Enhancing Perinatal Support and Services

Webinar Series for Doulas and Case Managers

Basics of Postpartum Support

October 22, 2025

About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Presenters

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Napa, Solano, and Yolo counties

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Guest Panelist

Learning Objectives

By the end of the presentation, you will be able to:

- Identify and discuss the three most common mood changes
- Discuss two early feeding and milk supply concerns
- Name three postpartum complications
- Describe the relationship between bonding and mutual regulation

Introduction to Postpartum Support

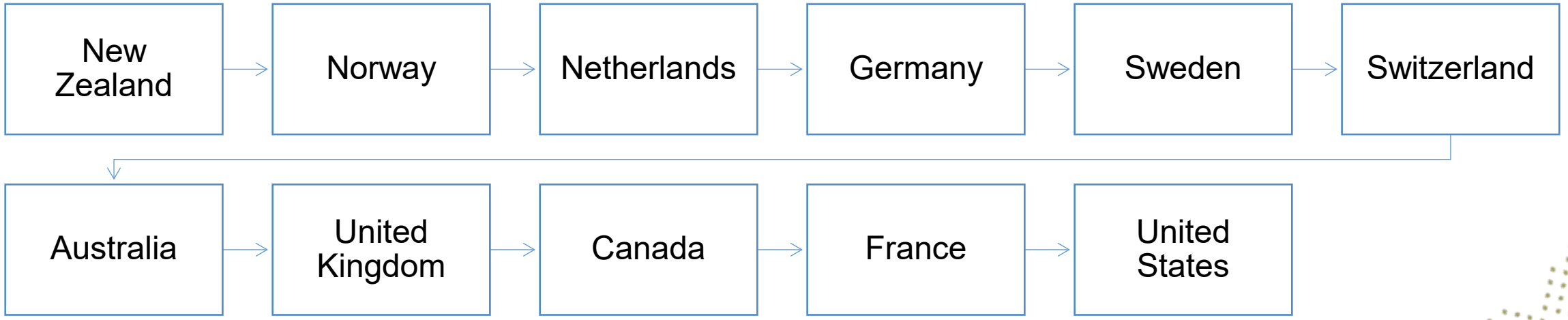
Let’s review a little:

- Being pregnant is an expectation-defying event.
- During this period, the pregnant person *re-organizes their identity*.
- The success, or lack thereof, has a significant effect on their well-being and their family.
- The birthing person is the gatekeeper of their family. Their success through this profound experience is of the utmost importance to their future health and the health of their family.

Why Postpartum is Important and Why We Do This Work

First, let's define mortality (pregnancy and postpartum)

- Mortality associated with pregnancy and postpartum is the number of deaths per 100,000 live births
- The US has the highest pregnancy and postpartum mortality rate among the 10 most developed countries. Here they are listed from *lowest* mortality rate to **highest**:



- In the U.S., our women of color are heavily affected at almost two times the rate of white women

Important Definitions to Remember

- Pregnancy associated: While pregnant or within one year of any cause.
- Pregnancy-related: death from a pregnancy-related complication or chain of events. The CDC uses this measure and reports it in the U.S. ratio, which is per 100,000 births.
- Maternal/birthing person mortality: Defined as death while pregnant or within 42 days of the end of the pregnancy, no matter how long it lasted. From any cause related to or aggravated by the pregnancy or its management, but not from accidents or incidental causes. Used by the World Health Organization (WHO) in international comparisons. Ratio per 100,000 births.

Important to Remember - continued

To understand this phenomenon, it is important to know the associated timeframes.

- Pregnancy-related deaths:
  - 33% during pregnancy
  - 17% the day of delivery
  - 52% after the baby is born - postpartum
    - 19% between one to six days
    - 21% between one to six weeks
    - 12% during the rest of the year, called “late maternal deaths”

Most Pregnancy and Postpartum Deaths Are Believed To Be Preventable

- In 2018 there were 17 deaths / 100,000 births, more than double the lowest rate of other developed countries (New Zealand 1.7 / 100,000).
- The U.S. has an undersupply of maternity care providers, including midwives and primary care physicians.
- There is a lack of comprehensive postpartum support, including access to home visits.

