



# Unmet need for contraception<sup>1</sup>

at a glance

## The concept of unmet need

The concept of “unmet need for contraception”, which refers to the proportion of women who do not want to become pregnant but are not using contraception, has been used in the international population field since the 1960s. The concept was developed from the first family planning and fertility surveys conducted in developing countries, which found a disconnect between women’s knowledge, attitudes, and practices (KAP) about contraception. This gap between what the respondents knew, their fertility preferences, and behaviors to achieve their stated preferences, became known first as the “KAP-Gap” and was used as a strong rationale for investment in family planning programs (Casterline and Sinding, 2000)[1]. The subsequent development of the unmet need concept has been supported by the availability of datasets from over 75 countries collected by the Demographic and Health Surveys (DHS) program. Difficulties with the measurement and interpretation of the concept have been described in several papers by Westoff and coauthors since the 1970s[2–6]. In this note, we summarize the strengths and weaknesses of the unmet need indicator, discuss the differences between demand and supply factors for unmet need, show the differences between unmet need and the intention to use contraception, and clarify the relevance of the concept for investing in family planning programs.<sup>2</sup>

Unmet need for contraception is one of several frequently used indicators for monitoring of family planning programs, and was recently added to the MDG goal of improving maternal health. Some other indicators that are used in combination with unmet need are the *contraceptive prevalence rate (CPR)*, the method mix, sources of contraceptive supplies, and reasons for not using contraception. In this note, we deal mainly with the unmet need indicator, but believe that other indicators should also be part of monitoring and evaluation of family planning programs to broaden the understanding of the use of family planning in countries.

The indicator **unmet need for contraception is defined as the proportion of currently married women who do not want any more**

**children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of family planning (unmet need for contraception for spacing)**[2]. The unmet need measure gives an estimate of the proportion of women who might potentially use contraception. Women who are using contraceptives are said to have *met need for family planning*. The *total demand for family planning* is made up of the proportion of married women with unmet need and married women with met need for family planning.<sup>3</sup>

The existence of unmet need is sometimes interpreted as evidence of lack of access to a source of contraceptive supplies. However, there are many reasons why women do not use contraception, and unmet need should not be equated with the lack of access to contraception due to supply constraints (such as distance to a source for obtaining contraceptives, stockouts of contraceptives among providers, or legal obstacles), or to financial costs associated with using family planning. As assessed by surveys, women with unmet need may still not have any intention to use contraception were it readily accessible and of good quality. Non-use of contraception may be due to demand side reasons, including cultural or religious objections to contraception, objections from a spouse, lack of knowledge, or fear of side effects.

In countries such as Niger or Nigeria, in which large families are the norm and women do not want to space or limit fertility, both contraceptive use and unmet need are low (Figure 1). In countries in which

<sup>1</sup> This note was written by Samuel Mills, Ed Bos, and Emi Suzuki, of the Human Development Network at the World Bank. Correspondence to: [smills@worldbank.org](mailto:smills@worldbank.org). Peer reviewer comments from John May (AFHTE) and Thomas Merrick (WBIHS) are gratefully acknowledged.

<sup>2</sup> This note will not review the extensive literature on the predictive validity of stated reproductive attitudes and intentions on contraceptive demand and reproductive behavior. See, for example, A. Bankole and C.F. Westoff, *The consistency and validity of reproductive attitudes: evidence from Morocco*, *J Biosoc Sci.* 1998 (4):439–55; and T.K. Roy et al., *Can women’s childbearing and contraceptive intentions predict contraceptive demand?* *Family Planning Perspectives* 2003, 29 (1): 25–31.

