Pregnancy Options Counseling for Adolescents: Overcoming Barriers to Care and Preserving Preference

Loren M. Dobkin, RN, FNP, MPH,[a] Alissa C. Perrucci, PhD, MPH,[b] and Christine Dehlendorf, MD, MAS[c,d,e]

Current clinical guidelines for counseling adolescent patients about their pregnancy options fail to give concrete suggestions for how to begin and hold conversations that support patient autonomy, provide accurate and unbiased information, and address barriers to care. Recent research suggests that relative to adult women, adolescents are at increased risk of being denied abortion because they present beyond facilities' gestational age limits. Counseling that neglects to address the structural and developmental challenges that adolescents face when seeking care may contribute to the risk of abortion denial as well as subsequent delays in prenatal care. The task of providing non-directive, patient-centered, evidence-based pregnancy options counseling to an adolescent while ensuring that she receives her chosen course of care in a timely manner is challenging. This article presents a shared decision-making framework and specific suggestions for healthcare providers to support adolescent patients in coming to their decision about whether to continue or terminate an unplanned pregnancy and access follow-up care within the current sociopolitical environment.

Curr Probl Pediatr Adolesc Health Care 2013;43:96-102

Adolescent pregnancy is a common occurrence, with roughly 7% of adolescent girls aged 15–19 years becoming pregnant each year.[1] Therefore, all primary care providers caring for adolescent patients (including pediatric and family medicine providers) will encounter these patients, give pregnancy test results, present options for continuing or terminating the pregnancy, and either provide ongoing care for abortion or prenatal care or refer to outside clinics.

Current clinical guidelines for counseling advise adolescent providers to give "complete information on all available options."[2] These guidelines fail to give concrete suggestions for how to begin and hold conversations with adolescents that support patient autonomy while providing accurate and unbiased information. In addition, as recent research suggests that relative to adult women, adolescents who go on to seek abortion are at increased risk of being denied care because they present further along in pregnancy,[3] these guidelines fail to address the logistical and legal barriers that change which options are accessible and for how long. The reasons adolescents present beyond abortion facilities' gestational age limits may include inappropriate information or referrals, not being able to rely on absence of regular menstrual cycle to signal pregnancy, not recognizing symptoms of pregnancy, or denying the possibility of pregnancy.[4] Counseling that neglects to account for these hurdles may not only contribute to the risk of abortion denial but also subsequent delays in prenatal care. The task of providing non-directive, patient-centered, evidence-based pregnancy options counseling to an adolescent while ensuring that she receives her chosen course of care in a timely manner is challenging. This piece offers a framework for adolescent care providers to support their patients in coming to their decision about whether to continue or terminate an unplanned pregnancy while more fully accounting for barriers to care, and then

From the [a]Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, University of California, San Francisco, CA; [b]Women's Options Center, San Francisco General Hospital, Department of Obstetrics, Gynecology & Reproductive Sciences, University of California San Francisco, CA; [c]Department of Family & Community Medicine, University of California, San Francisco, CA; [d]Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco, CA; and [e]Department of Epidemiology & Biostatistics, University of California, San Francisco, CA.

Curr Probl Pediatr Adolesc Health Care 2013;43:96-102
1538-5442/$ - see front matter

http://dx.doi.org/10.1016/j.cppeds.2013.02.001

provides specific suggestions for provision of this counseling.

A General Approach: Shared Decision-Making in Pregnancy Options Counseling

Pregnancy options counseling provides an example of a situation in which there is healthcare equipoise, in that there are two or more options that are clinically reasonable. In these situations, healthcare providers are challenged to refrain from offering prescriptive advice, but rather to engage in collaborative decision-making with their patients.[5] In this model of care—most often referred to as shared decision-making—clinicians' responsibility is to present all the options, convey the medical evidence of health risks and provide support to patients to help them integrate their values and preferences with this evidence, so that patients are able to carry out an informed and value-concordant decision.[6,7] In addition to adhering to the core ethical precept of supporting patient autonomy, shared decision-making is designed to ensure that patients are offered all appropriate options, to promote patient comprehension and satisfaction, and to elicit partnership in the patient–provider relationship. Over the past several decades, there has been increasing advocacy for its use and evidence that this process improves both patient satisfaction and health outcomes, as compared to more traditional prescriptive approaches to medical decision-making.[8,9]

