

Access to contraception across the world

Petta CA¹, Obiol Saiz M², Fruzzetti F³, Yadav A⁴

1 Clínica Fertilidade & Vida, Campinas, São Paulo, Brazil

2 Centro de Salud Sexual y Reproductiva, Fuente de San Luis, Valencia, Spain

3 Gynecological Endocrinology Unit, San Rossore Clinical Center, Pisa, Italy

4 Department of Obstetrics and Gynaecology, AIIMS Nagpur, India

Introduction

Access to modern contraceptives varies widely across regions, shaped by socio-economic, cultural, and policy-related factors. While some countries have made significant progress, others continue to face substantial barriers, including financial constraints, restrictive laws, religious opposition, and social stigma. The scale of the issue is underscored by the fact that, in 2021, approximately 164 million women of reproductive age worldwide lacked access to the contraception they needed, a significant proportion of whom reside in low- and middle-income countries. Across the globe, marginalised populations are among the most vulnerable; for example, indigenous communities

frequently encounter structural barriers to accessing health care, including reproductive services, due to geographic isolation, poverty, and cultural mismatch with mainstream systems [1]. Overcoming these challenges requires more than simply expanding supply; it demands deliberate, equity-focused strategies that recognise and address the specific needs of underserved populations. Ensuring universal access to contraception is not only essential to safeguarding reproductive autonomy but also critical to advancing health equity, gender justice, and sustainable development. As the following section will demonstrate, translating global commitments into tangible outcomes depends on targeted, context-sensitive policies and sustained investment.



Africa

Contraceptive policies in Africa vary widely, with some countries making strong commitments to reproductive health while others lack comprehensive frameworks [2]. Countries such as Mozambique (87.7%), South Africa (85.4%), and Ghana (85.3%) have implemented progressive policies to ensure access to contraceptives. In contrast, Libya (16.0%) and Equatorial Guinea (17.8%) rank among the lowest due to weak policy frameworks and legal restrictions. While many African nations have endorsed international agreements promoting access to contraception, implementation remains inconsistent.

Access to contraceptives remains a complex issue, influenced by factors such as socio-economic status, policy implementation, and international commitments. Despite notable progress in recent years, including a rise in contraceptive prevalence (ranging from 7% to 24% depending on the region), many women still face significant barriers [2]. A 2023 qualitative review across sub-Saharan Africa identified major obstacles, including misinformation, provider bias, limited clinic availability, transportation challenges, and social stigma, which collectively resulted in a combined 26% prevalence of disrupted access during the COVID-19 pandemic [3,4]. In addition, a decomposition analysis of 466,282 women from 33 African countries found that modern contraceptive use remains significantly skewed toward the wealthier, with key contributors being socio-economic status, rural residence, and mass media exposure, which collectively perpetuate inequitable uptake [5]. In Kenya, nomadic and semi-nomadic pastoralist communities face significant inequities in access to family planning, largely due to their remote locations and reliance on subsidised services [6].

Around 50 million women in sub-Saharan Africa have an unmet need for modern contraceptive methods, meaning they want to avoid pregnancy but do not use any form of contraception [7,8]. Countries in Southern and Eastern Africa, such as South Africa, Kenya and Mozambique, have made substantial gains in contraceptive uptake, contributing to regional prevalence levels rising from approximately 13 % in 1990 to nearly 29 % by 2019, and are characterised by comparatively low unmet need (~15 %) [9,10]. In contrast, the Democratic Republic of the Congo and Chad continue to face significant gaps: in the Democratic Republic of the Congo, only 6.7 % used modern methods in 2007, with unmet need around 24 %, and in Chad, modern method use was below 2 % in 2004, despite substantial unmet need [8].

Funding remains a significant challenge, with many African countries relying on external donors for the procurement of contraceptives. While Ghana, Kenya, and South Africa allocate domestic resources for family planning, nations such as Chad, Sudan, and the Democratic Republic of the Congo lack budgetary commitments [11-13]. Only a handful of countries include contraception in national health insurance schemes,

leading to out-of-pocket costs that restrict access for low-income populations. The periodic withdrawal or restriction of U.S. aid, such as under the Mexico City Policy, has been associated with disruptions in service delivery, reduced access to modern contraceptives, and increased abortion prevalence in sub-Saharan African countries.[14] Reduced financial support for family planning may have led some women to substitute abortion for contraception [15].

MENA region

Policies on contraceptive access in the Middle East and North Africa (MENA) region are inconsistent, with only 6 out of 21 countries enshrining the right to choose the number, timing, and spacing of children [16]. Additionally, only four countries have an updated national policy or strategy on contraception. Countries like Tunisia and Algeria demonstrate relatively progressive policies, with Tunisia updating its national policy and Algeria incorporating contraceptive rights into its laws. Conversely, Iran, Libya, and Kuwait lack national policies or strategies, limiting structured access to contraception. In many MENA countries, the absence of robust, gender-responsive legislation, combined with centralised governance systems and the influence of conservative religious doctrines, has entrenched policy inertia on contraceptive access and reproductive rights [17]. The impact of religious jurisprudence also shapes access and policy. While some interpretations of Islamic law support birth spacing and family welfare, others oppose specific modern contraceptive methods, particularly for unmarried women. These divergent interpretations have led to policy ambivalence, where access may be technically permitted but is socially or institutionally restricted [18].

