

Access to reproductive healthcare for adolescents: establishing healthy behaviors at a critical juncture in the lifecourse

Lauren J. Ralph^a and Claire D. Brindis^{a,b}

^aPhilip R. Lee Institute for Health Policy Studies and Bixby Center for Global Reproductive Health and ^bNational Adolescent Health Information and Innovation Center, University of California, San Francisco, California, USA

Correspondence to Lauren J. Ralph, MPH, Philip R. Lee Institute for Health Policy Studies, Bixby Center for Global Reproductive Health, University of California, San Francisco, 3333 California Street, Suite 265, San Francisco, CA 94143-0936, USA
Tel: +1 415 476 2317;
e-mail: Lauren.Ralph@ucsf.edu

Current Opinion in Obstetrics and Gynecology
2010, 22:369–374

Purpose of review

This review summarizes recent research on the topic of adolescents' access to reproductive healthcare, including an overview of recommended reproductive health services, access to the healthcare system and reproductive health specifically, and barriers and emerging service delivery and policy issues in the field.

Recent findings

Recent research confirms the need for diverse healthcare points of access to the reproductive healthcare system for adolescents. It also highlights key policy and service delivery strategies that can improve access to and use of reproductive healthcare among adolescents.

Summary

Access to high quality, confidential, and comprehensive reproductive healthcare is critical to ensuring the overall health of adolescents. Most adolescents are sexually active, and as a result require a wide range of counseling, clinical, and preventive care. The current healthcare system is not adequately structured to meet the diverse needs of adolescents, in particular for reproductive health needs. Continued attention to removing common barriers to care, such as concerns about confidentiality and cost, as well as promoting new screening and delivery strategies, are critical to reducing the incidence of unintended pregnancy and sexually transmitted infections among youth.

Keywords

access to care, adolescents, reproductive health

Curr Opin Obstet Gynecol 22:369–374
© 2010 Wolters Kluwer Health | Lippincott Williams & Wilkins
1040-872X

Introduction

Adolescence represents a period of tremendous physical, psychological, and cognitive growth and development. Adolescents undergo significant changes as they transition from childhood to adulthood, developing habits, behavior patterns, and relationships that influence their lifelong health outcomes [1^{••}]. This period is also marked by increasing involvement in risk behaviors, including the initiation of sexual activity. By age 18, over one-half of adolescents in the United States have had sex [2]. Inconsistent contraceptive use places many at risk for unintended pregnancy and sexually transmitted infections (STIs). Despite substantial declines over the past two decades, the United States has one of the highest adolescent pregnancy rates among all industrialized countries [3]. Each year, approximately 750 000 young women aged 15–19 become pregnant [4], and the vast majority of these pregnancies are unintended [5]. Although young women from all economic and ethnic backgrounds experience unintended pregnancies, poor

youth and youth of color continue to be disproportionately impacted. For example, 8% of non-Hispanic white teens have had a first birth by age 20, compared with 20% of non-Hispanic black and 24% of Hispanic teens [2]. The negative effects of teen childbearing have been well documented, and include delayed entry into prenatal care, poor birth outcomes, lower educational attainment, and persistent poverty [6].

Sexually active adolescents also face significant risk for STIs, including HIV. Rates of the most common STIs, including chlamydia and gonorrhea, peak in late adolescence and early adulthood, with 15–24-year-olds accounting for nearly half of all new STIs, including HIV, diagnosed annually. Young females are disproportionately affected by these patterns of STIs [7[•]]. Early and regular access to reproductive healthcare, including contraceptive counseling, STI testing and treatment, cervical cancer screening, and other preventive care, is key to assuring that early sexual behavior does not result in negative outcomes [8,9^{••}].

When are reproductive health services necessary?

