Breastfeeding and Contraception: Counseling Considerations

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Individuals who are breastfeeding† may want to prevent pregnancy. Family planning providers can use this resource to counsel clients on: (1) the use of breastfeeding as a form of contraception, and (2) the considerations for contraceptive method use during breastfeeding.

Breastfeeding benefits and recommendations

Breastfeeding has proven maternal and child health benefits, which result in improved individual and population health outcomes; visit Breastfeeding: Why It Matters.[1, 2] The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend, as desired, exclusive breastfeeding for the first six months of life, followed by continued breastfeeding for one year or longer while gradually introducing solid foods into the child's diet.[1, 3]

That said, the decision to breastfeed is personal. It is important to respect client preferences and decisions on infant feeding. As needed, family planning providers can connect clients with community resources for breastfeeding support; visit Finding Breastfeeding Support and Information.[4]

Lactational amenorrhea method

The lactational amenorrhea method, or LAM, is a highly effective, **temporary** contraceptive method based on the natural effect of breastfeeding on fertility (i.e., infant suckling suppresses ovarian function in the person breastfeeding). As commonly used, LAM is 98% effective at preventing pregnancy, meaning that two out of 100 people who use LAM will become pregnant in the first six months after childbirth.[5]

For LAM to be effective, a person must meet all three of the criteria below:

- The person's menstrual periods have not returned
- The person is breastfeeding their baby fully or nearly fully (with no supplementation), and frequently (at least every 4 hours during the day and every 6 hours at night).[6] **Milk expression by hand or pump does not provide the same fertility inhibiting effect as breastfeeding.**[5]
- The person's baby is younger than six months old

Contraceptive method considerations for breastfeeding

All contraceptive methods are safe to use while breastfeeding, both for the person breastfeeding and the infant being breastfed. Some hormonal methods are associated with the possibility of decreasing milk supply and/or reducing breastfeeding duration, although research on these effects is of limited quality.[5] Contraindications to breastfeeding are rare; for more information, visit Breastfeeding and Special Circumstances.[1] Using contraception is not contraindicated when breastfeeding, nor is breastfeeding contraindicated when using contraception.

Family planning providers should counsel clients on the risks and benefits of contraceptive method use during breastfeeding, and discuss options within the context of the client's reproductive and breastfeeding goals and contraceptive preferences. Some clients may choose to delay the use of hormonal methods until breastfeeding is well-established.

† Breastfeeding is used throughout to refer to feeding an infant milk from one's lactating breast or chest. This process is known as breastfeeding or chestfeeding. For more information on chestfeeding, see ACOG's Health Care for Transgender and Gender Diverse Individuals

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Table 1: Contraceptive method considerations for breastfeeding: safety, potential effects, and additional guidance

Contraceptive method type	Breastfeeding and US MEC category[7]	Potential effects[5]	Additional guidance
Non-hormonal: barrier methods, spermicides and contraceptive gels, and copper IUD *Not categorized by MEC:* sterilization, LAM, and fertility awareness-based methods (FABMs)[¥]	**Anytime postpartum: MEC 1** No restriction for the use of the contraceptive method. *Rationale:* Use of a non-hormonal method during breastfeeding does not pose a risk.	**Breast milk:** none **Breastfeeding outcomes:** none **Infant growth and development:** none	FABMs are one non-hormonal method that can be difficult to use effectively during the postpartum period and when breastfeeding. Use of FABMs should be delayed while breastfeeding until menstrual cycles return and other fertility indicators become regular.[5, ß]
Progestin-only: progestin-only pills, implants, injectables, and levonorgestrel (LNG) IUD	**< 30 days postpartum: MEC 2** Advantages of using the method generally outweigh theoretical or proven risks. *Rationale:* Use of a progestin-only method theoretically could adversely impact breast milk production when started in the early postpartum period prior to establishing a milk supply.[9] **≥ 30 days postpartum: MEC 1** No restriction for the use of the contraceptive method. *Rationale:* Use of a progestin-only method during breastfeeding does not pose a risk at 30 days postpartum and beyond.	**Breast milk:** no proven effect; theoretical risk for decrease of milk supply if the method is initiated before breastfeeding is well-established **Breastfeeding outcomes:** none **Infant growth and development:** none	Research demonstrates no impact of progestin-only methods on lactogenesis, milk supply, or breastfeeding duration; studies are of limited quality. There is theoretical concern that progestin-only methods could decrease milk supply because progesterone withdrawal after delivery of the placenta triggers milk production. It may be prudent to advise that hormonal contraceptive methods may decrease milk supply, especially in the early postpartum period.[5, 8, 9] While hormones from progestin-only methods do pass through breast milk to the infant, studies indicate no impact on growth and development.[5, 8]
Combined hormonal contraceptives (CHCs): combined pills, patch, ring	**< 21 days postpartum: MEC 4** Unacceptable health risk if the method is used. **21 to < 30 days postpartum: MEC 3** Theoretical or proven risks usually outweigh advantages of using the method. **30–42 days postpartum *with other* VTE risk factors: MEC 3** Theoretical or proven risks usually outweigh advantages of using the method. **30–42 days postpartum *without other* VTE risk factors: MEC 2** Advantages of using the method generally outweigh theoretical or proven risks. **> 42 days postpartum: MEC 2** Advantages of using the method generally outweigh theoretical or proven risks. *Rationale:* Risk for venous thromboembolism (VTE) increases during pregnancy and postpartum; risk is most pronounced during the first 21 days after delivery and decreases to normal risk level by 42 days postpartum. The estrogen in CHCs increases risk of VTE.[7] Additionally, clinical studies demonstrate conflicting results regarding effects on breastfeeding continuation or exclusivity in those exposed to combined pills during lactation.[7]	**Breast milk:** potential decrease of milk supply if the method is initiated before breastfeeding is well-established **Breastfeeding outcomes:** potential decrease in breast-feeding duration if the method is initiated before breastfeeding is well-established **Infant growth and development:** none	While hormones from CHCs do pass through breast milk to the infant, studies indicate no impact on growth and development. Studies involving initiation of CHCs in the first six weeks postpartum are of limited quality.[5] Older studies show a decrease in milk supply and breastfeeding duration with CHC use, but this finding may be due to higher doses of estrogen than the estrogen levels in CHCs today. Two recent studies indicate no impact on milk supply or breastfeeding duration.[5]
Emergency contraception: copper IUD, LNG, ulipristal acetate (UPA), and combined pills	**Anytime postpartum: MEC 1** No restriction for the use of the contraceptive method. *Rationale:* Use of an emergency contraception method during breastfeeding does not pose any risks.	**Breast milk:** none **Breastfeeding outcomes:** none **Infant growth and development:** none	Although LNG does pass into breast milk, quantities are minimal and do not seem to alter breastfeeding outcomes.[7] Breast milk should be expressed and discarded for 24 hours after taking UPA (one type of emergency contraception). UPA is passed into breast milk, with highest concentrations in the first 24 hours after it is taken.[7]

¥ Sterilization, FABMs, and LAM are not assigned categories of medical eligibility by MEC. In general, no medical conditions absolutely restrict a person's eligibility for sterilization. No medical conditions worsen because of FABMs. In general, FABMs can be used without concern for health effects in persons who use them. Use of FABMs is categorized as "Accept," "Caution," or "Delay." No medical conditions exist for which LAM is restricted. However, breastfeeding might not be recommended for people or infants with certain conditions. Additional information is available in the U.S. Medical Eligibility Criteria (MEC), 2016.

ß Additional information on using FABMs is available in the Reproductive Health National Training Center's Job Aid on FABMs.