AMERICAN COLLEGE of NURSE-MIDWIVES

POSITION STATEMENT

Extended Postpartum Care Through 12 Months After Birth

The American College of Nurse-Midwives (ACNM) and its members are committed to providing safe, respectful, holistic, and high-quality care for postpartum people and their infants. To achieve this commitment, it is the position of the ACNM that there should be a plan for addressing postpartum people's ongoing care needs through at least 12 months after birth, delivered by an interdisciplinary team (e.g., midwives, nurses, physicians, social workers, lactation consultants, doulas, pediatricians, community health workers, peer navigators, etc.). ACNM affirms the following:

- Postpartum care is defined as the period from birth until at least 1 year postpartum.
- Insurance providers should support midwifery care and connection to primary care to support postpartum people through the year postpartum.
- Timing for postpartum well-care beyond six weeks after birth can be aligned with infant vaccinations through at least 12 months after birth (per the American Academy of Pediatrics' immunization schedule at 2, 4, 6, 9, and 12 months).
- Postpartum well-care should be holistic – at *each touchpoint*; priorities for contact include addressing (in the form of screening and/or assessment) the following:
- Cardiovascular health[15–17]
- Contraception[18]
- Full spectrum reproductive health services including interconception/preconception, and abortion care[9,19,20]
- Endocrine/metabolic conditions (if positive history during/prior to pregnancy) (e.g., postpartum thyroiditis, pre-diabetes or type 2 diabetes)[21,22]
- Gender-based violence[9,23]
- Genitourinary conditions (e.g., pelvic floor function, perineal pain, fistula (any type), anal incontinence, urinary incontinence, urinary tract infection)[1,24]
- Gastrointestinal conditions (e.g., constipation, hemorrhoids)
- Lactation/breast/chest health[9]
- Mental health (e.g., postpartum depression, anxiety, birth-related post-traumatic stress disorder)[1,9,14,25,26]
- Nutrition[27,28]
- Observation of parent-child interaction[29,30]
- Oral health[31]
- Pain (including back and pelvic girdle pain [lumbopelvic pain])[1,32]
- Physical activity[9]
- Quality of relationships and social support[33]
- Sexual health (e.g., dyspareunia, sexually transmitted infections)[26]
- Sleep/fatigue[34]

- Social determinants of health and health related social needs[26]
- Substance use[29]
- Weight[35]
- Systemic inequities affect rates of morbidity and mortality in the postpartum period and targeted interventions should address disparities.
- Postpartum risk assessment tools for postpartum follow-up should be created and implemented.
- All postpartum people should receive anticipatory guidance and education throughout the 12 months after birth with proactive, universal sharing of resources.
- Multiple care modalities should be offered to postpartum people that could include:
- Group care
- Home visits
- Integrated postpartum and pediatric visits (dyad/family care)
- Mobile clinics
- Telemedicine including approaches such as remote blood pressure monitoring
- Postpartum Centers of Excellence should be established to model successful postpartum interventions and care modalities.
- Postpartum care should include both clinical and non-clinical support. This includes involving family, support people, and doulas in postpartum people's care plans.
- Supportive policies are necessary to address issues related to postpartum health including paid family leave.

Background

There is an urgent need for a paradigm shift in how midwives approach postpartum care. There are significant gaps in addressing the ongoing care needs of postpartum people in the first year after pregnancy and birth. Every year, at least 40 million postpartum people around the world experience long-term complications following labor and childbirth.[1] People also are at risk of complications following miscarriage, stillbirth, and abortion.[2,3] In the United States, racial disparities in maternal health outcomes, with Black and Indigenous people experiencing significantly higher rates of maternal morbidity and mortality than other groups, persist due to structural racism and inequities in structural and social determinants of health.[4–7] Complications after pregnancy and birth range from sexual health issues to mental health conditions to cardiovascular disease and are often rooted in systemic inequities. The Centers for Disease Control and Prevention (CDC) defines pregnancy-related deaths as "*a death during pregnancy or within 1 year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy*."[8] The World Health Organization (WHO) defines late maternal deaths as the death of a person from direct or indirect obstetric causes, more than 42 days but less than one year after termination of pregnancy. These definitions acknowledge that postpartum people face ongoing morbidities through 12 months after pregnancy and birth, yet postpartum health guidelines do not reflect this reality. Current WHO recommendations advise at least four postnatal visits at 24 hours, 48–72 hours, 1-week, and 6-weeks after birth to support maternal and newborn health, but no postpartum care guidelines exist beyond 6 to 12 weeks postpartum.

