virtually every survey analyzed here. In this article, we address the extent to which the actual-ideal gap increases the overall explanatory power of fertility preferences, as well as whether the marginal gain from including the actual-ideal gap varies by social factors such as stage of fertility transition and region.

Our primary aim is to determine the extent to which changes in fertility preferences can account for changes in contraceptive prevalence. To accomplish this, we employed a regression-decomposition approach, essentially the same as has been used in several previous regional and country-specific studies of contraceptive change.

Using the decomposition results, we can express the observed change in contraceptive prevalence as the simple sum of two components: the changes in fertility preferences and the changes in the effects of preferences on use (that is, the regression coefficients). Following the terminology of classic demographic decomposition, we labeled the first component as “composition” and the second as “rates.” Contraceptive prevalence can change as a result of either mechanism—changing preference structures or changing propensity to use a method within preference categories (much of which can be regarded as changes in the “implementation of preferences”). Either can account for a relatively small or large part of the observed change in prevalence.

Results

Trends in Use and Preferences

The increase in contraceptive prevalence between surveys among currently married women aged 15–44 (Table 1, page 103) was largest in Bangladesh (41 percentage points), followed by Thailand and Peru (32 points), Dominican Republic and Kenya (30 points), Indonesia and Colombia (28 points) and Sri Lanka (27 points). At the other extreme, six countries had an increase of less than 10 percentage points—Guatemala and Yemen (seven points), Côte d’Ivoire, Senegal and Tanzania (eight points) and Brazil (nine points). Some of the variability in the increase in prevalence may be due to the fact that the length of the intersurvey period differed among the 26 countries. However, some of the larger increases occurred over relatively short periods (for example, in Thailand and Sri Lanka).

With only a few exceptions, all of the indicators of fertility preferences (the percentage of women wanting no additional children, the mean ideal number of children, the mean actual-ideal gap and the percentage of women for whom the actual number of children equals or exceeds their ideal) suggest that the demand for fertility limitation increased during the period between surveys (Table 2). The largest increase in the desire for no additional children was in Kenya (29 percentage points), followed by Nepal (25 points) and Ghana (19 points). These countries were at the onset of transition at the time of the first survey.

Nearly half of the countries recorded increases in the desire to stop childbearing of less than 10 percentage points—Colombia, the Philippines, Senegal and Zambia (four points), Brazil (five points), Tanzania (six points), Peru and Thailand (seven points), Egypt and Paraguay (eight points), and the Dominican Republic (nine points). In Guatemala, the percentage of women wanting no more children declined by one percentage point (a decline that could be accounted for by sampling error). Countries with relatively small percentages of women wanting no more children at the first of the two surveys tended to show larger increases in the intersurvey period.

Further evidence of the increase in demand for fertility limitation is that the ideal number of children declined between the two surveys in all countries except Yemen (Table 2), and that the difference between the number of living children and the ideal number of children became more positive in all countries except the Philippines, Sri Lanka and Thailand. Moreover, the percentage of women for whom the actual number of children exceeds the ideal increased in all countries except those three Asian nations.