Minors' ability to understand the risks, benefits and alternatives to proposed medical treatments and their competence to consent for medical care in general is a question that continues to be debated in the literature and judicial proceedings,[10] with implications for the use of shared decision-making with this population. However, in this case of unintended pregnancy, longitudinal research suggests that younger women and adolescents do not demonstrate any increased risk of poor judgment compared to older women. While adolescents and younger women may be more likely to express discomfort with their decision to have an abortion than older counterparts, they do not show an increased risk of any serious negative psychological repercussions from making this decision.[11] Several recent reviews of mental health outcomes conclude that there is no evidence that having an abortion increases the risk of psychological disorders in women or adolescents, relative to continuing an unplanned pregnancy to birth.[11–13] Further studies investigating this decision-making in adolescents that limit analysis to unintended pregnancies may provide further evidence on this topic.[14]

Pregnant adolescents are therefore in a position to independently engage in shared decision-making with their providers about their pregnancy options. However, it should be noted that most teenagers involve a parent in making pregnancy decisions, including in states where parental involvement is not required by law,[15] and almost all involve at least one adult. For some, pregnancy decisions may occur in the context of "the struggle for autonomy and agency that occurs between a teen and her parents,"[16] which may complicate the decision-making process. Healthcare providers are therefore in a unique position of providing a neutral context in which an adolescent can express feelings, consider alternatives, and envision her future, and to provide support in an adolescent's interactions with her parents and other individuals she involves in her decision, with the ultimate goal of providing "guidance and tools for (the adolescent) to make the best decision for herself."[16]

When engaging in shared decision-making around adolescent pregnancy, providers must be aware that in the United States, women from disadvantaged groups face political, social and economic challenges when making decisions about their pregnancies, whether they are choosing to parent, adopt or have an abortion.[17] At times, medical providers have played an active role in undermining reproductive rights, and there is some recent evidence that their counseling in this arena is biased by race and socioeconomic status, though age has not been independently examined.[18–20] Several critical works have encouraged self-reflection in those individuals from higher socioeconomic backgrounds in order to examine biases around the framing of teenage pregnancy and parenting as a vast social problem; instead, they encourage energies to be focused upstream to solve the problems of poverty and racism.[21,22] Increased provider awareness of the potential for these biases to influence care is a necessary first step in decreasing their potential negative influence on counseling and the patient–provider relationship.[23]

Understanding the Relative Physical Health Risks of the Pregnancy Options

Shared decision-making also requires that providers be able to communicate about the available medical

evidence on the relative health risks of the pregnancy options. Being able to communicate the most accurate evidence on the relative safety of the options upon the patient's request allows the health provider to promote patient-centered care.[7] Studies have consistently shown that there is a greater risk of a serious physical complication from childbirth than from abortion, with the risk of mortality on average 14 times greater for continuing a pregnancy to birth.[24] Although this ratio has not been specifically calculated for adolescents, the risk of complications from abortion remains low at younger ages, including less than 20 years old.[25] With respect to morbidity, it is essential to have evidence-based information to counter commonly held misconceptions. For example, rigorous studies have found no association between abortion and decreased future fertility.[26] Immediate adverse events associated with abortion—including infection, injury to the cervix or uterus, or hemorrhage—are rare, with the risk of complications estimated to be less than 1–3%.[27–29] Providers should also be aware that although the risk is low, it increases with gestational age, underlining the importance of prompt diagnosis of pregnancy and expeditious referrals. There are few studies comparing morbidities of childbirth and abortion,[24] though one recent publication suggests that the relative risk of morbidity is significantly higher among women who give birth.[30]

Barriers to Abortion for Adolescents

Adolescents who desire to terminate their pregnancies face barriers to accessing this care, with the Turnaway Study, a multisite, longitudinal, prospective study of women seeking abortion, finding that being younger than 19 years of age was significantly associated with presenting beyond gestational age limits, and therefore being denied abortion care.[3]

Gestational age restrictions vary widely among abortion facilities in the United States due to differences in provider training, facility regulations, medical resources, and legal restrictions. Gestational age limits vary starting from within the first trimester through the end of the second trimester.[14] At this writing, 87% of counties in the United States do not have an abortion provider; providers are clustered in major metropolitan areas on both coasts. The number of facilities that offer abortion after 20 weeks has declined to 23%; only 11% of all facilities provide abortions at 24 weeks gestation.[31]

