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Urban Health Extension Project

Urban FP/MCH Working Paper No. 15

Perceptions of Pregnancy Risk and Contraceptive Use in the Postpartum Period among Women in Dhaka Slums

Sarah Salway
Kanta Jamil
Quamrun Nahar
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International Centre for Diarrhoeal Disease Research, Bangladesh

November 1993

The **International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)** is an autonomous, non-profit organisation for research, education, training and clinical service. It was established in December 1978 as the successor to the Cholera Research laboratory, which began in 1959 in response to the cholera pandemic in southeast Asia.

The mandate of the ICDDR,B is to undertake and promote research on diarrhoeal diseases and the related subjects of acute respiratory infections, nutrition and fertility, with the aim of preventing and controlling diarrhoeal diseases and improving health care. The ICDDR,B has also been given the mandate to disseminate knowledge in these fields of research, to provide training to people of all nationalities, and to collaborate with other institutions in its fields of research.

The Centre, as it is known, has its headquarters in Dhaka, the capital of Bangladesh, and operates a field station in Matlab thana of Chandpur District which has a large rural area under regular surveillance. A smaller rural and a large surveyed urban population also provide targets for research activities. The Centre is organised into four scientific divisions: Population Science and Extension, Clinical Sciences, Community Health, and Laboratory Science. At the head of each Division is an Associate Director; the Associate Directors are responsible to the Director who in turn answers to an international Board of Trustees consisting of eminent scientists and physicians and representatives of the Government of Bangladesh.

The **Urban Health Extension Project (UHEP)** is a follow-on activity of the Urban Volunteer Program (UVP). In 1981, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) began training women volunteers in urban Dhaka in the use of ORS packets for diarrhoeal disease on the assumption that community women could play an important role in teaching others about the home treatment of diarrhoea with ORS. The United States Agency for International Development (USAID) began funding the project in 1986 with a mandate to provide primary health care services to the urban slums and conduct research on child survival related issues. UHEP continues to focus on health and family planning issues of the urban slums with an overall goal to strengthen the ability of the government and non-governmental agencies to provide effective and affordable family planning and selected maternal and child health services to the urban poor through research, technical assistance, and dissemination of its research findings.

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Foreword

I am pleased to release these reports on urban health and family planning issues which are based on the activities of the Urban Health Extension Project (UHEP). UHEP is a follow-on activity of the former Urban Volunteer Program, a pilot project funded by the United States Agency for International Development (USAID).

The poor health status and the health needs of the urban poor continues to be an important emerging public health issue in the Developing World. Bangladesh is no exception. Despite the constraints of poverty and illiteracy, there are proven strategies to provide basic health and family planning services to the urban poor. In Dhaka alone, aside from the Government health care facilities, there are numerous NGOs and private sector providers giving needed services to the urban population. The Centre's own Urban Health Extension Project continues to focus on the urban poor, especially the slum populations, in providing basic family planning and health services through outreach activities (viz. health education, ORS distribution and referral services to service points).

However, enormous challenges remain in providing an optimum level of services to the urban poor. The UHEP, with the support of the USAID, will focus on health and family planning services delivery strategies in reaching the needed services to the urban poor. We certainly look forward to learning more about the health and family planning needs of the urban poor, testing sustainable strategies and applying these proven strategies in collaboration with other partners in government, NGOs and the private sector.

Demissie Habte, MD
Director

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Contents

List of Tables

Summary

A qualitative investigation was conducted in the urban slums of Dhaka to understand more about the perceptions of the postpartum period held by women. Interviews with 25 respondents revealed that the return of menses is the signal of renewed risk of pregnancy, and that most women see no need, or even potential dangers in adopting contraception prior to this. The study raises several policy issues and illustrates the importance of considering the attitudes and preferences of clients, an area that continues to be overlooked in family planning programme recommendations.

Introduction

Despite the fact that recent years have seen tremendous inputs into family planning and rising levels of contraceptive use in Bangladesh, many women continue to have more children than their expressed desires (1). As programme managers and researchers look for ways to improve the performance of family planning services, the issue of postpartum contraception deserves increased attention. Although the concept of postpartum contraception is by no means new, debate continues as to the appropriate timing of adoption of contraception following a birth, and the most effective strategy of service provision to women in the postpartum period (2). The Bellagio Consensus on the contraceptive potential of breast-feeding (3) led many to advocate that contraception should be delayed until the 6th month postpartum for amenorrhoeic women. More recent research has produced recommendations that in Bangladesh this should be extended to 12 months (4). Others, however, advocate a strategy of early adoption. It is argued that, since pregnancy may occur before the return of menses, delayed adoption of contraception may result in considerable numbers of unwanted pregnancies and undesirably short birth intervals (5).

