Reproductive Life Planning

A TOOL TO IMPROVE THE HEALTH AND LIVES OF PREGNANT AND PARENTING TEENS
Acknowledgements

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Acknowledgements

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  - North Carolina Division of Public Health, Women’s Health Branch
  - UNC Center for Maternal & Infant Health
  - North Carolina Healthy Start Foundation
  - Merry-K Moos, FNP, MPH, FAAN
  - Alvina Long Valentin, RN MPH
  - Sarah Verbiest, DrPH, MSW, MPH

- Specific resources used to guide the development of this training:
  - The Case for Reproductive Life Planning
  - Putting the Pieces Together, Promoting Healthy Living and Healthy Families toolkit
  - The National Preconception Curriculum and Resources Guide for Clinicians (Module 1: Preconception Care: What it is and what it isn’t)
Young Moms Connect

- Brings together community partners to address challenges faced by pregnant or parenting teens using collaborative, multi-faceted strategies
- One component of Young Moms Connect is training for health care providers on six maternal and child health best practices

Have local coordinator say a few words about the project in the local county at this point, if available.
MCH Best Practices

- Early entry and effective utilization of prenatal care
- Establishment and utilization of a medical home (for non-pregnant women)
- Reproductive life planning
- Tobacco cessation counseling using the 5 A’s approach
- Promotion of healthy weight
- Domestic violence prevention

We’ll talk about this one today.
Objectives

- Increase knowledge about the key components of reproductive life planning
- Understand how reproductive life planning relates to opportunistic preconception health counseling
- Increase awareness about the importance of counseling all female patients of childbearing age about reproductive life planning
- Improve reproductive life planning counseling skills
- Learn strategies to improve reproductive life planning service delivery (within a practice or across agencies/partners)
What is preconception care?

- Identification of modifiable and non-modifiable risk factors for poor health and poor pregnancy outcomes before conception
- Timely counseling about risks and strategies to reduce the potential impact of the risks
- Risk reduction strategies consistent with best practices

Preconception refers to a woman’s health status and risks before a first pregnancy or shortly before any pregnancy.
Components of preconception care

- Giving protection
  - (eg.: folic acid, immunizations)

- Managing conditions
  - (eg.: diabetes, maternal PKU, obesity, hypertension, hypothyroidism, STIs, sickle cell)

- Avoiding exposures known to be teratogenic
  - (i.e.: medications, alcohol, tobacco, illicit drugs)

Today we will be discussing how to help women prevent a poor birth outcome by avoiding their fetus’s exposure to tobacco.

Source: The National Preconception Curriculum and Resources Guide for Clinicians. CDC Module 1
“Opportunistic” care

- Preconception care is for every woman of childbearing potential every time she is seen

- Every woman, every time

This is not necessarily doing more; it’s reframing the things you already do every day with the long-term lens of healthy women for healthy pregnancies for healthy birth outcomes and healthy women.

Opportunistic care: provide counseling at every visit (sick, wellness, chronic condition, pediatric visit, prenatal, post-partum etc.)

Source: The National Preconception Curriculum and Resources Guide for Clinicians. CDC Module 1
Every woman, every time

- Young women who are at risk of pregnancy
- Young women who are pregnant
- Young mothers who are postpartum
- Young mothers who are between pregnancies
Reproductive life planning

- One of the primary CDC preconception health recommendations is to encourage all men and women to have a reproductive life plan.

1. Encourage men and women to have a reproductive life plan.
2. Increase public awareness about preconception health.
3. Provide risk assessment and counseling during primary-care visits.
4. Increase the number of women who receive interventions after risk screening.
5. Use the time between pregnancies to provide intensive interventions to women who have had a pregnancy that resulted in infant death, low birth weight, or premature birth.
6. Offer one pre-pregnancy visit.
7. Increase health insurance coverage among low-income women.
8. Integrate preconception health objectives into public health programs.
9. Augment research.
10. Maximize public health surveillance.
What was your reproductive life plan at age 18?

Ask audience to respond to this question.

While very few of us had/have a formal life plan, many people do have thoughts about childbearing that are the first steps of a plan.

Give examples from your audience answers or others:

“I always wanted a boy and a girl.”
“I always wanted 4 children.”
“I wanted to be done with college before I had kids.”
“I wanted to be done having kids by the time I was 30.”
“I knew I never wanted to have children.”