California Has The Lowest Pregnancy Associated Death Rate in the Nation

Here are some recent stats:

- 13.4 maternal deaths / 100,000 in 2015
- 21.6 maternal deaths / 100,000 in 2021
- 15 maternal deaths / 100,000 in 2022 (a welcome decline, but still too high)
- From 2020 – 2022, the leading causes were:
  - COVID-19 = 25% of pregnancy-related deaths,
  - cardiovascular disease = 17.2%
  - hemorrhage = 17.7%
  - pulmonary embolism = 8.6%
  - non-COVID sepsis and infections = 8.2%
  - amniotic embolism = 7.8%
  - hypertensive disorders of pregnancy = 4.7%

This crisis disproportionately affects our Black, Brown, Alaska Native, American Indigenous, and Pacific Islander pregnant and postpartum individuals. Black individuals are 3.7 times more likely to die than their white peers.

R-2

Risk Factors

- Pre-existing and/or pregnancy-induced cardiovascular disease
- Pre-existing and/or pregnancy-induced hypertension
- Hemorrhage
  - Immediate, at the time of birth
  - Early, in the hospital after birth
  - Delayed after discharge home
- Infection or sepsis
- Additional but not insignificant in effect
  - Pulmonary embolism (?)
  - Maternal/birthing person mental health
  - Substance use
  - IPV – intimate partner violence
  - Unhoused

R-5

Believe It or Not, Postpartum Starts In Pregnancy

- The imagined baby
- Birth stories – theirs, their family, and or friends
- Imagining the parent, they will become
- Identification of support systems
- Anticipated birth
- Seeking safe passage

This is all part of the process of moving toward the birth and transitioning into parenthood and postpartum.

Today's Postpartum Presentation
Where Do We Start?

- The transition – from pregnancy to postpartum
- Listen to the birth story
- Ask about any labor and birth complications*
- Review early lactation or feeding challenges and offer support
- Talk about mood changes
- Discuss the dynamics of family role adjustments
- Address questions or concerns

(These are interactions where you may pick up info about specific problems)

Postpartum Wellbeing – "Look and Listen"
The Focus of the Doula, Case Manager, and Perinatal Educator

1. **Mental Health**
   - Have their complaints or comments moved beyond the "baby blues"?
   - Any verbalized harmful ideation requires an immediate referral to their health care provider.
   - Complains of mood swings or they share thoughts of self-harm or hurting the baby
2. **Fever**
   - How high a temperature is too high?
     - Fever > 100.4 when not taking Tylenol, ibuprofen, or aspirin.
   - If they report not feeling well or think they may have a temperature.
     - Ask them to take their temperature.
     - No drinks of water or other liquids for 30 minutes before.
3. **Physical stability**
   - Are they able to perform self-care activities (showering, dressing, going to the bathroom and back, eating)?
   - Are they caring for and feeding the baby?
   - Do they appear well, relatively happy? (Some tiredness is normal.)
4. **Bleeding**
   - Presence of blood clots or heavy bleeding (soaking more than 1–2 pads in one hour).
   - Heavy bleeding that returns after it had stopped or lightened in color.

Postpartum Wellbeing, continued

5. **When does the uterus return to prepregnant size?**
    - The uterus takes around six weeks to return to its normal size, nestled deep in the pelvis.
6. **Blood pressure problems. How can you tell?**
    - Visual changes, blurred vision, severe headache, swelling, especially of the face – even if it comes and goes
7. **Cardiovascular problems**
    - Do they feel like their heart is beating too fast? Calf pain (back of their lower legs)
    - Complaints of trouble breathing – shortness of breath, wheezing
8. **What might an infection without fever look like?**
    - Bladder – pain, burning, trouble peeing. If they tell you they see small amounts of blood in their urine, and it hurts to urinate.
    - They report swelling, redness, or yellow/green discharge at any site that has been affected by the birth: vaginal, rectal, abdominal, or on their back at the epidural site.
    - They report that the vaginal discharge is foul-smelling
9. **Do they have pain?**
    - Do they complain of pain? Where? How often? What level on the pain scale of 1 – 10, with 10 being the worst? Did they have a surgical birth?

Your task is to advocate for them to be seen by a health care provider
When to call 911 or go to the ER?

Commonalities

- As you can see there are common areas in late pregnancy and early postpartum.

