Public Health in Unintended Pregnancy and Prevention Care
Nancy is a 24 year old, English-speaking Caucasian woman. She does not have a regular place to live because she cannot afford rent despite working at a fast food restaurant. She splits her time between two friends’ apartments and her primary partner’s apartment. She takes oral contraceptive pills (OCPs) but has difficulty taking them regularly because she leaves the pill pack in one apartment or another for a few days at a time.

The Health Care Setting

A Family Planning Department in a federally qualified community health center that provides comprehensive reproductive health services. A full range of FDA-approved contraceptives are available on site.
Nancy’s Intake Form

PREGNANCY TEST HISTORY

Name: _______Nancy________ Age: _____24_____  
I identify as:  X Female  __Male __Transgender __Specify: __________________________
Gender pronoun:  X She  __He  __Specify: _________________________________
Would you like a companion in the room with you for your visit?  
__Yes  X No  If so, whom? ________________________________

With whom can you talk with for support?  
__Partner(s)  __Parent(s)  __Family Member(s)  __Friend(s)  X No One  
Pregnancy History:  
Pregnancies ______0_____
Births ______0_____
Miscarriages ______0_____
Abortions ______0_____

Have you already taken a pregnancy test?  __Yes  X No  
What were the results _______________________
When was the first day of your last menstrual period? _______5 weeks ago_______
Are you using any form of birth control?  X Yes  __No  
If so, what are you using? ___pills, but sometimes I forget_____
If you are pregnant, which options would you like to discuss?  
 X Adoption  X Abortion  __Parenting

Case: Nancy is a 24-year old woman here for a pregnancy test. She missed her period and is concerned about pregnancy. She does not have a regular place to live so she stays at a friend’s house or at her boyfriend’s house. She has a full-time job at a fast food restaurant. Nancy has a prescription for OCPs, but sometimes forgets to take them because she left them at one of the places she is staying.

Common Concern: Wants to be a mom someday, but is not ready now.

Personality: Hopes to go to nursing school someday.
Nancy - Insecure Housing
(Patient Situation #1)

What Happened

Nurse: Hi Nancy, tell me what brings you in today.

Nancy: Well, I missed my period last week so I’m afraid I might be pregnant and I wanted to get tested here.

Nurse: Ok, I’ll run a pregnancy test. Before I do, I see on the intake form that you indicated that you do not want to be pregnant right now. Do you want to talk about this?

Nancy: I mean, I love babies, and I want to be a mom someday, but I wasn’t trying to get pregnant. I left my pills at Brian’s place so I didn’t take them for a few days. I don’t even have a place to live, how would I take care of a kid?

Nurse: Ok, Nancy, let’s run the test and we can talk more after. I’ll be back in a few minutes. (Nurse leaves to run the urine pregnancy test and it is negative.)

Nurse: Nancy, the pregnancy test is negative. You are not pregnant. (Pauses to let this information sink in. Nancy looks relieved).

Nancy: Wow, ok. I guess... that’s good to know.

Nurse: Nancy, you seem relieved about this news. Tell me more about how you are doing with the pills you are on. You said you left them somewhere?
Nancy: Yeah. I stay with my boyfriend, Brian, a lot, but his place is kind of far from work. When I work late I usually stay with Rafael — he’s an old friend. Sometimes I leave my stuff at one apartment and then end up staying at a different place so I don’t have my pills or my makeup or anything. It’s usually fine, though, because Brian and I use condoms, too.

Nurse: With your permission, I want to ask about any other sexual partners that you may have.

Nancy: Sometimes I sleep with Rafael. He’s had a crush on me forever and I feel like I owe him ‘cause I stay at his place all the time. He doesn’t like to use condoms, though.

Nurse: With your permission, we could discuss some strategies for having a conversation with Rafael about condom use. Would you like to discuss this?

Nancy: Yeah, sure.

**Condom Negotiation Skills**

The nurse could work with Nancy around her condom negotiation skills to protect herself and her partners from STIs. A few examples of things to say are:

- “I can’t relax without a condom — I want to protect us both.”
- “You won’t have to pull out if we wear a condom and it can feel even better.”
- “I really like this kind of condom, let’s give it a try.”