Prior studies reveal the reasons that women present at later gestational ages include a number of factors, such as not recognizing the early stages of pregnancy, ambivalence about whether to continue the pregnancy, difficulty finding an abortion provider, not being able to find the funds to cover the cost of the abortion, receiving inappropriate referrals from a healthcare provider and the logistical difficulty of arranging care.[32–34] These challenges may be heightened during adolescence, particularly considering risk factors for late detection of pregnancy—such as being unsure of last menstrual period or experiencing emotional denial—tend to coincide with normative physiological and psychological developmental stages of adolescence.[4] The tendency of some adolescents to delay pregnancy care may be attributable to a lack of decision-making rather than poor decision-making, as adolescents are less likely to obtain pregnancy tests in early pregnancy due to financial hurdles and more likely to experience prolonged denial when they are ultimately diagnosed with pregnancy.[4] In order to take into account these practical issues influencing abortion access, providers must work to promote timely diagnosis of pregnancy, as well as to educate themselves on the availability of abortion care in their state in terms of cost, location of clinics, gestational limits, parental involvement laws, and methods of abortion.

Recommendations for Pregnancy Options Counseling with Adolescents

In light of these emerging and established barriers to care, and in accordance with the overall framework for counseling described above, we suggest the following approach to and resources for pregnancy options counseling for adolescents. Our suggestions are intended to accompany those provided in "Tailoring Clinical Services to Address the Unique Needs of Adolescents from Pregnancy Test to Parenthood," which offers comprehensive guidance for working with adolescents who decide to parent.[35]

Ensuring Patient-centered Care

- In many states, reproductive health services require parental involvement or notification. (For an overview of these laws, see www.guttmacher.org/statecenter/spibs/spi

b_OMCL.pdf.) Providers must be prepared to comply with minor consent laws while supporting adolescents to access sensitive services.

- The Adolescent Health Working Group (AHWG) offers resources and suggestions for addressing adolescents' sexual and reproductive health needs in its Sexual Health Toolkit (available at http://www.ahwg.net/assets/library/104_sexualhealthtoolkit2010bw.pdf). The group advises, "Be clear with minor patients up front about confidentiality and its limits. Be as specific as possible, so that they know what to expect and do not feel betrayed if something needs to be reported to a parent."[36]
- In order to support adolescents in making pregnancy decisions, it is important for providers to recognize and acknowledge their own biases around who is 'fit' to parent, at what age parenthood should begin, and under what circumstances.[16] The values, hopes and expectations that one has for oneself can then be delineated and held in check when counseling patients with life circumstances different than one's own. Values clarification exercises for this purpose are available and may be adapted to working with younger patients.[16] Some questions that may be useful to promote self-reflection among adolescent providers include the following:
  - "What age is 'too young' to have an abortion?"
  - "What age is 'too young' to parent?"
  - "What are some thoughts or feelings that come to mind when you think of a 14 year old who has decided to parent? What about a 19 year old having her third abortion?"

Pregnancy Testing and Contraceptive Continuity

- In order to avail adolescents of all their pregnancy options and facilitate timely care, it is important that adolescent providers attempt to diagnose pregnancy in its early stages. Aruda et al. outline many strategies to achieve this, including a standard practice of assessing all adolescents for sexual risk behaviors at each visit.[4] Providers may also streamline pregnancy testing and care by offering drop-in appointments followed by either contraceptive consultation for negative results or pregnancy options counseling for positive results.
- Providers may help prevent pregnancy in adolescents by supporting contraceptive continuity of their chosen method, including providing adequate refills[37] and by offering the full range of methods including long-term intrauterine and implant contraceptives, as well as emergency contraception.[38,39]

Pretest Counseling

- Eliciting hopes and thoughts about potential pregnancy test results prepares both the patient and provider for discussing results and options.[16] This may be achieved by asking two main open-ended questions, followed by additional prompts concerning sexual and menstrual history. A visual events calendar may also help cue adolescents in recalling the time of their last normal menstrual period.[4] Using this approach, the provider may anticipate counseling challenges including possible maximum gestational age if the test is positive:
  - "Do you have an idea of what the results of your pregnancy test might be?"
    - Providers should prompt adolescents to think through the likelihood by specifically asking about any recent sex, their frequency of contraceptive use, whether their menses are regular and their last normal or missed periods, as well as any pregnancy symptoms, such as nausea.
  - "What are you *hoping* the results will be?"
    - If the patient is hoping for a negative result ask, "What would be bad about finding out that you were pregnant?"
    - The provider may prepare the patient to transition from discussing hopes to receiving the test results and coming to a decision by offering, "We'll hope for the result you want, but if it's different, we'll work through a plan together."

