

In Search of Seamless Transition to Post-Lactational Amenorrhea Method Contraception

Since the early 1990s, the lactational amenorrhea method has been considered an effective form of postpartum contraception, worthy of inclusion in international guidance documents, training efforts and national family planning programs. The method is simple and inexpensive, has no side effects and offers health benefits for mother and child.* Currently, hundreds of millions of women around the world benefit knowingly or unknowingly from the contraceptive protection of lactational amenorrhea.

The scientific basis for lactational amenorrhea is strong. Well-conducted studies and a 1988 international consensus meeting held in Bellagio, Italy, concluded that the method is more than 98% effective if women adhere to three simple criteria: They must be fully or nearly fully breastfeeding, they must remain amenorrheic and they must be less than six months postpartum.¹

Despite the compelling evidence showing that the lactational amenorrhea method works, many family planning providers in the field remain unconvinced. Training materials for the method have acknowledged this problem with caveats such as “some [providers] do not understand how it works”² or “it may be difficult to convince some providers unfamiliar with the method that [it] is a reliable contraceptive.”³ Nevertheless, guidelines for use of the method implicitly assume that once a woman is informed about the lactational amenorrhea method, she will be protected against pregnancy as long as she meets its simple criteria, and that the health care system will operate to allow a smooth transition from lactational amenorrhea to another contraceptive method. In other words, if the woman plays by the rules, so will the system.

THE DILEMMA OF LACTATIONAL AMENORRHEA

Unfortunately, it is overly optimistic to assume that women who wish to continue practicing contraception will make a smooth transition from lactational amenorrhea to another method. In controlled research settings, up to two-thirds of those using lactational amenorrhea do so successfully;⁴ however, when protection from lactational amenorrhea ends, many women encounter obstacles as they try to move seamlessly to another contraceptive method. In many developing countries where pregnancy tests are often unavailable and breastfeeding duration is long, lactational amenorrhea method users—both those who know that they are using the method (active) and those who do not (pas-

sive)—face a frustrating dilemma: They are well protected from pregnancy for six months, but just at the time when lactational infecundability becomes uncertain and they need a new method, providers enforce menstruation requirements that deny women contraceptive methods until the return of menses. Such requirements are quite common and reflect providers' misplaced fears that significant proportions of amenorrheic clients are actually pregnant.

To our knowledge, no research has ever focused on the “seamlessness” of the transition to post-lactational amenorrhea method contraception; however, several studies have shown that large proportions of amenorrheic women wanting contraceptive methods are sent home by providers to await menses, because pregnancy tests are unavailable and providers are unwilling to rule out pregnancy by other means.⁵ For example, in a recent survey we conducted in Kenya, four out of 13 new breastfeeding clients who were 3–6 months postpartum were denied services until they began menses. In addition, active users of lactational amenorrhea might not be able to move successfully to subsequent methods by returning to the provider from whom they obtained lactational amenorrhea method information if that provider is far away or does not offer other methods. Furthermore, the habit of requiring menses or a pregnancy test may be so strong that even trained family planning providers who recommend the lactational amenorrhea method may not trust it as a criterion for ruling out pregnancy. The end result is likely to be delays in obtaining effective contraception after coverage from lactational amenorrhea ends.

DISCUSSION

What can be done to improve the transition from lactational amenorrhea to other contraceptive methods? One obvious answer is that providers must learn to trust the basic assumption behind the lactational amenorrhea method—if a woman meets all three criteria for lactational amenorrhea, the likelihood of pregnancy is very small. Thus, she may safely initiate a new contraceptive method without a pregnancy test.

Some family planning handbooks and lactational amenorrhea method training materials do a good job of emphasizing what has been called the fourth element of lactational amenorrhea—the importance of timely introduction and ongoing use of another method. One training module even alludes indirectly to helping women rule out pregnancy.⁶ However, none of the materials about lactational amenorrhea we have seen—even those destined for use in

By John Stanback and Heidi W. Reynolds

John Stanback is senior associate and Heidi W. Reynolds is research associate, both with Family Health International, Research Triangle Park, NC, USA.

*The lactational amenorrhea method encourages longer breastfeeding duration, which provides nutritional and immunologic benefits for the infant and increases the spacing between births for the mother.

countries where pregnancy testing is often unavailable—emphasize the difficulties women may face if they seek a new method during amenorrhea, nor do any of the materials acknowledge the extremely important but overlooked role of lactational amenorrhea in ruling out pregnancy. Many international guidance documents recommend use of the three lactational amenorrhea criteria to rule out pregnancy, but lactational amenorrhea method training materials and many national family planning guidelines fail to mention it.⁷ This is not a minor omission: When providers in Kenya were trained how to rule out pregnancy without using expensive tests, the proportion of new nonmenstruating clients who were denied services was reduced from 34% to 4%.⁸

Lactational amenorrhea is a wonderful contraceptive method, but the unacknowledged key to its success in many poor countries is providing women with a seamless transition to subsequent methods. This can be accomplished only by convincing providers that a fully breastfeeding, amenorrheic woman is unlikely to be pregnant, so that such women can receive their method of choice within six months after giving birth. If providers are not better trained to ease the transition from lactational amenorrhea to other methods, then active users of the method will face the same, increasing risk of unwanted pregnancy as passive users since they both are forced to wait for their menses before obtaining a new method.

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Author contact: jstanback@fhi.org