The nurse could show Nancy the [Bedsider](https://www.bedsider.org) website, which is specifically designed for young people and contains videos of young men discussing their condom-use practices. Nancy might be interested in personal stories from other young women who want to convince their male partners to wear a condom during sex at Gurl.com.

**VOICES/VOCES**: Video Opportunities for Innovative Condom Education from the CDC is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons’ reactions. **VOICES/VOCES** is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change. An evaluation of the intervention showed that **VOICES/VOCES** is effective when delivered at a “teachable moment,” for instance when a visit to an STD clinic or a negative pregnancy test may motivate a person to change behavior.

With Nancy’s permission, the nurse can explore Nancy’s feelings of obligation to have sex with Rafael as a favor for overnight stays.
What Happened (continued)

Nurse: We can discuss other methods of contraception, too. Would you like to hear about some contraceptive methods that do not involve taking a daily pill or that you need not worry about leaving somewhere?

Nancy: Yes, that would be great.

Nurse: Let’s discuss some other contraceptive methods to see what be a good fit for you. Tell me, do you see yourself becoming a mom in the next year? Or the next 3 to 5 years?

Nancy: I don’t know. Definitely not this year. I want to be a mom someday, but I’m not ready. I want to go back to school, get a better job. I don’t know when that’s going to happen.

What is reproductive life plan counseling?

Unintended pregnancy continues as a public health issue. Healthy People goals address the reduction of unintended pregnancy, however, since the beginning of Healthy People Goals, the goal of reducing unintended pregnancy by 30% has not been met. In fact no reduction has occurred. For the 2020, the goal is set at reducing the unintended pregnancy rate by 7%.

Historically public health programs and strategies have focused on interconception health. In 2006, the CDC released 10 preconception health and health care recommendations to improve the health of women, men, and couples before conception of a first or subsequent pregnancy. The CDC developed these recommendations based on a review of published research and the opinions of specialists from the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. The recommendations are aimed at achieving four goals to:

1. Improve the knowledge and attitudes and behaviors of men and women related to preconception health.

2. Assure that all women of childbearing age in the United States receive preconception care services (e.g., evidence-based risk screening, health promotion, and interventions) that will enable them to enter pregnancy in optimal health.

3. Reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children.

4. Reduce the disparities in adverse pregnancy outcomes.
Assessing and helping a patient understand his/her reproductive life plan is a way for clinicians to provide preconception care including recommending a contraception that will work best for the patient to prevent unintended pregnancy. In Preconception Health and Health Care: Information for Health Professionals the CDC provides information on the evidence-based effectiveness of preconception interventions, how to incorporate them into clinical practice, and links to other resources such as “Clinical Content for Women” and “Reproductive Life Plan Tool.”

Before, Between, & Beyond Pregnancy also describes how to assess a patient’s reproductive life plan, provides some key questions that will help solidify the plan, and makes recommendations on integrating reproductive life plan assessments into clinic operations.

**Family planning is considered one of the ten greatest public health achievements in the 20th century:** Which contraceptive method might be best for Nancy?

After discussing Nancy’s experiences with various forms of birth control to understand her reactions and preferences, the nurse can use a tiered approach to contraceptive counseling, which involves presenting the most effective methods first. In 2014, the CDC released Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office Of Population Affairs, which offers guidance on providing high quality family planning and related preventive health services, includes recommendations to use a tiered approach to contraceptive counseling and management.

The interactive website, Method Match, from the Association of Reproductive Health Professionals (ARHP) provides fact sheets on different methods of contraception that includes information on efficacy, how each method works, benefits and contraindications to each. In addition, this Counseling Session video from LARC First is available in English and in Spanish, and provides a demonstration of high quality, non-directive counseling on contraception options.