[9,10] However, in many settings, insurance coverage limitations and gaps in reimbursement policies create barriers to accessing comprehensive postpartum care, particularly beyond the traditional 6-week visit.

Maternal morbidity and mortality are largely preventable through high quality healthcare and early identification and treatment of health issues across the care continuum. The traditional 6-week postpartum period is inadequate to address ongoing care needs and puts postpartum people at increased risk of current and future health complications.[1] In the United States, almost half of all pregnancy-related deaths occur between 7 days and 12 months postpartum.[8,11] The most frequent underlying causes of maternal deaths include mental health conditions, cardiovascular conditions, and infections.[8] For every postpartum person that dies, many more experience complications as a consequence of labor and birth. Rates of severe maternal morbidities (SMM) are also increasing in the US.[12] SMM includes unexpected outcomes of labor and delivery that can result in significant short- or long-term health consequences, and its rising prevalence is linked to factors such as chronic health conditions, healthcare disparities, and variations in maternity care quality. Individuals who experience SMM or a near-miss event have been shown to have a lower quality of life postpartum, increased risk of mortality, and increased risk of complications including from uncontrolled hypertension, cardiomyopathy, or congestive heart failure.[13] Consequences of labor and birth do not always present in the first 6 weeks after birth; as an example, symptoms of postpartum depression can arise as late as 9-10 months after birth.[14] The persistently high rates of maternal mortality and morbidities in the extended postpartum period necessitate action to address the full range of physical and psychosocial adaptations postpartum people experience after pregnancy and birth, to address the stark inequities in maternal health that persist, and to elevate the importance of maternal well-being in this critical time in the life course.

The current standard of 6 to 12 weeks of postpartum care is not adequate, particularly for those experiencing medium- and long-term consequences of labor and birth. We need to center postpartum people's needs in the care we provide and integrate this within existing health care services. This means addressing structural and social determinants of health and providing holistic care to postpartum people that includes addressing health related social needs of the postpartum person. No single clinician can address all postpartum people's health and health-related social needs. Midwives can facilitate good care coordination and work with interdisciplinary teams (e.g., nurses, physicians, community health workers, doulas, lactation consultants, pediatricians, social workers, etc.), so that midwives can provide holistic health care services that can improve outcomes and the overall postpartum experience. Improving and extending care to 12 months after birth would improve health outcomes, not just for the postpartum person and infant, but for families and communities. This will require health systems to reimagine how care is provided to postpartum people and their families. Throughout the postpartum period it is important to ensure transitions to primary care so that postpartum people continue to receive the care they need beyond the postpartum period to address any chronic conditions and for long-term disease prevention. In addition, risk assessment tools should be developed and implemented to determine the appropriate and ideal postpartum follow-up.

