

The comparative analysis of DHS data is carried out primarily by staff at the DHS headquarters in Calverton, Maryland. The topics covered are selected by staff in conjunction with the DHS Scientific Advisory Committee and USAID.

The *Comparative Studies* are based on a variable number of data sets reflecting the number of countries for which data were available at the time the report was prepared. Each report provides detailed tables and graphs for countries in four regions: sub-Saharan Africa, the Near East and North Africa, Asia, and Latin America and the Caribbean. Survey-related issues such as questionnaire comparability, survey procedures, data quality, and methodological approaches are addressed in each report, as necessary. Where appropriate, data from previous DHS surveys are used to evaluate trends over time.

Comparative Studies published under the current phase of the DHS program (DHS-III) are, in some cases, updates and expansions of reports published earlier in the series. Other reports, however, will cover new topics that reflect the expanded substantive scope of the DHS program.

It is anticipated that the availability of comparable information for a large number of developing countries will have long-term usefulness for analysts and policymakers in the fields of international population and health.

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Project Director

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Executive Summary

This report presents an update on knowledge, use, and sources of contraceptive methods among the 22 populations surveyed in the DHS-II project. The findings are consistent with earlier analyses of these issues. Contraceptive knowledge and use tend to be lower among rural than urban women and among less educated women. Generally, contraceptive knowledge and use are lower in sub-Saharan Africa, and also in Pakistan and Yemen, than in other populations studied.

Knowledge of Contraception

In all five of the populations studied in the Latin America/Caribbean region, and in four of the six populations studied in the Asia/Near East/North Africa region, nearly all women know of at least one method of contraception. A high degree of awareness of at least one method is observed also in Malawi, Namibia, Rwanda, and Zambia, but elsewhere in sub-Saharan Africa, and in Pakistan and Yemen, such knowledge is less prevalent. Knowledge of at least one method is particularly low in Nigeria.

Modern and traditional methods are not equally known among the women surveyed. In nearly all the countries studied, women are more likely to know of at least one modern method than to know of at least one traditional method. The most widely recognized modern method is the pill. Even in populations where injectables and female sterilization are more widely recognized, the pill is one of the three most widely known modern methods. Male sterilization and vaginal methods are not well known in most of the countries surveyed.

A much smaller percentage of married women know as many as five contraceptive methods than the percentage who report knowing at least one method. Only in the five surveys in Latin America and the Caribbean, and in Jordan and Rwanda, do more than 8 out of 10 married women have that level of contraceptive knowledge. Knowledge of five or more methods is particularly low in most of sub-Saharan Africa, and in Pakistan and Yemen, thus limiting the options that married women in these populations have for trying out and continuing to use methods of contraception.

Socioeconomic differentials in contraceptive knowledge tend to be greater than demographic differentials. All

differentials are greater for women knowing five or more methods. Knowledge of contraceptive methods is higher among urban residents and among women with higher levels of education. It is higher also among women age 25-34 than among younger or older women, particularly for knowledge of five or more methods. The association between a woman's contraceptive knowledge and the number of living children she has is generally weak and not very consistent across countries. In the Latin America/Caribbean and Asia/Near East/North Africa regions (except Pakistan and Yemen), knowledge of five or more methods is more prevalent among women with one to four children than among childless women or women with five or more living children.

In the five populations surveyed in Latin America and the Caribbean and in four of the six populations surveyed in the Asia/Near East/North Africa region, the majority of women who know at least one modern contraceptive method also know where to find a modern method. This is true also in Malawi, Namibia, Rwanda, Tanzania, and Zambia. In the other countries in sub-Saharan Africa, and in Pakistan and Yemen, less than half of married women reported knowing a source for modern contraception. Even among women who know at least one modern method, a large proportion do not know of a source. The differentials in knowledge of a modern contraceptive source are generally similar to those seen for knowledge of contraceptive methods and are weak in populations in which a large percentage of women know of a source for modern contraception.

Use of Contraception

The percentage of married women who have ever used a contraceptive method ranges from 11 percent in Niger to 86 percent in Colombia, while the percentage who are currently using a method ranges from 4 percent in Niger to 66 percent in Colombia. In general, the level of both ever-use and current use is low in populations in sub-Saharan Africa and in Pakistan and Yemen, and is highest in the Latin America/Caribbean region. Use of modern methods, particularly the pill, IUD, and female sterilization, dominates in the Latin America/Caribbean and Asia/Near East/North Africa regions, while traditional methods tend to be relatively more prevalent in sub-Saharan Africa, and also in Peru.

Both ever-use and current use of contraception are more common among urban than rural women, and among the better educated. Differentials tend to be more pronounced for current use than for ever-use and to be stronger in populations where use of contraception is low. However, socioeconomic differentials are smaller or even reversed in some populations for certain methods, particularly female sterilization, withdrawal, and other traditional methods.

The decision to use contraception is closely related to a woman's stage in her reproductive career. As a result, surveys find that demographic differentials are much stronger for both ever-use and current use than they are for knowledge of contraception. Use is generally lower among young women (age 15-24) and particularly among women with no living children. It peaks among women age 25-34 in most of the surveys, although in some populations use is highest among women age 35-49, especially in sub-Saharan Africa and in Pakistan and Yemen. In the Latin America/Caribbean region and in Egypt, Indonesia, and Morocco, both ever-use and current use are highest among women with 3 or 4 children. The other surveys in the Asia/Near East/North Africa region and in most of sub-Saharan Africa, found that use (especially use of modern methods) increases with the number of living children that a woman has.

Contraceptive use has increased in nearly all populations studied, due primarily to increased use of modern methods. In most countries, the pace of increase in contraceptive use appears to be steady, although it has slowed recently in a few populations, most notably in Indonesia, Morocco, and Colombia.

Source of Current Contraceptive Method

Government facilities remain an important source of modern contraceptive methods, particularly in sub-Saharan Africa and, to a lesser extent, in the Asia/Near East/North Africa region. In Latin America and the Caribbean, pharmacies and other private sources tend to play a more significant role. However, source patterns do vary among countries

within the regions. They also vary according to the type of method used. Clinical methods tend to be obtained from government stationary facilities or from other private providers, while supply methods are frequently obtained from pharmacies, particularly in the Latin America/Caribbean region, and in Egypt and Jordan. Other private providers play a limited role as a source of supply methods in most countries studied. In 17 of the 22 countries, a greater percentage of users of clinical methods than supply methods obtained their method from a government source. The five countries that do not conform to this pattern are all in sub-Saharan Africa.

The source of contraceptive methods does not vary much by demographic and socioeconomic characteristics, particularly in sub-Saharan Africa where the number of users of modern contraceptives is small. Older women and women with larger families rely less on pharmacies as they shift to longer-term clinical methods, such as female sterilization and the IUD, which are provided privately or by government stationary facilities rather than pharmacies. Urban users are generally less likely than rural users to obtain their contraceptive supplies from government sources, although there are some exceptions, particularly in sub-Saharan Africa. As expected, government mobile sources are cited by more rural than urban users in all populations in which they are available. In general, better-educated women are less likely to use government sources.

The percentage of users who obtain their methods from a government source is not systematically related to the level of contraceptive use in the population, nor to the strength of the family planning program. This finding, combined with the generally weak and inconsistent socioeconomic and demographic differentials in source of contraception, leads to the conclusion that the source patterns in a population are determined primarily by the circumstances of a particular country, and so detailed analyses of contraceptive source patterns and policies aimed at affecting them should be country-specific.