The American College of Obstetricians and Gynecologists (ACOG) recommends an initial reproductive health visit between the ages of 13 and 15 [10]. Although often in advance of their sexual debut, this visit offers adolescents the opportunity to build a trusting relationship with their provider and begin conversations about sexual decision-making and relationships. Numerous professional guidelines, including those issued by the American Medical Association and ACOG, recommend that all adolescents, regardless of sexual experience, receive anticipatory and ongoing counseling on responsible sexual behavior, including sexual decision-making, abstinence, birth control, and STIs/HIV [11]. For sexually active adolescents, care should also include contraceptive counseling and regular chlamydia, gonorrhea, and HIV testing as well as screening for other STIs as medically indicated [12].

The recent approval of two human papillomavirus (HPV) vaccines, including the quadrivalent Gardasil in 2006 and bivalent Cervarix in late 2009 has expanded the recommended guidelines for adolescent reproductive health-care [13]. The Advisory Committee on Immunization Practices currently recommends that all young women receive HPV vaccination at age 11/12, with catch-up vaccinations throughout adolescence [13]. Currently, one-quarter of women aged 13 to 17 has received at least one dose of the vaccine [14]. Recent studies have documented wide support for the vaccine among diverse groups of parents, providers, and clients [15–17].

In 2009, the Federal Drug Administration expanded its approval for the HPV vaccine to include use in adolescent and young adult males aged 9–26 years. A review article summarizing the small body of literature on patient, parent, and provider's acceptability of HPV vaccination for males documents overall support for the vaccine in this population, but to a lesser extent than had been observed in similar studies on women's vaccination [18*].

Adolescents' access to healthcare

The current system of health services and settings is often poorly equipped to meet the diverse acute and preventive health needs of adolescents [1**]. Although the vast majority of adolescents have health insurance, primarily through their parent's private, employer based coverage or through expansions in public health insurance programs (such as Medicaid and the State Children's Health Insurance Program), many adolescents remain underserved, as services delivered in private and public settings are not always accessible, acceptable, appropriate, or effective for all adolescents [19]. In addition, a

significant minority of adolescents, estimated at over four million in 2005, remains uninsured [1**]. Poor, racial/ethnic minority and noncitizen adolescents are disproportionately represented in the uninsured population [1**]. Adolescents without health insurance coverage are more likely to forgo or delay seeking medical care, fail to get needed prescriptions, have no usual source of care, and no physician visits in the last year [1**].

Adolescents' access to reproductive healthcare

Nationally, birth control and pregnancy-related services comprise the two largest medical expenditures for prescriptions and outpatient care among adolescent and young adult women [7*]. According to the 2002 National Survey of Family Growth, approximately 40% of adolescent women aged 15–19 received sexual or reproductive health services from a medical provider in the previous year [20]. Adolescents accessed services through diverse provider types and settings; females were equally likely to seek reproductive health services from a private doctor or managed care provider (55%) as they were a public clinic (53%), with some using more than one system during the year [21]. The types of providers utilized also vary according to clients' age. Pediatricians remain the primary source of care for adolescents aged 14 and under; however, by age 17 and 18, a larger proportion of women access care through OBGYNs (34%) and family practice specialists (34%) than pediatricians (23%) [22**]. This points to the importance of assuring a variety of entry points for different segments of the youth population.

The quality and comprehensiveness of reproductive services also varies substantially by site [23]. For example, only one-half (56%) of pediatricians indicate that they routinely offer at least some reproductive health services, and just one in five (22%) distribute or make condoms available to their patients [24]. In a separate study assessing service integration at adolescent health clinics, a minority of primary care settings were able to routinely offer same-day HIV, STI, and family planning services to their adolescent clients [25].

Reproductive health screening and counseling can be delivered in the context of primary or preventive health visits. However, only 38% of adolescents have had a recent (in the last 12 months) preventive care visit that included screening and anticipatory guidance for health-related behaviors [26]. Preventive visits are most common in younger adolescents (ages 10–14), and decline significantly between the ages of 16 and 19 [27], when adolescents typically become most in need of reproductive health services. In the context of primary or preventive care visits, less than one-third of providers routinely discuss or counsel their patients on reproductive

and other sensitive health topics [28,29], despite the fact that adolescents' satisfaction with care increases when these discussions occur [29]. As a result, alternative sources of care are critical, as well as improving current systems of care.

