

What Are Women Told When Requesting Family Planning Services at Clinics Associated with Catholic Hospitals? A Mystery Caller Study

CONTEXT: Catholic Church directives restrict family planning service provision at Catholic health care institutions. It is unclear whether obstetrics and gynecology clinics that are owned by or have business affiliations with Catholic hospitals offer family planning appointments.

METHODS: Mystery callers phoned 144 clinics nationwide that were found on Catholic hospital websites between December 2014 and February 2016, and requested appointments for birth control generally, copper IUD services specifically, tubal ligation and abortion. Chi-square and Fisher's exact tests assessed potential correlates of appointment availability, and multivariable logistic regressions were computed if bivariate testing suggested multiple correlates.

RESULTS: Although 95% of clinics would schedule birth control appointments, smaller proportions would schedule appointments for copper IUDs (68%) or tubal ligation (58%); only 2% would schedule an abortion. Smaller proportions of Catholic-owned than of Catholic-affiliated clinics would schedule appointments for birth control (84% vs. 100%), copper IUDs (4% vs. 97%) and tubal ligation (29% vs. 72%); for birth control and copper IUD services, no other clinic characteristics were related to appointment availability. Multivariable analysis confirmed that tubal ligation appointments were less likely to be offered at Catholic-owned than at Catholic-affiliated clinics (odds ratio. 0.1); location and association with one of the top 10 Catholic health care systems also were significant.

CONCLUSIONS: Adherence to church directives is inconsistent at Catholic-associated clinics. Women visiting such clinics who want highly effective methods may need to rely on less effective methods or delay method uptake while seeking services elsewhere.

Perspectives on Sexual and Reproductive Health, 2017, 49(4):207–212, doi:10.1363/psrh.12040

Catholic health care systems control a substantial proportion of the U.S. health care sector. As of March 2016, there were 548 Catholic-owned hospitals across the country, representing 15% of all hospitals, and accounting for one in six acute hospital beds.¹ Catholic health care systems have demonstrated significant growth over the past decade, largely through the acquisition of small, non-Catholic community hospitals.¹ All individuals involved in institutionally based Catholic health care services—the trustees, administrators, chaplains, physicians, health care personnel and patients—are expected to follow a set of guidelines called the *Ethical and Religious Directives for Catholic Health Care Services*.² The purpose of the directives is twofold: to reaffirm the ethical standards of behavior in health care that flow from the church's teaching about human dignity, and to provide authoritative guidance on certain moral issues faced by Catholic health care.²

The Catholic Church teaches that sexual activity should be limited to heterosexual married couples who intend to procreate.² Consequently, the only family planning service the directives allow is the medical provision of counseling about natural family planning methods for married couples.² Women attending Catholic medical institutions face restrictions in obtaining injectable contraceptives, emergency contraception, sterilization, and care for the

management of ectopic pregnancy and miscarriage;^{3–10} furthermore, referral practices for family planning services vary across sites.¹¹ Advocates for Catholic health care facilities argue that women should know that restrictions on reproductive health care exist at these facilities because this is part of Catholic identity. Since 2015, several patients have spoken out about how religious doctrine resulted in denial of necessary care at Catholic facilities;¹ some of these experiences have gained media attention¹² and led to legal action.^{13,14}

Because of the directives, new hospital mergers involving Catholic institutions have resulted in the prohibition of family planning services at institutions that previously offered them.^{15–17} However, health care systems have used various strategies after mergers to continue to offer reproductive health care services,^{16,17} and there is evidence that certain services prohibited by the directives are provided within Catholic health care facilities.^{3–5,7,10} Given this tension between the increasing reach of the directives and attempts to provide comprehensive women's health care, it is important to understand the state of access to a range of ambulatory family planning services at Catholic hospital clinics. Prior studies have demonstrated that most women anticipate similar access to family planning services at Catholic and non-Catholic institutions.^{18,19} It is unclear

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whether this discrepancy between perception and provision is because many women have not attended a Catholic clinic, because those who have attended a Catholic facility have not experienced significant restrictions on care or because many do not think their health care options can be influenced by a hospital's religious doctrine.