Providing Test Results

- Providers should deliver results clearly—stating that the positive result means the

patient is pregnant—and allow time for the adolescent to experience her initial reactions uninterrupted by questions.[16] Providers may then begin to solicit feedback by normalizing emotions and allowing for their transience: "Learning that you are pregnant can trigger many thoughts and feelings. What reactions are you experiencing at this point?"[4]
- Adolescent responses may differ by psychosocial development, with "early adolescents manifesting disbelief and denial; middle adolescents displaying denial, fear of consequences and ambivalence; and late adolescents being more objective about decisions regarding the pregnancy outcome."[4]

Discussing Options

- If the pregnancy may be too advanced for the adolescent to receive an abortion in the state where she lives, it is important to convey this as a possibility when discussing options.
- The conversation about possible next steps should open with neutral language, "What thoughts do you have about what you might do?"[16]
- We recommend that adolescent providers review guidelines and case studies for counseling parents during pregnancy decision-making.[16] These suggest first counseling each family member individually to normalize the difficulties of pregnancy decision-making during adolescence, to understand and distinguish respective goals, and to offer communication tips accordingly, prior to counseling family members together.
- It is important to engage in reality testing with adolescent patients about the practical aspects of the decision, such as how it might affect their finances, relationships, living situation, and future plans.[4,16,36]

Patients who Express Ambivalence

- Allowing adolescents to take their time in coming to a decision must be carefully balanced with the risk that abortion is no longer an option due to gestational age restrictions or other barriers, such as the increased cost of later procedures. It is normal for adolescents to experience ambivalence and fluctuations in desire for abortion, adoption or birth over time and for reactions and plans to change accordingly. Scheduling multiple follow-up visits and obtaining additional contact information may help to allow adolescent patients to more fully weigh their options while ensuring they are not lost to follow-up.[4] With adolescents' permission, back-up contact information may include the name and number of a trusted adult or the name of their school, as providers may need to make more extended efforts to reach adolescent patients when appointments are missed.[4]
- Having a strategic framework for counseling ambivalent patients and assessing pregnancy decisions may be especially relevant for adolescent patients. We recommend that adolescent providers practice decision assessment, an approach that turns on validating, normalizing, seeking understanding of feelings and beliefs, and reframing.[16] Provider readings, tools and training exercises for decision assessment, including counseling strategies for ambivalent patients, have recently become available.[16]

Key Points for Providers Whose Adolescent Patients are Considering Adoption

- We recommend that providers know whether their state offers open adoption. Even open adoption agencies should be screened to determine whether they are patient-centered, offer options counseling, and see abortion, adoption and parenting as morally equivalent alternatives, even for young teens.
- Adoption information is available through The Adoption Access Network at http://www.adoptionaccessnetwork.org.

Key Points for Providers Whose Adolescent Patients are Considering Abortion

- The locations and gestational age limits of abortion facilities in your area are available online at the website: www.laterabortion.org#resources or through the National

Abortion Federation (NAF) hotline at 1-877-257-0012. We recommend patients considering abortion be made aware of these resources and information.