Access to publicly funded family planning services

Over one-quarter of women accessing contraceptive services in the United States annually does so at one of 8199 publicly funded clinics, including county or city health departments, Planned Parenthoods, outpatient departments, and community health centers [30]. Title X, the nation's only dedicated family planning program, and Medicaid constitute the largest sources of federal funding [31], and synergistically ensure coverage to diverse populations [32].

In 26 states, Medicaid family planning waivers have greatly expanded access to reproductive health services using innovative outreach, enrollment, and service delivery strategies. These strategies, including point of service enrollment, eligibility determination based on individual (not family) income, and requirements protecting client confidentiality regardless of age, have particularly benefited adolescents [33,34]. Nationally, publicly funded family planning programs prevent an estimated 290 000 unintended pregnancies annually among adolescents, saving over four billion dollars in costs associated with maternity and infant care for these pregnancies [35].

Barriers to accessing reproductive healthcare

Adolescents face numerous barriers to accessing needed healthcare, including lack of familiarity with the healthcare system, limited ability to pay for services, fear of disclosure of confidential information to family and friends, and uncertainty about their ability to access services without the consent of a parent or guardian [8].

Confidentiality is critical to ensuring adolescents' willingness to access health services, disclose sensitive health information, and return for necessary follow-up care [36]. Confidentiality protections are particularly important for reproductive and other sensitive healthcare, as adolescents are likely to forgo needed care in the absence of these protections [37]. Confidentiality can be achieved by ensuring that adolescents have time alone with their provider. However, only 34% of adolescents reported having spent time alone with their physician at some point during the previous year. Reports of spending time alone were higher among men than women (42 vs. 37%), and lowest among younger Hispanic teens (18%) [38**]. These disparities raise significant concerns about the role of provider screening and counseling practices in contributing to overall health disparities [39].

Further, even if an adolescent has time alone with their provider, a complex patchwork of federal, state and case laws can limit that provider's ability to offer services confidentially [40]. Currently, only 26 states permit minors aged 17 and under to provide their own informed consent for contraceptive services [41]. For reproductive health specifically, insurance coverage alone will not guarantee access to needed care. Certain insurance benefits plans do not cover the full scope of contraceptive methods, or impose cost-sharing requirements (such as copayments or deductibles) that are beyond most adolescents' financial resources [42]. For example, despite increased awareness of the availability of emergency contraception, adolescents remain hesitant about their ability to access the method given its cost [43].

At the provider level, perceived inadequacies in training on adolescent health topics, lack of self-efficacy in providing confidential care, and concern about legal restrictions related to confidentiality of care limits provider's ability to screen and counsel youth on sensitive health topics [1**,44]. Healthcare systems barriers often compound provider-level issues, including inadequate reimbursement for reproductive health related counseling, particularly for private providers [45]. For example, in order to cover the United States Preventive Care Task Force's recommendations for adolescent health screenings, providers would need an average of 40 min with their patients, far more than most healthcare systems or reimbursement structures currently permit [46].

Emerging issues in the provision of reproductive healthcare to adolescents

A number of studies published in the last year offer new guidance to providers on counseling their adolescent clients.

Ensuring contraceptive continuity

Recent research highlights the need for providers to pay particular attention to the relationship context of sexual decision-making in counseling their adolescent clients, as relationship status, duration and quality each influence the likelihood of contraceptive use. Manning *et al.* [47**] recently found that adolescents in high quality relationships, defined by emotional closeness, relationship salience, and trust, used condoms less consistently than their peers, placing them at increased risk for unintended pregnancy. At the same time, young women in relationships characterized by negative relationship qualities, including partner's controlling behavior, mistrust, jealousy, and perceived partner inferiority were also significantly less likely to use condoms consistently.

