Lactational Amenorrhea Method (LAM)
Frequently Asked Questions (FAQ)

FAQ SHEET 3 **From the LINKAGES Project** **Updated September 2001**

FAQ Sheet is a series of publications of Frequently Asked Questions on topics addressed by the LINKAGES Project. This issue focuses on the Lactational Amenorrhea Method (LAM) and is addressed to the Child Survival and Family Planning Health Care Provider.

Q What is the Lactational Amenorrhea Method (LAM)?

The Lactational Amenorrhea Method (LAM) is a modern, temporary family planning method that has been developed as a tool to help support both breastfeeding and family planning use. It is based on the natural infertility resulting from certain patterns of breastfeeding. "Lactational" means related to breastfeeding; "Amenorrhea" means not having menstrual bleeding; and "Method" means a technique for contraception.

LAM is defined by three criteria:

1. the woman's menstrual periods have not resumed, AND
2. the baby is fully or nearly fully breastfed, AND
3. the baby is less than six months old.

When any one of these three criteria is no longer met, another family planning method must be introduced in a timely manner to ensure healthy birth spacing.

Optimal breastfeeding practices include exclusive breastfeeding for the first six months and breastfeeding with appropriate complementary feeding for two years or more. LAM is a family planning method which supports improved breastfeeding, healthy child spacing, child survival, and women's health.

Q How effective is LAM?

LAM provides family planning protection comparable to other family planning methods.

Pregnancies per 100 women
in first 12 months of use

	Typical Use	Perfect Use
Injectables	0.3	0.3
IUD	0.8	0.6
LAM	2	0.5
Combined Oral Contraceptives	6-8	0.1
Condom	14	3

Adapted from: the Essentials of Contraceptive Technology, Johns Hopkins Population Information Program, 1997.

LINKAGES ■ Academy for Educational Development ■ 1825 Connecticut Avenue, NW Washington, DC 20009
Phone (202) 884-8700 ■ Fax (202) 884-8977 ■ E-mail linkages@aed.org ■ Website www.linkagesproject.org

Q What are the three LAM criteria?

1. The woman's menstrual periods have not resumed

Following childbirth, the resumption of menses is an important indicator of a woman's return to fertility. During breastfeeding a woman is less likely to ovulate. However, once a woman starts to menstruate, ovulation has returned or may be imminent. Bleeding during the first two months postpartum is lochial discharge and is not considered menstrual bleeding. Menstruation is defined for LAM use as two consecutive days of bleeding, or when a woman perceives that she has had a bleed similar to her menstrual bleed, either of which occurs at least two months postpartum.

2. The baby is fully or nearly fully breastfed[1]

Full Breastfeeding is the term applied to both *exclusive breastfeeding* (no other liquid or solid is given to infant) and *almost exclusive breastfeeding* (vitamins, water, juice, or ritualistic feeds given infrequently in addition to breastfeeds). **Nearly Full Breastfeeding** means that the vast majority of feeds given to infants are breastfeeds.

While **exclusive breastfeeding** is not necessary for LAM to be effective, the closer the pattern is to exclusive, the better for mother and baby. The optimal pattern for the baby is to be nursed frequently and for as long as the infant wants to remain on the breast, both day and night. At night, no interval between feedings should be greater than six hours.

3. The baby is less than six months old

At six months of age, the baby should begin receiving complementary foods while continuing to breastfeed. Introduction of water, liquids, and foods can reduce the amount of sucking at the breast, triggering the hormonal mechanism that causes ovulation—and menses—to resume.

A mother may not want to switch to other family planning methods when she no longer meets the LAM criteria and may choose to continue to rely on lactational amenorrhea for pregnancy delay. In this case the woman should be counseled to keep breastfeeding frequently and to breastfeed before giving the infant other foods. She should be informed that her risk of pregnancy increases.

Q What are the advantages and disadvantages of LAM?