- The work being done is significant with an emphasis on the depth and connection of the psycho-social-emotional status of the pregnant/postpartum person.

Major Developmental Tasks

Seeking:

- Safe passage through pregnancy and birth
- Acceptance of this child by others
- Commitment and acceptance as the parent of this infant
- Learning to give of oneself on behalf of one's child

The First Month Postpartum
Dynamic Changes and Challenges

- Disorganization
- The real baby
- Isolation
- Moods
- Mutual regulation
- Feeding
- Language of the baby

- Strength based facilitation
- Physical changes
- Caring for the dyad
- Attachment
- The birth story
- ID support systems

Relationships and Development Tasks of the Second Month

- The parent(s)–different approaches
- Family building
- Day-to-day challenges
- Seeking anticipatory guidance
- Siblings
- Falling in love with the baby
- Temperament
- Language of the baby
- Continue to develop mutual regulation

The Third Month And Beyond

- Self acceptance
- The new normal defined
  - Physical, relational, and the integration of the new person
- The parenting team
- Family planning
- Reorganization of the intimate relationship

Feeding The Baby – Keeping It Simple

Feeding help in the *first week* is about making sure the baby is being feed and the mom is getting the help they need. If there are problems or questions please refer to the Physician, CNM/LM, Pediatrician or Lactation Educator, Specialist or Consultant

- How is the baby being fed? breast, chest, formula, pumped milk, combo?
- Are they using any devices: pump, nipple shield, etc?
- Have the breasts been engorged? Has the milk come in?
- Do they have questions?
- Is the baby being offered a feeding every two to three hours?
- If the baby is formula or combo fed, are they following the directions given to them at discharge? If something needed to change, what happened?

Keeping the Baby Safe and Healthy

Does the baby have two to three (or more) sloppy poops in 24 hours?

Does the baby have six to eight wet diapers each day (not just damp)?

Does the baby look yellow – eyes or skin?

How much did the baby weigh at birth?

Has the baby seen the pediatrician?

What does the infants sleep environment look like? Free from clutter, blankets, toys?

Is the baby having breathing difficulties?

Is the baby pale, grey, or have any blueish tinge to their face or lips?

Ask them to tell you about the feeding.

Relationships and the Involvement of Others

- Siblings
- Other extended family
- Influencing factors
- Partners
- The family as defined by the birthing parents
- Grandparents
- Alternative birthing options
- Surrogacy and adoption
- LBGTQ+

Ensuring a Safe Path for BIPOC Families

- BIPOC (Black, Indigenous, and People of Color) face disproportionate risks in perinatal care due to systemic inequities.
- Ensuring safety means addressing both clinical outcomes and cultural, emotional, and spiritual needs.
- True safety is not just the absence of harm, but the presence of trust, respect, and dignity care.

Why This Matters

- BIPOC families face disproportionate maternal and infant health risks.
- Historical inequities and systemic racism contribute to gaps in care.

Our Commitment

- Culturally responsive and community-based support.
- Collaboration across doulas, perinatal educators, and case managers.
- Centering family voices to shape safer, more equitable pathways.

The Goal

- Improve outcomes by aligning roles within perinatal care.
- Build trust, dignity, and generational wellness for families.

Considerations for LBGTQ+ Families: Inclusivity Matters

Responses from the last Webinar included thoughts shared on gender neutral birth work language. Going forward we will put forth our best effort to use more inclusive language.

Additionally, more than one respondent asked about how to establish a bond without chest feeding.

Bonding With Your Newborn Without Chest Feeding

This is an incredibly important question on a somewhat misunderstood topic. All parents are capable and deserving of bonding with their infant without regard to how the infant was born or how the infant is fed. Each situation, and each individual is unique.

Here are two time-tested ways to start:

1. Skin to skin
2. Responding to your infant

1. Skin to Skin

- One, two, three, or more times per day, sit with your baby skin-to-skin.
- Have the infant in a diaper, bring your baby to your chest area with your shirt off. If that initially makes you feel a little overwhelmed, then wear a shirt or bra, as the case may be, made out of thin material.
- At first, you may have a little surge of oxytocin, sometimes called the love hormone; it can be overwhelming at first. This is normal and a positive sign of bonding.
- You may recline (more like a slight slouch). Please do not lie side by side or flat on your back. Please do not imbibe in any alcoholic beverages, smoke, or ingest other substances before or during this time. Anything that alters your consciousness is a big no-no. This is for safety's sake.
- Bring your baby to your chest with their abdomen and chest lying on your chest.