The goal of this study was to describe the experiences of women seeking appointments for family planning services at obstetrics and gynecology clinics found on Catholic hospital websites. We were interested in determining if services are offered and, if not, at what point in the appointment process women are informed of restrictions. We hypothesized that access would be highly restricted and that this would be clearly communicated at the time of appointment scheduling.

We also examined whether clinics provided referrals if services were denied. Strict interpretation of the directives would suggest that referrals are not allowed, especially for abortion services. For example, directive number 45 states, "Catholic health care institutions are not to provide abortion services, even based on the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers."^{2(p.26)} Yet, the American College of Obstetricians and Gynecologists states that "institutions and professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to professional services."^{20(pp.4-5)}

METHODS

We conducted a cross-sectional survey of U.S. obstetrics and gynecology clinics found on Catholic hospital websites between December 2014 and February 2016. To ensure a geographically diverse sample of clinics that likely reflects the relative numbers of women who might access family planning services, we used state population densities to determine the number of clinics to contact in every state.²¹ We aimed to contact six clinics in states with 200 or more people per square mile, four clinics in states with 75–200 people per square mile, three in states with 25–75 people per square mile, two in states with fewer than 25 people per square mile and one in Washington, DC. Using this strategy, we would call up to 200 clinics across the United States.

We could not find a comprehensive list of obstetrics and gynecology clinics associated with Catholic hospitals or health care systems. To identify such clinics, we first referred to a report created by the MergerWatch Project and the American Civil Liberties Union.¹⁵ This report, one of the few we found that examines reproductive health care at Catholic institutions, includes a list of the 25 largest U.S. health care systems (assessed on the basis of number of hospital beds in 2011), 10 of which have Catholic associations. We searched the Internet for these 10 systems and listed the hospitals in their networks. We also included 30 Catholic hospitals listed in this report as "sole community providers."¹⁵ This designation means that the hospitals are located more than 35 miles from similar hospitals; are des-

ignated as "essential access community hospitals" by the Centers for Medicare and Medicaid Services; or are the sole sources of hospital inpatient services reasonably available to Medicare beneficiaries because of isolated location, weather conditions, travel conditions or the absence of other, similar hospitals.²² We examined the website of each Catholic hospital we identified and searched for an obstetrics and gynecology clinic.

The initial search strategy did not yield the number of clinics needed per state; therefore, we performed a secondary search, looking for publicly available websites of Catholic hospitals in the states for which we did not yet have adequate numbers of clinics. We verified that the hospitals were Catholic by reviewing their mission statements and then searched for their obstetrics and gynecology clinic. We were unable to find any Catholic hospitals in six states, and found fewer clinics than we had planned to call in others; as a result, our list comprised 176 clinics.

Using a mystery caller approach, three trained researchers called the clinics and requested appointments for each of the following family planning services: birth control, tubal ligation and abortion. If offered an appointment for birth control, they specifically asked for copper IUD services. For each clinic, we made calls for each service request at least one week apart. We chose these services because each is explicitly prohibited by the directives, requires a procedure for uptake and lacks noncontraceptive indications for provision within a Catholic facility. (By contrast, for example, the levonorgestrel IUD has U.S. Food and Drug Administration approval for the treatment of heavy menstrual bleeding, making its provision possible in a Catholic health care setting.) For each service, we created a telephone script on the basis of recommendations from patient care coordinators at our (non-Catholic) institution who schedule family planning services. To request tubal ligation, the caller said, "I'm new to the area and would like to get a tubal ligation. Do the doctors do tubals?" To reflect the need for an abortion that is not medically indicated, when the caller requested an abortion, she said, "Hi. I just took a pregnancy test, and I am pregnant. I really do not want to be. Do you do abortions?"

If the caller was unable to obtain an appointment for the requested service, she asked "Why not?" and recorded the response. If the response was that there were no obstetrics and gynecology providers at the clinic, we excluded that call from the analysis. When appointments were offered, the caller asked if the clinic's Catholic association was a concern for service provision and recorded the response. Using responses to these questions, we categorized clinics as Catholic-owned or Catholic-affiliated. If the person answering the phone indicated that a Catholic health care system or hospital owned the clinic, we coded it as Catholic-owned; if the person on the phone reported that the clinic was not owned by a Catholic entity, but that the clinic or provider had a business partnership with a Catholic health care system (e.g., was a private practice with admitting privileges at a Catholic hospital), we coded it as Catholic-

affiliated. We based the final categorization of each clinic on review of all three calls; for clinics with discordant or unclear responses, we made additional verification calls.

