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Breastfeeding Women and Family Planning Programs: Special Needs and Opportunities

by Nancy E. Williamson

OVER THE PAST DECADE it has become clear that breastfeeding makes a major contribution to fertility control and child spacing in many developing countries, although biological scientists are still exploring the endocrinological pathways by which breastfeeding delays the return of fecundity. Fertility surveys such as the World Fertility Surveys, the Contraceptive Prevalence Surveys, and the breastfeeding surveys of the World Health Organisation have documented the strong association between breastfeeding duration and length of postpartum amenorrhea

(e.g., Goldman, Westoff, and Paul 1987; Habicht et al. 1985; World Health Organisation 1981; World Fertility Survey 1984).

Despite the demonstrated effect that breastfeeding has on child spacing in less developed countries, the implications of this finding are not widely recognized among family planning managers, workers, and clinicians. Health programs typically focus on the very important nutritional and anti-infective contributions of breastfeeding, but not on its contraceptive effect.

This article examines the evidence of breastfeeding's effect on child spacing, considers why family planning programs in developing countries have overlooked this effect, and suggests how programs can help lactating women get the maximum contraceptive effect from breastfeeding while also helping them to adopt family planning methods at the appropriate time.

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ASIAN AND PACIFIC POPULATION FORUM

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The *Asian and Pacific Population Forum*, published quarterly, brings articles of potential value in policy formulation, program administration, and research to the notice of professionals concerned with population matters, particularly in Asia, the Pacific, and the United States.

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■ Demographic evidence

The demographic effect of breastfeeding on child spacing varies throughout the world. It is more important in some Asian countries and particularly in Africa than in developed countries and in Latin America, where contraception is more common and the breastfeeding period is shorter (Thapa, Short, and Potts 1987).

Many investigators have tried to quantify the additional amount of contraceptive protection (or "waiting time" until the next conception) conveyed by an additional month of breastfeeding for women using no contraception. For example, Goldman, Westoff, and Paul (1987) found in 20 surveys that each additional month of breastfeeding resulted in 0.76 to 0.80 months of waiting time. Other studies using slightly different approaches have put this figure at 0.40 months (Jain and Bongaarts 1981; Jain and Sun 1972), 0.56 months (Corsini 1979), and 0.70 months (Bongaarts and Potter 1983).

Various methodological problems are associated with assessing the contribution of breastfeeding to postpartum infecundity (see, e.g., Corsini 1979; Habicht et al. 1985; Santow 1987). However, for non-contracepting populations in many developing countries, "variations in breastfeeding duration appear to account for most of the observed variation in birth interval length" (Goldman, Westoff, and Paul 1987:134).

Of course, the fact that a woman is breastfeeding does not automatically mean she has contraceptive protection, and a few women become pregnant while still amenorrheic. In the developing countries cited in Table 1, from 1.5 to 7.5 percent of breastfeeding women who were using no contraceptive method became pregnant before their menses resumed. This range is sometimes rounded off to between 5 and 10 percent to be on the conservative side.

These percentages are neither life table failure rates nor Pearl

To Our Readers

Yes, this is Number 5 of Volume 1. We have decided to include five issues in this first volume in order to put the *Asian and Pacific Population Forum* on a calendar-year schedule. Volume 2, Number 1, will appear in February 1988.

The following persons generously reviewed manuscripts for the *Population Forum* over the past year. The editors are grateful for their advice and suggestions.

Fred Arnold	Griffith Feeny	Jane Menken
John Bauer	Indra Gajayanake	James A. Palmore
Ansley J. Coale	Victoria T. Ho	Robert D. Retherford
David Ellis	Andrew Mason	Shyam Thapa

pregnancy rates, since the duration and type of breastfeeding vary across the populations listed here. Nor do they take into account possibly overlapping effects of breastfeeding and postpartum sexual abstinence or reduced sexual activity. Nevertheless, they are suggestive of breastfeeding's contraceptive effect and are remarkably consistent for the developing countries listed.

