Young women who experience intimate partner violence or reproductive coercion have elevated risks of becoming pregnant unintentionally and acquiring an STD, and it seems reasonable to expect that those who feel confident in their ability to negotiate condom use and refuse unwanted sex may be able to reduce those risks. However, as Kelley A. Jones and colleagues report in this issue of *Perspectives on Sexual and Reproductive Health* (page 57), that was not the case in a sample of women recruited at Pennsylvania family planning clinics. Participants who had recently experienced intimate partner violence or reproductive coercion were more likely to report an STD diagnosis and had less condom negotiation self-efficacy than women not reporting these forms of abuse; those reporting reproductive coercion had elevated odds of having had an unintended pregnancy in the past year. Findings differed somewhat between adolescents and young adults, but for the most part, condom negotiation self-efficacy did not mediate associations between abuse and STD diagnosis or unintended pregnancy.

Noting that women who are confident in their ability to negotiate use of condoms may not be able to persuade their partners to use them, Jones and her team consider it unlikely that targeting condom negotiation self-efficacy will improve sexual health outcomes among those in abusive relationships. Rather, they recommend that future research seek to identify "more salient constructs of safer sex practices."

Also in This Issue

•Providing high-quality family planning services means, among other things, counseling pregnant women about all of their options—pursuing parenthood, placing their baby for adoption or having an abortion—and offering referrals for appropriate services if they are not available on-site. As Luciana E. Hebert and coauthors report (page 65), publicly funded facilities, a crucial source of care for low-income women, do not always offer the full range of options counseling or have the information necessary to make referrals. Of 567 publicly funded facilities surveyed in 16 states, 97% made referrals for adoption services, but only 84% referred women for abortion services. Fewer than nine in 10 respondents said that their facility had a list of abortion providers; 12% did not know where the nearest provider of first-trimester abortions was located, and 31–33% did not know where women could go for second-trimester or medication abortions. Provision of some components of options counseling was linked to facility type or location (urban versus rural).

•A qualitative study by Whitney Smith and fellow researchers sheds light on how young women in the U.S. South, who are at disproportionate risk of unintended pregnancy, perceive the social norms and stigmas that surround this outcome (page 73). In focus group discussions and cognitive interviews, low-income 19–24-year-olds in Birmingham, Alabama, reported that in their community, women faced with unintended pregnancies are stigmatized or even shunned, and are expected to bear and raise their children; abortion and adoption are considered unacceptable, and the choice to parent is seen as "an act of selflessness, strength and responsibility, regardless of socioeconomic circumstances." The shame attached to having an abortion, participants noted, drives many women to keep their abortions secret. According to the authors, their findings "suggest a need to reduce stigma and create a social environment in which young women are empowered to make the best reproductive decisions for themselves."

•Results of a longitudinal study of young adult Michigan women suggest that women's assessments of the potential personal consequences of early childbearing independently predict this outcome, Sarah K. Hayford and colleagues report (page 83). At baseline, most participants, who were interviewed weekly for up to 30 months beginning in 2008–2009, did not want a child and perceived pregnancy to have more costs than benefits. In multivariable analyses, those who became pregnant during follow-up were shown to have had more positive perceptions than others at baseline of how a pregnancy would affect their lives and how their friends would react to their becoming pregnant. Fertility desires and general perceptions of the costs and benefits of early pregnancy were among the measures that were not significant. The researchers contend that it is necessary to explore how perceived benefits of pregnancy affect women's contraceptive use and what unintended pregnancy means to women who consider early pregnancy to have benefits.

•Allowing nurses to dispense hormonal contraceptives during home visits may be a way to reduce the barriers to use of effective methods that are associated with clinic-based provision. In a nurse home-visit program in Washington State, described by Alan L. Melnick and colleagues (page 93), first-time mothers who had been randomized to receive enhanced care, in which nurses were allowed to provide hormonal methods, reported fewer days without use of an effective contraceptive during the first 90 days postpartum than women who did not receive that component of care. Although no differences were found in the remainder of a two-year follow-up period, the authors consider the results "promising," since many participants were adolescents, who are "particularly at risk of clinical, social and economic complications of pregnancies beginning within three months postpartum." Whether this approach could be "an effective, ongoing family planning intervention," the investigators write, merits further attention.

•The Digests section of this issue (page 101) contains summaries of research on the link between youths' abuse of prescription drugs and their sexual risk behaviors, sexual and reproductive health outcomes among young people who break an abstinence pledge, provision of contraceptives to young women who are prescribed teratogenic drugs and more.

—*The Editors*