These are all reproductive life plans – no one ever named them for us as such, but they are. Now, in addition to naming these plans, we have the opportunity to give young people tools to actually make these plans a reality. That’s what we’re going to discuss today.
Young adults in the US are taught to plan for many things: college, careers, retirement, etc.

In some European counties, reproductive life planning is also a normal part of planning to be an adult. This is not the norm here, but the CDC made a formal recommendation in 2006 that all men and women in the US be encouraged to develop RLPs.

In testing of a high school curriculum last year in NC, RLP was the single most popular (of 5) lesson plans we tested with students in non-college bound courses. Students were generally shocked and disappointed that adults might think this would be “over their heads.” The students also overwhelmed us with their thoughtfulness about this issue and the time they wanted to spend making their own personal plans. (They were neither well-informed about the facts nor particularly realistic in their thought-processes, but they were very, very thoughtful about this topic).

Particularly in the context of a “plan for your life,” RLP made sense to both young men and women and they worked very hard on their own RLPs when given the opportunity to do so. Do not underestimate your ability to open up this conversation with young people or their potential to be receptive.

So, let’s talk about what RLPs are and how they can be used in clinical settings.
Why is reproductive life planning important?

Lack of planning for pregnancy and pregnancy spacing, management of health conditions affecting pregnancy outcomes, environmental risk factors, and negative health behaviors affecting pregnancy outcomes leads to:
- unintended pregnancies
- increased risk for preterm births
- increased risk for low birth weight births
- increased rates of birth defects
- poorer health status for women
- increased health disparities

What does the term unintended pregnancies mean?

Wanted to become pregnant later or not at all.

Clarify the definition as encompassing either unwanted or mistimed (wanting to become pregnant later or not at all) as reported on PRAMS – self-reported, post-pregnancy survey.
Having a RLP does not guarantee that every pregnancy will be intended, but a RLP plan that also incorporates a contraceptive plan obviously decreases risk for unintended pregnancy.

Healthy timing and spacing of pregnancy provides couples the opportunity to prepare for the healthiest pregnancy possible. Unplanned pregnancies may mean that women would enter pregnancy with behavioral risks, genetic risks, and unmanaged chronic conditions which can all impact the health of her baby.

Becoming pregnant when its not planned may also mean that these women may not adopt healthy behaviors such as avoiding tobacco, illegal drugs, alcohol, certain medications or remember to take a daily multivitamin.

Unintended pregnancies are at greater risk for delivering a low birth weight baby, or babies who die before their first birthdays. Mothers with unintended pregnancies are also at greater risk of physical abuse.

What % of births in NC are unintended?

Unintended pregnancies

- 43% of N.C. women surveyed after the birth of their baby reported that the pregnancy was unintended, 2008

More than 4 in 10 pregnancies are unintended in NC. The rates are highest for African American women followed by Hispanic women.

Among women who have just given birth, nearly one in three (31%) say that they wanted to become pregnant later and 12% say that they did not want to become pregnant at all.

Nearly half of new mothers (47%) reported that they were not trying to get pregnant at the time of conception but were not doing anything to keep from getting pregnant.

Source: N.C. PRAMS 2008
Who is most at risk for unintended pregnancies?

- Teens
- Minority women
- Women with a high school education or less
- Women who are not married
- Women receiving Medicaid

We ourselves and some of our own children may be “unintended pregnancies” but there are associated health consequences.

75% of pregnancies to moms under age 19 were reported as unintended.

69% of pregnancies to African American women were reported as unintended.

Teens account for 1 in 6 of all unintended pregnancies annually in NC.

Five out of 6 unintended pregnancies are to women over 20 yrs of age.

Source: PRAMS 2008
### Teen pregnancy rates, ages 15-19, 2009

<table>
<thead>
<tr>
<th></th>
<th>Per 1,000 females, 15-19</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>56</td>
<td>45.4</td>
<td>80.2</td>
<td>118.4</td>
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<tr>
<td>Onslow County</td>
<td>88.7</td>
<td>93</td>
<td>78.1</td>
<td>113.4</td>
</tr>
<tr>
<td>Wayne County</td>
<td>68.2</td>
<td>53.7</td>
<td>94.2</td>
<td>127.6</td>
</tr>
<tr>
<td>Nash County</td>
<td>63.8</td>
<td>50.8</td>
<td>85.5</td>
<td>154.2</td>
</tr>
<tr>
<td>Rockingham Co.</td>
<td>59.1</td>
<td>54.1</td>
<td>74</td>
<td>*</td>
</tr>
<tr>
<td>Bladen County</td>
<td>55.9</td>
<td>51.8</td>
<td>68.9</td>
<td>*</td>
</tr>
</tbody>
</table>