Throughout most of this debate there has been an almost total neglect of issues other than the theoretical demographic impact of different adoption schedules. As Winikoff and Mensch (6) point out, many of the current recommendations are based on invalid or untested assumptions. Clearly, the effectiveness of any particular strategy at spacing and preventing unwanted births will vary according to context, and will depend upon a number of factors including the propensity of individuals to adhere to the strategy promoted, and the capacity of the family planning programme to provide the services efficiently.

The current study aims to redress this imbalance, by illustrating the importance of considering the clients' perspective when investigating the suitability of different approaches to providing services. Up till now studies have rarely sought to understand how women perceive the postpartum period and how their attitudes and beliefs might influence the success of family planning strategies.

Available evidence suggests that very few women initiate use of contraception during postpartum amenorrhoea in Bangladesh (1,7). This pattern of adoption undoubtedly reflects both client preferences and programme characteristics. The present investigation was intended to:

1) explore the perceptions of the postpartum period held by women, including beliefs regarding postpartum amenorrhoea, risk of pregnancy, and adoption of contraception, and,

2) evaluate the findings in light of the ongoing debate surrounding postpartum contraception in order to determine how programmes might better address the needs of these women[a].

[a] This paper forms part of a more comprehensive on-going study that is exploring various aspects of postpartum contraception in rural and urban Bangladesh.

Methods

The Urban Surveillance System (USS) of the Urban Health Extension Project collects information from a probability sample of the slum communities of five *thana*[b] of Dhaka city, Bangladesh. It is based on a multi-stage areal sampling model, the ultimate sampling units are clusters of households, the average size being around 30. A total of 235 such clusters are currently under surveillance. As well as collecting household-level data on socioeconomic status and demographic events, the USS collects a range of health-related information for currently married women of reproductive age and under-5 children, on a 3-monthly basis.

Women are asked whether or not they are currently using contraception and what method is in use. Those who report that they are not using any method are asked their main reason for non-use. In the present study, women who had told interviewers in October-December 1992 that they were not using contraception because they were experiencing postpartum amenorrhoea were identified from the USS records. In-depth interviews were conducted with 25 women. Since this study was not intended to produce statistically testable results, a random sampling method was not employed. However, an effort was made to include women from a range of locations, and with a range of characteristics, including age. In this way, the results of the study were made more generalizable. Each interview was conducted by a team of two female interviewers, one of whom was primarily responsible for recording the details of the interview. In all cases, one of the study investigators was a member of the team. Where possible interviews were tape-recorded to allow subsequent transcription. Interviews took place within 3 months of collecting the USS information on reasons for non-use. Interviewers collected detailed information on a range of issues related to contraceptive use, perceptions of pregnancy risk, and reasons for infecundity.

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[b] A *thana* is a police jurisdiction area of Dhaka city, comprising roughly 300,000 population.

Results

Background Characteristics of Respondents

Respondents ranged from 16 to 35 years of age (Table 1), though the majority fell into the agegroup 20-24 years. All of the women interviewed had of course given birth to at least one child, and most had borne 2 or more children (Table 2). All except two wanted to delay the next birth or to have no more children (Table 3).

Table 1. Age Distribution of Women Interviewed (n=25)

Age-group	Number
< 20	3
20-24	11
25-29	6
30-34	3
35+	2

Table 2. Number of Children Ever Born (n=25)

No. of Children	Number
0	0
1	6
2	4
3	5
4	6
5	2
6	2
7+	0

Table 3. Respondent's Expressed Desire for More Children (n=25)

Expressed Desire	Number
Yes, as soon as possible	1
Yes, but after some time	15
Indecisive/If god gives	1
No	8

The majority of respondents were born outside of Dhaka, though around half of them had been living in the city for 10 years or longer. Very few of the women had received any education, and only 5 were engaged in any kind of paid employment. The most common occupation among respondents' husbands was rickshaw pulling, with others being employed in various unskilled or semi-skilled jobs.

Contraception: Knowledge, Attitudes and Experience

Most of the women talked about family planning in positive terms, though many referred to various problems associated with the methods available, particularly the side-effects. In all but a few cases respondents stated that their husbands were not opposed to the use of contraception. Some mentioned religious barriers to the use of contraception, but none expressed these views strongly, and several stated an intention to use contraception despite recognized religious objections. Several respondents mentioned the necessity of using family planning in their current economic situation.