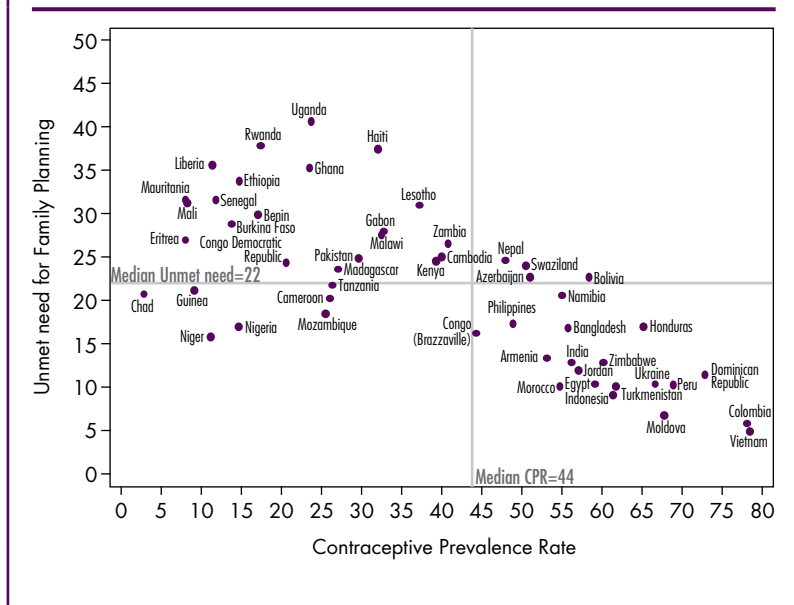
<sup>3</sup> A better term would be “total market for family planning”, as those with unmet need may not have a demand for contraception at the time unmet need is established.

desired family size has been declining and couples want to space or limit the number of children, as in Uganda or Ethiopia, unmet need frequently increases. In these countries, information on contraceptive methods, or where to obtain them is incomplete, or family planning services do not cover the entire population. Over time, family planning programs in countries with declining desired family size (such as Zimbabwe or Namibia) are often able to improve supply of contraceptives and improve information on method availability and safety, leading to an increase in contraceptive use and a decline in unmet need. It is important not to interpret high levels of unmet need as the failure of a family planning program, as unmet need is a dynamic indicator that changes from low levels in countries in which fertility preferences have not started to decline to higher levels during the transitional period between high and low fertility, when the demand for contraception has been created, and back to low levels as the demand becomes fulfilled. Trends in unmet need observed in countries will be discussed in section 6 below.