A further refinement in the analysis of breastfeeding has been to distinguish between full breastfeeding (un-supplemented by other

foods) and partial breastfeeding. A number of studies have found that full breastfeeding postpones fecundity longer than supplemented breastfeeding (e.g., Diaz et al. 1982; Gray et al. 1986; Howie and McNeilly 1982; Kivera et al. 1985, 1987).

Although it has proven difficult to predict precisely the time ovulation returns for breastfeeding women, it appears that duration of breastfeeding, breastfeeding intensity (frequency and duration day and night), and supplementation patterns are important predictors of the duration of postpartum infecundity. A woman who breastfeeds intensively (on demand, frequently, and at night), exclusively (using no bottles, pacifiers, or supplements), and for a prolonged time will usually experience longer lactational infecundity than a woman who breastfeeds less conscientiously.

A woman who breastfeeds intensively, exclusively, and for a prolonged time usually experiences longer lactational infecundity than a woman who breastfeeds less conscientiously.

The fecundity-inhibiting effect of breastfeeding can persist even after a breastfeeding woman has resumed menstruation (John, Menken, and Chowdhury 1988). This effect enhances the demographic contribution of breastfeeding but is of less practical relevance to an individual woman, who would be ill-advised to rely on the contraceptive

effect of breastfeeding after her menstrual cycles have resumed.

Nevertheless, the infecundity associated with breastfeeding fulfills many of the requirements of a good temporary contraceptive method: it is safe, coitus-independent, convenient, and free, and it does not require the services of medical personnel.

It can also be effective. As long as a breastfeeding woman is not ovulating, she has no chance of becoming pregnant. Thus it is 100 percent effective in that period.

Does the fact that 5-10 percent of amenorrhoeic breastfeeding women become pregnant mean that breastfeeding is less effective than temporary methods of birth control? We cannot directly compare the percentages in Table 1 with the pregnancy rates usually calculated for temporary contraceptive methods, such as those in Table 2. The former have number of women as the denominator, whereas the latter are rates based on woman-years of use. Nevertheless, it is important to note that the actual effectiveness of temporary methods can be much lower than their theoretical or clinical-trial effectiveness.

For example, although we may think of pills as having a failure rate of 1-2 pregnancies per hundred women-years of use, in developing countries pregnancy rates among the general population of women using the pill may be much higher. The survey data from the Philippines shown in Table 2 give a Pearl pregnancy rate of 19 failures per 100 woman-years of pill use. Although the Philippine rates may not necessarily be typical of all developing countries, they do serve to remind us that temporary contra-

Table 1. Percentage of noncontracepting women who conceived during lactational amenorrhea: selected countries

Country	Sample size	Percentage conceiving
Bangladesh	107	6.8
Canada (Eskimos)	116	2.6
Chile	170	7.0
Egypt	139	4.3
Egypt	148	6.8
India	68	3.0
India	1,480	1.5
India	1,500	7.0
India	1,079	7.5
Philippines	604	3.0
Rwanda	209	5.4
Rwanda		
Urban	57	2.0
Rural	47	5.0
Taiwan	2,000	6.0
United States	100	10.0
United States	89	13.0

Note: The various studies on which the table is based are not strictly comparable and do not establish a risk of conception specific to length of amenorrhea or type of breastfeeding practice.

Source: Based on Table 1 in Simpson-Hebert and Huffman (1981:126).

ceptive methods, especially those that depend on users' behavior, are far from perfect.

The limitation of breastfeeding as a child-spacing method for the individual is that we do not yet have an absolutely reliable way to predict when ovulation is going to resume. No matter how a woman breastfeeds, she will not be able to suppress ovulation indefinitely. Even exclusive and intense breastfeeding will not necessarily postpone fecun-

dity for the whole duration of breastfeeding or for all women.

Breastfeeding: a family planning method?

