IN THIS ISSUE

While it is clear that sexual minority young men have an elevated risk for HIV and other poor health outcomes, it is less clear whom, exactly, that group comprises. In this issue of *Perspectives on Sexual and Reproductive Health*, Amy M. Fasula and colleagues propose a broad definition of sexual minority status—encompassing identity, attraction and behavior—and examine its prevalence and correlates among U.S. men aged 15–24 (page 3). Applying their definition to data from three rounds of the National Survey of Family Growth, they find that 10% of men in this age-group can be categorized as sexual minorities. Among those who provided data on all relevant measures, nearly one in five reported same-sex attraction, identity and behavior; however, roughly the same proportion considered themselves heterosexual yet reported same-sex behavior.

What does all of this mean? Fasula and her coauthors note that little research is available that can help guide the development of effective, comprehensive HIV prevention approaches for young sexual minority men—research that, for example, identifies sexual minority men who are especially vulnerable to infection or assesses the particular needs of specific subpopulations. The population-level descriptive information presented in their article, they contend, "[lays] a foundation for future studies" that might begin to fill these gaps.

Also in This Issue

•Rural-urban variation in provision of family planning services in the United States has received little research attention, and existing measures that dichotomize geographic areas as rural or urban may obscure differences that would be apparent on a finer scale. In a study of 558 Title X–supported clinics in 16 states (page 9), Summer L. Martins and colleagues use rural-urban commuting area codes to categorize clinic sites on such a scale, distinguishing among locations described as urban, large rural city, small rural town and isolated small rural town. And they find substantial disparities across categories. For example, the proportion of clinics that offered appointments on a walk-in basis or during evening or weekend hours was significantly lower in the most isolated locations than in any other setting; differences also were seen in the proportion of clinics offering particular contraceptive methods. The findings, according to the authors, "suggest an opportunity for improving access to care among rural women."

•Confidentiality is a major concern for adolescents seeking contraceptive care, and a mixed-methods study by Tishra Beeson and her team (page 17) reveals inconsistencies in and confusion about practices related to confidentiality in federally qualified health centers. In a 2011 survey that asked centers which of five common practices they used to ensure adolescent patients' confidentiality, 93% reported using at least one, but only 5% used all five. Participants in case studies indicated that "a lack of protocols or procedures to ensure adolescent confidentiality appears to be undermining this important protection." The authors urge the Health Resources and Services Administration, which oversees federally qualified health centers, to develop guidelines that would "clarify legal responsibilities and establish standards" for these centers and thereby help them improve the services they provide to adolescents.

•Female adolescents who have older male partners are known to be at risk for several adverse physical health outcomes; in analyses of data from the National Longitudinal Study of Adolescent Health, Ann Meier and colleagues show that they may be at risk for poor mental health outcomes as well (page 25). Using information from women who were sexually inexperienced at Wave 1 and had had at least one romantic relationship by Wave 2, the researchers found a greater increase in depression between waves among those reporting a partner at least one year their senior—regardless of whether the relationship involved sexual activity—than among those reporting a nonsexual relationship with a partner closer to their age. The authors acknowledge that their study represents only a first step toward understanding associations between age-disparate relationships and mental health outcomes, but conclude that "focusing exclusively on physical and reproductive outcomes…underestimates the potentially harmful outcomes related to other dimensions of health and well-being."

•A great deal of research has explored the health consequences of unintended pregnancy, but much less has focused on social outcomes. In a study of women who gave birth in Oklahoma in 2004–2008, Isaac Maddow-Zimet and colleagues examine associations between pregnancy intention and mothers' transitions into and out of marriage within the child's first two years (page 35). They find that among women who were married when they conceived, those whose pregnancy had been unwanted were more likely than those whose pregnancy had been intended to no longer be married when their child turned two; among women who had conceived outside marriage, those whose pregnancy had been unwanted had reduced odds of marrying within two years of giving birth. Intention status was not associated with a change in marital status between conception and birth. The relationships between unintended pregnancy and marriage, the authors write, require further study and may "play an important role in the health and well-being of American families."

•The Digests section (page 45) contains summaries of studies on the link between men's attitudes toward homosexuality and their risk-related behaviors, the quality of physicians' communication about human papillomavirus vaccination, U.S. women's willingness to increase the interval between cervical cancer screenings and more.

—*The Editors*