Rockingham –Hispanic rate not reported, under 20 cases (19)

Bladen- Hispanic rate not reported, under 20 cases (4)

## Repeat teen pregnancy rates
### Ages 15-19, 2009

<table>
<thead>
<tr>
<th>County</th>
<th>Total Teen Preganacies</th>
<th># Repeat</th>
<th>% Repeat</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>18,142</td>
<td>5,192</td>
<td>29</td>
</tr>
<tr>
<td>Onslow County</td>
<td>511</td>
<td>152</td>
<td>30</td>
</tr>
<tr>
<td>Wayne County</td>
<td>272</td>
<td>78</td>
<td>29</td>
</tr>
<tr>
<td>Nash County</td>
<td>225</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td>Rockingham Co.</td>
<td>171</td>
<td>47</td>
<td>28</td>
</tr>
<tr>
<td>Bladen County</td>
<td>58</td>
<td>17</td>
<td>29</td>
</tr>
</tbody>
</table>

Don’t forget the adults!

- In spite of our high teen numbers, 5 of 6 unintended pregnancies are still to women over 20 years of age, so in terms of actual numbers unintended pregnancy affects “older women” more than teens.
Why is unintended pregnancy a concern?

- Increased elective abortion rate
- Increased risk for infant morbidity and mortality; including preterm birth, low birth weight, and birth defects
- Late entry into prenatal care
- Higher rates of smoking prior to pregnancy
- Increased child abuse and neglect
- Increased Medicaid costs
- Increased risk of physical abuse and partner relationship ending for mothers


The prevention of high risk and unwanted pregnancies can have a major impact on the reduction of infant mortality.

Sixty-three percent of women who started prenatal care late reported that their pregnancies were unintended (compared to 41% who began their care earlier)

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Let’s start by talking about late entry into prenatal care ...
13% of NC women enter prenatal care after 11 weeks (8.5% white, 18% African American, 20% Hispanic).

Sixty-three percent of women who started prenatal care late reported that their pregnancies were unintended (compared to 41% who began their care earlier)

Source: NC SCHS Risk Factors and Characteristics for 2009 NC Resident Life Births
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Now let’s turn to elective abortions and their relationship with unintended pregnancies
Increased abortion rate

- Abortions accounted for 16.5% of all reported pregnancies in 2009 in North Carolina

- Total Pregnancies: 153,763
- Abortions: 25,427
- Total Births: 126,785

- 16% of abortions in North Carolina are to teens

Contraception is only one piece of reproductive life planning. Health care providers starting the conversation about setting reproductive goals is likely to help prevent unintended pregnancies.

Note: Overall NC abortion rate is 13.4, for White women it is 7.7 and for minority women it is 21.9.

Source: NC SCHS, NC Reported Pregnancies, 2009

Note: Induced abortion by county, 2009
Bladen: 50
Nash: 276
Onlsow: 662
Rockingham: 175
Wayne: 297

Source: 2009 State Center for Health Statistics:

49% of abortions in NC are to minority women
75.3% are to unmarried women
46.3% are to women with high school education or less
16% are to teens
Increased abortion rate

In the U.S., the most common reasons cited by women for having an abortion are:
- Concern for or responsibility to other individuals
- Cannot afford a child
- Work, school, caring for dependents
- Do not want to be a single parent or having trouble with partner

Why is unintended pregnancy a concern?

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- Late entry into prenatal care
- Higher rates of smoking prior to pregnancy
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Now let’s look at infant outcomes that may be correlated with unintended pregnancy
Women who have unintended pregnancies may be more likely to engage in behaviors that affect birth outcomes.

Alcohol use
• Preterm birth
• Birth defects
• Mental retardation
• Stillbirth
• Miscarriage

Tobacco use
• Low birth weight
• Small for gestational age
• Pre-term delivery
• SIDS
• Still birth

Illicit drug use
• Fetal death
• Brain injuries
• Pre-term birth
• Developmental problems
• Birth defects

We know that various risk behaviors can lead to infant death, illness and/or disability. A new way of thinking about this is to consider the relationship between unintended pregnancies and the risk behaviors. Unintended pregnancies do not CAUSE infant morbidity and mortality, but looking at these graphics we can see how preventing unintended pregnancies will help us to prevent infant morbidity and mortality.

