staff may exacerbate confusion and delayed initiation of use by insisting on menstruation as evidence of nonpregnancy before offering methods. Finally, the current-status approach to assessing postpartum need for contraception is consistent with the behavior and beliefs of most women in low- and middle-income countries.

The relative merits of the current-status and prospective approaches to assessing postpartum need, and the programmatic implications of which approach is taken, depend to a large extent on local considerations. Among the 16 countries listed in Table 1, the percentage of women at 6–11 months postpartum for whom menses or sex (or both) has not resumed ranges from 2% in Jordan to 64% in Ghana (results not shown). Obviously, a policy of regarding amenorrheic nonusers as needing contraception is much more appropriate in Jordan than in Ghana. Comparing levels of unmet need across populations in the first year postpartum is one obvious way of setting international priorities for investment in postpartum family planning provision. Under the prospective definition, the countries of Sub-Saharan Africa have the greatest need. Of the 16 countries in Table 1, the top six in terms of prospective unmet need are African. In contrast, the six countries with the highest current unmet need are Guyana, Pakistan, Uganda, the Dominican Republic, Kenya and Ghana.

Neither measure is satisfactory because no account is taken of fertility level. The number of births per woman is an important consideration in setting priorities because it defines the number of times that an average woman will require postpartum protection and the proportion of all children who run the risk of inadequate spacing with adjacent siblings. For instance, with a fertility rate of two, only half of children on average run the risk of being born within 24 months of an elder sibling. With a fertility rate of five, this proportion rises to 80%. For this reason, it is preferable to establish priorities, not by unmet need measures, but by the straightforward expedient of multiplying the percentage of interbirth intervals that are shorter than 24 months by the total fertility rate (see Table 1). Under this approach to relative need, the top six countries are the DRC, Uganda, Pakistan, Nigeria, Jordan and Kenya. Guyana is now rated low in relative need because the high proportion of short intervals is offset by low fertility, while Ghana is rated low because high fertility is offset by a low proportion of short intervals.

Differences in Unmet Need by Duration Postpartum Among Exposed Women
As already established, unmet need is very low in the first year postpartum under the current-status definition, which classifies amenorrheic and abstaining women as having no need. However, the analysis thus far has not established the level of unmet need among postpartum women who have resumed sex and menstruation or how this level compares to the level among women at other stages of the reproductive cycle. Accordingly, we calculated unmet need for women who were fully exposed to the risk of conception at the time of the survey by excluding nonusers who are still amenorrheic and have not resumed sex, as well as those who are pregnant. The results of this approach are shown in Figure 2. To be precise, this figure shows the percentage of women—among all married, fecund, nonpregnant women who have resumed menses and sex—who do not want a child within the next two years but are using no method of contraception. On a priori grounds, a steady decrease in unmet need is expected as duration postpartum (i.e., open interval length) increases because of selectivity.