REFERENCES

1. Vogel JP, Jung J, Lavin T, et al. Neglected medium-term and long-term consequences of labour and childbirth: a systematic analysis of the burden, recommended practices, and a way forward. *Lancet Glob Health*. Published online February 2023. doi:10.1016/s2214-109x(23)00454-0
2. Curtis C. Meeting Health Care Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID's Postabortion Care Program. *J Midwifery Womens Health*. 2007;52(4):368-375. doi:10.1016/j.jmwh.2007.03.005
3. Kyriacou H, Al-Mohammad A, Muehlschlegel C, et al. The risk of cardiovascular diseases after miscarriage, stillbirth, and induced abortion: a systematic review and meta-analysis. *European Heart Journal Open*. 2022;2(5). doi:10.1093/ehjopen/oeac065
4. Hoyert D. *Maternal Mortality Rates in the United States, 2022*.; 2023. doi:https://dx.doi.org/10.15620/cdc/152992
5. Crear-Perry J, Correa-De-Araujo R, Lewis Johnson T, Mclemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. *J Womens Health*. 2021;30(2):230-235. doi:10.1089/jwh.2020.8882
6. Hailu EM, Maddali SR, Snowden JM, Carmichael SL, Mujahid MS. Structural racism and adverse maternal health outcomes: A systematic review. *Health Place*. 2022;78. doi:10.1016/j.healthplace.2022.102923
7. Kozhimannil KB, Interrante JD, Tofte AN, Admon LK, Kozhimannil KB. Severe Maternal Morbidity and Mortality among Indigenous Women in the United States. *Obstetrics and Gynecology*. 2020;135(2):294-300. doi:10.1097/AOG.0000000000003647
8. Trost S, Busacker A, Leonard M, et al. *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020*.; 2024. Accessed June 23, 2024. https://www.cdc.gov/maternal-mortality/php/data-research/index.html
9. World Health Organization. *WHO Recommendations on Maternal and Newborn Care for a Positive Postnatal Experience.*; 2022.
10. ACOG. Optimizing postpartum care. ACOG Committee Opinion No. 736. *Obstet Gynecol*. 2018;131(e140-150.).
11. Thoma ME, Declercq ER. All-Cause Maternal Mortality in the US before vs during the COVID-19 Pandemic. *JAMA Netw Open*. Published online 2022:E2219133. doi:10.1001/jamanetworkopen.2022.19133
12. Fink DA, Kilday D, Cao Z, et al. Trends in Maternal Mortality and Severe Maternal Morbidity during Delivery-Related Hospitalizations in the United States, 2008 to 2021. *JAMA Netw Open*. 2023;6(6):E2317641. doi:10.1001/jamanetworkopen.2023.17641
13. Soma-Pillay P, Makin JD, Pattinson RC. Quality of life 1 year after a maternal near-miss event. *International Journal of Gynecology and Obstetrics*. 2018;141(1):133-138. doi:10.1002/ijgo.12432
14. Robbins C, Ko JY, D'Angelo D, et al. Timing of Postpartum Depressive Symptoms. *Prev Chronic Dis*. 2023;20(230107). doi:http://dx.doi.org/10.5888/pcd20.230107.
15. Ackerman-Banks CM, Grechukhina O, Spatz E, et al. Seizing the Window of Opportunity Within 1 Year Postpartum: Early Cardiovascular Screening. *J Am Heart Assoc*. 2022;11(8). doi:10.1161/JAHA.121.024443
16. Lewey J, Beckie TM, Brown HL, et al. Opportunities in the Postpartum Period to Reduce Cardiovascular Disease Risk after Adverse Pregnancy Outcomes: A Scientific Statement

