

Contraception and Breastfeeding

This factsheet is intended to provide access to relevant evidence-based information. The national guidelines, research, data, pharmacokinetic properties and links shared are taken from various reference sources, they were checked at the time of publication for appropriateness and were in date. These are provided where we believe the information may be useful but we do not take any responsibility for their content. The factsheet is provided to empower users to make an informed decision about their treatment; but it does not constitute medical advice and cannot replace medical assessment, diagnosis, treatment or follow up from appropriately trained healthcare professionals with relevant competence.

The Breastfeeding Network factsheets will be reviewed on an ongoing basis, usually within three years or sooner where major clinical updates or evidence are published. No responsibility can be taken by the Breastfeeding Network or contributing authors for the way in which the information is used.

If you have any questions about this information, you can contact the Drugs in Breastmilk team through their [Facebook page](#) or on druginformation@breastfeedingnetwork.org.uk.

Lactational amenorrhoea method (LAM)

If your baby is under six months old and you are exclusively breastfeeding them (giving them no food or drinks other than your breastmilk) this can stop you ovulating. If you rely on this to prevent another pregnancy, it is called the lactational amenorrhoea method (LAM). According to [the NHS](#), [Fertility UK](#), and the [Faculty of Sexual and Reproductive Healthcare \(FRSH\)](#), LAM can be up to 98% effective in preventing pregnancy if all of the following conditions apply:

- you are fully breastfeeding – this means you are not giving your baby any other liquid or solid food and
- you are breastfeeding at least every 4 hours during the day and at least every 6 hours during the night and
- your baby is less than six months old and
- you have no periods.

The risk of pregnancy increases if:

- you start breastfeeding less often especially if there are long intervals between feeds – both day and night, or
- you stop night feeds or
- you use a dummy/pacifier or
- you give any artificial supplements

There is very little research on how expressing milk affects LAM, but one study suggests that being separated from your baby for even a few hours may reduce your level of protection, even if you express during this time (Valdes et al., 2000).

Using a dummy/pacifier may decrease how frequently your baby feeds. This can increase the risk of your fertility returning (Ingram et al., 2004). Once your baby is over six months old the risk of getting pregnant increases, so even if you don't have periods and are fully breastfeeding, you should use another contraceptive method.

To talk to a mum who knows about breastfeeding call the National Breastfeeding Helpline 0300 100 0212

Calls to 0300 numbers cost no more than calls to UK numbers starting 01 and 02 and will be part of any inclusive minutes that apply to your provider and call package.

Short-acting hormonal contraception

The Progesterone only pill (mini-pill, POP)

The progesterone only contraceptive pill (mini-pill) is generally recommended during breastfeeding. You need to take it at the same time every day continuously – a delay of more than 3 hours may mean contraceptive protection is lost. The POP is generally started a minimum of 3 weeks after delivery but ideally no less than 6 weeks to avoid interfering with milk production. Vomiting and severe diarrhoea can interfere with absorption. New [UKMEC guidelines \(2016\)](#) suggest that use from birth will not diminish supply. This is at variance with the experience of many breastfeeding workers and is currently a cause for concern. Decisions should be made with mothers fully informed about the risk of initiating contraception early.

Oral progestogen-only contraceptives can be started up to and including day 21 postpartum without the need for additional contraceptive precautions. If started more than 21 days postpartum, additional contraceptive precautions are required for 2 days. In most cases contraception is initiated at the 6 week post-natal check. Initiation too early after delivery may interfere with priming of prolactin receptors.

Normally, the POP does not affect lactation but we have had anecdotal reports from quite a few women who have noted a rapid drop in milk supply after beginning it. Anyone noticing such an effect should report it to the MHRA via <http://yellowcard.mhra.gov.uk/>

Brand names; Desogestrel (Cerazette®), Ethynodiol diacetate (Femulen®), Norethisterone (Micronor®, Noriday®), Levonorgestrel (Norgeston®)

The combined oral contraceptive pill

According to the most recent [UKMEC guidelines \(2016\)](#) "Based on breastfeeding status alone, CHC can be used by breastfeeding women safely after 6 weeks following childbirth"

This is at variance with the previous guidelines that the combined pill is not suitable for a breastfeeding mother in the first 6 months after delivery and with the experience of many breastfeeding workers and is currently a cause for concern. Decisions should be made with mothers fully informed about the risk of initiating contraception early.

In theory after this time the supply is established and will not be lowered by the oestrogen content of the combined pill. However, some mothers do notice an effect so the decision to use it should not be undertaken lightly if you want to carry on breastfeeding. If you take it and do notice your supply diminishes you can stop taking it (remember to take additional precautions!) and re-stimulate your supply with frequent breastfeeds.