1. Skin to Skin (continued)

- Then place a blanket, as an added layer of warmth, over both of you.
- **Note:** You may want to do this after a feeding. A hungry infant placed skin to skin with almost always automatically “root”; this is a normal, primitive instinct still active within us and designed for survival. Your infant may do this anyway. If so, let them suck on your pinky fingertip (clean hands, trimmed fingernail) or use a pacifier. If they have been fed it is probably an initial response only.
- This will benefit you both more than you can imagine. Your baby will feel your warmth, the rhythm of your breathing, and hear
  and feel your heartbeat.
- In developmental circles, this is called “mutual regulation”. It leads to the maturation of your relationship with your baby
  and “bonding”. You are getting to know each other.
- As you begin to “know” your baby, your baby begins to recognize you as a unique person(s)
  - This is plural because: Father/father or mother/father or mother/mother. Both parents can participate in this technique.

2. Responding to Your Infant

The other important thing that you can do to bond with your infant is *“respond to your baby.”*

Babies cry. Crying is the language of the baby. In the early days and weeks, you probably won’t understand much of what they are “saying” to you. It is important to respond when your baby cries. As you move through the first few weeks you will begin to recognize what they are trying to tell you – “I don’t like having a poopy diaper” “I don’t like having a wet diaper” “I’m hungry” (be aware crying is a late sign of hunger) It’s too hot…too cold” “I have gas” “I’m too tired” “I just want to be with you”. Please respond to your infant. Letting a baby cry will send the message that no one is coming to help them.

2. Responding to Your Infant (continued)

Each infant is different, even in the same family. For example, some babies couldn't care less if their diaper is wet, others will cry loudly until it is changed. It takes time to figure it out.

If you decide to "sleep train" your baby, that is your decision as their parent to make. Please wait until they are about 6 months to try. 0-6 months is a critical time for bonding and for the development of communication. As for sleeping, maybe they will have it figured out by then.

Again, this plays a part in the development of mutual regulation.

Perinatal Mental Health Issues

Overview

Perinatal mental health encompasses psychological well-being during pregnancy and the postpartum period (up to one year after birth). These issues can impact not only the mother/birthing person but also infant bonding, family stability, and long-term child development.