Although there is general agreement that breastfeeding makes an important demographic contribution to child spacing, it differs from family planning methods in several respects. It can be used only by new mothers and cannot be used to postpone the first birth. Nor is it

appropriate for women who have attained their completed family size.

It is not appropriate for women who need or want to avoid or postpone another pregnancy at any cost. For such women, immediate postpartum sterilization or the use of an intrauterine device (IUD), injectable, or implant is more suitable. If a woman can take a pill every day, the progestin-only pill is another alternative. Research is under way on whether natural family planning methods are appropriate for breastfeeding women.

Some lactating women may not know that breastfeeding postpones the return of fecundity after childbirth. Others who may suspect it has a contraceptive effect breastfeed not primarily for that reason, but rather to nourish their babies. The child-spacing motivation may be only one of several secondary objectives, such as strengthening the emotional bond between mother and child, convenience, saving money, or following tradition. Only a small number of women in developing countries are convinced that breastfeeding delays fecundity and consider it to be their "contraceptive method."

Finally, as already mentioned, the breastfeeding mother can neither control nor predict when the contraceptive effects of breastfeeding will end. Thus, if breastfeeding can be considered a family planning method, it is a very special kind of method.

Strictly speaking, it is not breastfeeding itself that is the "method." Rather, it is the *infecundity associated with breastfeeding* that constitutes the "method." This point must not be overlooked.

Table 2. Estimates of annual continuation rates, Pearl pregnancy rates, expected Pearl-type pregnancy rates, and contraceptive effectiveness, by method: Philippines

Method	Woman-months ^a	Annual continuation rate ^b	Pearl pregnancy rate ^c	Expected pregnancy rate ^d	Contraceptive effectiveness ^e
Pill	4,875	42	19	113	83
IUD	1,980	70	4	95	96
Rhythm	7,941	51	33	89	63
Condom	1,561	10	60	104	42
Withdrawal	10,668	43	44	90	51
Abstinence	871	13	(17)	107	(84)
Rhythm plus withdrawal	2,863	73	12-17 ^f	90	81
Rhythm plus condom	819	51	22-31 ^f	108	71

Note: Parentheses denote relatively unreliable estimates based on fewer than 600 woman-months of observation. The Pearl pregnancy rate for abstinence is in parentheses because it is based on a denominator of only 455 woman-months after exclusion of months of overlap with postpartum amenorrhea. The contraceptive effectiveness measure of abstinence is also in parentheses because it is derived in part from the Pearl rate.

- Number of woman-months of use from January 1978 to two months before the interview (denominator for annual continuation rate).
- In this case, the annual continuation rate is an index of first-method continuation.
- Pearl pregnancy rate (PRR) is the number of failures (pregnancies) occurring per 100 woman-years of method use by nonamenorrheic users.
- Expected pregnancy rate (EPR) is an estimate of the Pearl-type pregnancy rate that might have been expected in the absence of contraceptive practice.
- Contraceptive effectiveness is the percentage by which the probability of conception is reduced as a result of contraceptive practice. $CE = 100(1 - PPR/EPR)$.
- The higher Pearl pregnancy rate figures for combinations are based on more conservative estimates of the numbers of accidental pregnancies, obtained by counting all conceptions immediately following a month of use of the specified combinations. These estimates are viewed as more realistic and serve as the basis for the contraceptive effectiveness estimates.

Source: Table 1 in Laing (1985:141).

Although the general risks of pregnancy during breastfeeding are known, it is difficult for medical practitioners to predict what will happen in an individual case. But that is the usual situation in the medical field. Advice to a breastfeeding woman must acknowledge this uncertainty while helping the woman make an informed choice about family planning.

Why has the child-spacing effect of breastfeeding been ignored?

Family planning programs have ignored the contraceptive effect of breastfeeding for several reasons.

One reason relates to terminology. Contraception may imply, to both family planning program managers and potential program users, something modern, mechanical or chemical, whereas breastfeeding's contraceptive effect is a natural biological mechanism involving no modern technology.