Smoking nearly doubles a woman’s risk of having a low-birth weight baby.

Studies also suggest that smoking increases the risk of preterm delivery before (37 weeks of gestation).

Premature and low-birthweight babies face an increased risk of serious health problems during the newborn period such as SIDS and chronic lifelong disabilities (such as cerebral palsy, mental retardation and learning problems) and even death.
Increased infant morbidity and mortality

Women with unintended pregnancies may be more likely to have pre-existing medical conditions that adversely affect birth outcomes.

- Obesity
  - Fetal and neonatal death
  - Neural tube defects
  - Large baby
  - Increased risk for obesity in child

- Hypertension
  - Pre-term birth
  - Placental abnormalities
  - Birth defects from medications
  - Low birth weight

- Diabetes
  - Miscarriage/Still birth
  - Pre-term birth
  - Birth defects
  - Macrosomia

- Sexually Transmitted Infections
  - STI Transmission to infant
  - Low birth weight
  - Miscarriage/Still birth
  - Eye infections or blindness
  - Preterm birth
  - Pneumonia

- Poor mental health
  - Pre-term birth
  - Low birth weight

- Asthma
  - Pre-term birth
  - Low birth weight
  - Small for gestational age

We know that women with these various pre-existing conditions (some of which may not be diagnosed until pregnancy) are more likely to have adverse birth outcomes.

Women who do not plan or intend their pregnancies may also have a higher likelihood for these medical conditions.

This is why as health care providers, we need to ask questions about reproductive goals and provide counseling.

Source: Adapted from California Preconception Care Provider Training, County of Los Angeles, Department of Public Health, 2003
Increased infant morbidity and mortality

- **Birth defects**
  - In North Carolina, more than 3,500 babies are born each year with serious birth defects (1 in 33)\(^1\)
  - Birth defects are the underlying cause of almost 1 in 5 infant deaths in North Carolina\(^2\)
  - In 2009, birth defects were the cause of 19% of deaths for babies under 1 year old compared to 9.7% for Sudden Infant Death Syndrome\(^3\)

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*Now for some background on birth defects in NC*

**Sources:**
1 “Birth Defects in NC: A report by the NC Birth Defects Monitoring Program, NC SCHS Jan 2006
2 NC State Center for Health Statistics 2004 to 2008 data
3 NC SCHS 2010, NC 2009 Infant Mortality Report, Table 7
The cause of many birth defects is unknown but the ones caused by medications and environmental factors such as use of alcohol, drugs, or smoking can be prevented.

The main message about preconception care is Every Woman Every Time, so that these risk factors can be addressed before a pregnancy begins. Giving females the message to take a daily multivitamin with folic acid can prevent up to 70% of neural tube defects.

Women have reported that hearing these messages from their health care provider is key to helping them make healthy choices prior to pregnancy.

Late entry into prenatal care is higher for minority women (18% African American, 21% Hispanic)

Source: SCHS 2009, Risk Factors and Characteristics for 2009 NC Residents Live Births
Again, if about half of all pregnancies are unintended, counseling women about the connections between their current health risks BEFORE they become pregnant (again) becomes critical. As you know, much of a fetus’s development occurs in the early stages and the health choices of the mother in those early weeks can affect birth defects risk.

Organ formation: The period of time from 17-56 days after conception or 4-10 weeks from the last menstrual period (LMP) is the one where the pregnancy is most susceptible for developing major malformations. (Moore, 1998)

Prior to 17 days post-conception is when exposures to various hazards places pregnancy at risk of spontaneous loss and the period of time after 56 days post-conception is the period where exposures to these hazards may lead to growth disturbances.

Since the mean entry into prenatal care is in the 3rd month of pregnancy, issues concerning teratogenesis need to be addressed before the first prenatal visit.
Folic acid to prevent neural tube defects

- Women with unintended pregnancies are less likely to take a multivitamin during pregnancy

“Among women with unintended pregnancies, smaller proportions took a multivitamin every day during the month before becoming pregnant (17% compared to 40% intended).”

