

The Use of Contraception During Lactation

This Alberta Medical Association Committee on Reproductive Care fact sheet will assist physicians in advising women who are breastfeeding to make informed decisions about contraception. Breast milk is recommended for all infants, with few exceptions. Studies indicate that the benefits of breastfeeding are important to infants, mothers and society.^{1,2}

A Fact Sheet



INTRODUCTION

Postpartum women have specific contraceptive requirements. A primary concern for these women and health care providers is the suppression of milk supply associated with the use of hormonal contraceptives.

Benefits for breastfed infants:

- decreased risk of infections
- reduction of many childhood diseases, obesity and diabetes
- decreased risk for SIDS
- cognitive enhancement

Benefits for breastfeeding mothers:

- more rapid return to pre-pregnant weight
- delayed resumption of ovulation with increased child spacing
- improved bone remineralization postpartum
- reduced risk of ovarian and premenopausal breast cancer
- economic benefits

Benefits for society:

- reductions in disease load
- reductions in health care costs
- decreases employee absenteeism

The World Health Organization³ recommends that infants be exclusively breastfed for six months and that breastfeeding continue for two or more years.

HORMONAL CONTRACEPTIVE METHODS

Women at increased risk of lactation failure should be discouraged from using hormonal contraceptives while breastfeeding. This includes women who have or had:

- reduction mammoplasty
- a multiple pregnancy or preterm birth
- a history of lactation failure
- markedly asymmetric breasts
- uncontrolled hypo- or hyperthyroidism
- infertility secondary to anovulation
- hypoprolactinemia

Expert opinion suggests a link between both combined oral and progesterone-only contraceptives and a decrease in milk supply. Clinicians should monitor a breastfeeding mother and her infant after starting oral contraceptives to ensure that:

- the baby's behavior remains unchanged
- the baby examines well
- the baby maintains weight gain appropriate for his or her age
- the mother is aware if her milk supply decreases

PRACTICE POINT

COMBINED ORAL CONTRACEPTIVES (COCs)

COCs should not be used in the first six weeks postpartum. COCs are considered by many experts to be the method of last choice during any stage of lactation, especially in the first six months. Even low-dose COCs (30–35 micrograms of estrogen) decrease breast milk volume and composition, which may have a deleterious effect on the infant's health and growth.³

The International Planned Parenthood Federation states:

Under normal circumstances, breastfeeding women **should not** use combined oral contraceptives.⁴

PROGESTERONE-ONLY ORAL CONTRACEPTIVES (POCs)

POCs may be one of the few methods widely available and accessible to breastfeeding women immediately postpartum.³ Studies have detected no clinically measurable effects on the health or growth of breastfed babies. Most experts recommend delaying POC use for six weeks after delivery as a precaution against theoretical concerns of infant exposure to synthetic hormone.^{3,5}

EMERGENCY CONTRACEPTIVE PILL (ECP)

ECPs are approximately 75% effective if used within 72 hours of unprotected intercourse.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)

Because they contain estrogen, CICs should not be considered as the first option for breastfeeding women. Even low-dose CICs (30–35 micrograms of estrogen) decrease breast milk volume and composition, which may have a deleterious effect on infant health and growth.^{3,6}

INJECTABLE PROGESTINS

It is considered prudent for women to wait at least six weeks postpartum to initiate progestins due to the immaturity of the neonatal liver to metabolize exogenous steroids.^{3,5}

Studies have not detected a clinically measurable adverse effect on the health or growth of breastfed babies of women who began using progestin-only injectables at six weeks postpartum. However a woman's risk factors for failure of lactation should be carefully evaluated because of the restricted reversibility of these methods.

BARRIER METHODS

The following barrier methods have no impact on breastfeeding:

- diaphragms/cervical cap*
- spermicides
- latex condoms

* The fit of a previously used device should be checked prior to use postpartum.

INTRAUTERINE DEVICES

Copper-bearing IUD

With the appropriate technique, IUDs inserted immediately after vaginal delivery or Cesarean section can be safe and effective. Expulsion rates for postpartum insertion vary greatly depending on the type and provider's technique.

A Copper T may be safely inserted at four or more weeks postpartum in breastfeeding women. The withdrawal technique for Copper T insertion presumably helps minimize perforations when inserting IUDs at the routine four-or-six week postpartum visit.

Other IUDs that have a different profile or a push insertion technique might have different perforation rates. Given the relative lack of information on other IUDs at four-to-six weeks postpartum, it is prudent to wait until six weeks for the insertion of IUDs other than Copper Ts.⁷

Levonorgestrel (LNg) IUD⁸

The World Health Organization states that use of LNg IUDs prior to four weeks postpartum is not usually recommended unless other more appropriate methods are not available or acceptable. This is due to the theoretical concern that breastfeeding infants may be at risk of exposure to steroid hormones during the first six weeks postpartum. Little research has been done on women initiating IUDs before six weeks.

Levonorgestrel in maternal serum is low and infants receive only 0.1% of the maternal daily dose. Since there is virtually no risk of ovulating during the first six weeks postpartum in breastfeeding women, LNg IUDs may safely begin after six weeks postpartum.

PHYSIOLOGIC METHODS

Lactational amenorrhea method (LAM)

The lactational amenorrhea method of family planning is based on the physiology of breastfeeding. For the risk of pregnancy to be low (approximately 2%),⁶ the breastfeeding woman must meet all three LAM criteria as indicated below.

LAM CRITERIA

- Absence of menses. Menses return is defined as the first two sequential days of bleeding or spotting, which may occur two months postpartum.
- Fully or nearly fully breastfeeding:⁸
 - > breastfeeding should constitute the overwhelming majority of baby's diet
 - > breastfeeding frequency and duration should be high and not affected by additional feedings
 - > additional feeding should not act as replacements for breastfeeding
- Less than six months postpartum

To reduce the chance of a gap in protection, a woman should be advised to have an alternative contraceptive method available when she no longer wishes to rely on LAM.

Fertility awareness based (FAB)

Women who are breastfeeding can use natural family planning methods. However, since the hormonal patterns are altered, a woman may find it more difficult to interpret her fertility signs. Thus, because of the large range of failure rates of the various methods, FAB is not recommended until the woman is no longer fully or nearly fully breastfeeding, or at six months postpartum, whichever comes first.

Female surgical sterilization

Sterilization can be performed preferably within the first seven days postpartum or once the uterus is fully involuted.

COMPARISON OF EFFECTIVENESS OF CONTRACEPTIVE METHODS⁹

NUMBER OF PREGNANCIES PER 100 WOMEN DURING FIRST YEAR OF USE

METHOD	WITH PERFECT USE	TYPICAL USE
Hormonal methods		
Combined oral contraceptives	0.1	5
Progesterone-only oral contraceptives	0.5	5
Injectable progestins	0.1	n/a
Barrier methods		
Diaphragm/cervical cap	6	20
Spermicides	6	26
Condoms	3	14
Intrauterine devices		
Copper-bearing IUD	0.6	0.8
Levonorgestrel (LNg) IUD	1.5	2.0
Female sterilization	0.5	0.5

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