Access to contraceptives in the MENA region is uneven, with countries like Algeria (65%), Iraq (64.6%), and Tunisia (62.2%) showing higher access, while others, such as Libya (15.4%) and Iran (16.7%), lag behind [16]. Only six countries have legislation enshrining the right to choose the number and timing of children. Emergency contraception remains inaccessible in many parts of the region: it is illegal or unregistered in seven countries and not provided by the public health system in 9 countries. Additionally, only 3 out of 21 countries have government-led websites providing contraceptive information, and national awareness campaigns are infrequent.

Funding remains a critical barrier, as 9 out of 21 countries do not have a publicly available budget line for contraceptive procurement. Countries like Jordan and Tunisia allocate some public sector funding, while Oman, Libya, and Kuwait show limited or no financial commitment to contraceptive procurement. Furthermore, national health insurance covers contraception only in select countries, limiting affordability for vulnerable populations.

In these contexts, the most vulnerable populations include low-income households, women and girls in rural and remote areas, refugees and displaced persons, and individuals not covered by national health insurance systems. In Jordan and Tunisia, unique among some MENA countries for allocating public funds to contraception, refugees and low-income groups often still struggle to access services due to structural and financial constraints [19]. For instance, studies in Jordan show that Syrian refugees dependent on underfunded public systems frequently cannot obtain modern contraceptive methods. Refugee populations are often reliant on humanitarian organisations. Humanitarian programming often prioritises maternal care and emergency services, sidelining long-term family planning needs. In contrast, in Oman, Libya, and Kuwait, where public funding and insurance coverage for contraception are limited, rural women and those outside formal employment, including both citizens and migrant workers, often face affordability barriers to reproductive health services [19]. Gender norms and entrenched inequities further compound these disparities, particularly for female youth, unmarried women, and those with limited autonomy [16].

Asia-Pacific region

Contraceptive policies in the Asia-Pacific region vary significantly [20]. Only 13 out of 58 countries legally recognise the right to choose the number, timing, and spacing of children. Cambodia and Mongolia are among the top performers, with clear policies that support access to contraceptives and reproductive rights. In contrast, Brunei and Macao have no legal frameworks supporting contraceptive choice, limiting structured access to reproductive health services.

Access to contraceptives is inconsistent. Countries like Cambodia (90.1%) and Mongolia (83.2%) have the highest contraceptive prevalence rates, supported by national policies and healthcare frameworks. Conversely, Brunei (7.5%) and Macao (9.6%) have the lowest access, reflecting weak policy commitments and limited-service availability [20]. Emergency contraception is available without a prescription in 23 out of 58 countries, but remains restricted in many, including Japan and the Philippines, where bureaucratic and cultural barriers hinder access. Government-led awareness campaigns are also lacking in 44 out of 58 countries, limiting public knowledge of contraceptive options. Ethnic and linguistic diversity plays a critical role in shaping contraceptive access in the region [20]. Language barriers, illiteracy, and digital exclusion further exacerbate these gaps in countries like Nepal and Papua New Guinea [21,22].

In multi-ethnic countries such as India, Indonesia, and Myanmar, marginalised populations, including tribal communities and refugees, frequently encounter culturally insensitive services, geographic exclusion, and

systemic neglect. In remote island nations like Kiribati and Vanuatu, service delivery is further challenged by dispersed populations, traditional belief systems, and limited healthcare personnel [23,24].

Funding for contraceptives is a significant challenge. About 30 out of 58 countries lack a publicly available budget for contraceptive procurement [20]. Only ten countries provide full or partial coverage through national health insurance, with Thailand and India among those offering comprehensive support. Meanwhile, Papua New Guinea and Kiribati rely heavily on external aid. Only five countries in the region are entirely self-sufficient in contraceptive supply, highlighting financial dependency on international donors. This dependency particularly affects low-income, indigenous, and nomadic populations who rely on subsidised services.

Latin America and the Caribbean

Contraceptive policies across Latin America and the Caribbean show significant variation. Seventeen out of 33 countries legally recognise the right to choose the number, timing, and spacing of children, but only seven regulate conscientious objection to ensure consistent access to contraception. Countries like Mexico (91.4%) and Argentina (83.2%) lead in policy commitments, with comprehensive legal frameworks. Conversely, St. Vincent & the Grenadines (14%) and Dominica (26.9%) have the weakest policy structures, lacking legal protections for access to contraceptives.

