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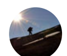

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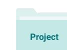

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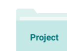

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Continuation of Unintended Pregnancy

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Abstract:

Background: Forty four percent of all pregnancies worldwide are unintended. Induced abortion has drawn a lot of attention from clinicians and policy makers, and the care for women requesting it has been covered in many publications. However, abortion challenges the values of many women, is associated with negative emotions, and has its own medical complications. Women have the right to discuss their unintended pregnancy with a clinician and receive elaborate information about other options to deal with it. Continuing an unintended pregnancy, and receiving the necessary care and support for it, is also a reproductive right of women. However, the provision of medical information and support required for continuation an unintended pregnancy has hardly been approached in the medical literature.

Objective: This paper presents a clinical approach to unintentionally pregnant patients, and describes the information and support that can be offered for the continuation of the unintended pregnancy.

Discussion: Clinicians should approach patients with a sympathetic tone. A complete clinical history can help frame the problem and identify concerns related to the pregnancy. Any underlying medical or obstetric problems can be discussed. A social history, that includes the personal support from the patient's partner, parents, and siblings, can be taken. Doctors should also be alert of possible cases of violence from the partner, or child abuse in adolescent patients. Finally, the clinician can provide the first information regarding the social care available and refer the patients for further support. For women who continue an unintended pregnancy, clinicians should start antenatal care immediately.

Conclusion: unintentionally pregnant women deserve a supportive and elaborate response from their clinicians, who should inform about, and sometimes activate, all the resources available for continuation of unintended pregnancy.

Background

Unintended pregnancies include those that are unwanted, unplanned, or mistimed (Moss 2015) It has been estimated that 44% of all pregnancies worldwide are unintended, around 56% of them end up in abortion, approximately 32% in birth, and 12% in miscarriage (Bearak et al. 2018, The Lancet 2018, Sedgh, Singh, and Hussain 2014). Evidence also suggests that in the last three decades the proportion of unintended pregnancies ending in abortion has increased in developing regions but decreased in developed areas of the world (Bearak et al 2018).

Many women report negative and positive feelings about getting pregnant unintentionally (Arteaga, Caton, and Gomez 2019, Askelson et al. 2015, Tanner et al. 2013). Studies also indicate that some women, who hold negative views towards having become pregnant unintentionally but have the child, after the delivery express a positive opinion on the pregnancy (Williams, et al. 2001, Joyce, Kaestner, and Korenman 2000, Sedgh, Singh, and Hussain 2014).

A substantial proportion of women have not decided whether or not they want to continue their unintended pregnancy when they first visit their primary care provider (Moss 2015). Induced abortion is legal in most countries, with regional variations of the law in places like Australia, the USA, or the UK (Centre for Reproductive Rights 2018). Abortion has been given a great deal of attention by clinicians and policy makers, and the legal frame, together with the medical, psychological, and social care, for women requesting it, has been covered in many publications (National Health and Medical Research Council 2013, The American College of Obstetricians and Gynaecologists 2014, Royal College of Obstetricians and Gynaecologists 2011). However, induced abortion challenges the social, cultural, and ethical values of many women and those around them (Moss 2015). It is also associated with negative emotions, including feelings of grief, regret, guilt, or emptiness (Lie, Robson, and

May 2008). Finally, induced abortion is associated with an increased risk some medical problems including obstetric haemorrhages and infections, alcohol or drugs misuse, and suicidal behaviour (The Royal College of Obstetricians and Gynaecologists 2011, Fergusson, Horwood, and Boden 2013).

Women have the right to discuss their unintended pregnancy with their primary care provider and receive elaborate, complete, and accurate, information about other options to deal with pregnancy (Moss 2015). Continuing an unintended pregnancy, and receiving the necessary care and support for it, is a reproductive right of women, and the role of primary care clinicians is essential to make sure that this right can be exercised. Evidence shows that women who receive more support are more likely to continue their pregnancy (Lie, Robson, and May 2008, González 2013). Despite all this, the provision of medical information and support required for continuation of unintended pregnancy has hardly been approached in the medical literature, and tends to be poor and unstructured in primary care settings. In this paper we present a clinical approach to unintentionally pregnant patients, and describe the information and support that can be offered in primary care for the continuation of an unintended pregnancy.

