Michigan Quality Improvement Consortium Guideline

May 2020

Prevention of Pregnancy in Adolescents 12 - 17 Years

The following guideline recommends specific interventions for open dialogue, assessment and non-judgmental counseling to lower the risk of pregnancy in adolescents.

Key Components, Recommendation and Level of Evidence

Assess males and females 12-17 years for risk of pregnancy. Be sensitive to cultural and religious beliefs, sexual orientation and gender identity with every patient.

Ask, at least annually, in a way that establishes trust:

Sexual activity, past pregnancy and outcome.

Behaviors and factors that increase risk of pregnancy (e.g., alcohol and substance abuse, lack of life goals, low self-esteem, poor school performance, dating at an early age, history of sexual abuse, inadequate support system, living in communities with low levels of education and income).[1]

Abuse (e.g., Were you pressured or forced to have sex when you did not want to?). Report all abuse to Michigan Department of Health and Human Services at 855-444-3911.

Introduce and discuss Planning for Pregnancy/preconception health.

Encourage adolescent to identify a supportive adult for adhoc issues.

Further assessment for at risk patients:

Knowledge of reproduction and birth control methods.

Consistent use of both birth control and sexually transmitted infection (STI) protection.

Intent to conceive or father a child.

Interventions to prevent pregnancy among patients at risk

Advise/Assess and discuss:

Patient's risk of pregnancy and STI/HIV testing when appropriate.

Implications, consequences and adverse outcomes associated with pregnancy in relationship to life goals.

Assist patients in preventing pregnancy by:

Developing a risk reduction plan based on patient's short- and long-term goals.

Discussing abstinence, long-acting reversible contraceptives (LARC; e.g., IUD, implantable progestins) as a highly effective strategy for preventing unintended rapid repeat pregnancy. Also discuss condom use, and other birth control methods.

Offering prescriptions, information on accessing condoms, and birth control resources when appropriate.

Offering emergency contraception as soon as possible (Plan B, Next Choice, or copper IUD) to women up to 5 days[2] after unprotected or inadequately protected sexual intercourse and who do not desire pregnancy. **[D]**

Encouraging consistent latex condom use for STI risk reduction. **[B]**

Referring to primary care provider, Ob-Gyn, local health department, family planning clinic, or federally qualified health center.

Arrange:

Follow-up for testing, counseling or review of their risk reduction plan. Frequency of follow-up is based on risk.

Minors may access sexual health services without parental consent. See summary of minor confidentiality laws.[3]

Confidentiality may be offered. However, for medical reasons, information may be provided to or withheld from the spouse, father of the child, or parent/guardian/caregiver without consent of the minor patient.

Ensure follow-up that protects the adolescent's privacy and confidentiality. Obtain confidential phone number or other contact information from adolescent. Note: Loss of confidentiality may occur through the billing process.

Antepartum care: before delivery, discuss and offer a full range of contraceptive methods (including LARC) to be implemented before leaving the hospital.

Interventions to engage parents, guardians, caregivers, or other invested parties

Converse with patient and parent/guardian/caregiver in a way that models being the adolescent's advocate for making healthy decisions.

Encourage the adolescent to identify a supportive adult in their environment, for ongoing conversation.

[1] cdc.gov/teenpregnancy

[2] ACOG supports up to 5 days; FDA supports up to 3 days

[3] Michigan Laws Related to Right of a Minor to Obtain Health Care without Consent or Knowledge of Parents

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 lists core management steps. It is based on several sources, including: The State of Adolescent Sexual Health In Michigan, Michigan Department of Community Health, April 2010; and Kirby, D. Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, November 2007; and Breuner CC, Mattson G, AAP Committee on Adolescence, AAP Committee on Psychosocial Aspects of Chid and Family Health, Sexuality Education for Children and Adolescents. Pediatrics. 2016;138(2):e20161348. Individual patient considerations and advances in medical science may supersede or modify these recommendations.