Access to contraceptives is uneven across the region. Countries like Mexico, Argentina, and Chile show high contraceptive coverage, with rates above 75%. However, nations such as Venezuela, El Salvador, and Haiti report significantly lower access rates, with rates below 50%. In Brazil, the largest country in the region, contraceptive access is hindered by the absence of a clear national strategy, weak regulation of conscientious objection, and insufficient public information efforts, despite universal health coverage. Although overall contraceptive use is high, it conceals significant inequities: women in wealthier states and parous women with greater primary care coverage have higher usage, while socially vulnerable nulliparous women are less likely to access contraception [25]. Most common contraceptive methods vary by age and marital status, but generally, modern methods are widely used, with female sterilisation and the pill being the most frequent. Younger, unmarried women often rely on condoms, while married women tend to use injectables or pills. LARCs like IUDs and implants are less prevalent, but their use varies across the region [26].

Many countries struggle with regulatory gaps, insufficient public funding, and inadequate distribution, particularly for emergency contraception. The

Caribbean region shows significant challenges in implementing national strategies for contraception and sexual education. Government-led awareness campaigns and websites are also lacking in many countries, further hindering access to essential reproductive health services [27].

Funding for contraception remains a significant barrier: 21 out of 33 countries do not have a dedicated public budget for contraceptive procurement. Argentina, Costa Rica, and Chile allocate substantial resources to ensure widespread access to education. However, countries like Belize and the Bahamas rely heavily on external aid and do not have sustainable funding strategies [27].

Europe

Contraceptive policies across Europe vary significantly [28]. While 20 out of 46 countries include contraceptives in their national health systems, only 14 countries provide special coverage for youth, and 19 have well-developed government websites with contraceptive information. The United Kingdom (96.9%) and France (93.2%) rank highest due to their strong legal frameworks and comprehensive national policies. Conversely, Poland (33.5%) and Bosnia-Herzegovina (39.0%) rank among the lowest, with restrictive policies, limited public funding, and barriers such as third-party consent requirements [28].

Access to contraceptives shows significant disparities across countries, although most have made progress toward ensuring modern, affordable contraception. Countries such as the United Kingdom (96.9%), France (93.2%), Belgium (91.1%), and the Netherlands (81.1%) rank highest in access to contraceptives, which are covered through national health systems, including long-acting reversible contraceptives (LARCs). However, other nations, such as Poland (33.5%), Hungary (40%), and Bosnia and Herzegovina (39%), show limited access due to the absence of comprehensive health coverage for contraceptives. Emergency contraception is widely available, but in countries like Poland, Russia, and Turkey, restrictions or third-party consent requirements limit access, especially for vulnerable groups [28].

Funding disparities remain a significant issue. Only 20 countries provide national health insurance coverage for contraceptives, while many others lack dedicated funding. France and Sweden offer some of the most comprehensive financial support, ensuring affordability for all populations. Meanwhile, countries like Bulgaria and Romania do not allocate sufficient funds, forcing individuals to bear contraceptive costs [28].

North America

Canada

Canada lacks a federal contraceptive coverage plan, leading to disparities between provinces. While 100% of provinces include contraception in their sexual education curriculum, policies regarding access and funding vary widely [29]. British Columbia (88.9%) has the most comprehensive policies, offering universal coverage, while Newfoundland and Labrador (41.8%) rank the lowest due to limited financial support and access barriers.

Access to contraceptives varies significantly by province. British Columbia leads with 88.9% coverage, followed by Ontario (73.1%) and Prince Edward Island (68.5%) [29]. However, Newfoundland and Labrador have the lowest coverage at 41.8%. While all provinces offer some form of financial support, the extent and target populations differ, with vulnerable groups receiving greater access. Most provinces provide comprehensive information on contraception through public health websites [29].

Additionally, cultural and ethnic diversity across Canada plays a critical role in shaping contraceptive equity. Indigenous communities in rural and remote regions face geographic isolation and limited culturally safe services, which contribute to lower utilisation rates. Immigrant and refugee women may experience linguistic barriers, stigma, or misinformation regarding contraceptive options. Sexual and gender minority populations, including LGBTQ+ youth, frequently report inadequate provider training and a lack of inclusive service environments, further constraining access [30,31].

Funding remains inconsistent across Canada. Only 46% of provinces provide financial coverage for all or most of their populations [29]. British Columbia leads in this area by offering universal coverage for contraceptives. Other provinces, such as Ontario and Alberta (66.3%), provide targeted support for specific populations. However, provinces like Newfoundland and Labrador and Manitoba (56.0%) offer limited financial assistance, making affordability a challenge for vulnerable populations [29].