When the caller was told that services were not provided, she asked “What should I do?” and recorded responses. If a referral was not spontaneously offered, she asked for one. We categorized the response as a direct referral if a provider name or site was given with a telephone number; as an indirect referral if a provider name or site was given or suggested, but no telephone number was provided; and as no referral if no specific provider or site was given, or if a nonspecific suggestion was given, such as “check online.”

Among the 176 clinics that we identified, seven reported no gynecology provider, and one had a nonworking telephone number. Twenty-four clinics denied any Catholic association during the phone calls. A few of these reported that they were no longer associated with a Catholic hospital or that there had been changes in ownership of their hospital (e.g., the hospital was now owned by a non-Catholic health care system); the remainder were unaware of any specific association. We completed phone calls with these clinics, but excluded them from our analysis. Thus, our final sample consisted of 144 clinics.

We calculated summary statistics to describe selected clinic characteristics (region, association with one of the top 10 Catholic health care systems¹⁷ and association with a sole community provider hospital¹⁷) and available family planning services. Then, using chi-square tests or Fisher’s exact tests (if the cell sizes were smaller than five), we compared the characteristics of and services available at Catholic-affiliated and Catholic-owned clinics. We also conducted bivariate tests to identify clinic characteristics that were related to the availability of each type of service appointment; if more than one characteristic was significant for a given type of appointment, we computed a logistic regression model to further assess correlates of the availability of that service. For all analyses, we used SPSS version 23.0. For answers to follow-up questions that we collected as free-text responses not described above, we created categories and report descriptive findings. We received exemption to conduct this study from the Colorado Multiple Institutional Review Board.

RESULTS

Our sample was geographically diverse (Table 1), covering 44 U.S. states. Overall, 53% of the 144 clinics were associated with one of the top 10 Catholic health care systems, and 17% were associated with a sole community provider hospital. Ninety-five percent agreed to schedule a birth control appointment, but only 68% a copper IUD appointment; 58% would schedule a tubal ligation, and 2% an abortion. (By contrast, among the 24 clinics we excluded because they reported no Catholic hospital association, 100% agreed to schedule an appointment for birth control, 96% for a copper IUD, 100% for a tubal ligation and 4% for an abortion.) Thirty-one percent of clinics were Catholic-owned, and 69% Catholic-affiliated.

TABLE 1. Percentage of obstetrics and gynecology clinics found on Catholic hospital websites and contacted in a mystery caller study, by selected characteristics and services offered, according to type of Catholic association, 2014–2016

Characteristic or service	All (N=144)	Catholic-affiliated (N=99)	Catholic-owned (N=45)
Characteristic			
Region			
Northeast	18.1	15.2	22.2
Midwest	29.2	27.3	37.8
South	31.3	33.3	24.4
West	21.5	24.2	15.6
Associated with one of the top 10 Catholic health care systems			
	53.4	53.5	53.3
Associated with a sole community provider			
	17.4	15.2	22.2
Service			
Birth control appointment***	95.1	100.0	84.4
Copper IUD appointment***	68.1	97.0	4.4
Tubal ligation appointment***	58.3	71.7	28.9
Abortion appointment	2.1	2.0	2.2

***p<.001. Note: “Catholic-affiliated” means that the clinic was not owned by a Catholic health care system, but had a business partnership with one. Source: Association with top Catholic health care system and sole community provider—reference 15.

In bivariate analyses, we found no differences in characteristics between Catholic-owned and Catholic-affiliated clinics, but several differences in services offered. Catholic-owned clinics were less likely than Catholic-affiliated ones to offer appointments for birth control (84% vs. 100%), a copper IUD (4% vs. 97%) and a tubal ligation (29% vs. 72%). There was no difference in relation to abortion; three clinics (two Catholic-affiliated and one Catholic-owned) offered this service, and two of these were in the Northeast. Other than type of Catholic association, no clinic characteristics were related to availability of appointments for birth control or copper IUD services (not shown); the availability of tubal ligation appointments was lower in the Northeast than in all other regions combined (31% vs. 64%), and lower among clinics affiliated with a large Catholic health care system than among others (51% vs. 67%).

