MQIC

Prevention of Unintended Pregnancy in Adults 18 Years and Older

Recommendations for specific interventions for assessing and counseling to lower the risk of unintended pregnancies, support patient reproductive goals and opportunities for healthy pregnancy. Discuss with men and women at least annually or more frequently at provider discretion.

Key Components	Recommendation and Level of Evidence
Assessment for risk of unintended pregnancy with sensitivity to cultural and personal preferences	**Ask about:** Sexual activity/involvement, past pregnancy and outcome. Patient's reproductive goals/desire for a pregnancy (e.g., "Do you think you might like to have children (more children) at some point?", "When do you think that might be?", "How important is it to you to prevent pregnancy (until then?)",[1] with particular attention to postpartum women. Understanding of preconception preparation - folate; vitamins, medication adjustments; nicotine cessation, substance misuse, opioids, performance enhancing drugs, etc.; depression; social support for a healthy pregnancy[2] Type and consistent use of birth control and protection (e.g., "What method do you plan to use until you or your partner wish to become pregnant?", "How sure are you that you will be able to use this method without any problems?")[3] Abuse (e.g., "Were you pressured or forced to have sex when you did not want to?") Per state law[4], report all abuse that you are legally required or permitted to report to the Michigan Department of Health & Human Services at 855-444-3911; Provide local intimate partner violence resources or national hotline at 1-800-799-7233; provide local sexual violence resources or MI hotline at 855-864-2374 (VOICES4); If patient is a victim of trafficking or at-risk call 888-373-7888; if imminent danger present, call 9-1-1 immediately.
Interventions to prevent unintended pregnancy; support reproductive goals	**Advise and discuss:** Fertility awareness: patient's risk of pregnancy or unintended pregnancy[5] Advise about the importance of preconception health to assure readiness for healthy pregnancy and importance of prenatal care. Risks and adverse outcomes related to substance misuse, especially opioid misuse, and risk of neonatal abstinence syndrome. **Assess:** Patient's satisfaction with current method. Patient's knowledge of risks and methods, and readiness to make behavior changes. Availability of personally appropriate, high-quality, low-cost contraceptive methods. Methods used in the past, the feasibility of these methods. Social determinants of health related to ongoing contraception methods: cost, access to clinic/provider, transportation. Understanding of risk: STI exposure; personal genetic or chronic disease history; history of travel to Zika[6] impacted areas; HIV exposure status; personal health; high risk medication adjustment; nicotine, alcohol, opioids, cannabinoids, or other substance use and depression, social isolation, or other mental health risks. Awareness of healthy birth spacing or higher risk of pregnancies that begin less than 18 months from conclusion of previous pregnancy.[7] **Assist patients with reaching their reproductive goals by:** Discussing patient preferences and benefits and risks of contraceptive methods[8] (e.g., menstrual-related problems, cardiovascular risks of combined hormonal contraceptive) **[B].** Assess compliance/adherence of latex condom use for sexually transmitted infection prevention **[B].** Offering emergency contraception as soon as possible (Ulipristal Acetate [Ella], Levonorgestrel [Plan B, Next Choice] or copper IUD [Paragard]) to women up to 5 days[8] after unprotected or inadequately protected sexual intercourse and who do not desire pregnancy[9] if needed. **[D].** Referring to primary care provider, local health department, family planning clinic, or federally qualified health center. **Arrange follow-up:** If currently pregnant, discuss prenatal care and postpartum contraception, e.g., immediate postpartum long-acting reversible contraceptive (LARC) and other reversible and permanent contraceptives.

[1] ACOG Bulletin No.736 Optimizing Post-Partum Care (Replaces No.666 May 2018, Reaffirmed 2021);Hatcher RA, et al (editors), *Contraceptive Technology*, 21st Ed. New York: Ayer Company Publishers, Inc.2018; 63-93.
[2] Centers for Disease Control and Prevention Before Pregnancy Planning for Pregnancy (Patient)
[3] PATH flow Chart Client-Centered Reproductive Goals & Counseling; Client-Centered Contraceptive Counseling Toolkit/Handouts
[4] Social Welfare Act (280 of 1939), MI. MCL § 400.11, §400.11a – 400.11f; Resources for Mandated Reporters; A Model Protocol for Joint Investigations of Vulnerable Adult Abuse, Neglect and Exploitation
[5] Guttmacher Institute Unintended Pregnancy in the United States Fact Sheet
[6] https://www.CDC.gov/Zika/prevention
[7] March of Dimes Birth Spacing and Birth Outcomes
[8] CDC Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use
[9] ACOG; Planned Parenthood and Contraceptive Technology support use of emergency contraception (EC) up to 5 days after unprotected sexual intercourse based on research; FDA labels Ulipristal Acetate for EC up to 5 days and Levonorgestrel up to 3 days. Hatcher RA, et al (editors), *Contraceptive Technology*, 21st Ed. New York: Ayer Company Publishers, Inc. 2018; 329-365.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline is based on the Centers for Disease Control and Prevention, Recommendations to improve preconception health and health care - United States, MMWR Recommendations and Reports. 2006;55(RR-06); and American College of Obstetricians and Gynecologists Practice Bulletin Number 112, May 2010. Individual patient considerations and advances in medical science may supersede or modify these recommendations.