Relationship quality has also been found to influence resumption of sexual activity following an STI diagnosis

in a sample of urban adolescents. Posttreatment counseling for adolescents should address their plans for contraceptive use once they resume sexual activity, in addition to recommending a period of abstinence while they are being treated [48]. There is a clear need for testing family planning service delivery models that encourage providers to assess the contextual and dynamic factors that influence contraceptive behaviors [49], including partner and relationship dynamics.

Increased involvement of male partners in contraceptive decision-making and use can also have direct benefits on young men's, as well as young women's reproductive health. Only one-quarter (26%) of adolescent males reporting high-risk sexual health behaviors receive STI/HIV counseling [50].

Increasing use of long-acting methods

Although condoms and oral contraception remain the most commonly used contraceptive methods among adolescents, recent efforts to promote the use of long-acting and highly effective methods, including intrauterine contraception (IUC), could have a significant influence on decreasing unintended [51[•]] and rapid repeat pregnancy [52] in this population. Professional organizations have issued guidelines supporting expanded access to IUCs [53,54]. Knowledge of IUCs among adolescents and young adults is generally low, so providers need to counsel eligible patients, including dispelling misperceptions about the long-term side-effects of these methods [55].

Understanding the association between intimate partner violence and reproductive health

Although past research has consistently documented the association between intimate partner violence (IPV) and unintended pregnancy among women of all ages, recent studies elucidate the mechanism through which this association occurs and highlight its prevalence in young women specifically. Reproductive control, when a male partner uses economic, emotional, and/or physical means to enforce his own reproductive intentions regardless of his partner's agreement, is a common component of IPV. Reproductive control encompasses a broad range of behaviors, including pregnancy promotion, contraceptive sabotage, sexual violence, controlling a pregnancy outcome, or interfering with care [56].

This violence occurs in adolescent relationships. For example, 51% of young women aged 16–20 surveyed at five family planning clinics in Northern California had experienced lifetime physical or sexual abuse from an intimate partner. Adolescents also reported pregnancy coercion (18%), and birth control sabotage (12%) by a male partner [57^{••}].

Emerging policy issues

Recent federal healthcare reform efforts will likely have an impact on access to and provision of reproductive health-care services in the United States. The new legislation enables states to expand their Medicaid coverage for family planning services through a less cumbersome state plan amendment process, as opposed to filing for a federal waiver which must be renewed on a regular basis [58], thereby increasing access to family planning services through Medicaid. It also increases the number of rebates that pharmaceutical companies must offer to safety net providers, including Medicaid and Title X clinics, and creates new funding to broaden the network of community health centers [59]. Other changes include insurance coverage expansion of young adults through their parent's health insurance plans up to the age of 26. Careful monitoring of reform implementation and assuring that expanded reproductive health services are made available to adolescents and young adults, given their profile of adolescent pregnancy, STIs, and health disparities, is key.

Conclusion

Although progress has been made in responding to the unique needs of adolescents, they are often underserved by the current healthcare system, especially for preventive and sensitive services. Disparities in access to overall care [1^{••}], confidential care [38^{••}], and reproductive health services [60] by demographic characteristics persist. Given its central role in ensuring overall health, access to high-quality, comprehensive, confidential reproductive health services remains critical to adolescents' ability to successfully navigate these years, as well as prepare them for a lifetime of positive health outcomes, including protecting their fertility. Adolescence represents a key window of opportunity for promoting life-long health behaviors, building health self-efficacy, and increasing their capacity to make healthy decisions [61,62]. Providers can and must play a critical leadership role in providing care, developing new models, and evaluating these efforts.

Acknowledgement

This research was supported in part by grants from the Maternal and Child Health Bureau, Health Resources and Services Administration, the United States Department of Health and Human Services (U45MC 00002 and U45MC 00023).

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- of special interest
- of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 430–431).

- 1 Lawrence RS, Gootman JA, Sim LJ, editors. Adolescent Health Services: missing opportunities. Washington, DC: the National Academies Press; 2009. This book provides a timely and comprehensive overview of the current status of adolescent health and health service delivery in the United States, including recommendations for policy and research.

