Having a disability does not preclude the possibility of a woman's having a healthy pregnancy with a good outcome, but adverse outcomes are more common among women with disabilities than among others. Ensuring that women with disabilities can plan their pregnancies is thus critical, yet research on contraceptive use within this population is scant. In this issue of *Perspectives on Sexual and Reproductive Health* (page 141), Justine P. Wu and colleagues fill in some of the gaps. Analyzing data from the 2011–2013 National Survey of Family Growth (NSFG), they find that four in 10 U.S. women who have physical or sensory disabilities are at risk of unplanned pregnancy, and three in 10 of those at risk—an estimated 2.1 million women nationwide—use no contraceptives. Use of both moderately effective (i.e., hormonal) methods and highly effective ones (i.e., IUDs and implants) is significantly less common among women with disabilities than among others. The difference in use of moderately effective methods may reflect that women with disabilities are more likely than others to smoke, be obese, or rate their health as fair or poor—all of which make them poor candidates for hormonal contraceptive use. However, the disparity in use of highly effective methods is more puzzling, given that women with disabilities have elevated odds of saying that they want no children in the future and that a doctor has advised them never to become pregnant; barriers associated with the clinical visits entailed in IUD and implant use may be part of the explanation. The authors call for more research on these disparities, as well as on differences in contraceptive use by type and severity of disability.

Also in This Issue

•When are long-acting reversible contraceptive (LARC) methods *too* effective? Some of the young adult women in a qualitative study by Jenny A. Higgins (page 149) related that because an "accidental" pregnancy would not necessarily be unwelcome, LARC methods—IUDs and implants—are too effective, long-term or "permanent." All of the participants recognized that these methods are reversible, but some considered removal procedures cumbersome and felt that LARC methods reduce women's contraceptive agency. Those who were not receptive to LARC use expressed what the author characterizes as "shifting fertility desires, ambivalence or soft hopes to have a baby in the not-too-distant future." Participants who were open to using IUDs or implants, by contrast, were strongly motivated to avoid pregnancy. Women's thinking about LARC methods was also colored by their age, where they stood vis-à-vis educational or career goals, and their relationship context. While urging continued efforts to ensure LARC methods' availability, Higgins stresses the importance of respecting that some women will choose other methods "even when fully informed of their options."

•Adult sexual minority women have an elevated risk of unintended pregnancy, according to analyses of 2006–2010 NSFG data by Bethany G. Everett and colleagues (page 157). In the five years before the survey, the proportion of women who had had a mistimed pregnancy was significantly higher among respondents who identified as heterosexual and reported same-sex experience than among their peers who considered themselves heterosexual and reported only male partners; the proportion who had had an unwanted pregnancy was greater among bisexual women than among heterosexuals reporting only male partners. Multivariate analyses confirmed these results and also showed an elevated risk of unwanted pregnancy among lesbians. Two risk-related characteristics that were particularly prevalent among sexual minority women—forced sex and early sexual debut—were included in the models but did not explain the disparities. "Given the social and economic consequences of unintended pregnancy," the authors write, "understanding populations at greatest risk for this outcome is of critical public health and social importance."

•Federal and clinical guidelines recommend that all women, men and couples be encouraged to have a reproductive life plan and that such plans be assessed during routine family planning service visits to help ensure the provision of appropriate preconception care; little research has explored the extent to which relevant written protocols exist and recommended care is provided. As a start, Cheryl L. Robbins and colleagues surveyed administrators and providers at a nationally representative sample of publicly funded sites that provided family planning services in 2013–2014 (page 167). Three-fifths of sites reportedly had written protocols for reproductive life plan assessment, and nine in 10 reportedly conducted such assessments frequently; half reportedly provided preconception care frequently. In multivariate analyses, reported existence of a written protocol was positively associated with reports of frequent assessment, and the latter was positively associated with reports of frequent provision of preconception care. Acknowledging that their study only "begins to characterize" the relationship between reproductive life plan assessment and delivery of preconception care, the authors comment that "the value of written protocols…merits attention."

•Despite the increasing inclusion of men in family planning services and research, studies of contraceptive use still generally rely on information gathered only from women. This approach, however, may be limited by the assumptions that women's preferences count more than men's and that couples are sociodemographically homogamous. To assess the contribution of a couple perspective, Mieke C.W. Eeckhaut used both a traditional, "individualistic" approach (employing multinomial logistic regression) and a couple approach (employing multinomial logistic diagonal reference models) to measure sociodemographic differences in reliance on sterilization (page 173); data were from female respondents to the 2006–2010 and 2011–2013 rounds of the NSFG. Results suggest that when sociodemographic homogamy is high, the two approaches yield minimal differences; when it is low, the couple approach may produce a more nuanced picture of differences in use. Eeckhaut points out

that the couple approach, like the individualistic one, has limitations, and that "since both…can advance the understanding of differentials in contraceptive use, the decision of which to use ultimately depends on the analytic goal."

•American Indian and Alaska Native men have poorer sexual health outcomes than white men. Yet their use of relevant services is not well understood, and evidence based on nationally representative data has been lacking. Using 2006–2010 NSFG data, Megan A. Cahn and colleagues take a national-level look at the prevalence and correlates of two types of sexual health care—birth control services and STD or HIV services—within this population (page 181). They find that overall, American Indian and Alaska Native men are as likely as white men to have received both types of services in the past year. In some demographic subgroups, however, the former are more likely than the latter to have used STD or HIV services. Among American Indians and Alaska Natives, having a usual source of care is positively associated with use of each type of care; other correlates of use differ between the two. The results, the authors conclude, "provide a baseline against which future researchers can assess whether [national] objectives are being met in this population."
—*The Editors*