The United States

In the United States, access to contraceptives is shaped by federal policies like the Affordable Care Act (ACA) and Title X of the Public Health Service Act [32]. The ACA improved access by mandating contraceptive coverage, reducing out-of-pocket costs, and expanding Medicaid, particularly benefiting low-income women. Title X-funded clinics have been crucial in offering affordable contraceptive care to underserved populations. However, gaps remain due to issues such as religious exemptions and the loss of Title X funding. The reduction of the financing and increased barriers

to abortion have contributed to a rise in sterilisation procedures, particularly female sterilisation. For example, a JAMA Health Forum study found a 70% increase in tubal ligations among 18–30 year-olds in states likely to ban abortion following Dobbs, and an observed monthly rise of 3% in sterilisation rates during the latter half of 2022 [33,34]. Access varies across states: California, New York, and Washington offer some of the best access, with California covering 71% of women through public programs. Conversely, states like Texas, Mississippi, and Alabama have poorer access, with Texas covering only about 45% of women due to policy restrictions [35–37].

Beyond disparities, research published in 2019 showed that contraception access in the United States has significant economic benefits, influencing individual income, education levels, and public spending [38]. Early legal access to birth control reduces female poverty by 20% and increases lifetime earnings. By their early 40s, women with early contraceptive access earn US\$2,220 more per year than those without, and by age 50, they earn 8% more per hour on average. Additionally, oral contraception has been credited with nearly one-third of the reduction in the gender wage gap since the 1990s.

Education outcomes also improve with access to contraception. College enrolment rates are 20% higher among those who had early access to birth control, and they are more likely to complete their degrees. These benefits extend to men as well, as those whose partners had access to contraception are more likely to complete college [39].

From a public finance perspective, access to contraception generates significant savings. Every US\$1 spent on contraceptive services prevents unintended pregnancies and saves US\$6 in public spending. Unintended pregnancies remain a major issue, comprising 45% of all pregnancies in the United States, yet publicly funded birth control prevents 2 million unintended pregnancies annually, leading to an estimated US\$10.5 billion in public savings [40].

Beyond individual and fiscal benefits, contraception access positively impacts future American generations. Children born to parents with contraceptive access attain higher education levels and future earnings, demonstrating long-term socio-economic advantages for families and society [39].

Persistent inequities amid global progress in contraceptive use

Global trends in the use of modern contraceptives over the past decades reveal significant progress alongside persistent inequities across countries, age groups, and

socio-economic strata. A study published in *The Lancet Global Health* (2020) examining 74 countries found that modern contraceptive use increased in over half of them, with demand rising in 42, particularly in low- and middle-income countries in sub-Saharan Africa and South Asia [41,42]. These regions experienced rapid growth in demand, especially among sexually active women delaying childbearing, yet often lacked the capacity in terms of infrastructure, trained personnel and supply chains to meet these needs fully. High-income countries, such as the US and several in Europe, saw stagnation or slight declines, potentially reflecting already high baseline usage. A broader analysis by the Global Burden of Disease Study, published in *The Lancet* (2022), further documented a 20% rise in the global modern contraceptive prevalence rate (mCPR) between 1970 and 2019 [43]. However, stark disparities remain: high-income countries achieved mCPRs above 60% and demand satisfied above 85%, while low-income countries continued to report mCPRs as low as 22% and demand satisfied below 50%.

Over time, there was a global shift from traditional to modern methods, with rising use of sterilisation, IUDs, implants, and injections. Younger and unpartnered women more often used combined hormonal or barrier methods, whereas older women, particularly in South Asia, relied heavily on female sterilisation. The availability of method mix remains limited in many low-resource settings, where contraceptive choice is often shaped more by supply-side constraints than informed preference [44]. Notably, the motivations and consequences of contraceptive use differ across contexts: in high-income countries, contraception is increasingly integrated into fertility care, enabling individuals and couples to plan, space, or delay pregnancies in alignment with life goals and broader reproductive health needs. In contrast, in low-income countries, contraceptive use is often framed within the context of family planning and population control, where access may be limited and choices constrained, and where the primary aim is often to reduce unintended pregnancies under resource-limited conditions. Both studies highlight the critical role of gender equality and female education in expanding contraceptive access and underscore the need for policies that broaden method choice and address age- and context-specific barriers to use.

Conclusions

Access to modern contraceptives remains highly unequal worldwide, reflecting ongoing disparities in socio-economic status, health system capacity, cultural norms, and political commitment. While some regions have achieved near-universal coverage, others continue to encounter high levels of unmet need, particularly among rural, low-income, displaced, and indigenous populations. These inequalities are reinforced by gaps in policy frameworks, limited domestic funding, service delivery challenges, as well as stigma

and restrictive legal environments that disproportionately impact vulnerable groups.

Simultaneously, substantial evidence indicates that equitable access to contraception yields significant benefits for individuals, society, and the economy. Better access is linked to decreases in maternal mortality, unintended pregnancies, and unsafe abortions, as well as supporting women's educational progress, workforce involvement, and long-term economic security. On a large scale, increased contraceptive access lowers health system costs and promotes gender equality and sustainable development goals.