Source: 2004-2006 PRAMS Unintended Pregnancies Fact Sheet March 2009
Increased infant morbidity and mortality

- **Preterm Births**
  - 13% of all births in North Carolina in 2009 were preterm
  - African Americans are at higher risk for preterm births than Whites or Hispanics
    - 17% of minority births in 2009
    - 12% of White births in 2009
  - Prematurity and low birth weight accounted for 23% of deaths for infants under 1 year old and for 34% of neonatal deaths (infants under 28 days old) in North Carolina in 2009, making them the #1 cause of infant death

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*Pre-term birth is also associated with unintended pregnancies. Compared to other states, we have a very high rate of prematurity. We rank #41 in the US for premature birth. Prematurity is defined as completing the pregnancy before the 37th week.*

9.1% of NC births are low birth weight (under 2,500 grams) [7.2% white, 13.6% minority]

13.2% of NC births are premature (before 37 weeks) [11.7% white, 16.8% minority]

Source: 2009 NC Infant Mortality Report, Table 7. 2009 Infant Deaths (<365 days) by Cause of Death.

Source: 2009 NC Infant Mortality report, Table 8. 2009 Neonatal (<28 days) Infant Deaths by Cause of Death.

Infant mortality in North Carolina

- 1,006 infants died in North Carolina in 2009 (7.9 per 1,000 live births)
- If North Carolina were a country we would rank between Hungary (#62) and Puerto Rico (#63) in infant mortality. (U.S. ranks 46th overall)
- We also have a striking racial disparity in NC, which in recent years has remained constant while the overall rate has decreased slightly:
  - 2009 IM rate for white women = 5.4 deaths per 1,000 live births
  - 2009 IM rate for minority women = 14.1 deaths per 1,000 live births
- In 2009 the minority rate and disparity both increased

For reference the countries with the lowest IM are:
1) Singapore 2.31; 2) Bermuda 2.46; 3) Sweden 2.75; 4) Japan 2.79; 5) Hong Kong 2.92
Source: CIA Fact Book 2009

NC fetal death rate is 6.7 (5.1 for white women and 10.7 for minority women).
Source: NC SCHS, 2009

NC Low birth weight rate is 9.1 (7.2 for white women, 13.5 for minority women.)
NC Very low birth weight is 1.8 (1.3 for white women, 3.1 for minority women)
Source: NC SCHS Live Birth Trends, 2000-2009

Infant Mortality rate: 7.9
  ➢ 14.1 for minority women

Fetal Death rate: 6.7
  ➢ 13.5 for minority women

Low birth weight rate: 1.8
  ➢ 3.1 for minority women

Infant deaths under 1 year, 7.9.

Source: 2009 NC SCHS Vital Statistics
Source: NC State Center for Health Statistics (accessed May 9, 2011)
Infant Mortality, 2009

<table>
<thead>
<tr>
<th></th>
<th>Rate per 1,000 live births</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>7.9</td>
<td>1,006</td>
</tr>
<tr>
<td>Onslow County</td>
<td>6.9</td>
<td>28</td>
</tr>
<tr>
<td>Nash County</td>
<td>10.2</td>
<td>4</td>
</tr>
<tr>
<td>Rockingham Co.</td>
<td>10.5</td>
<td>11</td>
</tr>
<tr>
<td>Bladen County</td>
<td>10.6</td>
<td>4</td>
</tr>
<tr>
<td>Wayne County</td>
<td>13.2</td>
<td>22</td>
</tr>
</tbody>
</table>

Overall in North Carolina, 4% of infant deaths were to mothers under age 18. 84% were to mothers ages 24-34.

NC State Center for Health Statistics, NC Infant Mortality Report, 2009. Table 1. Final Infant Death Rates (per 1,000 live births)

Keep in mind: one year-IMR’s are not the best indicator - should look at over time to get a fuller picture as the numbers are small from year to year.

Bladen: 4 deaths, rate: 29 for minorities, 0 for white
Nash: 4 deaths, rate: 15.4 for minorities, 5.8 for white
Onslow: 28 deaths, rate: 6.9, for minorities 13.9, 5.4 for white
Rockingham, 11 deaths, 17.4 for minorities, 8.6 for white
Wayne, 22 deaths, 22.4 for minorities, 7.7 for white

Source: 2009 NC SCHS, NC Infant Mortality Report Table 1. Final Infant Death Rates (per 1,000 live births)
Questions or concerns about data presented so far about unintended pregnancy?

Overall thoughts about the importance of reproductive life planning?