Furthermore, if family planning program managers, health professionals, or policymakers were educated in the West, where breastfeeding is of little contraceptive importance, they probably learned little about the child-spacing effects of breastfeeding. Breastfeeding was not listed as an intermediate variable in the well-known article by Davis and Blake (1956) about factors affecting fertility. Nor did Berelson (1969) mention breastfeeding in his compilation of "beyond family planning" policy options, a paper that influenced policymakers to think about what could be done to reduce fertility besides providing contraceptive services.

Regardless of where or how family planning professionals were

educated, they may consider claims about the pregnancy-postponing effect of breastfeeding to be examples of an "old wives' tale" or may not consider breastfeeding to be sufficiently effective at the individual level.

Direct-service providers tend to be especially skeptical about the contraceptive effect of breastfeeding. Sooner or later they will encounter a woman who was breastfeeding, using no contraceptive method, and became pregnant. The service provider may not stop to consider whether the breastfeeding woman had resumed menses or how intensively she had been breastfeeding, before concluding that the contraceptive effect of breastfeeding is unreliable.

The medical profession, with its preference for modern contraceptives, generally ignores or is unaware of evidence of the fecundity-inhibiting effect of breastfeeding. A recent study in Mexico (Potter, Mojarro, and Nuñez 1987) found that physicians were more likely than traditional midwives to advocate early food supplementation and shorter periods of breastfeeding. And only 17 percent of the physicians, versus 43 percent of the traditional midwives, thought breastfeeding was very effective at preventing conception.

In the Mexican study, practitioners were also asked to estimate the duration of contraceptive protection offered by breastfeeding. Traditional midwives' predictions were closer to the empirical results from a study in Durango, Mexico (Rivera et al. 1987), than were the predictions of the physicians, who underestimated the contraceptive effectiveness of breastfeeding.



Breastfeeding—a traditional practice attracting new interest because of its birth-spacing effect.

Breastfeeding does not conveniently fit into the "cafeteria" of family planning methods. It cannot be "delivered" to women by family planning programs. It requires an educational approach rather than a clinical or medical approach. Nor is there any financial advantage to be gained from the promotion of breastfeeding, as may be the case with some contraceptive methods.

Many family planning program managers are more concerned about increasing the use of the methods they deliver than about the effects of their methods on fertility, child spacing, or helping couples realize their ideal family sizes. According to this criterion, a program could declare itself a success if it increased use of the methods it delivered, even if breastfeeding (or

traditional methods) declined, birth intervals became shorter, and fertility increased in the population it served.

In countries where family planning programs are explicitly directed toward reducing fertility, policy-makers and program managers may emphasize methods that they believe have the best chance of bringing about a dramatic decline in fertility. Those methods usually include pills, injectables, sterilization, IUDs, and barrier methods.

Program statistics seldom record breastfeeding status, and programs usually assume that all women in need of contraception have normal menstrual cycles. Most training materials for family planning providers and consumers, for example, are aimed at women who have menstrual cycles, although breastfeeding women may make up a large percentage of potential users.

Little consideration has been given to methods appropriate for lactating women, how breastfeeding can ameliorate or worsen side effects from contraceptive use, and when lactating women should start using contraceptive methods. Programs typically advocate contraceptive use "the sooner, the better." Program workers worry that if a woman does not accept a contraceptive method at the time of delivery, they may never see her again.

Of course, breastfeeding alone can never bring about the amount of fertility control required for a one- or two-child family. At best, it can help women space their second- or higher-order pregnancies and complement the use of contraception. But this contribution, especially in settings where modern

family planning methods are not available or acceptable, is important. Should breastfeeding or other traditional child-spacing practices deteriorate, family planning programs may find it even more difficult to bring about fertility decline with modern methods (Thapa, Short, and Potts 1987).