Addressing current inequalities requires more than just increasing supply: it demands sustained investment, inclusive policy reform, and culturally responsive strategies that place reproductive autonomy and quality of care at the heart of health systems. Ensuring universal access to contraception is therefore not only a matter of health equity but also a catalyst for wider social and economic progress.

Summary of current challenges to accessing modern contraception around the world [45]

Limited access to sexual health services: By 2030, 70 million additional women should use modern contraceptives, but socio-economic and geographic inequalities remain significant barriers.

Socio-economic barriers: Low-income women, especially in shantytowns and rural areas, face higher rates of unintended pregnancies due to the financial cost of contraception. Seventy-four million unintended

pregnancies occur annually in low- and middle-income countries, leading to 25 million unsafe abortions and 39,000 maternal deaths.

Geographical disparities: The unmet need for contraception is 25% in Africa, 13% in Southeast Asia, 10% in Europe, 8% in the Americas, and 4% in the Western Pacific.

Poor quality of services: Limited contraceptive counselling results in low service utilisation. In the Philippines, only 3% of women seeking contraception receive proper counselling, contributing to 600,000 unsafe abortions yearly.

COVID-19 impact: The pandemic disrupted access to contraception, safe abortion, gender-based violence services, and STI/HIV screening.

Cultural & Social Barriers:

- Gender & couple relationships: 14% of married women who do not use contraception cite husband's opposition as the main reason.
- Social stigma: In some countries, unmarried women avoid contraception due to fear of judgment, while men attending family planning services face social ridicule.
- Religious beliefs: Some religions oppose contraception, linking it to infidelity and health risks.

Education & awareness:

- Low education levels correlate with higher rates of unintended pregnancies due to lack of information and misinformation.
- Fear of side effects: Two-thirds of women discontinue contraception due to concerns over health risks, infertility, or depression. A Guttmacher Institute study in 52 countries found that 25% of women avoid contraception due to side effect fears.



Table 1. Contraception access comparison by region

Region	Access characteristics	Policy needs	Unmet needs in the population
Africa	Access varies widely, with countries such as Mozambique (87.7%) and South Africa (85.4%) leading, while Libya (16%) and Chad (29.7%) lag. Unmet needs remain high, especially in Sub-Saharan Africa.	Improve domestic funding for contraceptive supplies, expand sexual education programs, and address cultural barriers. Strengthen health systems to increase access for rural and vulnerable groups.	Over 50 million women in Sub-Saharan Africa have unmet contraceptive needs, particularly in rural areas and among young women and low-income populations.
MENA (Middle East & North Africa)	Algeria (69.2%) and Morocco (72.8%) demonstrate good access, while Libya (16%) and Sudan (28.4%) face significant challenges, including limited availability of emergency contraception.	Update national contraceptive strategies, authorise over-the-counter access to emergency contraception, and create government-led awareness campaigns to normalise access to family planning services.	Over 30% of women have unmet contraceptive needs, especially in countries like Yemen and Libya, where socio-cultural norms and political instability are barriers.
Asia	Countries like Cambodia (90.1%) and Mongolia (83.2%) excel, but others, such as Japan (30.3%) and South Korea (26.7%), have lower coverage. Emergency contraception often requires a prescription.	Increase contraceptive coverage in countries with lower access, make emergency contraception available without prescription, and improve sexual and reproductive health education.	Approximately 10-25% of women in many Asian countries, particularly in rural and conservative areas, have unmet needs for modern contraception.
Latin America & Caribbean	High access in countries like Mexico (above 75%) contrasts with lower access in places like Haiti (below 50%). Emergency contraceptives are not always available in the public sector.	Allocate more public funding for contraceptives, integrate reproductive health into national health insurance, and enhance the availability of emergency contraception.	Unmet needs are concentrated in marginalised groups, adolescents, and low-income women, with rates reaching over 25% in some Caribbean and Central American countries.
Europe	Countries such as the UK (96.9%) and France (93.2%) provide excellent access, while Poland (33.5%) and Hungary (40%) face more restrictions and coverage gaps.	Expand public funding for contraceptives, improve access to modern methods like long-acting reversible contraception (LARCs), and remove barriers such as third-party consent.	Unmet needs are relatively low in Western Europe but higher in Eastern Europe (e.g., Poland), where up to 20% of women report difficulties accessing contraception.
North America: Canada	Access varies by province, with British Columbia (88.9%) having the highest coverage and Newfoundland and Labrador (41.8%) the lowest. Most provinces offer some financial support.	Create a national drug plan to equalise access, particularly for vulnerable groups, and standardise contraceptive information and services across provinces.	Unmet contraceptive needs are higher in low-income, rural, and indigenous populations, particularly in provinces with limited financial coverage for contraception.
North America: United States	Access varies significantly by state. California (71%) has one of the best access rates, while Texas (45%) faces restrictions due to policy and funding cuts. Title X clinics are key providers for underserved groups.	Increase funding for Title X, remove barriers related to religious exemptions, expand Medicaid coverage for contraceptives, and improve access for rural and low-income populations.	Unmet needs are concentrated in rural areas, low-income communities, and among uninsured women. In some states, over 20% of women lack access to needed contraception.