*These data make it more clear why the CDC has recommended RLP for all men and women – planning leads to intended pregnancies. Intended pregnancies have better outcomes.*
Overview: Reproductive life planning

1. Access to health services for preconception/wellness services including, but not limited to, family planning
2. Dialogue between health care providers and patients about a plan for future pregnancy or a plan to prevent pregnancy
3. Revisiting of reproductive life plan as time goes on

We’re going to focus on the third bullet today.
<table>
<thead>
<tr>
<th>Who can provide reproductive life planning?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pediatrics</td>
</tr>
<tr>
<td>- Primary care providers</td>
</tr>
<tr>
<td>- Family practice physicians</td>
</tr>
<tr>
<td>- OB GYNs</td>
</tr>
<tr>
<td>- Nurses/nurse practitioners/nurse midwives</td>
</tr>
<tr>
<td>- Physician assistants</td>
</tr>
<tr>
<td>- Health educators</td>
</tr>
<tr>
<td>- Social workers</td>
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<tr>
<td>- Community outreach workers</td>
</tr>
<tr>
<td>- Dieticians</td>
</tr>
</tbody>
</table>
Getting started: Reproductive life planning

- Thinking about whether or not an individual plans to have children and
- When?
- How many?
- How often?
- And...how they can implement their plan and maintain their health now, their health during pregnancy and their baby’s health

For patients, RLP is about:

How many of you use these questions with patients?

How does it work?

Suggestions you have for others in the room?
### Considerations

<table>
<thead>
<tr>
<th>• Age</th>
<th>• Relationship with partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Educational goals</td>
<td>• Readiness to become a parent</td>
</tr>
<tr>
<td>• Career plans</td>
<td>• Current health status</td>
</tr>
<tr>
<td>• Living situation</td>
<td>• Hereditary risk factors</td>
</tr>
<tr>
<td>• Financial situation</td>
<td>• Health behaviors</td>
</tr>
<tr>
<td>• Social support</td>
<td></td>
</tr>
</tbody>
</table>

Some of these topics are not part of our clinical standards of care (diagnose/treat).

Having an understanding of a woman’s life circumstances and goals will help build trust and will strengthen the impact of a reproductive life plan. This can be done in a brief way, even by handing her a resource to complete at home. Spending time with patients discussing their current health status (including a BMI assessment), hereditary risk behaviors and health behaviors is most important.

Some of these topics are more comfortable for health care providers than others, but it is important that all health care providers find the right moment to discuss all relevant life goals/plans with their patients. These are directly related to reproductive life planning goals and are best discussed in a comprehensive way.
Birth spacing

- Recommended birth spacing in the U.S. is at least 18 months between prior delivery and next conception (and no more than five years)
- 41.9% of North Carolina women have less than an 18 month interval
  - Under age 20, 74%
  - Age 20-24, 34%


Healthy Timing and Spacing of Pregnancy is recommended to help women and families delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children

Minimum recommendation based on 3 large studies in the U.S. is at least 18 months between delivery and next conception or about 27 months between birthdays.

Source: NC SCHS 2008 (Vital Statistics)
Increased risks for short birth intervals

- When pregnancy occurs 6 months or less after a live birth there is an increased risk for:
  - Induced abortion
  - Miscarriage
  - Newborn death
  - Maternal death
  - Preterm birth, low birthweight and stillborn
Short birth intervals (6 months or less)  
2005-2009

<table>
<thead>
<tr>
<th>County</th>
<th>Short birth intervals as % of live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>13</td>
</tr>
<tr>
<td>Bladen County</td>
<td>11</td>
</tr>
<tr>
<td>Nash County</td>
<td>15</td>
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<tr>
<td>Onslow County</td>
<td>14</td>
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<tr>
<td>Rockingham County</td>
<td>14</td>
</tr>
<tr>
<td>Wayne County</td>
<td>15</td>
</tr>
</tbody>
</table>

Interval from last delivery to conception of six months or less; recommended interval is 18 months from delivery of one child to conception of next child.

- **Statewide:** 12.9%
- **Bladen:** 10.7%
- **Nash:** 14.7%
- **Onslow:** 13.6%
- **Rockingham:** 14%
- **Wayne:** 15.1%
5 A’s of Reproductive Life Planning

This is adapted from the Michigan Department of Community Health who did quite a lot of work around strategic planning on prevention of unintended pregnancies.

This is modeled on the 5A’s counseling method of smoking cessation. There are no evidence-based RLP tools that have been published to date; this is an example of how you can approach reproductive life planning. Hopefully someone will test this model for us!
The important thing to remember is to ask every female in her childbearing years each time you see her what her reproductive plans are—the same way you take her blood pressure and weigh her. Sometimes it's easier to start with asking about her current contraceptive method. Don’t assume that a woman isn’t sexually active because of her age, relationship status or proximity to her last pregnancy.