Since Nancy expressed that she is not ready to become pregnant for several years, a long-acting reversible contraceptive (LARC) method could work well for her. Nancy’s unstable housing situation means she moves frequently, thus using a contraceptive method that she doesn’t have to remember would be ideal. The nurse presents information on the hormonal implant (Nexplanon), which would last up to 3 years or an IUD. Current IUDs are FDA approved for up to 3, 5 or 10 years.

Unwarranted concern continues to exist regarding IUD use and young women. Pelvic inflammatory disease (PID) was once thought to be higher in IUD users.
Current research from Grimes (2000) suggests that PID and infertility are no more likely to occur with IUDs than with any other method of contraception. The presence of STIs, usually chlamydia, not IUDs, use causes PID, thus all adolescents should be screened for STIs at the time of insertion of an IUD to reduce the risk of PID. In addition, a 2001 study conducted by Hubacher et al. concluded that “tubal infertility was not associated with the duration of IUD use, the reason for the removal of the IUD, or the presence or absence of gynecologic problems related to its use.”

Nancy’s Case (continued)

The nurse is thinking that if Nancy has a risk of unintended pregnancy, she has a risk of risk of contracting a sexually transmitted infection. The nurse asks, “With your permission, I would like to discuss any possible risks of exposure to sexually transmitted infections. I am going to ask you a few questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health.

Guide to Taking a Sexual History: https://www.cdc.gov/std/treatment/sexualhistory.pdf

Sexually Transmitted Infections

Incidence: The Centers for Disease Control and Prevention (CDC) estimates about 20 million new infections STIs in the United States each year. The CDC’s analyses includes eight common STIs: chlamydia, gonorrhea, hepatitis B virus (HBV), herpes simplex virus type 2 (HSV-2), human immunodeficiency virus (HIV), human papillomavirus (HPV), syphilis, and trichomoniasis. CDC’s surveillance reports, however, focus data on three STIs, gonorrhea, chlamydia, and syphilis. Clinicians must report these three infections to local or state public health authorities. Some common STDs, like human papillomavirus (HPV) and genital herpes, are not required to be reported. The latest published surveillance report shows and increase in the three treatable STDs:

- **Gonorrhea:** In 2015, the gonorrhea rate was 546.9 per 100,000 women in the 20-24 age group. There are worrisome signs that the infection is developing resistance to our current treatment options. The resistance pattern has been noted every few decades with the gonorrheal bacteria.

- **Chlamydia:** The chlamydia rate is 3,730.3 per 100,000 women in the 20-24 age group. A majority of infections go undiagnosed, as the person may not experience symptoms. Less than half of sexually active young women are screened annually as recommended by CDC.

- **Syphilis:** The syphilis rate dropped in the early 2000’s but the rates has increased almost every year since then. In 2014–2015, the national syphilis rate was 7.5 cases per 100,000 population, the highest rate reported since 1994. Men account for the most cases of syphilis, with the vast majority of those cases occurring among men who have sex
with men (MSM). Although rates of syphilis are lower in women, syphilis in pregnancy is a major health concern. Untreated early syphilis in pregnant women, if acquired during the 4 years before delivery, can lead to infection of the fetus in up to 80% of cases and may result in stillbirth or death of the infant in up to 40% of cases. In 2014, the national congenital syphilis rate was 11.6 per 100,000 live births. This represented 428 live births. In the U.S., a case of congenital syphilis reflects missed opportunities for primary prevention of syphilis between women and their partners and prevention of mother-to-infant transmission among pregnant women already infected with syphilis. Lack of prenatal care or late to prenatal care is a risk factor. Public health workers and prenatal care providers must work together to address barriers to obtaining early and adequate prenatal care for vulnerable pregnant women (CDC, 2016).

Prevalence: The proportion of individuals in a population having a disease or characteristic. For example, young people (ages 15-24) account for about 50% of all new STIs, although they represent only 25% of the sexually experienced population. Nancy, at age 24, is in the 20–24 year age group, which has the highest rates of chlamydia (3,730.3 cases per 100,000 females) and gonorrhea (546.9 cases per 100,000 females) compared with any other age and sex group in 2011. Syphilis rates in women have been highest each year among those aged 20–24 years with 1.1 cases per 100,000 females in 2014.