All women could spontaneously mention one or more modern methods of contraception. There was, however, large variation between

individuals in their levels of knowledge and confidence in their own understanding of contraception. There appeared to be a gap in most cases between being able to name a method and detailed knowledge of the method and its source of supply. Several respondents emphasized that they had heard of methods, but that they did not really know much about them or where they were available.

The ubiquity of the oral pill was apparent in the responses of women. This method was mentioned by all 25, even those who had no personal experience of contraceptive use. The phrase *'I do not eat'* or *'I will not eat'* was used to mean 'I do not' or 'I will not use contraception', suggesting that using contraception is synonymous with taking oral pills for many. It was apparent that many respondents knew only of 'Maya', an oral pill that has been heavily promoted by the Social Marketing Company in Bangladesh. The injectable was also mentioned in a large proportion of interviews. The IUD and sterilization were mentioned less often. The majority of the respondents had heard of menstrual regulation, though none admitted to ever having had the operation and few said that they would consider it in the future. Most could not say where this operation was available.

Around half of the respondents had no experience of contraceptive use, and only 2 had tried more than one method. The pill was most commonly mentioned as having been used in the past. The majority of women who mentioned having used a method in the past also mentioned various problems they had encountered with it. The pill was associated with loss of health in many cases, and in particular dizziness, and abnormal bleeding.

There was a good deal of variation between respondents in the level of discussion reported and the important sources of information that were named. Several said that they did not discuss family planning matters with neighbours or friends. In some cases, this seemed to be inconsistent with the level of knowledge that the individuals had regarding contraceptive use patterns in the area and available sources of supply. It may be that open

discussion of these issues is felt to be inappropriate and thus that women gave a normative response despite their actual behaviour. In other cases, particularly where the respondent was a new arrival to the area or had little knowledge about contraceptive use, it seemed likely that discussion with other individuals was absent. Other women reported a good deal of discussion with neighbours and friends regarding contraception and cited neighbouring women as their main source of information. Some respondents had particular female family members who were their source of information and advice. In general, women did not mention discussing contraception with their husbands, though a few had.

A number of individuals mentioned field workers who visit their homes as sources of information and several said that they would go to the doctor for advice on these matters. All respondents except one were not using any method of contraception at the time of interview.

Knowledge and Beliefs Regarding the Postpartum Period

Beliefs Regarding the Cause of Postpartum Amenorrhoea and the Timing of Return of Menses

The majority of women interviewed had given birth to more than one child, and so had experienced at least one period of postpartum amenorrhoea prior to the present one. However, most offered no explanation for why a birth is followed by a period without menstruation. A couple of women mentioned that blood loss during childbirth results in a lack of blood in the body, so that menses cannot occur until this blood is replenished. Women who were asked specifically whether they felt there was any relationship between breast-feeding and postpartum amenorrhoea all either said that they did not know or that they thought there was no connection between these two things. However, a number of women mentioned that when a child dies menstruation returns and conception happens more quickly than when the child survives.

At the time of interview, 6 women had resumed menstruation and the rest were still in a state of amenorrhoea. Respondents were asked when they expected their menses to resume. Several said that they expected the duration of postpartum amenorrhoea to be the same as that which they had experienced in the past, though some predicted longer durations than they had experienced before. In general, women expected their menses to resume one to two years after the birth of their child. Many said that they could not predict when their menses would resume.

Beliefs Regarding the Risk of Pregnancy During the Postpartum Amenorrhoeic Period

Initially, most respondents said that until menses returns there is no risk of pregnancy. However, a number of women mentioned *'mura baccha'* spontaneously, a term used to describe a pregnancy that occurs to a woman during the period of postpartum amenorrhoea, that is, before the return of menses. All except a couple said they had heard of *'mura baccha'* when the term was raised. One woman said that she herself had experienced such a pregnancy. After further discussion, the majority of women acknowledged that it was possible to get pregnant during the period of postpartum amenorrhoea, but most saw no real risk to themselves. It was common for individuals to give the fact that a *'mura baccha'* had never occurred in their own family as a reason for knowing that they would not conceive during postpartum amenorrhoea.

For most the indicator of return to fecundity was the return of menses. However, a number of women also referred to the age of their youngest child as an indicator that another pregnancy would not be possible at present.

'If this child is not big how will another one come?'

'If such a small child is present will another child be born?'

