Contraceptive use in the United States has been examined for decades, but attempts to place the U.S. picture in a global perspective have been rare. Brittni N. Frederiksen and colleagues do just that in this issue of *Perspectives on Sexual and Reproductive Health* (page 197), using data from two rounds of the National Survey of Family Growth to calculate three indicators of contraceptive use found in the United Nations Sustainable Development Goals (SDGs). They find that overall, contraceptive prevalence is fairly high, the level of unmet need is low and much of the demand for contraception is met by modern methods. However, variations by sociodemographic characteristics are evident. Moreover, on some measures, the United States is outperformed by several low- or middle-income countries. Comparative data for married women are available from 94 countries; 17 of these do better than the United States on at least one measure, and two do better on all three. "There is a need to continue efforts to expand access to contraceptive care in the United States," the authors conclude, "and to monitor the SDG indicators so that improvement can be tracked."

Also in This Issue

•Adherence to Catholic Church directives that forbid the provision of most family planning services in Catholic health care facilities is inconsistent, a mystery caller study by Maryam Guiahi and colleagues (page 207) reveals, but women may have a hard time ascertaining what services they can get at such sites. Investigators who phoned 144 Catholic-associated clinics inquiring about "birth control" services found that 95% would schedule an appointment; however, when callers asked specifically about copper IUD, tubal ligation or abortion services, the proportion dropped sharply. About half of the time that clinics refused to schedule a particular kind of visit, they also would not provide a referral so that women could get the service elsewhere. Given the inconsistencies and lack of transparency evident in the study, the investigators point out that women attempting to obtain family planning services from Catholic-associated clinics may need to use less effective methods than they desire or delay use while they seek care elsewhere.

•Women's happiness about giving birth is related to their sexual orientation concordance—that is, the consistency of their sexual identity, attraction and behavior. Using National Survey of Family Growth data, Caroline Sten Hartnett and colleagues show that heterosexual women who are attracted to or have sex with women are less happy about their births than are heterosexual women who are attracted only to men and have sex only with men (page 213). The difference is partly explained by two factors: The former group, or "heterosexual-identified discordant" women, are less likely than the latter to have intended to conceive, and their relationships with male partners are less favorable to childbearing than are those of "concordant" women. The "happiness gap" is larger if women had not wanted to become pregnant than if they had intended to. To help ensure that sexual minority women receive the care that best meets their needs, the authors recommend that providers "get in the habit of—and become comfortable with—asking women about their sexual attractions, behaviors and relationships."

•Dual method use, as defined by the World Health Organization (WHO), is consistent use of condoms along with other effective contraceptives to prevent both unintended pregnancy and STD transmission. Under a new definition, which takes into account HIV-positive women's viral load, the proportion of infected women who are protected against both becoming pregnant and transmitting the virus to sexual partners increases sharply, according to Angela Kaida and colleagues involved in the 2013–2015 Canadian HIV Women's Sexual and Reproductive Health Cohort Study (page 223). While two in 10 sexually active study participants aged 16–49 practiced the WHO strategy, four in 10 had dual protection because antiretroviral therapy had reduced their viral loads to undetectable levels and they used condoms consistently. The researchers note that condom use among HIV-positive individuals may be influenced by knowledge of the prevention benefits of antiretroviral therapy. Thus, they conclude, a dual protection strategy that does not rely on male-controlled condoms merits attention.

•Colleges' and universities' affirmative sexual consent policies often assume that miscommunication is the root cause of sexual assault and, therefore, that reducing the potential for misunderstanding will reduce the risk of assault. However, the matter is not so simple, as Kristen N. Jozkowski and her team learned through in-depth interviews with 30 college students (page 237). Women and men alike described a sexual double standard that makes it very difficult for women to refuse unwanted advances, largely because of norms dictating that women should put men's needs ahead of their own and that when men "work" to attract women—by buying them drinks, for instance—women "owe" it to them to have sex. Furthermore, men's discussions highlighted their view that obtaining consent is a game and that winning is important, even if it takes some effort to "convince" women. The authors write that as long as college students "defer to the traditional sexual script,…consent promotion initiatives may, whether intentionally or not, perpetuate a sexual double standard."

•Interviews with 21 U.S. servicewomen who had sought abortion services while on active duty, described by Kate Grindlay and coauthors (page 245), revealed the difficulties of the experience. The military's health insurance program covers abortion only in limited circumstances, and most of the women were not aware of that. In some ways, these women's abortion experiences were similar to those of U.S. women in general: Participants recalled logistical difficulties, apprehension about privacy

and stigma, and concerns about effects on their careers. However, they also discussed issues specific to the military context. For example, they noted that servicemembers who are stationed in regions with substandard health care may have few provider options and that if lack of insurance coverage or services forces personnel to have unwanted births, the consequences could extend to negative effects on troop preparedness and financial costs for the military. The authors call for wider dissemination of the military's policy about abortion and greater support for military personnel who need services.

—*The Editors*