- 2 Abma JC, Martinez GM, Mosher WD, *et al.* Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. *Vital Health Stat* 2004; 24:1–48.
- 3 Ventura SJ, Abma JC, Mosher WD, *et al.* Estimated pregnancy rates for the United States, 1990–2005. *Natl Vital Stat Rep* 2009; 58:1–14.
- 4 Hamilton BE, Martin JA, Ventura SJ. Births: preliminary data for 2008. *Natl Vit Stat Report* 2010; 58:1–18.
- 5 Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspect Sex Repro Health* 2006; 38:90–96.
- 6 Cheng D, Schwarz EB, Douglas E, Horon I. Unintended pregnancy and associated maternal preconception, prenatal, and postpartum behaviors. *Contraception* 2009; 79:194–198.
- 7 Muyle TP, Park MJ, Nelson CD, *et al.* Trends in adolescent and young adult health in the United States. *J Adolesc Health* 2009; 45:8–24.
- This review article presents a national health profile of adolescents and young adults, including overall demographics, mortality, health-related behaviors, and healthcare access and utilization. Key sources of data on reproductive health are included.
- 8 Brindis C. A public health success: understanding policy changes related to teen sexual activity and pregnancy. *Ann Rev Publ Health* 2006; 27:277–295.
- 9 Santelli J, Melnikas A. Teen fertility in transition: recent and historic trends in the United States. *Annu Rev Public Health* 2010; 31:17.1–17.13.
- This review article examines factors associated with trends in teen fertility in the United States, highlighting the importance of increased use of contraception among teens in recent reductions in teen birth rates.
- 10 Committee on Adolescent Health. ACOG Committee Opinion. Number 335, May 2006: The initial reproductive health visit. *Obstet Gynecol* 2006; 107:1215–1219.
- 11 American Medical Association. Guidelines for adolescent preventive services (GAPS): Recommendations Monograph. Chicago, Illinois: American Medical Association. 1997.
- 12 American College of Obstetricians and Gynecologists. Primary and preventive health services for female adolescents. Washington, DC; ACOG. 2009.
- 13 Centers for Disease Control and Prevention. FDA licensure of bivalent human papillomavirus vaccine (HPV 2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices. *MMWR Morb Mortal Wkly Rep* 2010; 59: 626–629.
- 14 Centers for Disease Control and Prevention. Vaccination coverage among adolescents ages 13–17 years – United States, 2007. *MMWR* 2008; 57:1100–1103.
- 15 Bernat DH, Harpin SB, Eisenberg ME, *et al.* Parental support for the human papillomavirus vaccine. *J Adolesc Health* 2009; 45:525–527.
- 16 Constantine NA, Jerman P. Acceptance of the human papillomavirus vaccination among Californian parents of daughters: a representative statewide analysis. *J Adolesc Health* 2007; 40:108–115.
- 17 Savage L. Proposed HPV vaccine mandates rile health experts across the country. *J Natl Cancer Inst* 2007; 99:665–666.
- 18 Liddon N, Hood J, Wynn BA, *et al.* Acceptability of the human papillomavirus vaccine for males: a review of the literature. *J Adolesc Health* 2010; 46:113–123.
- This study provides an overview of available literature on the acceptability of HPV vaccination of males among providers, parents, and young men. Given the relatively recent approval of the vaccine for use in men, this review could be helpful for providers integrating HPV vaccination for young men into their service delivery.
- 19 American Academy of Pediatrics Committee on Adolescence; American Academy of Pediatrics Committee on Child Health Financing. Underinsurance of adolescents: recommendations for improved coverage of preventive, reproductive, and behavioral healthcare services. *Pediatrics* 2009; 123:191–196.
- 20 Frost JJ. Trends in US women's use of sexual and reproductive healthcare services, 1995–2002. *Am J Public Health* 2008; 98:1814–1817.
- 21 Suellentrop K. Adolescent girls' use of health services. *Sciences Says*, 28. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy. 2006
- 22 Hoover K, Tao G, Berman S, *et al.* Use of health services in physician offices and outpatient clinics by adolescents and young women in the United States: implications for improving access to reproductive health services. *J Adolesc Health* 2010; 46:324–330.
- This article provides nationally representative data on the diverse types of providers through which young women access healthcare. It also documents young women's increasing utilization of reproductive healthcare through diverse provider types as they age.
- 23 American Academy of Pediatrics, Committee on Adolescence. Achieving quality health services for adolescents. *Pediatrics* 2009; 121:1263–1269.