Screening: Screening for disease is part of a public health approach of secondary prevention. The Unites States Preventive Services Task Force (USPSTF) recommends screening for chlamydia and gonorrhea in sexually active women age 24 years and younger (B rating). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men (I rating). This recommendation is helpful on a population level when developing screening programs. On an individual patient level, a risk assessment is needed to determine a male’s need for screening. If the individual has symptoms of an STI, the testing is no longer done for screening purposes but is considered diagnostic testing.

The USPSTF recommends screening for HIV infection in adolescents and adults up to age 65. Other individuals who are at increased risk should also be screening (A rating). All pregnant women should be tested for HIV (A rating). Universal screening will help to ensure the use of effective therapies to reduce mother-to-child transmission. Mother-to-child transmission is responsible for more than 90% of pediatric HIV infections in the U.S.

Women experience more frequent and more serious STI complications than men do. Complications include chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy, and infertility. In terms of health care costs, STIs cost the healthcare system about $16 billion in direct medical costs. A Healthy People 2020 Goal aims to reduce the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics. Currently 7.4% of females aged 15 to 24 years who attend family planning clinics in tested positive for Chlamydia trachomatis infection. The goal is to reduce this number to 6.7%, which would be a 10 % reduction of infections.
Nancy - Insecure Housing
(Patient Situation #1)

What Happened (continued)

Nancy: I guess the implant sounds good. It’s only 3 years, and I’ll be in a better place by then. Also, I won’t leave it anywhere by accident! Can we do it today?

Nurse: We can insert an implant for you today. If you are ready, we can begin the paperwork.

Nancy: I am, thanks.

What If...

This section offers a twist or a different perspective on “What Happened” to guide and encourage learners to tease apart various aspects of the Patient Situation.
Same-day insertion is not available? How can the nurse support Nancy to prevent pregnancy until her appointment?

According to ACOG’s Committee Opinion *Increasing Use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, it is ideal for clinical sites to offer same day insertions of the implant and IUDs. If the implant cannot be inserted that day, the nurse should discuss over-the-counter emergency contraception (EC). Depending on the health care system, some offices have the ability to dispense EC so Nancy could take it with her that day. A recent study by Matnock conducted in New Mexico found a strong correlation between women who discussed EC with their clinician and EC use.

Until her next visit, Nancy can continue to use her oral contraceptive pills. Together, Nancy and the nurse make a plan to help Nancy be more consistent in taking her pills to avoid unwanted pregnancy. Nancy decides to carry her pill pack with her and set a daily alarm on her cell phone until her implant insertion appointment.

Nancy was 17 years old instead of 24 years old?

In an updated 2014 policy, the American Academy of Pediatrics (AAP) supports recommending long-acting reversible contraceptives (LARCs) for adolescents. The AAP policy cites the Institute of Medicine as recommending “contraception as an essential component of adolescent preventive care.” In addition, ACOGs Committee Report *Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices* (Reaffirmed 2016) states that “increasing adolescent access to LARC is a clinical and public health opportunity. With top-tier effectiveness, high rates of satisfaction and continuation, and no need for daily adherence, LARC methods should be first-line recommendations for all women and adolescents. As with all nonbarrier methods, to decrease the risk of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), health care providers should advise sexually active adolescents to consistently use condoms along with LARC methods”.

Nancy’s pregnancy test was positive?

The nurse should be prepared to give pregnancy test results in a nonjudgmental manner. Hearing the results of a pregnancy test can be a life changing moment for patients. When giving pregnancy test results it is important for nurses to understand that the results belong to the patient. Women may be delighted, regretful, anxious, and sometimes ambivalent about the being pregnant. It is the nurse’s responsibility to provide her with the results, what they mean, and to ask if the patient would like more information.

