Unmet Need for Family Planning in the Postpartum Period

We also compared the method mixes of the two groups with a focus on the dominant method (results not shown). In three countries (Peru, Honduras and Lesotho), where pill use is widespread, this method was less common among breast-feeders than among others, but in Zimbabwe and the Dominican Republic, where pill use is equally common, there was no such difference. In other regards, the method mix in the two groups was similar in the 16 countries. The dominant method was the same among women who were still breast-feeding and those who had weaned the child; for instance, injectables in Uganda, Kenya and Lesotho; traditional methods in the Democratic Republic of Congo (DRC), the Republic of Congo and Jordan; and condoms in Guyana and Pakistan. The overall conclusion can be stated with confidence. Once the return of menses is taken into account, breast-feeding does not act as a deterrent to contraceptive use nor does it typically influence choice of method, with the exception of oral contraceptives in some countries. This conclusion is further supported by DHS evidence indicating that most women do not associate breast-feeding with reduced risks of conception.29

More penetrating insights into the influences on postpartum contraceptive use can potentially be derived from studies that use qualitative or mixed methods of enquiry. Regrettably, such studies vary in quality, some are very outdated and many are not fully published. One of the most compelling enquiries concerns the views of women in Matlab district and the slums of Dhaka, Bangladesh, in the 1990s.25,26 These women considered the postpartum phase to be one of extreme vulnerability for the mother and infant, and they regarded amenorrhea as a means by which the woman’s body recovered from the strain of pregnancy and childbirth. The onset of menses was understood to mean the return of reproductive capacity. The possibility of conception during amenorrhea was recognized, but the risk was considered small. Reluctance to start modern methods before the return of menses was reinforced by the belief that the methods were “strong” and even somewhat hazardous, particularly in the vulnerable months after childbirth. The net consequence was that adoption of methods was low during amenorrhea, particularly in Dhaka, and the onset of menses acted as a powerful trigger for initiation of use.

Studies coordinated by Family Health International in Ghana, India, Rwanda and Zambia give an impression about the importance of the return of menses as a signal to initiate contraceptive use similar to that of the Salway-Nurani study.27 In three of these countries, between a quarter and a half of postpartum women were unaware that a woman could get pregnant before the return of menses. In Ghana and Zambia, among women who were amenorrheic and sexually active at 9–12 months postpartum, contraceptive use was no higher among women who were aware than it was among those who were unaware. In Rwanda, both survey and in-depth interviews revealed that amenorrhea was a major reason for non-use.28 Some women thought that they had to await the return of menses before they could request a contraceptive method and, indeed, some providers insisted on proof of menstruation.

However, belief in the protection represented by lack of menses does not seem universal in low- and middle-income populations. For low-income women in Istanbul in the early 1990s, menses was not a consideration in postpartum contraceptive adoption; only 2% reported that they awaited the return of menses before starting use.29 In Ouagadougou, Burkina Faso, semistructured interviews with 33 women suggested that belief in amenorrhea as a protection against pregnancy was nonexistent, though one-third considered the return of menses an important factor when planning contraceptive initiation, perhaps because of service-related restrictions on eligibility for contraceptive adoption.30

Emphatic generalizations from the behavioral evidence, together with the findings of qualitative enquiries, are unjustified. However six tentative conclusions are warranted. First, the postpartum phase is regarded as a time of vulnerability for mother and infant. Thus any perception that use of modern contraceptive methods may be a potential hazard to health acts as a powerful disincentive for early postpartum use. Second, reliance on the absence of menses as an indicator that conception is impossible or unlikely is widespread but not universal. Third, accurate information on risks of conception before the return of menses is low among mothers and probably among staff. Fourth, once menses have returned, breast-feeding is not a deterrent to contraceptive adoption, except in some countries where oral contraceptive use is common. Fifth, family planning...