Results of multivariable analysis confirmed that the likelihood of tubal ligation appointments was reduced at Catholic-owned clinics (odds ratio, 0.1; 95% confidence interval, 0.1–0.3), at clinics in the Northeast (0.2; 95% confidence interval, 0.1–0.5) and at clinics associated with one of the top 10 Catholic health care systems (0.3; 95% confidence interval, 0.2–0.8).

All seven clinics that did not agree to schedule a birth control appointment were Catholic-owned. Of these, four reported that they could provide methods for noncontraceptive indications only. Among the 43 Catholic-owned clinics that reported that they could not schedule a copper IUD appointment, 12 said that they could schedule a levonorgestrel IUD appointment; two specified that the device could be placed only for a noncontraceptive indication, such as “irregular bleeding,” and one explained that it used to offer the copper IUD, but “for some reason, the Mirena

TABLE 2. Percentage distribution of referrals obtained from Catholic-associated clinics that denied service appointments, by referral type, according to service requested

Referral type	Contraception (N=46)	Sterilization (N=60)	Abortion (N=141)
Direct	13.0	33.3	26.2
Indirect	34.8	25.0	31.9
None	52.2	41.7	41.8
Total	100.0	100.0	100.0

Note: Percentages may not add to 100.0 because of rounding.

[a levonorgestrel IUD] is very popular.” We do not know why the remaining clinics could not schedule a copper IUD appointment, as this was not specifically elicited with our telephone script.

The most common reason that Catholic-owned clinics could schedule a tubal ligation appointment (cited by 10 of the 13 that could do so) was that the provider had admitting privileges at a non-Catholic hospital. The most common reason that Catholic-affiliated clinics could not schedule a tubal ligation appointment (cited by 22 of 29) was that the provider had privileges only at a Catholic hospital. Three Catholic-affiliated clinics in the Northeast stated that the doctors prefer not to perform tubal ligations; as one explained, the reason for that is that “women have heavy periods after tubals.”

For each family planning service that was not offered, approximately half of the clinics did not provide any referral information (42–52%), and at most, one-third offered referral information that included a provider name and phone number (13–33%—Table 2). We found no difference in referral patterns by Catholic association. When callers were denied abortion services and asked what they should do, responses were highly variable and included “call Planned Parenthood” (35%), “I don’t know” (21%), “go look it up” (11%) and “referral is not allowed” (4%).

DISCUSSION

Access to family planning services affects women’s social and economic well-being.^{23–25} In this study of 144 obstetrics and gynecology clinics across the country that reported an association with a Catholic hospital, we found that sites did not uniformly refuse to schedule family planning service appointments, as one might expect, given the requirements of the church directives. Rather, their likelihood of making such appointments appeared to depend on the service requested and, mostly, on specific business relationships with Catholic health care facilities that either allowed or prohibited service provision.

Most alarming was our finding that unless callers inquired about specific services, they were not informed that the services were not offered. For example, when our callers simply requested birth control appointments, they were not informed that copper IUDs or tubal ligation would not be provided. This is concerning because it places the onus on the woman to be educated about birth

control options, to know what she may want before being counseled by a physician and to specifically check, when scheduling an appointment, if her preferred method will be available. Although institutional policy based on religious doctrine should be respected, the assumption that patients are aware of restrictive policies without having received relevant information up front is incorrect and can be considered unethical.²⁶

We do not know if the birth control appointments that were offered would have been restricted to counseling on natural family planning, which is in accordance with the directives; if they would have included other options, such as a prescription for oral contraceptives that can be obtained outside of the clinician’s office; or if the providers have relationships with other clinics that can provide these services. Regardless, women visiting Catholic clinics who decide they want highly effective methods will likely experience delays in uptake or need to rely on less effective methods, which places them at greater risk of an unplanned pregnancy. They may also incur additional costs for extra visits necessary to obtain the services they desire.

