Clinicians working in Catholic health care facilities are bound by the church's ethical directives, which prohibit the provision of services related to contraception, abortion and assisted reproduction. Whether or not these providers may offer referrals for such services is not so clear-cut. So, what do physicians working in Catholic facilities do when patients ask for or are in medical need of prohibited services? This is the question Debra B. Stulberg and colleagues report on in this issue of *Perspectives on Sexual and Reproductive Health* (page 111). Through qualitative interviews with 27 obstetrician-gynecologists who were working or had worked in Catholic facilities, Stulberg's team learned that in some Catholic hospitals, referrals for prohibited services are tolerated, or even encouraged, by administrators and ethicists, while in others, referrals are actively discouraged. Some physicians reported having another affiliation or practice location where they could provide services that were forbidden at their Catholic hospital; most talked about making referrals, but they described processes that were often complex and did not always end with the hospital authorities' approving of the referral. Abortion referrals were described as particularly difficult to make, not only because of the church's position on the procedure, but because of objections of support staff and the potential of physicians' being stigmatized within the professional community.

Ultimately, many study participants felt that because of the church's ethical restrictions, their Catholic hospitals failed to meet the needs of substantial shares of their patients—particularly, women wishing to undergo sterilization at the time of a cesarean or immediately after a vaginal delivery, who would need an additional hospitalization or procedure; patients with limited financial resources, for whom the inability to get all services at one visit could create hardship; and women needing emergency care that conflicts with church guidelines on reproductive health services. Echoing the American College of Obstetricians and Gynecologists' position on conscientious refusal, the authors argue that "patients' wishes and well-being, not…institutional religious policy, should be the primary driver of health care decisions."

Also in This Issue

•Young, unmarried women's preferences regarding features of contraceptive methods do not always mesh with their method choices, Cassondra Marshall and colleagues found in analyses of data from the 2009 National Survey of Reproductive and Contraceptive Knowledge (page 119). Notably, most ever-users of contraceptives among the survey's sample of 18–29-year-olds considered it extremely important for a method to be very effective at preventing pregnancy, yet this preference was not associated with the effectiveness of the method they were currently using. By contrast, those who considered it important for a method to be hormone-free had reduced odds of using hormonal contraceptives, and those who valued effectiveness for HIV and STD prevention had elevated odds of employing dual methods. Future work, the researchers observe, is needed to better understand how accurately women rate methods in terms of the features that are important to them and how women's preferences for various contraceptive features interact with each other to influence their decision making.

•Both actual and perceived weight are linked to adolescents' sexual risk, and associations vary by gender, Aletha Y. Akers and colleagues have found in a study combining data from the 1994–1995 National Longitudinal Study of Adolescent Health and the 1997 National Longitudinal Survey of Youth (page 129). For example, being overweight, rather than normal-weight, was positively associated with risky behavior for males, but was not significant for females. Furthermore, whereas males who thought of themselves as overweight were less likely than their peers who considered their weight about right to engage in risky behavior, the opposite was true for females. While noting that the data do not permit them to assess the sequence of events, the researchers comment that their findings "emphasize the importance of considering the gendered and psychosocial context in which sexual behaviors occur, and likely reflect gender- and weight-based cultural norms regarding physical attractiveness that adolescents internalize."

•How best to measure, and even conceptualize, unintended pregnancy has been the subject of much debate and may have tremendous implications for public policies and programs. Two contributions by Abigail R.A. Aiken and colleagues bring new perspectives to the debate. First, Aiken and one team present original research (page 139) that used three measures to explore how a cohort of women seeking pregnancy tests viewed the possibility of a positive result: a standard U.S. measure that assesses whether women had intended a pregnancy at the time it occurred; a standard British measure that probes women's pregnancy planning and related behaviors; and a measure that combines the U.S. assessment of intendedness with information women provided about how happy or unhappy they would be if they learned they were pregnant. The analyses revealed substantial discrepancies between intention status, as registered by the U.S. measure, and planning status, as determined by the British one. The measure that took into account women's feelings about a pregnancy appeared to be the best predictor of pregnancy outcomes.

In a related comment (page 147), Aiken and a different set of coauthors extend the argument that it may be wrong to assume, as researchers, policymakers and program planners traditionally have done, that all unintended pregnancies are negative events. According to the authors, timing does not tell the entire story, and women might be quite accepting of pregnancies that they did not intend. The authors propose a new framework for "informing women-centered approaches to preventing undesired pregnancies and improving outcomes," which takes into account how women think of pregnancy and their perceptions of how a pregnancy will affect their lives. This approach, Aiken

and colleagues contend, "allows [women] to freely communicate their perspectives and avoids the need to impose a planning structure that may be inappropriate or irrelevant."

•The Digests section (page 153) includes summaries of research on changes in the sexual and reproductive health topics that U.S. adolescents report having had formal instruction about, links between friends' early motherhood and teenage women's sexual behavior, the prevalence of STD testing among adolescents and adults in the United States, and more.

—*The Editors*