Breastfeeding promotion tends to fall between the interests of funding agents. Family planning funders do not generally consider breastfeeding education to be their responsibility. Nor is breastfeeding promotion a major funding priority of child-survival funding agencies such as the U.S. Agency for International Development (USAID) and UNICEF. Service programs supported by these agencies have focused mostly on oral rehydration and immunization coverage, growth monitoring, and, more recently, treating acute respiratory infections.

Surveys have tended to overlook the contraceptive effect of breastfeeding. In many contraceptive prevalence surveys, even if a woman spontaneously mentions that she is relying on breastfeeding to postpone her next pregnancy, that fact may not be recorded, or breastfeeding may be included with "other" methods instead of being listed separately. Interviewers are not usually instructed to probe respondents about their use of breastfeeding to delay pregnancy. Fortunately, many recent surveys have begun collecting detailed information on breastfeeding patterns.

Implications of professional attitudes toward breastfeeding

There are negative consequences for both research and action programs

of ignoring the child-spacing effect of breastfeeding. In survey research, ignoring the practice of breastfeeding and its fecundity-inhibiting effect may lead to an underestimation of the extent of contraceptive behavior and protection. In family planning programs, supervisors and workers unaware of breastfeeding's contraceptive effect have little reason to be interested in breastfeeding behavior and how it may be changing.

Few programs have explicit guidelines for integrating contraception with breastfeeding. Thus workers may start a lactating woman on a temporary method immediately after delivery, with the result that she has double contraceptive protection during the early postpartum period. In many countries discontinuation rates are high, and a lactating woman may discontinue her temporary method at about the time ovulation returns and she needs contraception the most.

Combination pills reduce milk production if they are introduced too early in the postpartum period. Some researchers have even argued that use of hormonal contraceptives during lactation may cause ovulation to occur earlier than it otherwise would (Bhatia, Becker, and Kir: 1982). Many programs do not stock progestin-only pills, which are more appropriate for breastfeeding women than combination pills.

Most family planning programs consider breastfeeding women who are not using one of their methods to be noncontraceptors, even if the women are still amenorrheic. Such women may be considered prime candidates for contraception even if they themselves do not yet think they need one of those methods.

Some breastfeeding women fear that contraceptive methods will harm their babies. These differences of perception may cause an unnecessarily antagonistic relationship between breastfeeding women and family planning programs.

In programs that have targets for numbers of contraceptive acceptors, workers are not given credit for lactating women because breastfeeding is not considered to have contraceptive efficacy. If workers receive compensation for the number of acceptors they recruit or methods they deliver, they may even be tempted to discourage women from breastfeeding in order to start them on a method for which the workers are rewarded.

Many pediatricians and other health professionals recommend food supplementation one to three months after delivery rather than four to six months or more, which would be better for child spacing. Early supplementation may lead to a temporary improvement of nutrition for the child and can be justified in individual cases. But it may also cause the infant to suckle less intensively and thus bring about the resumption of fecundity. As an unplanned pregnancy could jeopardize the nutrition and health of this child as well as of its siblings, early supplementation can be counter-productive.

If a child is not thriving, it may be better to supplement the mother's diet and encourage her to breastfeed more intensively than to encourage direct supplements to the baby, who might then lose interest in breastfeeding. Although this is a controversial issue and more research on it is needed, there appears to be little justification for

recommending that breastfeeding mothers give food or liquid supplements to a baby who is growing normally before it is four to six months old.

How can women utilize the child-spacing effect of breastfeeding?

Women need to be able to predict when fecundity will resume or detect its resumption in order to take advantage of breastfeeding's child-spacing effect. Over time the probability increases that a woman will become pregnant before the warning sign of menses, and therefore the return of menses alone is an unreliable warning sign.

A woman could be more confident of avoiding an unplanned pregnancy if she had other indications of when to begin or resume contraception. For example, if she started using a contraceptive method as soon as she resumed menses, or when she began to give her baby food supplements, or by six months post partum—whichever came first—she could reduce her risk of pregnancy to a very low level.