Framing the problem

An empathic clinical relationship is ideal for this discussion. Clinicians should appreciate that unintended pregnancy increases women's vulnerability and causes stress and anxiety (Moss 2015). If the patient is ambiguous about the unintendedness of the pregnancy, it may help to continue a considerate clinical interview, as in routine pregnancy care (Moss 2015). This can be clarifying for the patient, who may find in the conversation with the clinician reassurance and support for her uncertainties. The doctor or nurse may ideally communicate to patients in a supportive way, making sure that all their concerns are addressed. The patient's capability

for abstract and future thinking needs to be assessed, especially in the case of adolescent women (Hornberger 2017). The clinicians may also need to deal with some difficulties in communication due to the patient's low educational level, which is associated with unintended pregnancy, or poor language skills, particularly in the case of migrant women who may not be native speakers of the local language (Wellings et al. 2013).

While women don't expect the doctor to give moral advice, the spiritual and cultural practices of patients have to be acknowledged (Hornberger 2017). Noting whether the patient recognises anthropological status for the fetus can help at this point, the language used to describe it may reflect the closeness that the woman feels towards the life growing in her body (Lie, Robson, and May 2008).

A complete reproductive and clinical history can help frame the problem, identify the medical concerns related to the pregnancy, and also build an empathic relationship with the patient. As with intentionally pregnant patients, the pregnancy should be confirmed and gestational age estimated (Moss, Snyder, and Lu 2015). Any possible complications of the pregnancy can also be recorded. Taking a reproductive history would also help to define the clinical background of the patient. Finally, the clinical history would include details on medical problems, such as hypertension, diabetes, or mental illness, as well medication, alcohol, or recreational drugs taken by the patient.

The risk of continuation of pregnancy to the mother's health is the most frequently presented reason to have an abortion, i.e: 97% of cases in the UK (The Royal College of Obstetricians and Gynaecologists 2011). It should be noted that maternal health has improved in recent decades, with maternal mortality falling by approximately 44% over the past 25 years worldwide, affecting now less the 20 women per 100000 live births in most high and middle income countries (World Health Organization 2015) The risks of all underlying medical problems or any obstetric complications can be discussed with the patient at this point.

Clinicians may also want to make patients aware that many medical problems, including diabetes, asthma, thyroid disorders, and depression, can be managed successfully during pregnancy, using conventional or alternative treatments. (National Institute of Health and Care Excellence 2017, Australian Government Department of Health 2018, Zolotor and Carlough 2014).

Social history

A social history can also be taken, including marital or partner status, employment, financial stability, and presence of any other social problems, e.g.: housing, legal, or migration issues. It has been reported that unintended pregnancy is associated with drug use, and with lower socioeconomic level (Wellings et al. 2013, Iseyemi et al. 2017).

In most countries, whether or not to continue a pregnancy is the woman's choice only, with the father of the child having no right to affect the decision (Center for reproductive Rights 2018). However, women who are supported by a partner are more likely to accept and continue their unintended pregnancy and have lower levels of psychological distress after birth (Lie, Robson, and May 2008, Barton et al 2017, Gomez et al. 2018). This source of support can be explored when seeing a patient with unintended pregnancy. "Is your partner aware of the pregnancy?", "What does he think about it?", "What is your relationship with him?", "Do you have any other children in common or separately?", are some of the questions that can be raised.

The support from other people, such as the patient's parents, sibling, or friends can also be explored (Moss, Snyder, and Lu 2015). Asking questions around who knows about the pregnancy and who the patient is going to tell, can help to identify these supportive figures (Moss 2015). In our experience, the pressure of unintended pregnancy can lead women to make an ineffective use of their own family or social network. Adolescent patients may find

difficult to tell their families about the pregnancy and underestimate the support they can offer (Rentschler 2003, Lloyd 2004). However, the clinician can help to release this pressure and unlock the communication with close and supportive relatives and friends, by openly discussing the potential support that the patient may have from them.

In patients who report a lack of personal support, doctors should also be alert of possible coercion that could lead the woman towards an unwanted abortion (Moss 2015, Broen et al. 2005). Two systematic reviews have reported associations of intimate partner violence with requests for abortion, especially repeated abortion, and with higher risk of pre-term birth and low birth weight (Hall et al. 2014, Hill et al. 2016). Therefore, questions about exposure to violence from partner should also be standard (Moss 2015, The Royal College of Obstetricians and Gynaecologists 2011). While the evidence on the effectiveness of interventions to reduce violence from the partner during the pregnancy is still inconclusive, it can be hypothesised that interventions conducted by multidisciplinary teams, involving the social services and justice institutions, initiated by the clinician at this point, may result in violence being stopped, a reduction in abortion requests, and better birth outcomes (Jahanfar, Howard, and Medley 2014).

