Teenagers with older sexual partners are known to be at risk of poor health-related outcomes, but how an age gap between partners at sexual debut relates to later sexual health outcomes has received relatively little attention. Analyses by Saba W. Masho and colleagues reported in this issue of *Perspectives on Sexual and Reproductive Health* shed light on this question (page 77). Using data from National Survey of Family Growth respondents who first had intercourse before age 18, the researchers found that associations betweeen partner age gap at sexual debut and sexual health outcomes differed by respondents' sex and their age at first intercourse. For example, the likelihood of females' reporting a lifetime number of partners that exceeded the sample median was reduced if the age gap was five or more years, but only among those whose sexual debut occurred before age 15; it was reduced if the gap was 3–4 years, but only among those who first had intercourse at ages 15–17. Males' likelihood of reporting this outcome was elevated if first intercourse occurred before age 15 and the gap between partners was five or more years, or if debut was later and involved a gap of 3–4 years. The investigators recommend that future work aim at teasing out the mechanisms underlying these associations.

Also in This Issue

•Sexual and reproductive health care providers are well positioned to assess women for intimate partner violence and reproductive coercion. However, screening is uncommon in family planning clinics, and traditional approaches, which rely on women to disclose their experiences, may miss those who do not wish to do so. An intervention described by Elizabeth Miller and colleagues (page 85), which was designed to be delivered as part of routine care, showed promise in a trial in 11 Pennsylvania family planning clinics. The intervention provided education about pertinent resources and harm reduction strategies, and encouraged women to share educational materials with others. In qualitative interviews, clinic administrators reported that the intervention was feasible to implement; providers said that it increased their confidence in discussing violence and coercion with women; and women noted that it made them feel supported and less isolated, and empowered them to help others. Barriers to implementation also were discussed, as were areas that patients would like to see strengthened.

•When women have to travel long distances for abortions, the barriers to care mount and the consequences can be substantial, as Jenna Jerman and colleagues learned in a 2015 qualitative study (page 95). Interviewers spoke with 29 women seeking abortion services in Michigan and New Mexico. Both of these states are near at least one state that had harsher abortion restrictions; participating women had traveled either across state lines or more than 100 miles within state to obtain services. Women described 15 barriers to abortion care, which the researchers characterized as travel-related issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions. The effect of any particular barrier was unclear, but barriers often overlapped and exacerbated one another, leading women to delay seeking care, experience mental health problems or consider terminating the pregnancy themselves. The findings, the authors write, "highlight the importance of taking a holistic and broad view of the many barriers that women may encounter in seeking abortion services."

•Publicly funded family planning providers see large numbers of uninsured individuals, offer comfortable environments for clients to discuss sensitive issues and thus seem well suited to participate in health insurance outreach and enrollment efforts. In a 2014 survey of sites participating in California's Family PACT program, Jennifer Yarger and colleagues found that most were "actively engaged" in health insurance enrollment, providing eligibility screening, enrollment education, enrollment assistance or referrals for off-site enrollment support (page 103). However, the proportion offering each kind of assistance varied by clinic characteristics, including clinic type, specialty and receipt of Title X support. Lack of staff time, funding, physical space and staff expertise were cited as barriers to providing assistance. Whatever the fate of the Affordable Care Act, the authors observe, "women will continue to need contraceptive care and a wide array of preventive health services," and "publicly funded family planning providers will remain a gateway to comprehensive insurance coverage for those who are eligible."

•Sexual and gender minority youth are at heightened risk of HIV, yet are underrepresented in HIV research, partly because parental permission is often required for participation. To help inform institutional review boards' decisions on parental permission requirements for HIV studies, Brian Mustanski and colleagues conducted an online focus group that explored youths' perspectives on the issue (page 111). The sample of sexual and gender minority 14–17-year-olds saw few risks in participating in a hypothetical HIV study and noted several benefits, including that it would increase their likelihood of being tested. However, most said that they would be reluctant to enroll in a study if they needed their parents' permission; among their concerns were that a parental consent requirement would out them to their parents or lead to punishment. Noting that further empirical data are needed to inform ethical inclusion of sexual and gender minority youth in HIV research, the authors conclude that "such inclusion will ultimately help narrow disparities in sexual health between this vulnerable population and other youth."

•According to a number of literature reviews, there is no evidence that abortion causes mental health problems; however, little research has examined possible links between abortion-specific measures and the experience of mental disorders after abortion. To help fill that gap, a Dutch study, described by Jenneke van Ditzhuijzen and colleagues (page 123), followed a cohort of women who had abortions in 2010–2011 for an average of nearly three years to assess correlates of incident

or recurrent mental disorders. The "most remarkable" finding was that postabortion mental disorders were not related to any of the abortion-related variables studied, including having a second-trimester abortion, preabortion decision difficulty or negative emotions following the abortion. Having conceived within an unstable relationship, the number of negative life events experienced in the last year and having a history of mental disorders—all of which are risk factors for mental disorders in general—were positively associated with the outcome. The findings, according to the authors, imply that abortion-specific interventions are not necessary to help prevent women from having postabortion mental disorders.

—*The Editors*