Also concerning was the finding that clinics were not transparent about their Catholic identity and how it affects women’s care. We found inconsistent adherence to the directives regarding contraceptive and sterilization services; the only family planning service consistently restricted was abortion. The most common reason for denial of services was the clinic’s ownership by a Catholic health care facility, but this usually was not revealed unless the caller inquired specifically. A lack of transparency was also apparent when we searched for clinics to meet our inclusion criteria. Online directories provided minimal information on religious affiliation and the likelihood of compliance with family planning–related directives, and no information about the business arrangements between the clinics and hospitals. In fact, 24 clinics denied any association with a Catholic hospital, even though we found their contact information on a Catholic hospital website. To improve women’s abilities to act as well-informed health care consumers, Catholic health care facilities should have a uniform approach to service provision that clearly delineates what they will and will not provide; alternatively, they should increase their transparency with regard to restricted services early in the appointment-making process and should improve their referral strategies.

Our study provides some insight into why many women do not anticipate restrictions on family planning services at clinics associated with Catholic institutions.^{18,19} Put simply, access was not completely restricted; more than half of all clinics offered to schedule an appointment for birth control, a copper IUD or a tubal ligation. Variations were strongly related to clinic ownership and affiliations. For example, many Catholic-affiliated clinics could not perform surgery because the doctor had privileges only at a Catholic hospital. On the other hand, some Catholic-owned clinics could schedule appointments for tubal ligation because

the doctor had admitting privileges at non-Catholic hospitals. Such arrangements are in opposition to the directives, which require that any partnership with Catholic health care institutional services respect church teaching and discipline,² and again demonstrate inconsistent adherence to the directives. We believe that because access at Catholic facilities is not uniformly denied and because multiple characteristics related to religious affiliations play a role in access, many women may not understand how Catholic ownership or affiliation affects their care.

Limitations and Strengths

There are limitations to our study. Our sample comprises 144 clinics associated with 26% of the 548 Catholic hospitals operating in the United States,¹ and we do not know if our findings are entirely representative. We obtained responses from individuals answering the phone, including patient care coordinators, who may not be aware of clinic policies related to reproductive health care. Our field sense during calls was that many of the referrals, or lack thereof, were reflective of individual responders rather than clinic protocols. Thus, we may have overestimated or underestimated providers' willingness to offer services or referrals. Further, we had a limited set of clinic characteristics with which to perform analyses, and other characteristics may be significant. For example, the finding that clinics in the Northeast and those associated with large Catholic health care systems were less likely than others to offer tubal ligations is difficult to explain. In addition, we did not examine appointment provision at non-Catholic institutions. We expect that contraceptive service provision is common at non-Catholic clinics, because institutional barriers do not exist; on the other hand, sterilization services may vary because of hospital or surgical center affiliations, and the majority of abortion services occur at freestanding clinics (e.g., Planned Parenthood sites).²⁷ Our findings of ubiquitous access to birth control, IUD and tubal ligation at the 24 clinics that we had initially identified as Catholic but were not, and at the clinics with business arrangements with non-Catholic facilities, support these expectations.

A strength of our study is that it simulates the real-life experience of U.S. women calling to request family planning services at obstetrics and gynecology clinics associated with Catholic hospitals.

Conclusion

Several points related to our study outcomes merit further investigation. Our study highlights the experience of women during the initial scheduling process. More research is needed to understand what happens when women are informed about restrictions at their appointment. For example, how often do women receive direct referrals from physicians? How do they feel about delays, especially if direct referrals are not provided? Is there a difference between the experiences of women in rural communities and those of women in urban settings? It is also

important to understand how women's experiences are associated with such variables as the influence of local bishops, providers' personal religious affiliations and providers' knowledge about the directives. Further, the perspectives of Catholic health care system leaders should be explored. Do these leaders intentionally prefer this lack of transparency to remain competitive in the health care market, or do they agree that improved transparency about their Catholic identity and restricted services is needed to better inform consumers? Gaining more insight from relevant stakeholders will better elucidate the relationship between Catholic directives and women's health care.

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