Table 2. Challenges and opportunities in contraception access by region

Region	Challenges	Opportunities
Africa	Limited Access and Unmet Needs: Many African countries face significant barriers to contraceptive access, including limited availability of modern methods and cultural opposition.	Policy Initiatives: Efforts to improve family planning services and integrate them into primary healthcare systems are ongoing, aiming to enhance accessibility and reduce unmet contraceptive needs.
Asia	Cultural and Social Barriers: In countries like Pakistan, traditional social norms and familial constraints significantly influence contraceptive use, leading to reluctance in adopting family planning methods.	Government Initiatives: Some Asian countries are implementing policies to improve reproductive health services, including free provision of contraceptives in urban areas and efforts to space pregnancies appropriately.
Europe	Variability in Access: Access to contraceptives varies across European countries. Some nations have insufficient information on contraception, showcasing only a limited range of methods, which can hinder informed choices.	Policy Reforms: Initiatives like the European Contraception Atlas categorise countries based on access to contraceptive supplies and counselling, identifying areas for improvement and promoting policy reforms.
MENA (Middle East & North Africa)	Unequal Access and Legal Barriers: While some countries provide contraceptive access, others heavily restrict it, particularly for emergency contraception. Only a few countries legally protect reproductive autonomy.	Expanding Family Planning Programs: Increasing regional initiatives aim to enhance access to contraceptives, with international organisations supporting reproductive healthcare efforts.
North America	Healthcare Access and Financial Barriers: In the United States, access to contraceptives is influenced by factors such as insurance coverage, socio-economic status, and the availability of healthcare. Disparities exist, with African American and Hispanic women disproportionately affected by limited access due to financial constraints.	Policy Changes: Recent developments, such as the approval of over-the-counter birth control pills, aim to reduce barriers and improve access to contraception.
Latin America & the Caribbean	Legal and Cultural Barriers: In several Latin American countries, legal restrictions and cultural opposition limit access to specific contraceptive methods, including emergency contraception. Court decisions granting personhood to fertilised eggs have led to extreme limits on emergency contraceptive access.	Increased Contraceptive Use: Despite challenges, the use of modern contraceptives in Latin America has increased, leading to a decline in fertility rates and presenting opportunities for further improvements in reproductive health services.

Key messages

Africa

Access remains highly unequal; countries like Chad and the Democratic Republic of the Congo face major gaps despite regional progress.

Reliance on external funding and limited insurance coverage hinders access for rural and low-income populations.

MENA

Policies are inconsistent; few countries guarantee contraceptive rights or provide structured access.

Refugees, rural women, and migrant workers face affordability and access barriers due to weak public support.

Asia-Pacific

Strong performers like Cambodia contrast with countries lacking legal frameworks or service coverage.

Indigenous, tribal, and remote populations face exclusion due to cultural, geographic, and funding barriers.

Latin America & Caribbean

High overall use masks inequalities; some countries lack legal protections and adequate funding.

Socially vulnerable groups face access issues linked to regulatory gaps and limited public information.

Europe

Western Europe ensures broad access; Eastern and Southeastern countries lag due to policy and funding gaps.

Adolescents and uninsured populations face persistent barriers where public coverage is lacking.

North America

Canada shows provincial disparities; Indigenous and minority groups remain underserved.