This presentation, Giving Pregnancy Test Results: A Primer for Nursing Students, serves as a guide for nursing students on giving pregnancy test results, identifying immediate health concerns, and providing referrals. An overview of laboratory pregnancy tests is also provided. Recommendations are given on specific questions to ask and on counseling language to use when providing negative and positive test results, and on working with a patient who is ambivalent about the test results.

After giving Nancy the results of the pregnancy test, the nurse would have to determine gestational age. Nancy mentioned she missed her period about a week ago. Pregnancy wheels are commonly used to determine the due date or estimated date of confinement (EDC). Wheels are based on Naegele’s Rule which estimates the EDC by adding one year, subtracting three months, and adding seven days to the first day of a woman’s LMP. The result is approximately 280 days (40 weeks) from the LMP. Wheels may vary by a day or two and it is easy for a health care provider to misread a wheel by a day or two. Applications for electronic calculation of EDC are freely available and eliminate calculation errors.

Depending on Nancy’s reaction to the test results, and with her permission, the nurse would discuss Nancy’s options in a non-directive, patient-centered manner. Nancy could have a first trimester abortion procedure, continue with the pregnancy, or she could make an adoption plan. Options Counseling for Unintended Pregnancy is a presentation designed to give nurses and APNs information on attitude, skills, and knowledge needed to provide options counseling to patients who experience unintended pregnancy.

Truly non-directive options counseling can be difficult because of one’s own beliefs, especially when there is a strong feeling that we know what the best option is for a woman. In Options Counseling: Techniques for Caring for Women with Unintended Pregnancies, Singer provides a guidance for clinicians on examining their own beliefs and values to improve their skills in providing nonjudgmental and nondirective options counseling for women experiencing unplanned pregnancy
First Trimester Abortion

These nursing education modules use the term aspiration abortion when discussing first trimester abortion care because it more accurately depicts a first trimester abortion than does aspiration abortion. According to Weitz et al. (2004) surgical “implies incision, excision and suturing and is associated with the physician subpopulation of surgeons” whereas, first trimester abortion in practice uses no incisions, excisions, or suturing.

The chart First Trimester Abortion: A Comparison of Procedures from the National Abortion Federation shows a side-by-side comparison of three types of abortion procedures, how they work as well as advantages and disadvantages to each.

In addition, the National Abortion Federation has Clinical Policy Guidelines, which are evidence-based guidelines and standards on abortion care. They include clinical practices on patient care and counseling and different types of abortions. These guidelines, which are revised annually, are based on rigorous review of medical literature and known patient outcomes to support and educate providers on the most current information, standards, and recommendations. The following modules are specific to this competency:

- Module 5: Limited Sonography in Abortion Care
- Module 6: Early Medication Abortion
- Module 7: First-Trimester Aspiration Abortion

Making an Adoption Plan

If Nancy were to make an adoption plan, she would likely place the baby for adoption shortly after birth. In a domestic infant adoption there are several options for how the process could work for Nancy and the adoptive family. A social worker can work with Nancy to find an optimal good match in an adoptive family. Nancy could then chose to have an open adoption, where identifying information is shared between families with an agreed-upon level of contact, or she could opt for a closed adoption with no shared identifying information. The Basics of Adoption Practices: A Bulletin for Professionals from the U.S. Department of Health and Human Services’ Administration for Children and Families via the Child Welfare information Getaway, details types of adoption, family and child assessments, birth parent involvement, and how the placement and adoption process works including post-adoption services.

The nurse could also direct Nancy to view Open Adoption: Could Open Adoption be the Best Choice for You and Your Baby? a resource from the U.S. Department of Health and Human Services’ Administration for Children and Families for expectant parents. There is a specific section on open adoption that details how
it works, the benefits, legalities and action steps for this type of adoption.

If she chose to make an adoption plan, Nancy would commit to continuing the pregnancy. Obtaining regular prenatal care could be challenging because of Nancy's unstable living situation.

**Continuing the Pregnancy**

Nancy could chose to continue the pregnancy and decide to parent. The nurse would provide her with some basic prenatal health information, including the importance of taking daily folic acid, provide her with a referral for prenatal care services, and arrange for social work services.