Brand names: Gedarel® 20/150, Mercilon®, Femodette®, Millinette® 20/75, Sunya 20/75®, Loestrin 20®, Gedarel® 30/150, Marvelon®, Yasmin®, Femodene®, Katya 30/75®, Millinette® 30/75, Levest®, Microgynon 30®, Ovranette®, Rigevidon®, Loestrin 30®, Cilest®, Brevinor®, Ovysmen®, Norimin®, Norinyl-1®, Femodene® ED, Microgynon 30 ED®, Triadene®, Logynon®, TriRegol®, BiNovum®, Synphase®, TriNovum®, Logynon ED®, Qlaira®

Contraceptive Patch

The contraceptive patch contains Ethinylestradiol with Norelgestromin (Evra®) so is a combined contraceptive which may reduce supply depending on the time when it is first used. The instructions are: apply first patch on day 1 of cycle, change patch on days 8 and 15; remove third patch on day 22 and apply new patch after 7-day patch-free interval to start subsequent contraceptive cycle.

Long acting reversible contraception (LARC)

During the pandemic many Trusts began providing long acting reversible contraception (LARC) immediately after delivery as many women were having difficulty obtaining contraception. This is being adopted widely. The [FSRH recommends](#) that *"Women should be informed about the effectiveness of the different contraceptive methods, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after childbirth."*

If you experience changes in your milk supply or difficulty in establishing a full breastmilk supply after starting a LARC, please submit a yellow card report <https://yellowcard.mhra.gov.uk/>.

LARC methods include: progesterone injection, progesterone subdermal implant, progestogen only intra uterine system (IUS) and simple coil (intra uterine device, IUD).

Progesterone injection

The progesterone injection is often given to new mothers who value not having to remember to take a tablet daily.

Medroxyprogesterone acetate (Depo Provera®) can be used 6 weeks after delivery if you are breastfeeding and repeated every 12 weeks. It can be used 5 days after delivery if you do not intend to breastfeed. Use too early if you are breastfeeding may interfere with prolactin priming.

Norethisterone enantate (Noristerat®) is not advised if your baby has symptoms of severe or persistent jaundice – it is repeated every 8 weeks.

In light of the response of some mothers to oral preparations of progesterone it may be advisable to try one month of tablets before using any depo product to rule out any lowering a milk supply.

Progesterone subdermal implant

Etonogestrel releasing implant (Nexplanon®) consists of a single, radiopaque, rod-shaped implant. It must be removed no later than by the end of the third year. It can be inserted 28 days post-partum.

In light of the response of some mothers to oral preparations of progesterone it may be advisable to try one month of tablets before using any depo product to rule out any lowering a milk supply.

Levonorgestrel-releasing intrauterine system (LNG-IUS)

Intra-uterine progestogen-only contraceptives release levonorgestrel directly into the uterine cavity. The Mirena® system is used as a contraceptive method for women with excessively heavy periods. It can be inserted 4-6 weeks after delivery and is effective for 5 years. As with the depo injection, in light of the response of some mothers to oral preparations of progesterone, it may be advisable to try one month of tablets before using the coil.

Simple coil (Copper-bearing intrauterine device, Cu-IUD)

An IUD is a small plastic and copper device that is inserted into the uterus. There are different types and sizes of IUD to suit different women. An IUD can stay in for 5–10 years, depending on type. An IUD is sometimes called a 'coil'. Simple coils do not affect breastfeeding as no medication is involved.

Other forms of contraception

Barrier methods of contraception such as condoms, diaphragms and caps have no implications for breastfeeding. Lubricants and spermicides are also compatible with breastfeeding.

Emergency Hormonal Contraception

See separate [fact sheet](#).

Yellow card reporting of adverse events

If you notice a lowered milk supply with early use of progesterone only contraception or combined oral contraception, you can file a yellow card report at <https://yellowcard.mhra.gov.uk/>. Until evidence is collected to support the concerns of breastfeeding advocates breastmilk supply may be put at risk in mothers who have not had the opportunity to make fully informed decisions.

Other sources of information on oral contraceptives

1. *Hale Medications and Mother's Milk (online access Jan 2017)* "Clinicians should suggest that the mother establish a good milk production prior to beginning oral contraceptives. Avoid combination (estrogen-progestin) contraceptives if at all possible. Use oral progestin-only preparations initially preferably after 4 weeks postpartum. Warn mothers that even progestin-only preparations may suppress milk production and to discontinue them at the first sign of low milk supply. Use medroxyprogesterone (Depo-Provera) only in those patients who have used it previously and have not experienced breastfeeding problems, or in those who have used progestin-only mini pills without problems. Attempt to wait for 4 weeks postpartum prior to using medroxyprogesterone. The transfer of progestins and estrogens into breastmilk is exceedingly low, and numerous studies confirm that they have minimal or no effect on sexual development in infants.