References

- [1] United Nations Department of Economic and Social Affairs. State of the world's indigenous peoples 2016 [Accessed 25 September 2025]. Available from: https://www.un.org/esa/socdev/unpfii/documents/2016/Docs-updates/SOWIP_Health.pdf?utm
- [2] European Parliamentary Forum for Sexual and Reproductive Rights. Global Contraception Policy Atlas Africa 2023 [Accessed 25 September 2025]. Available from: <https://contraception.srhrpolicyhub.org/region/?region=afr>
- [3] Bolarinwa OA, Odimegwu C, Ajayi KV, et al. Barriers and facilitators to accessing and utilising sexual and reproductive health services during the COVID-19 pandemic in Africa: a systematic review and meta-analysis. *BMC Health Serv Res.* 2024;24(1):1554.
- [4] Sidamo NB, Kerbo AA, Gidebo KD, et al. Socio-Ecological Analysis of Barriers to Access and Utilization of Adolescent Sexual and Reproductive Health Services in Sub-Saharan Africa: A Qualitative Systematic Review. *Open Access J Contracept.* 2023;14:103-118.
- [5] Fentie EA, Asmamaw DB, Shewarega ES, et al. Socioeconomic inequality in modern contraceptive utilization among reproductive-age women in sub-Saharan African countries: a decomposition analysis. *BMC Health Serv Res.* 2023;23(1):185.
- [6] Kenny L, Bhatia A, Lokot M, et al. Improving provision of family planning among pastoralists in Kenya: Perspectives from health care providers, community and religious leaders. *Glob Public Health.* 2022;17(8):1594-1610.
- [7] Habte A, Tamene A, Bogale B. Women empowerment domains and unmet need for contraception among married and cohabiting fecund women in Sub-Saharan Africa: A multilevel analysis based on gender role framework. *PLoS One.* 2023;18(9):e0291110.
- [8] Rattan J, Noznesky E, Curry DW, et al. Rapid Contraceptive Uptake and Changing Method Mix With High Use of Long-Acting Reversible Contraceptives in Crisis-Affected Populations in Chad and the Democratic Republic of the Congo. *Glob Health Sci Pract.* 2016;4 Suppl 2(Suppl 2):S5-S20.
- [9] United Nations. World Fertility and Family Planning 2020: Highlights: United Nations Department of Economic and Social Affairs, Population Division; 2020 [Accessed 25 September 2025]. Available from: https://www.un.org/en/development/desa/population/publications/pdf/family/World_Fertility_and_Family_Planning_2020_Highlights.pdf?utm
- [10] Bankole A, Remez L, Owolabi O, et al. From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress 2020 [Accessed 25 September 2025]. Available from: <https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa>.
- [11] DESIP. Increasing domestic financing for family planning commodities in Kenya: Delivering Sustainable and Equitable Increases in Family Planning in Kenya (DESIP); 2024 [Accessed 25 September 2025]. Available from: <https://options.co.uk/wp-content/uploads/2024/07/Increasing-domestic-financing-for-family-planning-commodities-in-Kenya.pdf?utm>
- [12] The development Research and Projects Center. Comparative analysis of family planning funding in Africa 2021 [Accessed 25 September 2025]. Available from: <https://drpcngr.org/wp-content/uploads/2021/05/COMPARATIVE-ANALYSIS-OF-FAMILY-PLANNING-FUNDING-IN-AFRICA.pdf?utm>
- [13] National Research Council. Factors Affecting Contraceptive Use in Sub-Saharan Africa. 1993 [Accessed 25 September 2025]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK236398/?utm>
- [14] Brooks N, Bendavid E, Miller G. USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. *Lancet Glob Health.* 2019;7(8):e1046-e1053.
- [15] Bendavid E, Avila P, Miller G. United States aid policy and induced abortion in sub-Saharan Africa. *Bull World Health Organ.* 2011;89(12):873-880C.
- [16] European Parliamentary Forum for Sexual and Reproductive Rights. Family Planning Policy Atlas Middle East and North Africa 2023 [Accessed 25 September 2025]. Available from: https://www.epfweb.org/sites/default/files/2023-10/CCInfoMENA_A3_EN_2023_AUG31.pdf
- [17] The Organisation for Economic Co-operation and Development. Transforming laws and norms to achieve universal sexual and reproductive health and rights. 2025.
- [18] Chalem A, Nzali A, Cordeiro AA, et al. Perspectives of Muslim Religious Leaders to Shape an Educational Intervention About Family Planning in Rural Tanzania: A Qualitative Study. *Glob Health Sci Pract.* 2023;11(1).
- [19] The World Bank. Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa 2018 [Accessed 30 September 2025]. Available from: <https://documents1.worldbank.org/curated/en/223181468299192501/pdf/817230WP-0P12940Box0379842B00PUBLIC0.pdf?utm>
- [20] European Parliamentary Forum for Sexual and Reproductive Rights. Contraception Policy Atlas Asia Pacific 2023 2023. Available from: <https://www.epfweb.org/sites/default/files/2024-08/2023-contraception-atlas-epf-asia-pacific.pdf>
- [21] Rosewell A, Shearman P, Ramamurthy S, et al. Transforming the health information system using mobile and geographic information technologies, Papua New Guinea. *Bull World Health Organ.* 2021;99(5):381-387A.

