Close to half of pregnancies in the United States are unintended, and a large proportion of unintended pregnancies occur despite couples' use of contraceptives. There is good news, however. In this issue of *Perspectives on Sexual and Reproductive Health* (page 7), Aparna Sundaram and colleagues report that for all reversible methods combined, the rate of failure within the first year of use declined from 12% to 10% between the 2002 and the 2006–2010 rounds of the National Survey of Family Growth. The failure rate for a group of methods comprising all hormonal contraceptives and IUDs hit a record low for the United States, as did the rate for the condom. Long-acting reversible methods (the IUD and implant) have the lowest failure rates; condoms and withdrawal, the highest. (Despite the change in the failure rate for condoms, and an earlier decline in the one for withdrawal, the researchers point out that these methods' probabilities of failure are still relatively high.) Failure rates declined in almost every demographic subgroup examined, and although the analyses do not explain the changes, the authors suggest that "continued efforts to provide women and men with full access to available methods, and with public education to help ensure those methods are used effectively, may lead to even further declines in contraceptive failure rates and unintended pregnancy."

Also in This Issue

•In a somewhat similar vein, Rachel K. Jones and Jenna Jerman report (page 17) that the number of abortions performed in the United States fell by 12%, and the abortion rate by 14%, between 2011 and 2014. Although explaining the reasons for the changes was beyond the scope of the study, the researchers speculate that while declines in unintended pregnancy may have played a part, changes in service availability could also have contributed: The number of facilities providing abortions declined during the period examined; the most dramatic decline was in the number of clinics, which provide the majority of abortions. Some parts of the country were harder hit than others, but the investigators found no clear correlation between the state-level abortion policy context and the incidence of abortion. Future research, Jones and Jerman write, should explore the reasons for changes in abortion incidence and the number of providers. And given the continued passage of abortion restrictions, "subsequent research will need to monitor the accessibility of abortion services."

•When Amanda Gelman and colleagues set out to examine how a sample of low-income women obtaining abortions in Western Pennsylvania reacted to abortion stigma, they did not expect to find "pervasive" stigma within the sample itself, but that was one of their most striking findings (page 29). In qualitative interviews, women described partners, relatives and members of their broader communities as holding negative attitudes toward abortion, but "participants themselves were the most common source of disapproving attitudes." Women dealt with antiabortion attitudes (their own and those of others) in various ways—by emphasizing the uniqueness of their particular situations, experiencing negative emotions, and concealing or delaying their abortions. The researchers call for future work to determine the best ways to support low-income women in need of abortion, as well as to change community-level attitudes toward abortion. And they note that interventions need "to be mindful of not further stigmatizing women who do not have or plan to have children."

•When heterosexually active men who do not wish to be involved in a pregnancy also do not wish to use condoms or vasectomy, they must be able to talk with their partners about birth control options. To understand correlates of intention to have such discussions, N. Tatiana Masters and her team conducted an online survey of men aged 18–25 in 2010–2011 (page 37). They found men's likelihood of saying that they would talk with a hypothetical new partner about birth control to be positively associated with their attitudes toward such discussions, their perceptions of peers' attitudes and their confidence in their ability to have such discussions. The more strongly men endorsed a sexual script representing traditional gender roles, the less likely they were to express such intention. "Strategies that merit further exploration as potential supports for men's intention to discuss birth control," the authors comment, "include improving men's self-efficacy and positive attitudes and norms pertaining to such discussions, and reducing belief in traditionally masculine sexual scripts."

•Results of a pilot study suggest that computer-based family planning counseling aids merit consideration as a way for clinics to provide comprehensive counseling, Helen P. Koo and colleagues report (page 45). The tool that the researchers evaluated, Smart Choices, has two components, which are designed to encourage women's active participation in counseling and help providers identify issues that are important to address. First, when women visit a clinic, before seeing a provider, they fill out a computerized questionnaire that covers the social and medical topics that federal guidelines recommend be assessed in contraceptive counseling; second, they use the tool's interactive birth control guide to explore methods of interest. Study participants who received the intervention subsequently knew more methods, discussed more sexual health issues during counseling and rated their counseling as more patient-centered than women in a control group; however, they were less likely than controls to decide to use an IUD or implant. The researchers suggest that results of their evaluation "can help to inform the development of improved tools."

•"Sexual debut" is typically measured by first experience of vaginal intercourse, but this approach is irrelevant to many young people, especially those who are sexual minorities, as Shoshana K. Goldberg and Carolyn T. Halpern illustrate in a study based on data from the National Longitudinal Study of Adolescent to Adult Health (page 55). Latent class

analyses identified eight unique patterns of sexual initiation among sexual minority respondents, which were distinguished by the timing, sequence and spacing of first experiences of various behaviors; initiation patterns differed between males and females, and within each sex, they differed by sociodemographic characteristics. "This study," Goldberg and Halpern write, "serves as a reminder to clinicians and researchers of the importance of collecting information on sexual behaviors other than vaginal intercourse." Future work on sexual and reproductive health later in life should "aim to devise a sexual minority–specific model…that [accounts] for the social determinants, stressors and contexts unique to sexual minority populations."

—*The Editors*