If she wanted to be certain she was protected, she could begin using contraception at three months post partum even if fully breastfeeding and amenorrheic. Of course, this would mean only a short period of reliance on breastfeeding to postpone pregnancy.

If past experience were a reliable guide, then women breastfeeding a second or later child in the same manner as the first might expect a similar duration of postpartum amenorrhea. Unfortunately, no one has systematically studied the reliability of past experience. Such a

study could be of considerable practical value to practitioners who counsel women about postpartum contraception.

Various organizations, however, including Family Health International, the World Health Organisation, Johns Hopkins University, the International Institute for Studies in Natural Family Planning, and several research institutions in Australia, Belgium, Chile, the United Kingdom, and other countries, have been studying the contraceptive effect of breastfeeding and how long it lasts. Researchers have been hoping to come up with simple guidelines for women.

Studies in progress are investigating whether other experiential or subjective signs of renewed fecundity, besides the return of menses, exist that women could rely upon. Possible symptoms are changes in cervical mucus, basal body temperature, and cervical position.

Completed studies have found that different frequencies and intensities of breastfeeding have had varying effects on the duration of postpartum amenorrhea in the countries studied (e.g., Diaz et al. 1982; Gray et al. 1986; Howie and McNeilly 1982; Rivera et al. 1985, 1987). Still, it appears that if a woman breastfeeds in what can be called a "traditional" style, she will get high effectiveness from the breastfeeding, especially before menses resume. The traditional style involves

- keeping the baby nearby and feeding on demand rather than according to a schedule
- feeding frequently
- sleeping near the baby and maintaining night feedings

- not giving the baby bottles or pacifiers
- giving the baby only breastmilk for at least four months or, if giving the baby other foods or liquids, giving them as minor supplements rather than as substitutes for breastmilk.

These practices all contribute to the maintenance of frequent and intense suckling, which in turn is linked to the suppression of ovulation.

The traditional style of breastfeeding still exists in rural areas of many developing countries. In such situations, social policies should be directed toward protecting the practice so it will not erode. In urban areas the task is more difficult. Women whose jobs separate them from their infants may be unable to breastfeed in a traditional fashion and hence will derive less contraceptive protection from breastfeeding. In both rural and urban areas, however, one can find examples of programs that have successfully promoted breastfeeding, for example, through education and hospital practices such as encouraging rooming in (Tognetti 1985).

In the long run it may prove easier to promote breastfeeding than many other socially desirable behaviors because most new mothers are favorably disposed toward it and it has the backing of tradition. What mothers may lack is encouragement and accurate information—both of which can be provided by breastfeeding promotion efforts.

Integrating breastfeeding into family planning programs

To integrate breastfeeding into family planning programs, national and

local family planning personnel will need such information about breastfeeding as its incidence, usual duration, types of breastfeeding practices, normal duration of postpartum amenorrhea, and contraceptive use by breastfeeding women. Such information should enable family planning workers to prepare guidelines on when lactating women should start using contraception and what methods they should use. Family planning personnel will need training in this new approach, and educational materials will have to be prepared for both workers and clients.

Family planning staff need instruction in how breastfeeding may affect women's experiences with contraceptive methods. For example, the menstrual changes (such as spotting) that women experience with hormonal methods may be less pronounced for breastfeeding women. Just as programs use checklists of contraindications for oral contraceptives, they could develop and use a list of contraindications for continued reliance on the child-spacing effect of breastfeeding. An illustrative example appears in the Appendix.

Programs using quotas or targets for family planning acceptors will need to add a category for amenorrheic breastfeeding women. Such women could be considered contraceptors but would need to receive advice on when to start a family planning method. Workers who receive fees for recruiting clients should be compensated for promoting breastfeeding for child spacing as well as child welfare and for providing breastfeeding women with appropriate family planning methods at the appropriate time.