For some young women who haven’t had children yet it is sometimes helpful to ask them how old they see themselves being when they have their first babies. And then help them think through how old they see themselves when they have any subsequent children. Using a Reproductive Life Planning tool designed specifically for young women may be helpful.

Other standard questions include:

Do you hope to have (anymore) children?

How many children do you hope to have?

How long do you plan to wait until you next become pregnant?

How much space do you plan to have between your pregnancies?

What do you plan to do until you are ready to become pregnant?
What can I do today to help you achieve your plans?

Source: The National Preconception Curriculum and Resources Guide for Clinicians. CDC Module 1. (sample questions)
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- Risks of unintended pregnancy
- Adverse outcomes of unintended pregnancies related to risk behaviors, chronic conditions or genetics (i.e. sickle cell status)
- Recommendations for healthy pregnancies, including optimal child spacing

Review with clients their ability to become pregnant. Help provide them with information to make an informed decision.

Explain what the risks are for herself and/or a baby if she were to become pregnant now. Emphasize the importance of having a Reproductive Plan and revisiting that plan at least every six months. Explain what the health benefits are of having planned pregnancies compared to unplanned ones and stress the importance of early prenatal care.

Women often don’t understand the risks that their current health status might have on a pregnancy and/or baby. Many women don’t realize how preventable medical conditions (i.e: obesity) or high risk behaviors (binge drinking, smoking) can affect a fetus in the first few weeks of pregnancy.

An 18 year old woman who says she wants to have 4 children close together would benefit from hearing from her health care provider what the risks to herself and her babies’ health would be with short birth spacing. She may decide to stick to that plan. It would be important to advise her to take a daily multivitamin with folic acid and avoiding exposures such as some prescription medications, alcohol, illicit drugs and tobacco when trying to become pregnant and during pregnancy. Discussing healthy weight maintenance and the advantages of breastfeeding would also be important.

A 22 year old who already has a 2 year old child who is in a new relationship but is only using condoms sometimes should be asked about if and when she might want to become pregnant again. She may benefit from contraceptive counseling about different methods, side effects and a discussion about what her barriers to effective contraception are.
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Assess a woman’s LIFE circumstances - relationship status, family life, employment status, health of dependents, etc.

Using a Preconception Health Checklist, assess a patient’s reproductive risks.

Determine a woman’s understanding of her current risk of becoming pregnant. Make a plan with her to address any risk factors (genetic, behavioral, environmental). Explain that even if pregnancy isn’t something she is planning for soon it should be something to prepare her body.

Also assess where she is on the continuum in terms of preventing a pregnancy. (i.e. is she ready to select a family planning method or is she in denial of fertility) or doing all she can to have a healthy pregnancy?

Questions:
Are you sexually active?

What contraceptive method(s) are you using?
Preconception health checklists

- Samples in the Training Materials & Tool Kit binder
  - Are you ready? Sex & your future (Spanish & English) (DPH Women’s Health Branch)
  - Am I ready to be a mom? (DPH Women’s Health Branch)
  - Am I ready to be a dad? (DPH Women’s Health Branch)
  - Are you ready for a baby? (March of Dimes)
  - Personal Reproductive Health Risk Assessment for Females (N.C. Preconception Health Campaign/March of Dimes)
  - Adolescent Reproductive Life Plan (N.C. Preconception Health Campaign/March of Dimes)
  - Becoming a Parent (Wisconsin Association for Perinatal Care)

If time allows, have participants find these tools in the binder and choose one that might work best for their setting and personal practice.
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- Discuss contraception methods and offer prescriptions
- Review correct use and advocate for long-acting reversible contraceptive methods that reduce patient error
- Condom use for STI prevention
- Refer to family planning clinic, primary care provider, obstetrician/gynecologist or hotline for additional counseling and services

Assist women with obtaining contraceptive methods of choice and any treatment options for existing risk factors. Give her a Reproductive Planning tool and ask her to fill it out and revisit it at least every six months or whenever her life circumstances or goals change.
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- Recommend birth control options appropriate for chronic health conditions & infections
  - Obesity
  - Hypertension
  - Cancer history
  - Blood clotting disorders
  - Sickle cell
  - Sexually transmitted infections

Source: Planned Parenthood
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- Arrange follow-up appointment or services as needed to promote healthy pregnancy or prevent unintended pregnancy

Your clinic may not be able to provide primary care services needed by the patient, or mental health counseling but you can help facilitate a referral.