Some women mentioned that until the youngest child is one or one and a half years old there is no risk of another pregnancy, regardless of whether menses has returned. Other women felt there was no risk until the child was 2 years old. A woman who mentioned *'mura baccha'* spontaneously also asked rhetorically:

'Would this happen when the child is only 5 or 6 months old?'

A couple of women expressed a more complicated understanding of the indicators of pregnancy risk. They mentioned both the return of menses and the child's age as indicators of return to fecundity.

Beliefs Regarding the Use of Contraception During the Postpartum Amenorrhoeic Period

Most women were able to express opinions about contraceptive use during the postpartum period. However, a few offered little information, saying that they did not know, or had no experience of this.

When asked whether they were using any method of contraception many women replied that the time had not yet come, or mentioned specifically that they had not adopted any method since their menses had not yet resumed. Many expressed the belief that starting to use contraception before the return of menses was pointless:

'If you start before there will be no benefit'

Aside from the belief that there was no need to start contraception before the return of menses, several women said that it is better to start contraception after menses. The idea that once menses has resumed the woman knows that everything is normal and so she can start to use a method was expressed by several respondents. They said that once menses starts everything is *'clear'*. In some cases, this was associated with the idea that if a woman is already pregnant then it is dangerous to use contraception, and thus that the return of menses indicates the woman is not pregnant. This seemed to be in conflict with the assertion, made by most individuals, that the risk of pregnancy during postpartum amenorrhoea is very small. Others did not mention the possibility of pregnancy, but still felt that the woman should wait until things are *'clear'* before starting to use contraception.

Some respondents felt that it was actually harmful to initiate contraception while amenorrhoeic, because menses would not resume properly, that it would be irregular, or that there would be other problems with menstruation. Several women felt that there could be problems, but were unable to specify what type of problems would occur. Nevertheless, they felt strongly that it was not advisable to begin using contraception in the amenorrhoeic state, and did not intend to do so. Others mentioned side-effects that would be felt, such as dizziness and loss of blood.

Women were also asked about the effect of adoption of contraception on a woman's young child, particularly via breast-feeding. In most cases women did not think that the adoption of contraception posed any threat to a young child. In a few cases, women mentioned that breast-milk may 'dry up' if contraceptive pills are taken. One mother did not want to start taking contraception because that would mean her menses would resume. She would then have to bathe early in the morning, thus risking 'catching cold' and transferring this to her baby. However, concerns regarding the suckling child were not often cited as the reason for non-adoption of contraception.

In several cases, rather than being adamant that contraception should not be adopted during postpartum amenorrhoea, women were unsure and stated that they did not know anyone who had done so. A number of individuals were interested in the idea of adopting contraception prior to the return of menses, but felt that none of the available methods were suitable for this.

> *'What type of method can be taken before menses, that's what I don't understand'*

> *'A method should be used but what can I take?'*

Intentions to Use Contraception in the Future

Women were asked whether they intended to use contraception in the future, and if so when they would start, what method they would use and where they would acquire the method.

In only one case had the respondent started to use contraception; the pill. Many of those who were non-users expressed the intention to use contraception in the future. The majority of respondents said that they would initiate use following the return of menses. Some intended to adopt a method immediately after the start of their first menses. Several of those who stated an intention to use oral pills said that they would start the method on the 5th to 7th day of their first cycle. Others said that they would start one month or longer after the return of menses. Others specified no particular time after the return of menses, or said that they would discuss contraception and seek advice once their menses had returned. Very few of the respondents said that they did not intend to use a contraceptive method in the future.

Among the 6 women who had already resumed menstruation at the time of interview, only one had started to use contraception. The other women were split between those who appeared to have clear intentions to start use shortly, and those who had no fixed plans.

The intended method most often mentioned by women was the oral pill, though the injectable was also the choice of some. A number of women could not state what type of method they would use. Respondents were divided between those who could state the source of supply that they would use, and those who were uncertain as to where contraceptives would be obtained from.

There was thus a wide variation in the degree to which respondents were prepared to adopt contraception, although all except one expressed a desire for no more children or to delay the next birth. Some women knew which method they would use, and when and where they would get it. Others said that these were '*things to be thought about later*' and could not say what they intended to do.

Interactions with Service Providers

Although the majority of women interviewed had not sought contraceptive services following the birth of their last child, since they recognized no risk of pregnancy, a number had had contact with family planning or health service providers.

In some cases, family planning workers had told women that contraception can not be used prior to the return of menses, others had been advised to start after the return of menses. It was apparent that some women had been unable to obtain services despite a felt need for contraception.