Advantages	Disadvantages
Very effective	Can only be used for a short period (up to six months postpartum)
Provides up to 0.5 CYPs (Couple Years Protection)	Requires breastfeeding frequently both day and night
Has no side effects	
Does not require insertion of any device at the time of sexual intercourse	
May attract new family planning users	
Contributes to family planning prevalence directly and through increased acceptance rates	
Can be initiated immediately postpartum	
Is economical and requires no commodities or supplies	
Contributes to optimal breastfeeding practices and therefore enhances maternal and infant health and nutrition	
Acceptable to all religious groups	

Q When can LAM be initiated?

LAM can be initiated at any time during the first six months postpartum. The best time to begin counseling a woman about LAM and other family planning methods is during the antenatal period to allow her to make an informed choice about which method she wishes to use following the birth of her baby. LAM can be started immediately postpartum. The health care provider can help prepare the woman to begin breastfeeding immediately after birth and, if the woman has decided to use LAM, verify that she understands the three criteria for LAM use.

If a woman wants to initiate LAM use within the first two months postpartum, she must verify that she has been fully or nearly fully breastfeeding her baby since delivery. A woman may still be having postpartum bleeding (lochial discharge) that may be similar to a monthly bleed. As long as she is fully or nearly fully breastfeeding, the bleeding in the first two months does not disqualify her from initiating LAM during this period.

If a woman wants to start using LAM when she is more than two months postpartum, the health care provider must carefully verify that she has met the three criteria for LAM use since delivery.

Q What is the difference between LAM, breastfeeding, and amenorrhea?

- LAM is a *contraceptive method*, based on the physiology of breastfeeding. LAM is a method of contraception that a woman consciously chooses to use to reduce her chance of becoming pregnant by adhering carefully to the three criteria.
- Breastfeeding is a *feeding practice*.
- Amenorrhea, or the *absence of menstrual bleeding*, reflects a reduced risk of ovulation, but neither breastfeeding nor amenorrhea is a family planning method.

Q What are the optimal breastfeeding practices[1] that contribute to breastfeeding and LAM success?

1. Breastfeed as soon as possible after birth, and remain with the newborn for at least several hours following delivery.
2. Breastfeed frequently both day and night.
3. Breastfeed exclusively for the first six months: no water, other liquids, or solid foods.
4. After the first six months when complementary foods are introduced, breastfeed before giving complementary foods.
5. Continue to breastfeed for up to two years and beyond.
6. Continue breastfeeding even if mother or baby is ill.
7. Avoid using bottles, pacifiers (dummies), or other artificial nipples.
8. Mothers who are breastfeeding should eat and drink sufficient quantities to satisfy their hunger and thirst.

[1] *Guidelines: Breastfeeding, Family Planning, and the Lactational Amenorrhea Method (LAM). Institute for Reproductive Health, Georgetown University, 1994 (available in Arabic, English, French, Russian and Spanish).*

Q How many return visits are needed by LAM users?

When counseling a new LAM acceptor, the health care provider should discuss her follow-up needs and determine with the client how frequently she needs to be seen and what setting is most accessible for her. At the very least, a client needs to return for a visit if she perceives any breastfeeding difficulties or as soon as any one of the LAM criteria changes. An additional follow-up visit at five to six months postpartum is essential to determine the client's plans for switching to another contraceptive method and for introducing complementary foods when her baby is six months old. Whenever possible, the health care provider should schedule the visit when the client brings her baby for assessment or immunization, in this way saving the mother time by reducing the total number of visits to the clinic.

If the client is unable to schedule a visit or if she lives far away and will have difficulty returning, the provider should give her a supply of condoms, spermicides, and/or progestin-only pills. In this way she can maintain contraceptive protection if LAM is discontinued before she is able to return to the clinic.

Q What contraceptive methods can be used after LAM?