The NC Family Planning Waiver is another important resource for women who need insurance coverage for family planning services.

Helping a woman think through her options helps remove barriers. Helping to make the appointment, making sure she has transportation or child care, helping her navigate insurance and payment- these are all ways to help arrange services.
**Ideal world: A pre-pregnancy check up**

Use a preconception health checklist and:

- Screen for STIs, HIV, genetic conditions, medical conditions like diabetes, thyroid disorders, hypertension.
- Raise awareness of risk of complications as necessary (including from prior pregnancy)
- Encourage compliance with prenatal care visits
- Recommend daily multivitamins with folic acid
- Recommend regular dental exams

If a patient mentions that she is planning to become pregnant soon you can provide a pre-pregnancy check up as part of whatever visit she is there for (opportunistic care).
Advice for women planning a pregnancy

- Encourage no use of tobacco, alcohol, illicit drugs
- Assess immunization status: hepatitis B, hepatitis A, rubella, varicella, tetanus, pertussis, flu and HPV
- Parenting and breastfeeding education
Advice for women planning a pregnancy

- Screen for depression and domestic violence
- Assess social support
- Screen for environmental stressors: lack of insurance, underinsurance, lack of housing, stressful activities in the home
**Keys to success**

- Rapport building
- Motivational counseling
- Goal setting

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**Diane Pearson, Dulce Program, San Diego Family Care**

Women are most likely to make health behavior changes if recommended by her health care provider.

Building a relationship with your patient and understanding her life circumstances can help you counsel about reproductive goals.

If a woman lost a late term pregnancy 6 months prior, she may be anxious about becoming pregnant soon. Understanding her personal feelings can help you explain the benefits of interval spacing in a sensitive way that may result in a better health outcome.

A woman who recently lost her job and started smoking again in response to her increased stress might be receptive to setting a quit date and beginning pharmacotherapy if its part of a conversation about her reproductive goals.

Similarly, a young woman who isn’t planning to become pregnant soon but is struggling with a weight problem might be willing to enroll in a weight loss program if recommended by her health care provider and its part of her reproductive life plan.

Meeting patients where they are in their LIFE is the first step in helping them create a Reproductive LIFE Plan.
Keys to success

- Find the individual motivation for current behaviors and desired changes
- Help patients choose small goals in which they are likely to succeed, then build on that success
- Preparation and motivation compensate for lack of confidence or will power

Asking some basic questions about a patient’s life circumstances will help you as the healthcare provider or counselor understand what suggestions would be motivational.

For example, quitting smoking might be more appealing to a woman when she learns about the effects of 2nd and 3rd hand smoke on her children.

Setting small goals like having a written Reproductive Life Plan, replacing some or all soda or sugared drinks with water, or using condoms every time you have sex to prevent STIs can help patients feel successful.

Have Reproductive Life Plans, brochures, referral forms, and contraception samples ready.
Getting started with behavior change

- Talk to patient about current behaviors, motivators, and barriers
- What changes would you like to make?
- Why is this important to you?
- What’s keeping you from making changes?
- What would make it easier for you to change?
- What do you need in order to make the change?

This is the time in the training to do some demonstration and small group work to practice the counseling skills that were just reviewed:

Trainer Demonstrations of some tools:

Title: Sex and Your Future: Are you Ready?
Description: Adolescent RLP tool, female self-risk assessment

Read Aloud and Group Process Case Studies

Participant Practice Role Plays
Improving reproductive life planning services at your facility

- Who provides reproductive life planning counseling?
- Who should provide reproductive life planning counseling?
- What should it include?
- Where should it take place?
- When should reproductive life planning counseling be offered?
- What tools are used?
- What tools should be used?

If time allows, break participants into small groups, using the RLP Service Delivery Improvement Worksheet. If short on time, facilitate a group brainstorm.

Facilitate a brainstorm activity with these questions.

Record responses on flip chart paper (or a dry erase board). Once all the possibilities are recorded and displayed ask groups of people who work together to make an action plan for their own practice or facility.
Take home message

- Ask **all of your patients** about reproductive life planning! Just one simple question can get the ball rolling ...

*Please take a few moments to fill out the self assessment quiz.*