Risk Factors

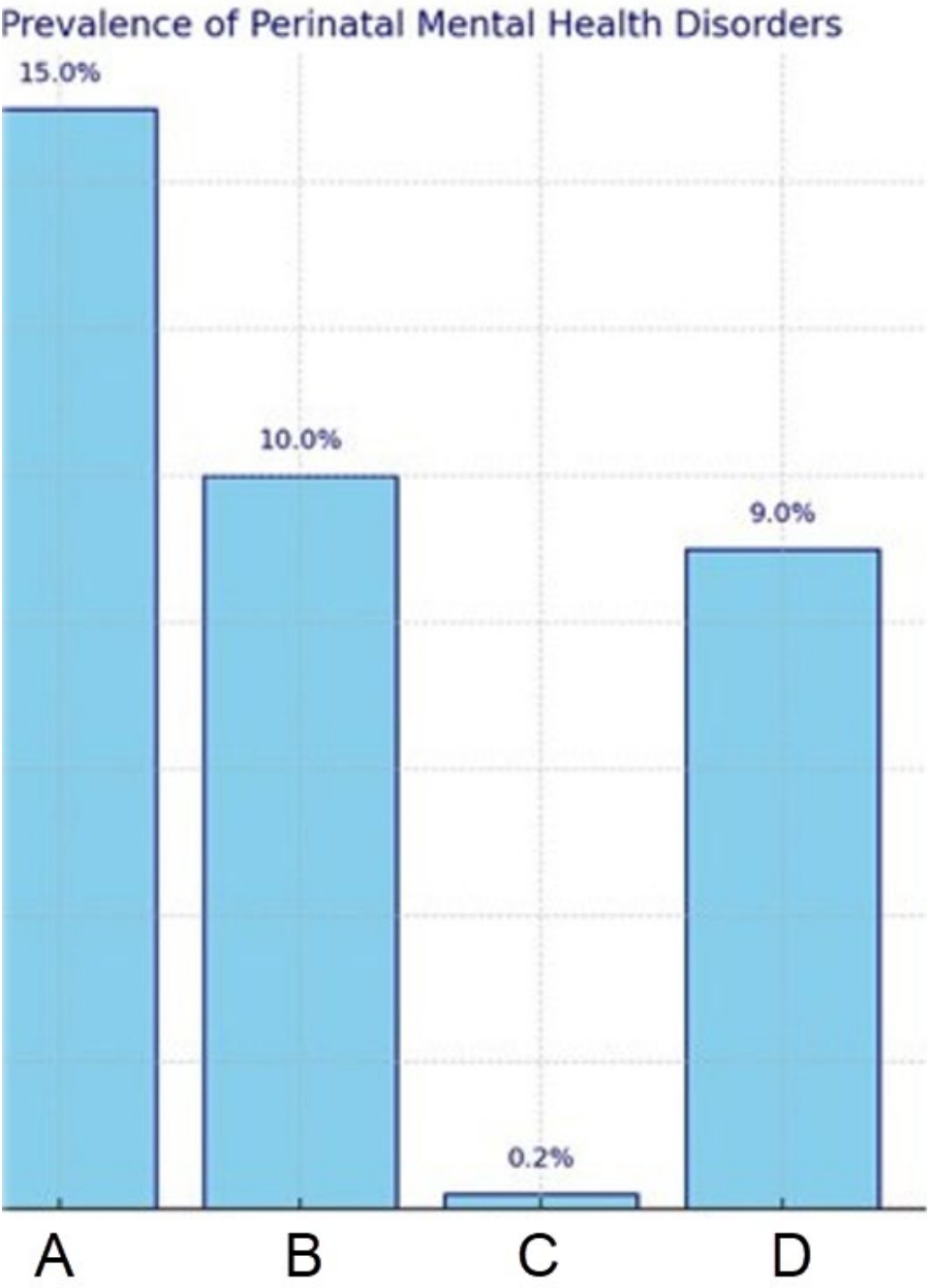
Previous mental health history.

Lack of social support or intimate partner violence.
Complicated pregnancy or birth trauma.

Health disparities: BIPOC families often face systemic racism, provider bias, and reduced access to culturally competent care.

Protective Factors and Interventions

- Screening and early detection: universal screening during prenatal and postpartum visits.
- Supportive care: doulas, peer support groups, culturally rooted healing circles.
- Therapeutic interventions: Cognitive Behavioral Therapy (CBT), IPT, trauma-informed care.
- Medication: safe options for depression/anxiety when indicated.
- Community-based supports: faith-based networks, culturally specific maternal health programs, family education.



❖ **Perinatal Depression (A)**
Most common complication of pregnancy.
Symptoms: sadness, hopelessness, irritability, withdrawal, difficulty bonding.

