IN THIS ISSUE

Production for this issue of *Perspectives on Sexual and Reproductive Health* was wrapping up amid the profound uncertainty triggered by the U.S. presidential election upset. As the hopefulness of the days leading up to the election give way to feelings of bewilderment and foreboding, the sexual and reproductive health and rights community—like so many other social and political sectors—will have to redouble its efforts to limit the damage and try to at least maintain the status quo. One key area of concern, particularly given the multitude of restrictions put in place in recent years, is abortion. The number of abortions that occur in the United States every year, the scarcity of services, the challenge of reducing levels of unintended pregnancy—all of this is familiar territory. What often gets lost in the statistics and the debate, however, is how the abortion experience plays out for the people involved: the women who need to find affordable services in a timely way, the partners who support them through the process and the practitioners who provide the care. At this critical moment in our nation's history, *Perspectives* is proud to present a special issue devoted to these topics. When we planned this issue, our hope was that the work it brings together would help point the way toward undoing some of the damage that has been done by past policies, and ensuring that newly elected officials and others understand the value of making abortion available as a matter of basic reproductive health, free of stigma and of restrictive policies and practices. We may need to recalibrate our expectations now, but we remain committed to the notion that good, solid science is the only appropriate foundation for the policies and practices that affect women's and men's sexual and reproductive health.

Following is what you will find in this issue.

•In an analysis of 40 American TV shows that featured plotlines involving abortion between 2005 and 2014 (page 161), Gretchen Sisson and Katrina Kimport found that "legal abortion care using medical methods was depicted as effective and safe, and legal providers were presented as compassionate, while providers operating outside of medical and legal authority were depicted as ineffective, dangerous and uncaring." Although portrayals of abortion providers to some extent reflected the genres of the shows in which they appeared or the periods in which they were set, these differences, according to the authors, suggest that abortion remains stigmatized. At the same time, Sisson and Kimport write, the differing treatments of abortion providers indicate that placing abortion in a medical context can help reduce stigma and that cultural media may have a role to play in that process.

•In a systematic review of the English- and German-language literature through early 2015 (page 169), Franz Hanschmidt and colleagues identified 14 studies, both quantitative and qualitative, addressing abortion stigma. Most of the studies were U.S.-based, but Africa, Latin America and Great Britain also were represented. Findings indicate that women who have had abortions often fear being judged socially and feel a need to keep their abortion a secret; secrecy, in turn, is frequently linked to psychological distress and social isolation. Abortion providers, too, experience stigma; as a result, some report that they avoid disclosing the kind of work they do, and some say that they have difficulty doing their work effectively. The review turned up little evidence on interventions aimed at reducing stigma.

•In 2012, Utah became the first state to require that women seeking abortions wait 72 hours after receiving face-to-face counseling before having the procedure, ostensibly to ensure that they are certain about their decision. Sarah C.M. Roberts and colleagues surveyed a cohort of women who sought abortions at four clinics in Utah in 2012–2013 and found that few women were conflicted about the decision at the time of the counseling visit; three weeks later, most had had the abortion or still planned to have it (page 179). Decisional conflict at the first visit was the strongest predictor of whether women had an abortion within the next three weeks. During the wait, which averaged eight days, the predominant difficulty women reported was that they simply wanted the procedure to be over with. The authors suggest that individualized counseling for women who seem unsure of their abortion decision may be more appropriate than blanket waiting requirements.

•Texas, too, has passed highly restrictive abortion laws in recent years, mandating, among other things, that providers have admitting privileges at a nearby hospital and that abortion facilities, even ones that offer only medical abortion, meet the standards of ambulatory surgical care centers. Yet, Kari White and her team report that Texas women aged 18–49 surveyed in 2014–2015 were largely unaware of these laws (page 189). One-fifth of women with any awareness of the laws supported them, largely because they mistakenly believed that the laws would make abortion safer. The 2016 Supreme Court decision in *Whole Woman's Health v. Hellerstedt* struck down the onerous restrictions on providers and facilities, but White and colleagues' findings stand as a reminder that misperceptions or lack of knowledge about abortion can affect policies and public opinion.

•In 2014, when Judy Margo and colleagues (page 199) conducted in-depth interviews with 45 women obtaining abortions in South Carolina, state regulations governed several facets of abortion provision—including gestational limits, waiting periods and insurance coverage—and the state had only three freestanding abortion clinics. Nearly half of study participants had had contact with a medical professional to establish or confirm their pregnancy, but few had been given referrals for abortion. Some who had received referrals had felt judged by the referring provider, and one had been advised to visit a crisis pregnancy center; a few women who had sought out services on their own had inadvertently found themselves contacting crisis pregnancy centers. The findings, the authors comment, illustrate the need for a "wider net"

of committed, trained professionals who can support women in need of timely, affordable and nonjudgmental abortion care.

•Women who wish to include male partners in the abortion process may benefit from their involvement, according to findings from a systematic review of the literature by Anna L. Altshuler and colleagues (page 209). The researchers found 15 studies, conducted in six countries and published between 1985 and 2012, that examined male involvement at various points in the process and its associations with women's abortion experiences. Although the evidence is limited and "not high-quality," it shows that partner involvement generally is positively associated with women's emotional comfort and assessment of the abortion experience; none of the studies revealed any negative associations. Further research is warranted, according to the authors, because "if inclusion enables men to better comprehend the experiences of their partners, it may not only strengthen couples' relationships, but also help men become stronger advocates for women in general."

•In a comment piece, Katrina Kimport looks at the structural differences between the abortion rights and marriage equality movements to gain insight into why they have not been equally successful (page 221). She concludes that the marriage equality movement has had in place "all the components for success": broad-based organizational participation, the ability to appeal to different audiences and employ innovative strategies, a "frame" for its message that resonates with diverse groups and, over time, increasing political support. The abortion rights movement, by contrast, has been dominated by a small number of more homogeneous organizations that take a conventional approach and, despite notable victories, have faced an unsympathetic political climate. Kimport observes that although the structure of movements alone does not account for social change, lessons from the marriage equality movement may suggest "areas where the abortion rights movement could invest resources to change its fortunes."

•Sarah K. Cowan and colleagues argue in their comment (page 229) that the absence of estimates on the lifetime prevalence of abortion among American women, due largely to the well-established underreporting of abortion history in surveys, is a "glaring gap": It contributes to the spread of misinformation and impedes understanding of the implications of restrictions on abortion availability, as well as of abortion trends, patterns and disparities. The authors report on a pilot study of an estimation technique based on an approach that was developed to explore sensitive issues by not asking about them directly. Results indicated that the "double list" approach did, indeed, yield greater reporting of abortion than did a direct question about abortion history. Thus, while noting its weaknesses, the authors consider it a potentially useful strategy for estimating lifetime abortion prevalence.

•The Digest section of this issue (page 235) presents summaries of research on how long it takes for U.S. women to obtain an abortion after they have made an appointment for one, teenage pregnancy risk among women of different sexual orientations, preconception care at publicly funded clinics and more.

—*The Editors*