A third strategy for estimating unmet need in the postpartum period is to restrict unmet need to women who have resumed menses and sex, are not practicing contraception, but wish to postpone childbearing for two or more years. In other words, amenorrheic or abstaining women are classified along with women practicing contraception and those who want another child within two years as having no unmet need. This “current-status” approach comes closer than the standard DHS definition to capturing women’s immediate need for contraception, though it is subject to the criticism that reliance on amenorrhea is not 100% effective.

To determine how the use of these differing definitions affects the level of unmet need in the postpartum period, we analyzed data from 16 countries that had a recent DHS. The countries were selected purposively to obtain a geographic spread and equal numbers with high and low prevalence of short interbirth intervals. In Table 1, the first two countries in each regional group have a high prevalence and the second two a low prevalence of short intervals. We then applied the three measures of unmet need and compared the results.

The three measures yield very different results for women 0–11 months postpartum (Table 1). The denominator for all three estimates is currently married (or cohabiting) women, and all three categorize the small minority (about 3%) of currently pregnant women according to the intendedness of their pregnancy; that is, those who reported the pregnancy as mistimed or unwanted were classified as part of the group with unmet need. The prospective measure gives the highest estimates of unmet need for any method, ranging from 23% in Morocco to 82% in Ghana. The mean for all 16 surveys is 47%. These estimates are similar to those given by Ross and Winfrey for a different set of surveys and are the origin of the assertion that unmet need is particularly high in the postpartum period.

The current-status method gives the lowest estimates, with a range of 3–21% and a mean of 9%. In every survey, the DHS definition yields values that are intermediate. Depending on which approach is preferred, unmet need in the 12 months postpartum may be regarded as exceptionally high or exceptionally low—an unhelpful situation.

The prospective definition has influenced the priorities of major donors and helped revitalize the postpartum family planning agenda, which had been neglected since the end of the Population Council’s International Postpartum Program in 1974. It can be argued that the promotion of highly effective long-acting reversible methods (LARC) or sterilization early in the postpartum should be a top priority because short interbirth intervals, with their well-established adverse health consequences, remain common. As mentioned in the introduction, an analysis of DHS data from 72 countries found that 25% of interbirth intervals, on average, were shorter than 24 months. This strong health rationale may justify early postpartum promotion of methods even in settings where prolonged breast-feeding and amenorrhea act to postpone pregnancy. Provided that method continuation is high, the problem of redundant protection stemming from the overlap between amenorrhea and contraceptive use can be dismissed.

Conversely, postpartum uptake within a few months of childbirth of methods associated with low continuation,