- Assess the gestational age of your patient's pregnancy as accurately as possible if they are considering abortion to help them receive care upon arrival at an abortion facility. Ultrasound, fundal height or bimanual clinical examination findings are helpful in approximating gestational age, but in the absence of equipment or training in these techniques, providers may estimate gestational age from a detailed menstrual and sexual history and any pregnancy symptoms.
- We recommend that either your staff or an outside abortion support service assists the adolescent to make an appointment and travel arrangements.[14,36] The NAF hotline provides this service free of charge.
- Adolescents should be informed that costs vary among different clinics and increase with the duration of pregnancy. Although the average cost of abortion in the United States is $543 at 10 weeks gestation, it nearly triples to $1562 at 20 weeks.[40] Patients may receive information and assistance with costs via the NAF funding hotline at 1-800-772-9100.
- Ensure compliance with any parental notification or consent laws for minors seeking abortion in your state (see http://www.plannedparenthood.org/health-topics/parental-consent-notification-laws-25268.htm). Discuss any legal requirement for parental involvement in the abortion with the adolescent patient promptly and straightforwardly, and assess for possible consequences, ways you may support the adolescent to disclose a pregnancy and actively address any safety concerns.[36]
- Follow-up with your patients at least weekly following their pregnancy diagnosis to assess for the need for additional referrals so they may receive care, including prenatal care if abortion is no longer a desired or accessible option.[4,14]
- Offer any adolescent patients who are planning to have or who had an abortion contact information for Backline, a confidential talkline for before and after abortion, adoption and parenting: 1-888-493-0092, http://www.yourbackline.org and Exhale, a confidential after-abortion talkline: 1-866-4-EXHALE, https://exhaleprovoice.org.[36]

Conclusion

Pregnancy options counseling for adolescents should adopt a framework of shared decision-making in which comprehensive information about options are combined with a supportive approach to counseling designed to identify the option that is most appropriate for each individual. In addition, providers must be aware that the legality and availability of pregnancy options for continuing or terminating a pregnancy pivot on gestational age and therefore adolescents cannot be adequately counseled about their options without accounting for the duration of pregnancy vis-à-vis local clinics' gestational age limits and state laws. The problem of adolescents presenting too late for abortion services is likely to become increasingly prevalent due to the accelerated pace of abortion restrictions.[14] In order to offer adolescents the full range of pregnancy options and care, it is critical that providers reflect on and adapt their counseling and referral strategies to the sociopolitical environment in which they practice, as well as to the needs and desires of these patients.

References

1. Kost K. HSaCL. U.S. teenage pregnancies, births and abortions: national and state trends and trends by race and ethnicity. 2010.
2. American Academy of Pediatrics, Committee on Adolescence. Counseling the adolescent about pregnancy options. *Pediatrics* 1998;101(5):938–40.
3. Upadhyay U, Foster DG. Denial of abortion due to advanced gestational age in the United States. *Paper Presented at American Public Health Association* 2012; San Francisco, CA.
4. Aruda MM, Waddicor K, Frese L, Cole JC, Burke P. Early pregnancy in adolescents: diagnosis, assessment, options counseling, and referral. *J Pediatr Health Care* 2010;24(1):4–13.
5. Wallace RR, Goodman S, Freedman LR, Dalton VK, Harris LH. Counseling women with early pregnancy failure: utilizing evidence, preserving preference. *Patient Educ Couns* 2010; 81(3):454–61.
6. Makoul G, Clayman ML. An integrative model of shared decision making in medical encounters. *Patient Educ Couns* 2006;60(3):301–12.
7. Stacey D, Legare F, Pouliot S, Kryworuchko J, Dunn S. Shared decision making models to inform an interprofessional perspective on decision making: a theory analysis. *Patient Educ Couns* 2010;80(2):164–72.
8. Medicine Io. *Crossing the Quality Chasm: A New Health System for the 21st Century* 2001.