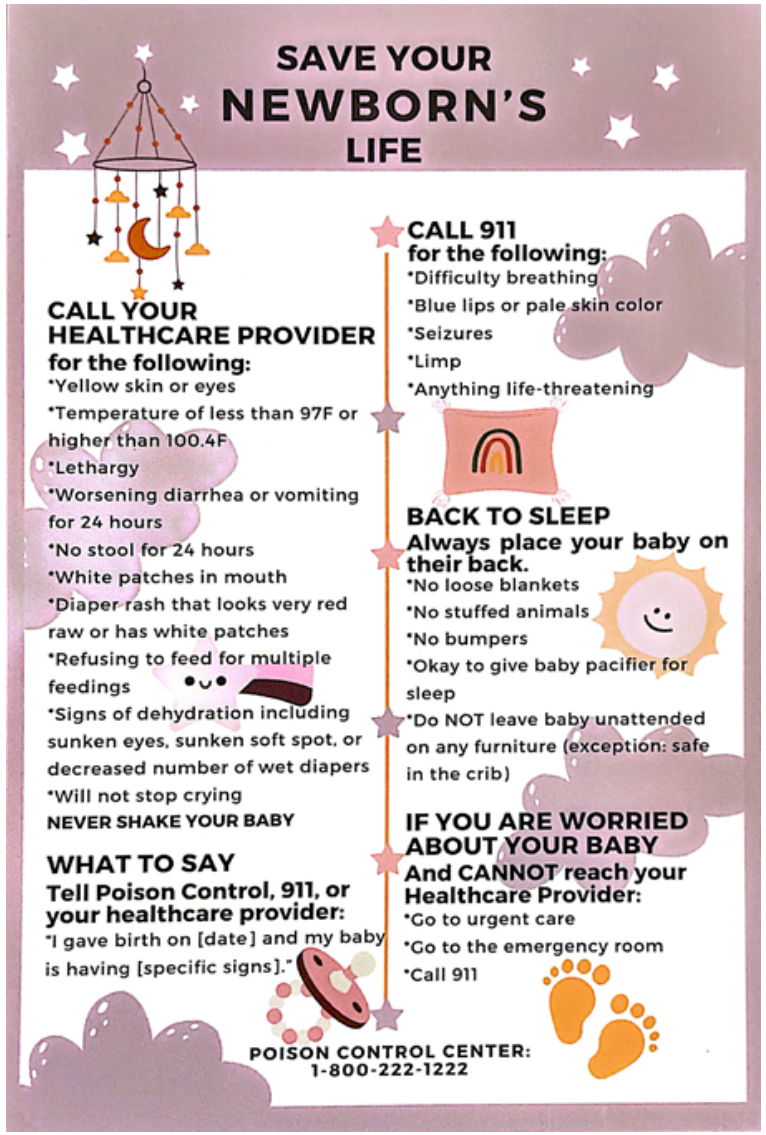
❖ **Perinatal Anxiety Disorders (B)**
Includes generalized anxiety, panic disorder, and obsessive-compulsive symptoms.
May involve excessive worry about baby's safety, intrusive thoughts, or physical symptoms (racing heart, restlessness).

❖ **Postpartum Psychosis (C)**
Rare (1-2 per 1,000 births) but severe.
Onset: days to weeks after birth.
Symptoms: hallucinations, delusions, confusion, mania, high suicide/infanticide risk.
Psychiatric emergency requiring immediate care.

❖ **PTSD After Childbirth (D)**
Triggered by traumatic birth, loss, or NICU stays.
Symptoms: flashbacks, nightmares, avoidance, hypervigilance.

Save Your Life and Your Newborn's Life

Use this resource to know post-birth warning signs



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A Public Agency

Upcoming Webinars

Webinar: Basic Life Support in Obstetrics (BLSO)

Date: January 9, 2026

Time: 8 a.m. – 5 p.m.

Location: Mercy Medical Center Mt. Shasta

914 Pine Street Mount Shasta, CA 96067

To register, click here or scan the QR code below:

For questions, contact Liezel Lago at Llago@partnershiphp.org
For additional details, click here.

Connect Your Pregnant or Postpartum Client to Behavioral Health Services

- If your client is experiencing a mental health emergency, please call **988**.
- If you or someone you know would like more information regarding mental health services, call Partnership Behavioral Health at **(855) 765-9703**, 24 hours a day, seven days a week.
- For Partnership contracted providers, referrals for mental health or substance use disorder services may be made through one of the following:
  - Call **(855) 765-9703**
  - Fax **(707) 914-0453** for referrals for behavioral health access or case management
  - Email BH-Access@partnershiphp.org for behavioral health access
  - Please use this referral form to refer member for mental health services

Questions

Please enter your questions in the chat box.

For example: Questions about perinatal mental health as a public health priority. By integrating clinical care, community support, and culturally responsive approaches, we can reduce disparities, improve outcomes, and foster resilience for families.

Take-Aways

Please put your take-aways in the chat box.

For example: Ensuring a safe path for BIPOC families means dismantling systemic barriers, centering family voices, and fostering collaborative, culturally grounded care that goes beyond clinical safety to include dignity, belonging, and holistic wellness.

Thank you!

Next webinar: Wednesday, November 19, 2025

Time: Noon – 1:30 p.m.

Topic: Lactation Support

We truly appreciate your feedback and ask you to fill out the survey after the webinar. Once you have completed the survey, you will get credit for attending the webinar presentation. Thank you!

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- *Compilation of developmental theories and resources.* (n.d.). **(R-4)**
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