Suggestions for OC therapy

1. Always start with an oral progestin-only pill first, if only for a month. If milk production is sustained, then continue on the oral preparation, or a sustained release preparation like Depo medroxyprogesterone may be suitable.
 2. Avoid using any form of progesterone the first week postpartum, as these may suppress early milk production.
 3. Avoid estrogen-containing preparations, particularly early postpartum. While controversial, extensive clinical experience with these preparations suggest caution as significant loss of milk supply has been frequently reported.
 4. We have numerous reports of loss of milk supply following placement of Mirena IUDs. While one suggests no such loss, caution is recommended until this is clear"
2. *World Health Organization (WHO) Task Force on Oral Contraceptives. Effects of hormonal contraceptives on breast milk composition and infant growth. Stud Fam Plann. 1988 NovDec;19(6 Pt 1):361-9.* "Breast milk volume and composition and infant growth were measured at three- and four-week intervals, up to six months, in a multicenter randomized double-blind trial comparing a low-dose combined oral contraceptive (OC) with a progestogen-only OC. A nonrandom group using nonhormonal methods was also studied in the three centers: Szeged, Hungary; Bangkok, Thailand; and Khon Kaen, Thailand. A fourth group, users of depot-medroxyprogesterone acetate (DMPA) was included in the two Thai centers. Altogether, 341 women were recruited into the study. Combined OCs caused a significant decrease in milk output and total energy content as well as widespread changes in milk constituents. In the DMPA group, no significant changes were observed in milk volume, and only minor shifts occurred in milk composition, which varied between centers. No differences were found between the progestogen-only pill and DMPA. No hormonal contraceptive was associated with any significant difference in infant weight or fat fold, nor in the rate of discontinuation for failure to gain weight. This study reiterates the need to avoid combined OCs during the first few weeks or months of lactation. Both norgestrel and DMPA appear to be safe for use in both developing and developed

countries, at least when the nutritional status of the mother and infant are adequate, but further research is needed on the safety of these contraceptives in populations with malnutrition.”

3. Lopez LM, Grey TW, Stuebe AM, Chen M, Truitt ST, Gallo MF. *Combined hormonal versus nonhormonal versus progestin-only contraception in lactation. Cochrane Database Syst Rev.* 2015 Mar 20;(3):CD003988. doi: 10.1002/14651858.CD003988.pub2. Older studies often lacked quantified results. Most trials did not report significant differences between the study arms in breastfeeding duration, breast milk composition, or infant growth. Exceptions were seen mainly in older studies with limited information. For breastfeeding duration, two of eight trials indicated a negative effect on lactation

Mothers should be enabled to make an informed decision based on their own family circumstances, the risk of pregnancy and be aware of the need to be alert for lowered milk supply. Breastfeeding advocates world wide seem to be aware of anecdotal reports of lowered, lost milk supply but these reports do not appear to have been published leading to variance with academic researchers.

Bibliography

- British National Formulary
- Hale TW Medication and Mothers Milk
- Ingram, J., Hunt, L., Woolridge, M., & Greenwood, R. (2004). The association of progesterone, infant formula use and pacifier use with the return of menstruation in breastfeeding women: a prospective cohort study. *European journal of obstetrics, gynecology, and reproductive biology*, 114(2), 197–202. <https://doi.org/10.1016/j.ejogrb.2003.12.003>
- Jones W Breastfeeding and Medication 2018; Routledge
- Lactmed website <https://www.ncbi.nlm.nih.gov/books/NBK501922/>
- Faculty of Sexual & Reproductive Healthcare, Clinical Guidance on contraception after pregnancy <https://www.fsrh.org/Public/Standards-and-Guidance/Contraception-After-Pregnancy.aspx>
- Faculty of Sexual & Reproductive Healthcare, UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) <https://www.fsrh.org/Public/Standards-and-Guidance/uk-medical-eligibility-criteria-for-contraceptive-use-ukmec.aspx>
- The Family Planning Association www.fpa.org.uk
- Valdés, V., Labbok, M. H., Pugin, E., & Perez, A. (2000). The efficacy of the lactational amenorrhea method (LAM) among working women. *Contraception*, 62(5), 217–219. [https://doi.org/10.1016/s0010-7824\(00\)00170-0](https://doi.org/10.1016/s0010-7824(00)00170-0)

With thanks to Sarah Panzetta for her valuable input on fertility awareness and LAM.