When any one of the three criteria for LAM use is no longer met or when a woman decides to stop using LAM, she needs to begin using another contraceptive method for as long as she wants to prevent another pregnancy. Women who are breastfeeding and who switch to another method should be advised on contraceptive options. Combined oral contraceptive pills (COC) and combined injectables are not recommended before six months postpartum because they contain estrogen, which may decrease the quantity of breastmilk. After six months postpartum, a woman who is breastfeeding can use any method of her choice as long as she is properly screened and meets the eligibility criteria.

Q Can a woman who is separated from her baby use LAM?

The amount of time that a woman is separated from her baby is a key factor in establishing the LAM criterion of full or nearly full breastfeeding, day and night, with no long intervals between feedings. A woman who is separated from her baby regularly for more than four to six hours cannot expect a high level of contraceptive protection from LAM, even if she expresses milk during the separation. Expressing breastmilk may not be as effective as suckling at the breast in suppressing ovulation, and for this reason a woman who expresses her milk may not be able to rely on LAM. In a study on LAM in working women, the pregnancy rate increased to five percent. Some women can make arrangements to have their babies brought to them to nurse and/or are able to go to their baby at regular intervals. Women who are able to keep their babies with them at the work site, market, or in the fields and are able to breastfeed their children frequently can rely on LAM.

Q How flexible is the method?

LAM is a flexible method. In some countries, programs may modify the criteria slightly to reflect cultural norms or national policies without decreasing the method's efficacy. Many women have occasionally had longer intervals between feedings, their baby has slept through a night, or they have fed the baby regularly with small amounts of complementary foods, and still have had the same high level of effectiveness.

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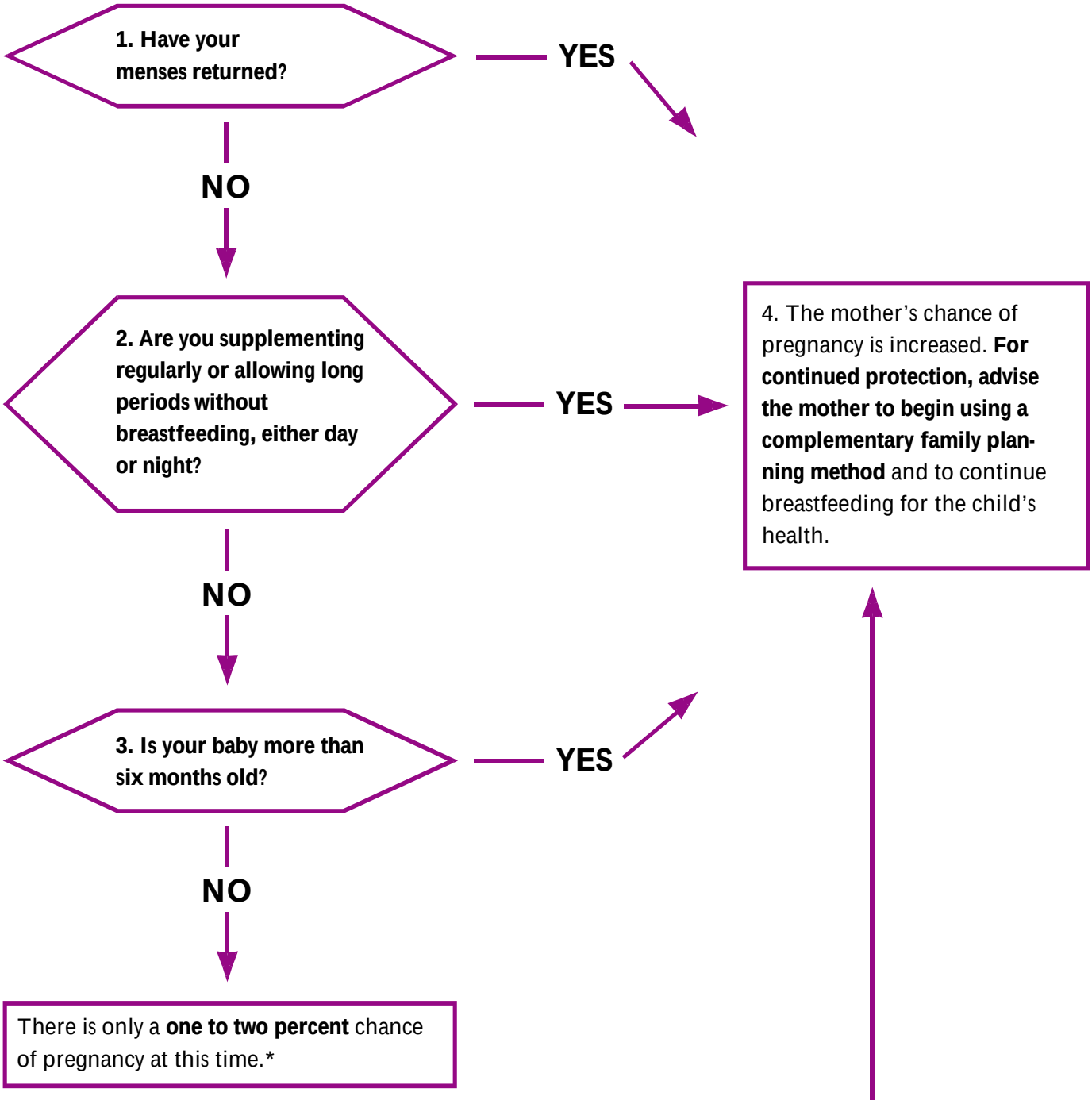
LAM Decision Making Path[1]