According to the National Center on Family Homelessness from American Institutes for Research, children experiencing homelessness:

- Are sick four times more often than other children.
- Have 4 times as many respiratory infections, 2 times as many ear infections, 5 times more gastrointestinal problems, and are 4 times more likely to have asthma.
- Are twice as likely to go hungry compared to children in stable housing.
- Have 3 times the rate of emotional and behavioral problems compared to children with stable housing.
- Are 4 times more likely to show delayed development and 2 times as likely to have learning disabilities as non-homeless children.

Given these risk factors, Nancy would need additional and intensive support to secure housing while continuing her pregnancy and either placing the child for adoption or parenting. The nurse could provide her with referrals to social service agencies in the community that could assist her with securing housing and other related services such as financial assistance and/or Women, Infants, and Children (WIC).
Contemporary Health Concerns in Community Health Nursing: Homelessness

The National Coalition for the Homeless is a national network of people who are currently experiencing or who have experienced homelessness, activists and advocates, community-based and faith-based service providers, and others committed to a single mission: to prevent and end homelessness while ensuring the immediate needs of those experiencing homelessness are met and their civil rights protected. The NCH report (2016) No Safe Place: A Survey of Hate Crimes and Violence Committed against Homeless People:

Data from 2015:

- There were 77 victims of attacks against people experiencing homelessness:
  - 27 of the victims of these attacks lost their lives.
  - 73% of perpetrators whose ages are reported were under the age of 30
  - 90% of all perpetrators whose genders are reported were male
  - 57% of victims whose ages are reported were over the age of 40
  - 77% of all victims whose genders are reported were male
  - The true number of attacks may be worse than the data currently shows. Many attacks go unreported and are unrepresented. Hate crimes against the homeless community are a vital public health issue.

The U.S. Conference of Mayors conducts an annual assessment of hunger and homelessness. This report presents the results of a survey of 22 of the cities whose mayors serve on The U.S. Conference of Mayors’ Task Force on Hunger and Homelessness. Officials were asked to provide information on the extent and causes of hunger and homelessness in their cities, and the emergency food assistance and homeless services provided between September 1, 2014 and August 31, 2015. They also were asked for their assessment of the demand for services and the resources available to them in the year ahead. This year’s survey found continuing increases in demand for services and continuing shortfalls in meeting service needs. Among its key findings:

**Hunger**

- 66% of the surveyed cities reported that the number of requests for emergency food assistance increased over the past year.
- Among those requesting emergency food assistance, 67% were persons in families, 42% were employed, 2% were elderly, and 10% were homeless.
• Low-wages led the list of causes of hunger cited by the surveyed cities, followed by poverty, and high housing costs.

• City officials said that more jobs with higher wages, including a living wage, as well as more affordable housing are actions that should be taken to reduce hunger. Access to preventive health and an increase in SNAP benefits are other important actions to take to reduce hunger.

• In 47% of the responding cities, the emergency kitchens and food pantries had to reduce the quantity of food persons could receive at each food pantry visit or the amount of food offered per meal at emergency kitchens. In 5% of the cities, they had to reduce the number of times a person or family could visit a food pantry each month. Also in 57% of the cities, facilities had to turn away people because of lack of resources.

Homelessness

• The number of homeless families experiencing homelessness decreased across the survey cities by an average of 5.2%, with 53% of the cities reporting a decrease, 42% reporting an increase, and 5% said it was the same.

• The survey cities reported that on average, 29% of homeless adults were severely mentally ill, 22% were physically disabled, 18% were employed, 17% were victims of domestic violence, 12% were veterans, and 4% were HIV Positive.

• City officials identified lack of affordable housing as the leading cause of homelessness among families with children. This was followed by poverty, unemployment and low-paying jobs.

• City officials also identified lack of affordable housing as the leading cause of homelessness among unaccompanied individuals. This was followed by poverty, mental health and the lack of needed services, and substance abuse and the lack of needed services.
References


Singer. (2004). Options counseling: Techniques for caring for women with


