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Postpartum Family Planning: Increasing awareness among patients of the health benefits of spacing pregnancies and options for postpartum birth control

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Postpartum Family Planning:
Increasing awareness among patients of the health benefits of spacing pregnancies and options for postpartum birth control

HANNAH WOODRUFF, CLASS OF 2021
FAMILY MEDICINE ROTATION, MAY-JUNE 2019
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Short interval pregnancies increase health complications for mothers and infants (Shachar & Lyell, 2019).
- For mothers, increased risk of anemia in pregnancy and uterine rupture if attempting VBAC
- For infants, increased risk of preterm birth, low birth weight, and stillbirth

ACOG recommends an interval of at least 6 months between pregnancies

Short interval pregnancies are more likely to be unintended (Gemmill & Lindberg, 2013), particularly among certain populations of women (younger, economically disadvantaged).
- HOWEVER, providers should avoid assuming that short interval pregnancies are unplanned or unwanted.

Goal: Support women in family planning while acknowledging that decisions are shaped by personal experiences and cultural context.
In 2018, the rate of preterm birth in Chittenden county was 8.2% of live births—increased from previous year (Premature Birth Report Card, March of Dimes).

Preterm birth is associated with increased healthcare costs from both inpatient stays and healthcare visits throughout infants’ first year of life.


Annual cost of term birth in U.S. in 2005: $3,325

Takeaway: Interventions that promote healthy pregnancy outcomes may reduce healthcare costs.
Clinicians perspective on misconceptions about postpartum fertility:

“I always tell women that you ovulate before you get your period, so if you’re waiting for your period to return before you start birth control... that might be a mistake.”

-Dr. Gibson, Milton Family Practice

“I think [the idea that] you can’t get pregnant while breastfeeding is a common one.”

-Dr. Heath, Community Health Centers of Burlington
Intervention and Methodology

- Pamphlet (see next slide)
  - Contained information on 3 main topics:
    - Return of fertility postpartum
    - Health benefits of spacing out pregnancies for both mom and baby
    - Postpartum birth control options
What about breastfeeding as birth control?
Breastfeeding can be effective for birth control, but only if the following conditions are met:
- Nursing every 6 hours during the day, every 4 hours at night
- Less than 6 months postpartum and period has not returned
- Pumping, introducing solid foods, and your baby sleeping for longer stretches at night can all make breastfeeding less effective as birth control.

While breastfeeding has many other health benefits for both mom and baby, many women choose to start an additional contraceptive method in the postpartum period.

Have questions?
Ask your healthcare provider, and check out the following websites:
- Planned Parenthood
- ACOG- Postpartum Birth Control
- KellyMom
- La Leche League

Cultural beliefs, personal experiences with pregnancy and parenting, finances and life goals are just a few things women consider when making decisions about family size. Know the facts about postpartum fertility so that you can choose what’s right for you.

When will my period return?
The timing of the first postpartum period varies from woman to woman. Progesterone, the hormone responsible for milk production, can keep ovulation from occurring in women who are exclusively breastfeeding.

Breastfeeding: Among women who are breastfeeding, the timing of the first postpartum period can vary. One study found the median time to first period was 7 months postpartum.

Not breastfeeding: Women who are not breastfeeding can expect their period to return 6-8 weeks postpartum.

What are the health benefits of spacing out pregnancies?
The American College of Obstetricians and Gynecologists (ACOG) recommends at minimum waiting 6 months postpartum before becoming pregnant again. Waiting 18-24 months may be even better. A short time in between pregnancies is associated with health complications.

For mom:
- Anemia
- Uterine rupture if attempting VBAC

For baby:
- Low birth weight
- Preterm birth
- Stillbirth

What are my birth control options?
For most women, all types of birth control are an option. Some types of birth control can be started immediately after delivery in the hospital. For others, it is best to wait until the 6-week postpartum visit.

Options that contain estrogen (combined birth control pill, patch, ring) may affect milk supply, so for women who plan to breastfeeding it is often best to wait to start those options until supply is established (around 6 weeks).

Longest-acting: IUDs (3-10 years), implant (3 years)
Able to start immediately after delivery: IUD, implant, shot (Depo-Provera), progestrone-only pill (mini-pill).

Even though IUDs and implants last for years, they are quick and typically easy to remove if your family plans change.

Effectiveness:
- IUD (copper or hormonal, implant (Nexplanon)
  - 99%
- Shot (Depo-Provera)
  - 94%
- Pills (combined or progestrone-only), patch, ring
  - 91%
- Condoms
  - 85%
Response from providers at Milton Family Practice was enthusiastic

- Felt that having informational materials available for patients would be useful, especially if a follow-up conversation about birth control would take place at a later visit.

- Options for distribution include individual distribution by providers to patients, having pamphlets available in the waiting room, or having a copy of the pamphlet displayed on the bulletin board in exam rooms.
Evaluation of Effectiveness and Limitations

- **Evaluation of effectiveness:**
  - Pamphlet effectiveness could most directly be assessed by administering a follow-up survey to those who received the information at one of their antenatal visits. Questions could include whether the pamphlet provided them with new information, and whether this information influenced their plans for future pregnancies.

- **Limitations of intervention:**
  - Does not replace a conversation between patient and provider about family planning
  - Importance of a shared decision-making framework
    - “When engaging in shared decision making regarding contraceptive use, obstetrician–gynecologists should be aware of and address their own biases, work to empower patients, and strive for equitable outcomes for all patients regardless of age, race or ethnicity, class, or socioeconomic status.”
      
      -ACOG Committee Opinion #699
Future Directions

- A more structured needs assessment involving interviews with pregnant patients
  - Could formally assess understanding of fertility postpartum, plan for contraception and factors that influence contraceptive method choice.

- Exploration of how cultural beliefs and values surrounding family planning differ among VT populations, including refugee and socioeconomically disadvantaged groups.
  - Could be made into an educational session for providers to increase cultural competency.


Thank you to both Dr. Heath and Dr. Gibson for their insights!