Ask the mother, or advise her to ask herself, these three questions:



**However, the mother may choose to use a complementary family planning method at any time.*

In some settings, programs modify or simplify the method to meet local conditions. For example, they may require exclusive breastfeeding as an eligibility criterion and not accept nearly full breastfeeding. It is important for the health care or family planning provider to understand the criteria and the parameters of flexibility of LAM when modifying any aspect of the method.

Q *What guidance can health workers give mothers about the use of LAM in areas of high human immunodeficiency virus (HIV) prevalence?*

Women who are HIV+ and who choose to breastfeed can use LAM if they meet the three eligibility criteria. HIV+ women need to be carefully counseled regarding their reproductive intentions and the contraceptive methods available to them. These women and women at risk for HIV infection should be advised to use condoms *in addition to* whatever contraceptive method is used. It is important that HIV+ women be counseled about the benefits and risks of breastfeeding and other infant feeding options. In fact, some studies indicate that exclusive breastfeeding may help reduce the risk of passage of HIV to the infant when the mother is infected. The infant feeding decision is the mother's to make.

Some general counseling guidelines are:

- Where confidential testing for HIV is not available or used and a mother's HIV status is not known, promote exclusive breastfeeding for the first six months as safer than breastmilk substitutes as these may not be *regularly* available, affordable, or safely used. If status is unknown, exclusive breastfeeding is especially important. Promote use of condoms and teach women how to avoid exposure to HIV and other sexually transmitted infections. Under these conditions, if the mother chooses to breastfeed, LAM can be used.
- If a mother knows she is HIV+ and breastmilk substitutes are not available, not affordable, or cannot be safely used, promote exclusive breastfeeding (never mixed breastfeeding) for the first six months as safer than breastmilk substitutes. Promote use of condoms and teach her how to prevent transmission of HIV to her partner and how to protect herself from repeated exposure to HIV and other sexually transmitted infections. Under these conditions, LAM can be used.
- If a mother is HIV negative, promote exclusive breastfeeding for the first six months as the safest option for infant feeding. Promote use of condoms and teach her how to avoid exposure to HIV.[2] Under these conditions, LAM can be used.

Encourage your local family planning and health care providers to include LAM in their programming for its double impact, supporting both optimal infant feeding and optimal child spacing of three years or more. Many training curricula, job aids, and other modules are available to help you include LAM in your program.

For additional information or questions, please contact the LINKAGES Project.

[2] *FAQ Sheet 1, "Frequently Asked Questions on: Breastfeeding and HIV/AIDS," LINKAGES, October 1998.*

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