from the American Heart Association. *Circulation*. 2024;149(7):E330-E346. doi:10.1161/CIR.0000000000001212
17. Poon LC, Nguyen-Hoang L, Smith GN, et al. Hypertensive disorders of pregnancy and long-term cardiovascular health: FIGO Best Practice Advice. *International Journal of Gynecology and Obstetrics*. 2023;160(S1):22-34. doi:10.1002/ijgo.14540
18. Grandi G, Del Savio MC, Tassi A, Facchinetti F. Postpartum contraception: A matter of guidelines. *International Journal of Gynecology and Obstetrics*. 2024;164(1):56-65. doi:10.1002/ijgo.14928
19. Goossens J, Delbaere I, Dhaenens C, et al. Preconception-related needs of reproductive-aged women. *Midwifery*. 2016;33:64-72. doi:10.1016/j.midw.2015.10.012
20. Ogunwole SM, Chen X, Mitta S, et al. Interconception Care for Primary Care Providers: Consensus Recommendations on Preconception and Postpartum Management of Reproductive-Age Patients With Medical Comorbidities. *Mayo Clin Proc Innov Qual Outcomes*. 2021;5(5):872-890. doi:10.1016/j.mayocpiqo.2021.08.004
21. ACOG. Gestational Diabetes Mellitus. *ACOG Practice Bulletin*. Published online 2018. http://journals.lww.com/greenjournal
22. Alexander EK, Pearce EN, Brent GA, et al. 2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease during Pregnancy and the Postpartum. *Thyroid*. 2017;27(3):315-389. doi:10.1089/thy.2016.0457
23. Laughon K, Renker P, Glass N, Parker B. Revision of the abuse assessment screen to address nonlethal strangulation. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing*. 2008;37(4):502-507. doi:10.1111/j.1552-6909.2008.00268.x
24. Moossdorff-Steinhauser HFA, Berghmans BCM, Spaanderman MEA, Bols EMJ. Prevalence, incidence and bothersomeness of urinary incontinence between 6 weeks and 1 year post-partum: a systematic review and meta-analysis. *Int Urogynecol J*. 2021;32:1675-1693. doi:10.1007/s00192-021-04877-w/Published
25. Grisbrook MA, Letourneau N. Improving maternal postpartum mental health screening guidelines requires assessment of post-traumatic stress disorder. *CanadianJournalofPublicHealth*. 2021;112:240-243. doi:10.17269/s41997-020-00373-8/Published
26. Souza JP, Day LT, Rezende-Gomes AC, et al. A global analysis of the determinants of maternal health and transitions in maternal mortality. *Lancet Glob Health*. Published online December 2023. doi:10.1016/S2214-109X(23)00468-0
27. MAMI Global Network EL. *MAMI Care Pathway Package*.; 2021. https://www.ennonline.net/mamicarepathway
28. Moya E, Phiri N, Choko AT, Mwangi MN, Phiri KS. Effect of postpartum anaemia on maternal health-related quality of life: a systematic review and meta-analysis. *BMC Public Health*. 2022;22(1). doi:10.1186/s12889-022-12710-2
29. World Health Organization. *Improving the Health and Wellbeing of Children and Adolescents: Guidance on Scheduled Child and Adolescent Well-Care Visits*.; 2023.
30. World Health Organization. *NURTURING CARE FOR EARLY CHILDHOOD DEVELOPMENT IN SUPPORT OF*.; 2018.
31. ACOG. *Oral Health Care During Pregnancy and Through the Lifespan*.; 2013. http://www.mchoralhealth.org/PDFs/OralHealth

32. Horvath B, Kloesel B, Cross SN. Persistent Postpartum Pain – A Somatic and Psychologic Perfect Storm. *J Pain Res*. 2024;17:35-44. doi:10.2147/JPR.S439463
33. Khademi K, Kaveh MH. Social support as a coping resource for psychosocial conditions in postpartum period: a systematic review and logic framework. *BMC Psychol*. 2024;12(1). doi:10.1186/s40359-024-01814-6
34. Okun ML. Disturbed Sleep and Postpartum Depression. *Curr Psychiatry Rep*. 2016;18(7). doi:10.1007/s11920-016-0705-2
35. Harrison CL, Teede H, Khan N, et al. Weight management across preconception, pregnancy, and postpartum: A systematic review and quality appraisal of international clinical practice guidelines. *Obesity Reviews*. 2021;22(10). doi:10.1111/obr.13310

Note. Midwifery as used throughout this document refers to the education and practice of certified nurse- midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

Source: Clinical Standards & Documents
Approved by the ACNM Board of Directors: May 2025, links updated January 2026