9. Sepucha KR, Floyd J, Fowler J, Mulley AG. Policy support for patient-centered care: the need for measurable improvements in decision quality. *Health Affairs* 2004;10(54):1377–87.
10. Steinberg A. Disclosure of information and informed consent: ethical and practical considerations. *J Child Neurol* 2009; 24(12):1568–71.
11. Major B, Cozzarelli C, Cooper ML, et al. Psychological responses of women after first-trimester abortion. *Arch Gen Psychiatry* 2000;57(8):777–84.
12. Charles VE, Polis CB, Sridhara SK, Blum RW. Abortion and long-term mental health outcomes: a systematic review of the evidence. *Contraception* 2008;78(6):436–50.
13. Steinberg JR, Finer LB. Examining the association of abortion history and current mental health: a reanalysis of the National Comorbidity Survey using a common-risk-factors model. *Soc Sci Med* 2011;72(1):72–82.
14. Foster DG, Dobkin LM, Upadhyay UD. Denial of abortion care due to gestational age limits. *Contraception* 2013;87(1):3–5.
15. Henshaw SK, Kost K. Parental involvement in minors' abortion decisions. *Fam Plann Perspect* 1992;24(5):196–207:[213].
16. Perrucci AC. Decision Assessment and Counseling in Abortion Care: Philosophy and Practice. New York, NY: Rowman & Littlefield Publishers, Inc, 2012.
17. Fried MG. Reproductive rights activism in the post-Roe era. *Am J Public Health* 2013;103(1):10–4.
18. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol* 2010;203(4):319:e311-318.
19. Harrison DD, Cooke CW. An elucidation of factors influencing physicians' willingness to perform elective female sterilization. *Obstet Gynecol* 1988;72(4):565–70.
20. Downing RA, LaVeist TA, Bullock HE. Intersections of ethnicity and social class in provider advice regarding reproductive health. *Am J Public Health* 2007;97(10):1803–7.
21. Geronimus AT. Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Soc Sci Med* 2003;57(5):881–93.
22. Luker KC. A reminder that human behavior frequently refuses to conform to models created by researchers. *Fam Plann Perspect* 1999;31(5):248–9.
23. Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *J Gen Intern Med* 2007;22(6):882–7.
24. Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. *Obstet Gynecol* 2012;119(2 Pt 1):215–9.
25. Bartlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol* 2004;103(4):729–37.
26. Rowlands S. Misinformation on abortion. *Eur J Contracept Reprod Health Care* 2011;16(4):233–40.
27. Westfall JM, Sophocles A, Burggraf H, Ellis S. Manual vacuum aspiration for first-trimester abortion. *Arch Fam Med* 1998;7(6):559–62.
28. Thonneau P, Fougeyrollas B, Ducot B, et al. Complications of abortion performed under local anesthesia. *Eur J Obstet Gynecol Reprod Biol* 1998;81(1):59–63.
29. Tietze C, Lewit S. Legal abortions: early medical complications. An interim report of the joint program for the study of abortion. *J Reprod Med* 1972;8(4):193–204.
30. Bruce FC, Berg CJ, Hornbrook MC, et al. Maternal morbidity rates in a managed care population. *Obstet Gynecol* 2008; 111(5):1089–95.
31. Jones RK, Zolna MR, Henshaw SK, Finer LB. Abortion in the United States: incidence and access to services, 2005. *Perspect Sex Reprod Health* 2008;40(1):6–16.
32. Drey EA, Foster DG, Jackson RA, Lee SJ, Cardenas LH, Darney PD. Risk factors associated with presenting for abortion in the second trimester. *Obstet Gynecol* 2006;107(1): 128–35.
33. Finer LB, Frohwirth LF, Dauphinee LA, Singh S, Moore AM. Timing of steps and reasons for delays in obtaining abortions in the United States. *Contraception* 2006;74(4): 334–44.
34. Foster DG, Jackson RA, Cosby K, Weitz TA, Darney PD, Drey EA. Predictors of delay in each step leading to an abortion. *Contraception* 2008;77(4):289–93.
35. Moriarty Daley AL, Sadler LS, Reynolds HD. Tailoring clinical services to address the unique needs of adolescents from pregnancy test to parenthood. *Curr Probl Pediatr Adolesc Health Care* 2013;43(3):71–95.
36. Monasterio E, Combs N, Warner L, Larsen-Fleming M, St. Andrews A. Sexual health: an adolescent provider toolkit. 〈http://www.ahwg.net/knowledgebase/nodates.php?pid=79&tpid=2〉; 2010.
37. Foster DG, Rostovtseva DP, Brindis CD, Biggs MA, Hulett D, Darney PD. Cost savings from the provision of specific methods of contraception in a publicly funded program. *Am J Public Health* 2009;99(3):446–51.
38. Smith E, Daley AM. A clinical guideline for intrauterine device use in adolescents. *J Am Acad Nurse Pract* 2012; 24(8):453–62.
39. Hartman LB, Monasterio E, Hwang LY. Adolescent contraception: review and guidance for pediatric clinicians. *Curr Probl Pediatr Adolesc Health Care* 2012;42(9):221–63.
40. Jones R, Kooistra K. Abortion incidence and access to services in the United States, 2008. *Perspect Sex Reprod Health* 2011;43(1):41–50.