Family planning programs in developing countries can serve the contraceptive needs of breastfeeding women and the health needs of their infants better by offering family planning methods compatible with intensive breastfeeding.

Service-statistics forms and other records will have to be modified slightly to reflect this new approach. The types of methods provided may also need to be expanded. For example, for women who want a very high degree of contraceptive effectiveness and do not want to rely on breastfeeding, programs will need to offer postpartum sterilization and immediate postpartum IUD insertion. They will need to stock temporary methods appropriate for other breastfeeding women: progestin-only pills, injectables, implants, and barrier methods.

National programs will have to monitor breastfeeding patterns and trends, including whether lactating women initiate family planning methods at the right time (Knodel and Kamnuansilpa 1986) and whether breastfeeding patterns are deteriorating. Fortunately, national surveys such as the Demographic and Health Surveys and other studies such as that by the World Health Organisation (1985) are making this kind of monitoring easier than in the past. Problems will remain at the local level where data are less available.

(continued on page 20)

BREASTFEEDING WOMEN . . .

(continued from page 8)

In summary, family planning programs need to take more seriously the special needs of breastfeeding women and to devise procedures, training programs, supervision routines, and informational and outreach materials that meet those needs. The task is to integrate traditional methods of child spacing with modern ones.

Although, in the short run, this new approach may increase the complexity of family planning pro-

grams, integrating breastfeeding promotion and family planning promotion should be less difficult than, say, integrating health and family planning programs. It will involve mainly role integration for family planning workers rather than structural or administrative integration. Family planning workers will have to counsel new mothers about appropriate contraceptive methods and timing, and they will need to see the women more frequently than is currently the practice.

The main advantage of this proposed approach is that family planning workers and breastfeeding women will be "on the same team," both concerned with the women's special needs. A woman who does not want to use contraception immediately after delivery will be given advice about the risks of an unplanned pregnancy and appropriate means of avoiding it. She will then be able to make an informed choice about family planning. □

APPENDIX

The following checklist could be used by a family planning counselor to determine whether a woman who is not interested in a terminal contraceptive method is likely to receive contraceptive protection from breastfeeding or whether she should start a family planning method. As our ability to predict resumption of fecundity improves through research, the checklist could be modified.

ILLUSTRATIVE CHECKLIST FOR WOMEN USING BREASTFEEDING TO SPACE BIRTHS

1. Are you currently breastfeeding your child? Yes No
2. Have you resumed sexual activity with your partner (or do you plan to do so very soon)? Yes No
3. Do you want to postpone your next pregnancy? Yes No
4. Are you using breastfeeding as your only means of delaying pregnancy? Yes No

Note: If the woman responds "yes" to all four questions, ask her the following questions:

5. Regarding the baby you are currently breastfeeding, when was he or she born? _____ Mo. _____ Day _____ Yr.
6. How many months old is your baby? _____ months

(Answers to questions 5 and 6 should be consistent.)

7. Have your menses resumed since you gave birth? Yes No
8. Have you stopped breastfeeding your baby at night? Yes No
9. Are you giving your baby foods or liquids as a substitute for breastfeeding? Yes No
10. Are you giving your baby liquids from a bottle? Yes No
11. Have you had a previous unplanned pregnancy while you were breastfeeding? Yes No

Note: If the respondent answers "yes" to at least one of questions 7-11, she should be advised that she is at risk of an unplanned pregnancy and should start using a contraceptive method. If she answers "no" to each question but the baby is at least X months old, the respondent should nevertheless be advised to start using a contraceptive method. (X is a local estimate of mean duration of postpartum amenorrhea. In some settings it will be six or eight months; in other settings it could be 12 or 18 months. The duration must be determined from local data.) If the respondent answers "no" to questions 7-11 and her baby is less than X months old, she should be told to return to the family planning clinic in a month to be reevaluated. She should also be told to return immediately if any of the conditions described in questions 7-10 changes (i.e., her menses resume, she begins supplements, or she discontinues night breastfeedings.)

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