- 24 Henry-Reid LM, O'Connor KG, Klein JD, *et al.* Current pediatrician practices in identifying high-risk behaviors of adolescents. *Pediatrics* 2010; 125:e741–e747.
- 25 Brindis CD, Loo VS, Adler NE, *et al.* Service integration and teen friendliness in practice: a program assessment of sexual and reproductive health services for adolescents. *J Adolesc Health* 2005; 37:155–162.
- 26 Irwin C, Adams SH, Park MJ, *et al.* Preventive care for adolescents: few get visits and fewer get services. *Pediatrics* 2009; 123:e565–e572.
- 27 Rand CM, Shone LP, Albertin C, *et al.* National healthcare visit patterns of adolescents: implications for delivery of new adolescent vaccines. *Arch Pediatr Adolesc Med* 2007; 161:252–259.
- 28 Klein JK, Wilson D. Delivering quality care: adolescents discussion of health risks with their providers. *J Adolesc Health* 2002; 30:190–195.
- 29 Brown JD, Wissow LS. Discussion of sensitive topics with youth during primary care visits: relationship to youth perceptions of care. *J Adolesc Health* 2009; 44:48–54.
- 30 Frost JJ, Frohworth L, Purcell A. The availability and use of publicly funded family planning clinics; U.S. trends, 1994–2001. *Perspect Sex Repro Health* 2004; 36:206–215.
- 31 Sonfield A, Gold RB. Public funding for contraception, sterilization, and abortion services, FY 1980–2001. New York, NY: Guttmacher Institute, 2005. www.guttmacher.org/pubs/funding/index.html.
- 32 Gold R. Stronger together: Medicaid, Title X bring different strengths to family planning effort. *Guttmacher Policy Review* 2007; 10:13–18.
- 33 Sonfield A, Alrich C, Gold RB. State government innovation in the design and implementation of Medicaid family planning expansions. Guttmacher Institute: New York, New York; 2008.
- 34 Brindis CD, Llewelyn L, Marie K, *et al.* Meeting the reproductive healthcare needs of adolescents: California's Family Planning Access, Care and Treatment Program. *J Adolesc Health* 2003; 32S:79–90.
- 35 Frost JJ, Finer LB, Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. *J Healthcare Poor Underserved* 2008; 19:778–796.
- 36 Ford CA, Millstein SG, Halpern-Felscher BL, *et al.* Influence of physician confidentiality assurances on adolescents' willingness to disclose health information and seek future healthcare. *JAMA* 1997; 278:1029–1034.
- 37 Jones RK, Boonstra H. Confidential reproductive healthcare for adolescents. *Curr Opin Obstet Gynec* 2005; 17:456–460.
- 38 Edman JC, Adams SH, Park MJ, *et al.* Who gets confidential care? Disparities in a national sample of adolescents. *J Adolesc Health* 2010; 46:393–395.
- Using national data, this analysis highlights significant disparities in the extent to which adolescents in the United States have time alone with their clinician, and as a result have time to speak with their clinician about sensitive health issues.
- 39 Ford C. Which adolescents have opportunities to talk to doctors alone? *J Adolesc Health* 2010; 46:307–308.
- 40 Brindis CD, Ott M. Adolescents, health policy, and the American political process. *J Adolesc Health* 2002; 30:9–16.
- 41 Guttmacher Institute, Minors' access to contraceptive services, *State Policies in Brief*, updated 1 January 2010. http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf. [Accessed 26 January 2010]
- 42 Hock-Long L, Herceg-Baron R, Cassidy AM, *et al.* Access to adolescent reproductive health services: financial and structural barriers to care. *Perspect Sex Reproduct Health* 2003; 35:144–147.
- 43 Johnson R, Nshom, Nye AM, *et al.* There's always Plan B: adolescent knowledge, attitudes, and intention to use emergency contraception. *Contraception* 2010; 81:128–132.
- 44 Goldstein LS, Chapin JL, Lara-Torre E, *et al.* The care of adolescents by obstetricians-gynecologists: a first look. *J Pediatr Adolesc Gynecol* 2009; 22:121–128.
- 45 Landry DJ, Wei J, Frost JJ. Public and private providers' involvement in improving their patients' contraceptive use. *Contraception* 2008; 78:42–51.
- 46 Chung PJ, Lee TC, Morrison JL, *et al.* Preventive care for children in the United States: quality and barriers. *Annu Rev Public Health* 2006; 27:491–515.
- 47 Manning WD, Flanigan CM, Giordano PC, *et al.* Relationship dynamics and consistency of condom use among adolescents. *Perspect Sex Reproduct Health* 2009; 41:181–190.
- This article provides insights into areas that impact contraceptive adherence, which traditionally has not received sufficient attention by clinicians. By further understanding the relationship context, providers may be able to provide more tailored counseling.