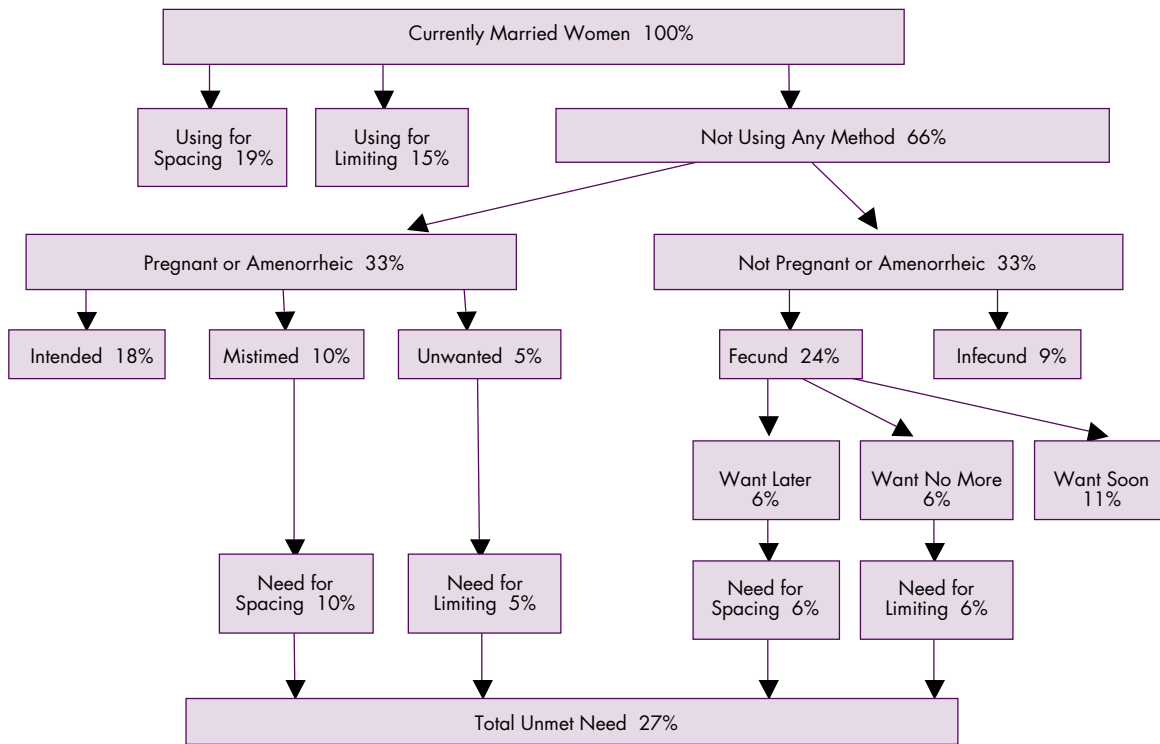
## How unmet need is measured

Unmet need for contraception is generally measured with household surveys, in which married women of reproductive age respond to a number of precisely worded questions. The steps involved in calculating whether unmet exists are illustrated in Figure 2, which shows a flow chart for how information is collected used to calculate the level of unmet need. A woman is first asked whether she is using any method of contraception, whether for the purpose of limiting or spacing births. If she is using contraception, including traditional methods, she is considered to be a contraceptive user, and therefore does not have unmet need. Women who are not using contraception are then asked whether they are pregnant or amenorrheic (not menstruating, often due to a recent pregnancy or lactation). In the calculation of unmet need, pregnant or amenorrheic women whose pregnancy was mistimed or unwanted are added to the proportion with unmet need, even though they do not at the time of the survey have an immediate need for contraception, given their pregnancy. Women who are not pregnant or amenorrheic and are infertile do not have unmet need, nor do women who want to become pregnant soon. Note that the measurement

**Figure 1. Unmet need for family planning vs. contraceptive prevalence rate, 2000–2008 DHS reports, selected countries**



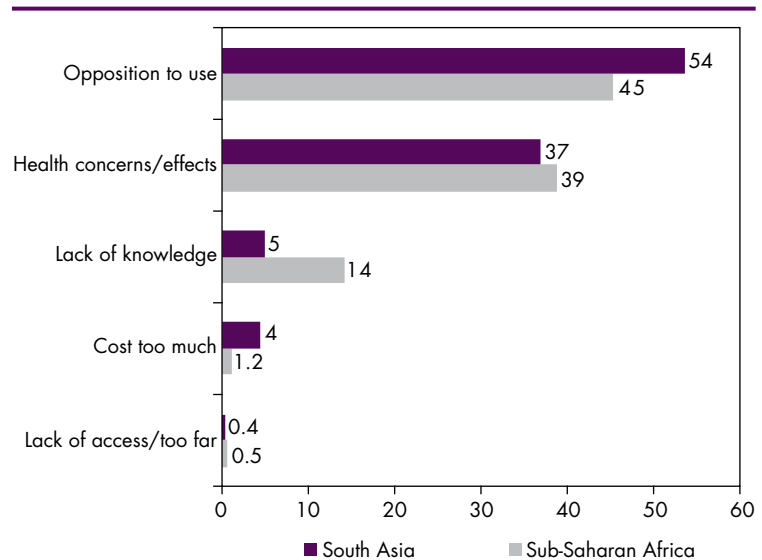
**Figure 2. The Measurement of unmet need among currently married women, Zambia 2001–2002**



Source: Westoff 2006.

are not planning to use in the future. Figure 3 shows the mean values for South Asian and Sub-Saharan African countries of all surveys conducted from 2000 to 2008. For women whose reasons for not using contraception are not related to a desire to have more children or other fertility-related reasons such as infertility and infrequent sex/no sex, the most important reasons are opposition to use contraceptives, and a fear of side effects and health concerns. Lack of knowledge is somewhat important in Sub-Saharan Africa; the costs of contraceptives or access to a family planning provider are not important reasons in either region. This indicates that family planning programs must do more than supplying methods of contraception at affordable prices. An understanding of the nature of concerns of side effects, and the reasons for opposition to use is critical to design appropriate communica-