Clinicians must be alert to the possibility of child abuse, in adolescent patients, especially when they refuse to involve their parents, or they are accompanied by a controlling adult who wishes to remain particularly close to the patient. Laws regulating clinical care of underage patients, the minor's and their parents’ rights and responsibilities, vary between and within countries. However, it is widely accepted that doctors and nurses have to acknowledge the opinions of underage patients when planning their clinical management (General Medical Council 2007, American Academy of Pediatrics 1995). The ethical obligations of clinicians to benefit patients may require that they provide medical care for underage women with unintended pregnancy, sometimes without parental knowledge. (General Medical Council

2007, Torralba i Rosello 2001). In some cases, the parental intervention may be negative or unnecessary, such as for underage women abused by their parents, emancipated, or considered legally mature (General Medical Council 2007). Clinicians have to be familiar with the laws that apply in their area of practice. In any case, adolescents should be asked very carefully about their parents, which can be a strong source of support (Moss 2015).

The age of consent, the legal age at which an individual is considered mature enough to consent to sex varies between, and sometimes within, countries. Therefore, a girl who is pregnant and under the age of consent has suffered a statutory rape, even in some jurisdictions if both partners are younger than the age of consent. In this case, the appropriate authorities must be informed (Ageofconsent.net 2018).

Many women with unintended pregnancies express concerns on social issues around pregnancy and childcare (Askelson et al. 2015). The role of the partner, the will, the rights, and the obligations, that he has towards the education of the child can be discussed, acknowledging the local regulations, with which clinicians may need to be familiar.

The doctor or nurse can also provide the first information on the social care available in the area and refer the patients to the social services for further support (Moss, Snyder, and Lu 2015). In many countries, employment of pregnant women and maternity pay have legal protection, there is financial support for people with children, and both education and healthcare receive public funding (GOV.UK n.d., Department of Human Services of the Australian Government 2018, USA.GOV 2018). For women who feel unable to look after a child, family and friends care (kinship care), private fostering, or adoption can be an option. However, all policies around child care are complex and require assessment beyond primary care clinics.

Follow up and antenatal care

Some patients may prefer to address their unintended pregnancy in a single appointment of average duration, requiring that the clinician moves quickly through these complex topics. Other patients may prefer to be seen over more than one appointment. This would help to build rapport, allow time for patient reflection, and for the clinician to arrange resources to meet her needs, between visits. Written, objective, evidence-guided information on the medical and social support available for continuation of unintended pregnancy can also be given.

Three systematic reviews have reported that unintended pregnancy is associated with late initiation and inadequate use of antenatal care services, pre-term birth, low birth weight, and higher risk of perinatal depression (Dibaba, Fantahun, and Hindin 2013, Shah et al. 2011, Abajobir et al. 2016). These results may be affected by methodological limitations and confounders such as women's socioeconomic status or previous health issues. However, this evidence seems enough to recommend that for women who continue an unintended pregnancy, clinicians start antenatal care immediately and are proactive in the follow up, to prevent adverse maternal and perinatal outcomes (The Royal College of Obstetricians and Gynaecologists 2011, National Health and Medical Research Council 2013, Dibaba, Fantahun, and Hindin 2013).

Future research

To improve the care for women to continue an unintended pregnancy, further clinical, social, and legal research and development is needed. More studies of good quality on the long term clinical and social outcomes, experiences, and needs of women who continue unintended pregnancies, are required. This should help to develop effective interventions to support unintentionally pregnant women in different circumstances. The male partners of

unintentionally pregnant women are frequently cited in the literature mostly as negative characters, related to abuse, irresponsibility, and abandonment. Studies on the views of partners would improve the understanding of women's social network, and could be used to articulate the support they need. Similarly, the role of parents and siblings of women with unintended pregnancy, that may constitute a substantial source of support, requires further research. The liberalisation of abortion laws should not stop medical research to make the continuation of medically or socially complicated pregnancy safer. The continuation of unintended pregnancy of underage women, those who have been raped, illegal migrants, or those exposed to violence, needs specific research. Studies on all these topics, based on developing countries, are specially required as this part of the world has the highest incidence of unintended pregnancies and its management, given the social circumstances, can be very different from the one in developed areas (Bearak et al. 2018). This paper addresses an international audience. However, future reviews should ideally be written locally, acknowledging each country, or area, cultural values, social resources, and regulations.

Conclusion

In conclusion, unintentionally pregnant women are in a vulnerable situation and deserve an open-minded, supportive, elaborate, and positive response from primary care clinicians, who should inform about, and sometimes activate, all the resources available for continuation of unintended pregnancy.

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