Can postpartum contraception do more to support breastfeeding?

The Bill and Melinda Gates Foundation is making a significant contribution to improving maternal and child health in low-income countries.

So we were surprised that the research they funded about postpartum contraception in Uttar Pradesh, India[1] did not mention the lactational amenorrhoea method of contraception (LAM), despite its obvious benefits for infant nutrition.

We appreciate that LAM is not understood or communicated as well as it could be, despite work to simplify the criteria.[2] A study of data from 45 countries[3] found that only 26% of self-reported LAM users met all three criteria.

Yet the study authors do not dismiss LAM, instead they say "family planning, maternal health, child health and nutrition programming together must address this widespread misunderstanding of LAM among the general population broadly and among women of reproductive age more specifically".

Unfortunately the view seems to be that LAM should be forgotten. We have other methods of contraception that work just as well and are more convenient for healthcare professionals. LAM is no longer included in the latest edition of the *UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2016)*. Cochrane says "LAM should be studied only if its advocation does not hamper the introduction of longer-term methods of contraception".[4]

The main problem with this approach is the impact of hormonal contraception on breastfeeding.

Breastfeeding counsellors and lactation consultants are increasingly concerned about the anecdotal reports they are receiving around the impact of hormonal contraception (including progestogen only) on milk supply.

Lactogenesis is triggered by the loss of progesterone when the placenta is delivered. Any retained placenta impacts on lactation hormones, so large doses of progestogen in the early postpartum period are an area for concern.

The Lancet report on breastfeeding[5] noted:

> *"Our systematic reviews emphasise how important breastfeeding is for all women and children, irrespective of where they live and of whether they are rich or poor… Appropriate breastfeeding practices prevent child morbidity due to diarrhoea, respiratory infections, and otitis media [ear infections]. Where infectious diseases are common causes of death, breastfeeding provides major protection but even in high-income populations it lowers mortality from causes such as necrotising enterocolitis and sudden infant death syndrome."*

Supporting breastfeeding saves lives and improves child health in all countries. So it seems sensible to follow the Breastfeeding Network's approach to postpartum contraception.

This includes advice that breastfeeding women avoid hormonal contraception for 21 days postpartum. If desired, a woman can then take the mini-pill for a month to check that her milk supply is not affected. Any problems should be reported using the Yellow Card Scheme (i.e. the UK system for collecting information on suspected adverse drug reactions to medicines and medical devices). Only if breastfeeding is going well should longer-acting hormonal methods such as depot medroxyprogesterone acetate or the implant be considered.

This staged approach might not always be appropriate, but improving the way we communicate about LAM and adopting a more cautious approach to hormonal contraception seem like good strategies for improving child and maternal health.

We look forward to hearing from those with an interest in both providing effective postpartum contraception and supporting breastfeeding.

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