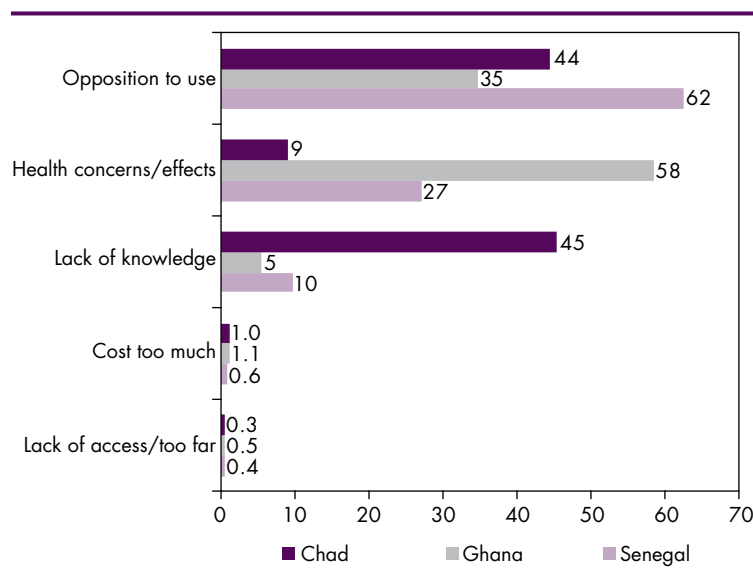
**Figure 3. Reasons currently married women who are not using contraception do not intend to use in future, 2000–2008 DHS reports, regional means**



Note: Fertility-related reasons such as wanting more children are excluded

tion campaigns. IEC efforts need to address the reasons for opposition to use (this could include opposition from husbands or other family members, or religious reasons), as well as provide sufficient information so that women can make informed choices about the significance of side effects and potential health impacts. Such information efforts need to take individual country findings into account, as reasons for not intending to use contraception may vary substantially in different socioeconomic contexts, as shown in Figure 4. Lack of knowledge is the most important reason for the intention not to use contraception in Chad, whereas this is unimportant in Ghana, where health concerns and side effects are the reported reasons for non-use. In Senegal, more than half of all women who are not using contraception are not doing so because of opposition to family planning (the exact nature of which is also collected in the DHS).

**Figure 4. Reasons currently married women who are not using contraception who do not intend to use in future, 2000–2008 DHS reports, selected countries**



Note: Fertility-related reasons such as wanting more children are excluded

In most low- and middle income countries, knowledge of contraceptive methods and where to obtain them is high for married women of reproductive age (between 90 and 100 percent of survey respondents), but in a few Sub-Saharan African countries (include Chad, Mali, Niger), knowledge of at least one contraceptive method is much lower (between 60 to 80 percent). In these countries, both contraceptive use and unmet need are low, as the desired level of fertility is high. IEC efforts in these countries need to focus on the potential benefits of small family sizes and the untoward health effects such as low birth weight, preterm birth, high infant mortality, and high maternal mortality.

## Levels of unmet need in low- and middle income countries

Table 1 shows the levels of unmet need in recent DHS country reports during 2000–2008, showing aggregate results for the Bank regions, and detailed country results for the Africa region. Some of the key findings from this table include:

- Unmet need is higher for limiting than spacing childbearing, in all regions except Sub-Saharan Africa, where unmet need for spacing is almost twice as high as for limiting
- Across regions, unmet need ranges from 11 per-

cent (Middle East and North Africa) to 26 percent (Sub-Saharan Africa); met need (Contraceptive Prevalence Rate) ranges from 25 percent (Sub-Saharan Africa) to 63 percent (Latin America and the Caribbean).

