


Commentary

Public health services have never taken full advantage of the potential for breastfeeding to save lives

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Back when lactation management was a new thing, I published a paper in the second volume of the *Journal of Human Lactation* called “Making optimal use of breastfeeding for birth spacing: planning for action within the health sector” (Greiner 1986). Soon thereafter, Alan Berg and a colleague took up a similar theme in an equally ignored monograph (Berg and Brems 1989).

I was surprised soon afterwards to hear from the late Miriam Labbok that she opposed my ideas. She said, “I know the family planning people and they will never accept your ideas. What is needed for them is to package the issue as a family planning method.” Accepting that she was right, from then on, I kept my mouth shut. She and others went on to develop the lactation amenorrhea method (LAM). It is impressive. Kennedy, Rivera, and McNeilly (1989) showed that when properly practiced (exclusive breastfeeding, which indirectly means breastfeeding through the night as well as daytime), as long as menstruation does not return (which it rarely does), LAM works as well for the first six months as modern contraception does; with a much lower failure rate than condoms. Its failure rate gradually increases after that. But for those who add complementary foods “the right way” (as a complement, not a replacement for breast milk – see Greiner 1996), it continues to provide substantial protection against another pregnancy for many months in the vast majority of cases.

But LAM itself has never lived up to its potential. I once asked a well-known Swedish expert in gynecology and family planning why he never mentioned LAM as an option. He replied, “Because when it does fail, it’s such a dramatic failure.” I suppose it could turn the family against breastfeeding somehow, but I doubt that he meant that. So I still wonder why he thought it is somehow less dramatic when modern methods fail. Nevertheless, here I intend to explain why neither the family planning sector (some workers in which may have some conflict of interest if they get benefits for the number of modern methods that are adopted by their patients) nor the public health sector have made optimal use of breastfeeding for birth spacing, even in the rare case where LAM receives the prominent attention it deserves.

Professor Labbok might have been correct that trying to introduce both my idea and hers at the same time might have created confusion or competition. But that would not be true now, so I raise my tiny voice again: BOTH methods ought to be used in any public health setting but particularly in low-income settings. Let me explain briefly what I’m proposing.

Lactation amenorrhea can be considered to be, not a family planning method, but a way to space births safely. Directly after a birth, a discussion of family planning would in many cases be considered inappropriate or unlikely to be welcomed. But birth spacing ought to be welcomed anywhere, especially in a low-income setting where it is life-saving (Conde-Agudelo et al. 2012; Moli-toris, Barclay, and Kolk 2019).

In the case of the mother’s youngest baby, about a century ago colonial doctors learned the main reason for this from the Ga on the coast of Ghana who had coined the word “kwashiorkor,” meaning “disease of the displaced child” (Stanton 2001). Sadly, very few cultures accept that breastfeeding can safely continue throughout pregnancy, let alone tandem breastfeeding after another birth. A pregnancy soon after giving birth in a setting where artificial feeding is dangerous is often, as the late Michael Latham warned at an IUNS meeting in 1966, “tantamount to signing the death certificate of the child.”

In 1981, I was running an “illuminative evaluation” of a breastfeeding project that had been going on for a couple years in Yemen (Greiner 1983). I asked an anthropologist to go in depth in discussions with women to better understand “positive deviant” breastfeeding practices, one of which was exclusive breastfeeding – quite rare throughout the world at that time. Time after time, she heard something like this, “I was fed up with having babies ‘foke foke’ (one on top of the other), so I decided to breastfeed, breastfeed, breastfeed to try slowing them down.” Old ladies said, mystified, “We used to use breastfeeding to space out babies, but for some reason that doesn’t work nowadays with these young women.” I realized that the knowledge that breastfeeding had to be as exclusive as possible in order to have this birth spacing effect would not be imposing on

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families (which family planning was considered to do) but would empower them. While men wanted as many babies as quickly as possible (and thus would often check that my interviews with mothers about breastfeeding did not include any questions about family planning), they did not want dead wives and babies.

Certainly in 1986, but even in many high-fertility cultures today, the use of modern family planning methods is not even to be discussed. When a health worker knows or suspects this is the case, the obvious thing to do is empower the family with the knowledge that the chances of achieving a longer birth space will be greater, the more exclusive the breastfeeding is. LAM, because it is presented as a safe and effective family planning method, may be rigidly worded. But when the goal is to increase the chances of a longer birth space, empowerment consists in understanding that the more exclusive the better. The efficacy of LAM is not as sensitive to occasional lapses in exclusive breastfeeding as it is to the return of menstruation. Occasionally having to give something else besides the breast rarely results in a pregnancy as long as menstruation has not returned and exclusive breastfeeding soon resumes. Similarly, LAM says rather dogmatically that the protective effect of breastfeeding ends at 6 months, but in

the context mentioned above, this is unnecessary information. In such a case, a "failure" does not result in an unwanted child, just a shorter than desirable birth space.

Even when working in low-income settings, health workers and family planning workers rarely grew up in such a setting, let alone now live in one themselves. So they may not understand that exclusive breastfeeding is not as intrusive in such settings as it is in cultural contexts where babies do not sleep in the same bed as their mothers or where mothers do not tend to carry their baby on their body during the day. Indeed, unlike elsewhere, in low-income settings, family knowledge of the importance of exclusive breastfeeding for the health of mother and baby and what this means (not giving the usual ritual prelacteal feeds, preventative herbal teas, heavily promoted commercial baby foods, or introducing solids before the baby needs them) are likely to be the main missing factors in achieving widespread exclusive breastfeeding. (See, for example, Shirima, Gebre-Medhin, and Greiner 2001).

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