In one case, a family planning worker had given oral pills as a kind of pregnancy test. The woman was worried she might be pregnant again,

since her menses had not returned a long time after her last birth. The worker told her that, if she was not pregnant, her menses would resume on taking the oral pill, and if she was already pregnant her menses would not come. Interviews with service providers have also documented this use of 'testing pills'[c]. Traditional health practitioners, such as *dai* and *kobiraj*, were also mentioned as advocating contraceptive use following menses, not before.

[c] Unpublished data from Urban Health Extension Project.

Discussion and Conclusions

Beliefs about Postpartum Amenorrhoea and Contraceptive Use

The study generated some interesting information regarding women's perceptions of the postpartum period which have important implications for postpartum family planning strategies.

The finding that none of the women in the group explicitly referred to an association between breast-feeding and amenorrhoea is perhaps surprising in light of previous work. Zeitlyn and Rowshan (8) have described the belief that breast-milk is made from blood and thus that the body can not produce both at the same time. Van Ginneken (9) also mentions the strong belief in the pregnancy-preventing capacity of lactation of some Muslim societies. The fact that this was not mentioned by our respondents may be due to inadequate probing, or an unwillingness to reveal what may be considered old-fashioned beliefs. However, respondents did mention other beliefs that are not in line with 'modern scientific' thinking. Work in other areas of Dhaka slums has found women who recognize a link between breast-feeding and amenorrhoea[d]. On the other hand, Maloney *et al.* (10) found in rural Bangladesh that 'most people are not conscious of any physical link between breast-feeding and renewed pregnancy'. Thus, variability is apparent in these beliefs among women in Bangladesh. It seemed clear from this study, however, that those interviewed were not practising breast-feeding consciously as a way of delaying pregnancy. Clearly, these are important considerations for any programme that tries to encourage reliance on natural protection against pregnancy, and changes in breast-feeding behaviour to achieve this end.

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[d] Reports from UHEP field staff.

Several researchers have recommended a strategy where contraception is adopted at the return of menses or at a certain time postpartum, whichever is sooner. The 'Lactational Amenorrhoea Method' of contraception, as it has been called (11), generally advocates adoption of a modern method at 6 months postpartum, though Weis (4) suggests that for Bangladesh this should be extended to 12 months. The fact that the majority of individuals recognized no personal risk of pregnancy during postpartum amenorrhoea, and that many saw potential problems or dangers in adopting contraception prior to menses has clear implications for any strategy that promotes adoption prior to the return of menses.

Of particular importance is the fear expressed by some women that they may already be pregnant. The issue of pregnancy testing for women in postpartum has been overlooked in most discussions of postpartum contraception and is a neglected area in service provision in urban Bangladesh.

Risk of Unwanted Pregnancy

The study was not designed to produce estimates of postpartum risk of pregnancy experienced by women in this population. Nevertheless, an examination of the information on desire for additional children (Table 3) and the time since last birth (Table 4) suggests that many of the women interviewed were at risk of unwanted pregnancy. Resumption of menses, as recognized by the majority of women interviewed, is probably a good indicator of return to fecundity for the first few months following a birth. However, without better information on patterns of resumption of fecundity in this population it is difficult to state confidently which women interviewed should be regarded as facing a risk of unwanted pregnancy. The lower estimate would include only those who were more than 12 months

postpartum (7 cases), however, those with infants aged 6-12 months probably also face a significant risk (9 cases)[e]

Table 4. Time Since Last Birth (n=25)

Months since Last Birth	Number
< 6	3
6-12	12 (3)
13+	10 (3)

Note: The figure in parentheses denotes the number of respondents who had resumed menstruation before the time of interview.

Adoption of Contraception Following the Return of Menses

The effectiveness of the post-amenorrhoeic strategy of contraception adoption that has been advocated in several studies depends heavily on the strict compliance of clients (14,15). If contraception is not adopted *immediately* after the resumption of menses, this strategy becomes less effective at preventing unwanted pregnancies than a strategy of early adoption during amenorrhoea (5,9).

[e] Most studies on the return to fecundity suggest that in the first 6 months of postpartum amenorrhoea, the risk of pregnancy is very low (3). However, evidence on the risk of pregnancy after 6 months is less consistent, and seems to vary from setting to setting (4,12,13).