- The total demand for family planning across regions ranges from 51 percent (Sub-Saharan Africa) to 80 percent (Latin America and the Caribbean). In Africa, only 45 percent of demand is satisfied, contrasting to 70–84 percent in the other regions.
- In Sub-Saharan African countries, unmet need for limiting is very low in Chad, Congo, and Niger (below 5 percent); it is also low in Zimbabwe (5 percent), where most of the unmet need has been addressed through increased contraceptive use.
- Different levels of unmet need and total potential demand for family planning in Sub-Saharan African countries reflect the non-linear pattern of unmet need over the fertility transition, pointing to the need for careful interpretation of levels and trends of the unmet need indicator.

## Levels of unmet need by poverty quintiles

**Unlike many of the other health indicators, levels of unmet need do not show clear**

**Table 1. Unmet need, met need, and total demand for family planning. Countries with DHS surveys 2000–2009 (unweighted means for regional aggregates)**

Region/Country	Unmet need for spacing A	Unmet need for limiting B	Unmet need Total C (=A+B)	Met Need (CPR) D	Total demand for family planning E (=C+D)	Percentage of demand satisfied F (=D/E)
<b>East Asia and Pacific</b>	<b>6</b>	<b>8</b>	<b>14</b>	<b>57</b>	<b>71</b>	<b>79</b>
<b>Europe and Central Asia</b>	<b>4</b>	<b>9</b>	<b>13</b>	<b>60</b>	<b>73</b>	<b>83</b>
<b>Latin America and Caribbean</b>	<b>7</b>	<b>10</b>	<b>17</b>	<b>63</b>	<b>80</b>	<b>77</b>
<b>Middle East and North Africa</b>	<b>4</b>	<b>7</b>	<b>11</b>	<b>57</b>	<b>68</b>	<b>84</b>
<b>South Asia</b>	<b>8</b>	<b>12</b>	<b>20</b>	<b>47</b>	<b>67</b>	<b>70</b>
<b>Sub-Saharan Africa</b>	<b>17</b>	<b>9</b>	<b>26</b>	<b>25</b>	<b>51</b>	<b>45</b>
Benin	18	12	30	17	47	36
Burkina Faso	22	7	29	14	43	32
Cameroon	14	6	20	26	46	56
Chad	18	2	21	3	24	12
Congo, Rep.	13	3	16	44	61	73
Congo, Dem. Rep.	19	5	24	21	45	46
Eritrea	21	6	27	8	35	23
Ethiopia	20	14	34	15	49	30
Gabon	20	8	28	33	61	54
Ghana	23	13	35	24	59	40
Guinea	13	8	21	9	30	30
Kenya	14	10	25	39	64	62
Lesotho	11	20	31	37	68	55
Liberia	25	11	36	11	47	24
Madagascar	11	12	24	27	51	54
Malawi	17	10	28	33	60	54
Mali	21	10	31	8	39	21
Mauritania	23	9	32	8	40	20
Mozambique	11	8	18	26	44	58
Namibia	9	12	21	55	76	73
Niger	13	3	16	11	27	42
Nigeria	12	5	17	15	32	46
Rwanda	25	13	38	17	55	32
Senegal	24	7	32	12	43	27
Swaziland	7	17	24	51	75	68
Tanzania	15	7	22	26	48	55
Uganda	25	16	41	24	64	37
Zambia	17	9	27	41	67	61
Zimbabwe	8	5	13	60	73	83

Source: Demographic and Health Surveys (2000–2009).

**patterns by poverty quintiles as shown in Figure 5.**

In some countries such as Benin, Chad, Mali, and Nigeria, women in the wealthiest quintile have higher unmet need than the women in lower quintiles, whereas in other countries such as Bolivia, Ghana, Togo, and Zimbabwe, the patterns are reversed. The reasons for these patterns are essentially the same as for differences among countries at different stages of fertility decline. Countries in which unmet need increases with increasing wealth tend to be in the earlier stages of declining desired family size, which declines first in urban areas, among more educated women, and among wealthier households. As family planning programs and other providers are at first not able to fill the increased demand for contraceptives or address concerns about health and side effects, unmet need increases in the wealthier quintiles, while it remains low in the poorest quintiles where demand for family planning remains low. Over time, contraceptive use increases among the wealthier quintiles and met need reduces unmet need, at which time the patterns reverse. At the pre-transition and late transition phases of fertility decline, unmet need may be uniformly low for all quintiles.