- 48 Ott MA, Ofner S, Tu W, *et al*. Characteristics of sex after periods of abstinence among sexually experienced young women. *Perspect Sex Reprod Health* 2010; 42:43–48.
- 49 Hock-Long L, Whittaker PG, Herceg-Brown R. Family planning service delivery research: a call to focus on the dynamics of contraceptive use. *Perspect Sex Reprod Health* 2010; 42:10–11.
- 50 Marcell AV, Bell DL, Lindberg LD, Takruri A. Prevalence of sexually transmitted infection/human immunodeficiency virus counseling services received by teen males, 1995–2002. *J Adolesc Health* 2010; 46:553–559.
- 51 Deans EI, Grimes DA. Intrauterine devices for adolescents: a systematic review. *Contraception* 2009; 79:418–423.
 This is an important overview on the appropriateness of intrauterine contraception for adolescents.
- 52 Goodman S, Hendlish SK, Reeves MF, *et al*. Impact of immediate postabortal insertion of intrauterine contraception on repeat abortion. *Contraception* 2008; 78:143–148.
- 53 Allen RH, Goldberg AB, Grimes DA. Expanding access to intrauterine contraception. *Am J Obstet Gynecol* 2009; 201:456e1–456e5.
- 54 Society of Family Planning. Use of Mirena™ LNG-IUS and Paragard™ CuT380A intrauterine devices in nulliparous women. *Contraception* 2010; 81:367–371.
- 55 Whitaker AK, Johnson LM, Harwood B, *et al*. Adolescent and young adult women's knowledge of and attitudes toward the intrauterine device. *Contraception* 2008; 78:211–217.
- 56 Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. *Soc Sci Med* 2010; 70:1737–1744.
- 57 Miller E, Decker MR, McCauley HL, *et al*. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception* 2010; 81:316–322.
 This article elaborates on the prevalence and types of intimate partner violence experienced by young women accessing reproductive health services.
- 58 Kaiser Family Foundation. Focus on health reform: implications for women's access to coverage and care. Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2009.
- 59 Guttmacher Institute. The new healthcare reform legislation: Pros and cons for reproductive health. <http://www.guttmacher.org/media/inthenews/2010/03/29/index.html>.
- 60 Potter J, Trussell J, Moreau C. Trends and determinants of reproductive health service use among young women in the USA. *Hum Reprod* 2009; 24:3010–3018.
- 61 Ozer EM. The adolescent primary care visit: time to build on strengths. *J Adolesc Health* 2007; 41:519–520.
- 62 Gavin LE, Catalano RF, Markham CM. Positive youth development as a strategy to promote adolescent sexual and reproductive health. *J Adolesc Health* 2010; 46:S1–S6.