An intention to use contraception in the future was common among the women interviewed in this study, almost all expressing an intention to adopt a method following the resumption of menses. It was not uncommon, however, for women to express uncertainty about the method and the source of supply they would use, raising doubts as to their degree of preparedness, and the likelihood that they would adopt swiftly following the return of menses. Several of those who intended to use the oral pill said that they would start on the 5th or 7th day of their menses. However, it is unclear whether they were merely repeating instructions they have heard about the way a new packet of pills should be started, or whether this would actually be translated into rapid uptake of the method following the resumption of menses. Only one individual who had resumed menses was using contraception, and she had started use prior to menses.

Service Provision

The interviews provided some information on current contraceptive service provision to women in the postpartum period.

In many cases respondents were misinformed about their risk of pregnancy, and about family planning in general, indicating a need for better information. Some had been advised that contraceptives can not be used during amenorrhoea, or that they should wait until their menses resumes. In his study of oral pill users in Bangladesh, Davies (7) found that less then half had received any specific instruction regarding postpartum use, and 28% had been told to wait until the resumption of menses. More recent research suggests that, although many service providers recognise a risk of pregnancy in the postpartum period, a combination of misinformation and inappropriate policies often means they can not effectively meet the needs of this group[f].

[f] Unpublished data from Urban Health Extension Project

There is a need for a greater variety of contraceptive methods and for services that are more responsive to the needs of individual women. Although in theory several methods are available in Bangladesh, the dominance of the oral pill in the urban slums of Dhaka was clearly evident. This method is unsuitable for lactating mothers because it may inhibit milk production. In addition to government services many NGOs now have workers who visit the urban slums of Dhaka. However, it appears that the services offered amount to little more than the provision of oral pills and condoms. Workers should be better equipped to advise and refer women for other contraceptive options and to treat women differently according to their age and the stage of their reproductive life.

The current lack of explicit attention to postpartum family planning service provision by government and the majority of NGOs in Bangladesh is an important omission. This is particularly true since many of the current recommendations fail to consider the realities of contraceptive service provision. Research is needed to identify appropriate strategies of postpartum contraceptive provision in the context of Bangladesh. The present study illustrates the importance of talking to the recipients of family planning services, to understand their attitudes and opinions. Recommended policies that neglect the client perspective will fail to adequately meet the needs of those they seek to serve. This study has shown that carefully conducted interviews with community women can yield important information for programme planners. Future research in this area should consider the many factors that influence the success of a strategy and ensure that the views of clients are given adequate attention.

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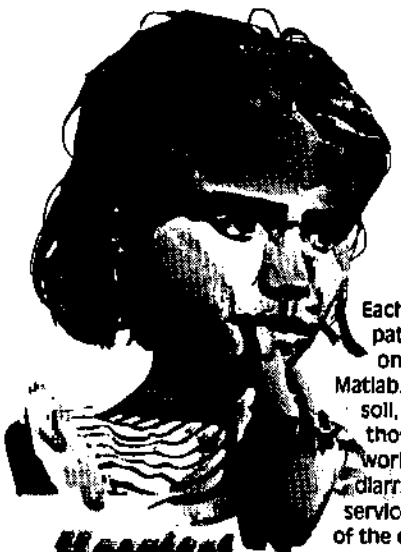

An Appeal

Each year, ICDDR,B treats over 70,000 patients attending its two hospitals, one in urban Dhaka, the other in rural Matlab. Though they are planted in Bangladeshi soil, they grow because of the dedication of thousands of concerned people throughout the world. The patients are mostly children with diarrhoea and associated illnesses and the services are offered free to the poorer section of the community

Hospital Endowment Fund

Since these services are entirely dependent on financial support from a number of donors, now we at the ICDDR,B are establishing an entirely new endeavour: an ENDOWMENT FUND. We feel that, given securely implanted roots, the future of the hospitals can confidently depend upon the harvest of fruit from perpetually bearing vines.

To generate enough income to cover most of the patient costs of the hospitals, the fund will need about five million dollars. That's a lot of money, but look at it this way:

JUST $150 IN THE FUND WILL COVER THE COST OF TREATMENT FOR ONE CHILD EVERY YEAR FOREVER!

We hope you will come forward with your contribution so that we can keep this effort growing forever or until the world is free of life-threatening diarrhoea. IT IS NOT AN IMPOSSIBLE GOAL.

Cheques may be made out to: ICDDR,B Hospital Endowment Fund.

For more information please call or write to:
Chairman, Hospital Endowment Fund Committee
GPO Box 128 - Dhaka, 1000, Bangladesh

Telephone: 600-171 through 600-178
Fax: (880-2)-883116

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