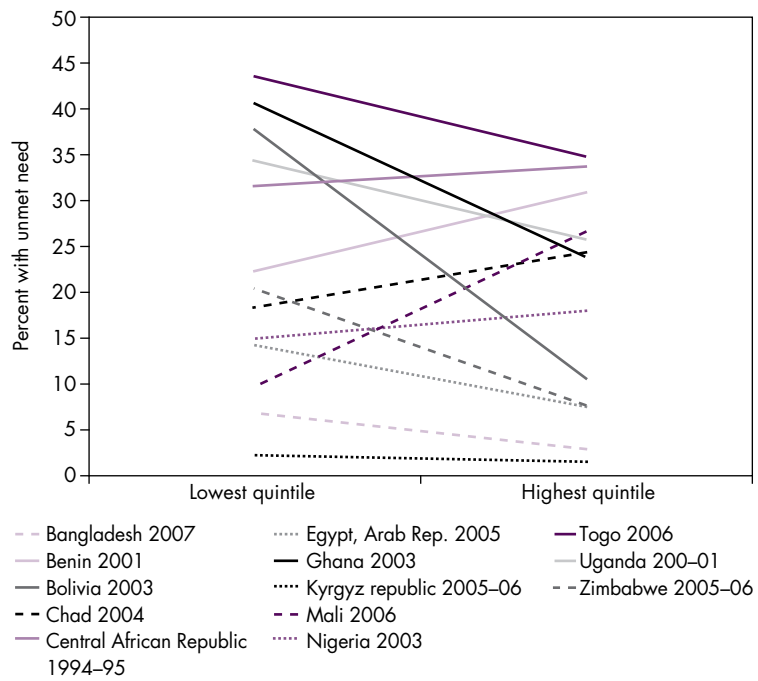
**Trends in unmet need**

As discussed above, the extent of unmet need for contraception in a given country changes over time as desired family size and contraceptive use patterns change, and does not necessarily decrease with improved access to family planning services[3]. Thus, **low levels of unmet need do not always indicate success of family planning programs and vice versa.**

Indeed, as shown in Figure 6, in the past two decades unmet need for contraception increased in Uganda, it decreased in Egypt, and in the case of Ghana there was no appreciable change. In Bangladesh contraceptive use increased from 45 percent to 56 percent during 1993–2007. During this period, unmet need first decreased, then increased.

In a country with high TFR but low unmet need such as Niger, an initial increase in unmet need in

