method in the past. The relevant discontinuation rate (past users with unmet need as a percentage of ever-users) was estimated to be 19% for all countries combined.

Important regional differences were found. For example, the current use of modern methods in the 20 Sub-Saharan African countries was lower than that in the 14 countries from other regions (18% vs. 47%), and unmet need was higher (31% vs. 25%). The proportion of past users with unmet need in the two regions was about the same (10–11%). However, the proportion of past users among women with unmet need in Sub-Saharan Africa was lower than in other regions (32% vs. 43%). Conversely, the proportion of never-users among women with unmet need in Sub-Saharan Africa was higher than in other regions (68% vs. 57%), and the relevant discontinuation rate in Sub-Saharan Africa was also higher (27% vs. 16%).

Variations among countries were even more pronounced. For example, past users accounted for at least 50% of unmet need in 16 of the 34 countries (Table 2). In another seven countries, past users accounted for 33–46% of the unmet need, and in six countries, for 22–28%. Indeed, this proportion was less than 20% in only five countries. The relevant discontinuation rate (i.e., past users with unmet need as a percentage of ever-users) also varied considerably, from 5% in Indonesia to 45% in the Republic of the Congo.

Contraceptive Access and Use

Both access to and composition of available methods varied by country and region. The access to available methods ranged from 1.6 in the Philippines to 3.9 in Nepal (not shown). Composition scores indicate that long-acting and permanent methods were least available in Haiti and most available in India (12 vs. 54). Access to and composition of available methods were positively correlated ($r=0.55$; $p<.001$). Women in Sub-Saharan Africa had lower access than women in other regions, regarding both access to available methods (2.7 vs. 3.1) and relative availability of long-acting and permanent methods (27 vs. 36). However, the regional difference in access to methods available was not significant ($r=0.35$; $p<.10$), whereas the regional difference in relative availability of long-acting and permanent methods was significant ($r=0.52$; $p<.01$).

The relationship between the number of methods available in a country and contraceptive use is well established, and was also confirmed in our analysis. Table 3 presents associations between the access to and the composition of available methods and contraceptive use and method mix. Contraceptive prevalence increased with both access to and composition of methods available in a country, as shown by the positive correlation (0.6 for each) and regression coefficients (12.1 and 0.8, respectively). Although there was no association between access and method mix, an increase in the relative availability of long-acting and permanent methods was associated with a method mix with a higher proportion of these methods, as shown by the positive correlation (0.7) and regression coefficient (1.8).

Further analysis showed that a higher level of contraceptive use was related to the rising use of multiple methods (Figure 1). Contraceptive use was estimated at between 7% and 34% when only short-acting modern methods were considered. The availability and use of long-acting reversible methods were estimated to contribute another 0.4–11 percentage points to contraceptive prevalence, and the availability and use of permanent methods another 0.3–15 percentage points.

Contraceptive Discontinuation and Access

No association was found between the HDI, reflecting countries’ socioeconomic conditions, and average relevant discontinuation rates (Table 4, page 138). In contrast, method access, method composition and region were associated with contraceptive discontinuation. Expanding access by adding one method or its equivalent was associated with an eight-percentage-point decrease in contraceptive discontinuation (model 1). A 10-point increase in the composition score was associated with a six-percentage-point decrease in discontinuation (model 2). Obviously, simply

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**TABLE 3. Correlation and regression coefficients from multiple regression analysis identifying associations between measures of women’s modern method use and measures of access to modern methods in 34 countries**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Modern method use</th>
<th>Method mix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correlation</td>
<td>Regression</td>
</tr>
<tr>
<td>Access to no. of methods</td>
<td>0.57**</td>
<td>12.12*</td>
</tr>
<tr>
<td>Composition (relative access to long-acting/permanent methods)</td>
<td>0.57**</td>
<td>0.81*</td>
</tr>
<tr>
<td>Constant</td>
<td>–30.5</td>
<td>0.418</td>
</tr>
<tr>
<td>$R^2$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Method mix=use of long-acting and permanent methods as percentage of all modern method use. Regression coefficients represent the magnitude of net change in the outcome variable that is expected with a one-unit change in the explanatory variable after controlling for the other variable included in the analysis.

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**FIGURE 1. Contraceptive method mix in 34 countries, by level of contraceptive use**

- Short-acting reversible
- Long-acting reversible
- Permanent