- [22] Tanaka M, Manandhar Shrestha R, Shah R, et al. Gaps in Migrants' Access to Contraceptive Services: A Survey of Nepalese Women and Men in Japan. *Healthcare (Basel)*. 2024;12(13).
- [23] Najafi-Sharjabad F, Zainiyah Syed Yahya S, Abdul Rahman H, et al. Barriers of modern contraceptive practices among Asian women: a mini literature review. *Glob J Health Sci*. 2013;5(5):181-192.
- [24] Harrington RB, Harvey N, Larkins S, et al. Family planning in Pacific Island Countries and Territories (PICTs): A scoping review. *PLoS One*. 2021;16(8):e0255080.
- [25] Araujo FG, Velasquez-Melendez G, Felisbino-Mendes MS. Socioeconomic inequalities in contraceptive use among Brazilian women: A multilevel analysis stratified by parity. *Heliyon*. 2024;10(14):e34833.
- [26] Ponce de Leon RG, Ewerling F, Serruya SJ, et al. Contraceptive use in Latin America and the Caribbean with a focus on long-acting reversible contraceptives: prevalence and inequalities in 23 countries. *Lancet Glob Health*. 2019;7(2):e227-e235.
- [27] Rights EPfSR. Contraception policy atlas latin america and the caribbean (LAC) 2023 2023 [Accessed 25 September 2025]. Available from: <https://www.epfweb.org/sites/default/files/2024-09/Whitepaper-LAC-EN-AUG28-LoRes.pdf>
- [28] European Parliamentary Forum for Sexual and Reproductive Rights. Contraception Policy Atlas Europe 2024 [Accessed 25 September 2025]. Available from: https://www.epfweb.org/sites/default/files/2024-02/CCInfoEU_A3_EN_2024_FEB12_0.pdf
- [29] European Parliamentary Forum for Sexual & Reproductive Rights. Contraception Policy Atlas Canada: European Parliamentary Forum for Sexual & Reproductive Rights and Action Canada for Sexual Health and Rights; 2023 [Accessed 25 September 2025]. Available from: https://www.actioncanadashr.org/sites/default/files/2023-09/CCInfoCAN_A3_EN_2023_SEP20_0.pdf
- [30] Hulme J, Dunn S, Guilbert E, et al. Barriers and facilitators to family planning access in Canada. *Healthc Policy*. 2015;10:48-63.
- [31] Aptekman M, Rashid M, Wright V, et al. Unmet contraceptive needs among refugees. *Can Fam Physician*. 2014;60:613-619.
- [32] Swan LET. Policy impacts on contraceptive access in the United States: a scoping review. *Journal of Population Research*. 2023;40(5).
- [33] Ellison JE, Brown-Podgorski BL, Morgan JR. Changes in Permanent Contraception Procedures Among Young Adults Following the Dobbs Decision. *JAMA Health Forum*. 2024;5(5).
- [34] Kavanaugh ML, Leong E, Haas M. Measuring the Relationship Between the 2019 Title X Final Rule and Patients' Sexual and Reproductive Health Care Access and Behavior in Iowa Using a Difference-in-Difference Approach. *Sex Res Social Policy*. 2024;21:598-615.
- [35] White K, Hopkins K, Aiken AR, et al. The impact of reproductive health legislation on family planning clinic services in Texas. *Am J Public Health*. 2015;105(5):851-858.
- [36] Ranji U, Salganicoff A, Sobel L, et al. Financing Family Planning Services for Low Income Women: The Role of Public Programs Henry J Kaiser Family Foundation; 2019.
- [37] Stevenson AJ, Flores-Vazquez IM, Allgeyer RL, et al. Effect of Removal of Planned Parenthood from the Texas Women's Health Program. *N Engl J Med*. 2016;374(9):853-860.
- [38] Joint Economic Committee. The Economic Impacts of Contraception: Joint Economic Committee; 2022 [Accessed 26 September 2025]. Available from: <https://www.jec.senate.gov/public/index.cfm/democrats/2022/10/the-economic-impacts-of-contraception>
- [39] Jones KB. Ensuring Contraception Options Are Accessible and Affordable 2024 [Accessed 25 September 2025]. Available from: <https://www.americanprogress.org/article/playbook-for-the-advancement-of-women-in-the-economy/ensuring-contraception-options-are-accessible-and-affordable/?utm>
- [40] Kaye K, Gootman JA, Ng AS, et al. The Benefits of Birth Control in America: Getting the Facts Straight 2014 [Accessed 25 September 2025]. Available from: <https://powertodecide.org/sites/default/files/resources/primary-download/benefits-of-birth-control-in-america.pdf?utm>
- [41] Slaymaker E. Correction to Lancet Glob Health 2020; 8: e567-79. *Lancet Glob Health*. 2020;8(5):e648.
- [42] Slaymaker E, Scott RH, Palmer MJ, et al. Trends in sexual activity and demand for and use of modern contraceptive methods in 74 countries: a retrospective analysis of nationally representative surveys. *Lancet Glob Health*. 2020;8(4):e567-e579.
- [43] Haakenstad A, Angelino O, Irvine CMS, et al. Measuring contraceptive method mix, prevalence, and demand satisfied by age and marital status in 204 countries and territories, 1970-2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet*. 2022;400(10348):295-327.
- [44] Ndayizigiye M, Fawzi MC, Lively CT, et al. Understanding low uptake of contraceptives in resource-limited settings: a mixed-methods study in rural Burundi. *BMC Health Serv Res*. 2017;17(1):209.

[45] FOCUS. The access to contraception around the world : situational analysis and current challenges 2024 [Accessed 25 September 2025]. Available from: <https://focus2030.org/The-access-to-contraception-around-the-world-situational-analysis-and-current>