**Figure 5. Unmet need by poverty quintiles, 1990–2008**



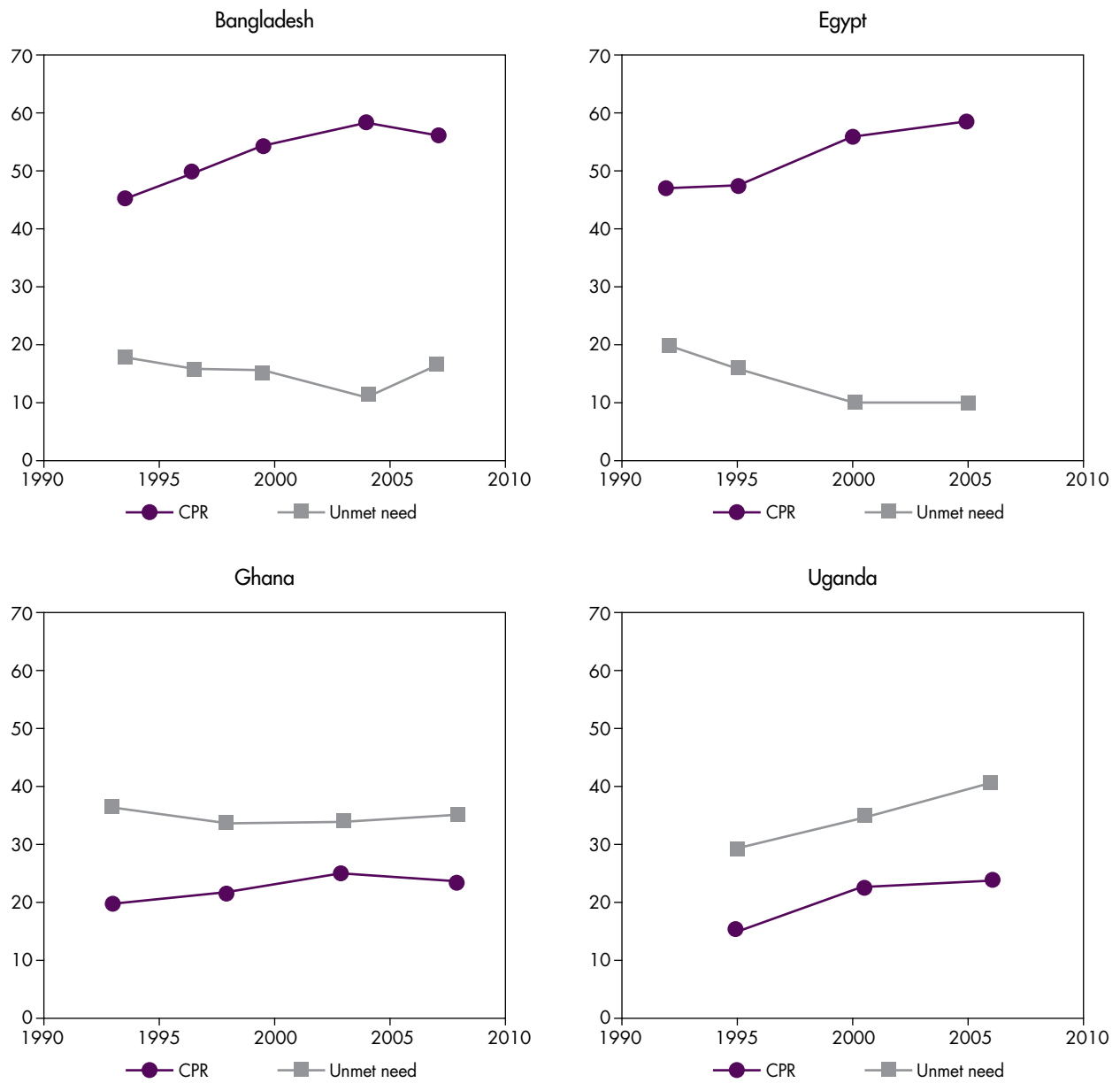
Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys.

response to a BCC programs instituted to influence couples to desire smaller families could be interpreted as a success; subsequently, unmet need should decrease with increasing access to quality family planning services.

**Summary and implications for Bank operations**

- It is important not to interpret high levels of unmet need as the failure of a family planning program, as unmet need is a dynamic indicator. It changes from low levels in countries in which fertility preferences have not started to decline to higher levels during the fertility transition period, and back to low levels as the demand for small family size becomes fulfilled.
- The existence of unmet need is sometimes interpreted as evidence of lack of access to a source of contraceptive supplies due to supply constraints or to financial costs. However, there are many reasons why women do not use contraception and family planning programs must do more than supplying methods of contraception at affordable prices.

**Figure 6. Trends in unmet need and CPR during 1990–2008, selected countries**



Source: Demographic and Health Surveys

■ In monitoring and evaluation of family planning programs, an increase in unmet need or no change in unmet need does not always imply that the intervention was not successful. One needs to take into account other indicators such as CPR, TFR, fertility preferences, method mix, and reasons for not using contraceptives.

■ In the design of projects which aim at improving access to and quality of family planning programs, it is important to understand the reasons why women are not using contraceptives. Information on the reasons for not intending to use contraceptives is available in the DHS and other surveys.

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