'Presentation of numerical data' we have provided a very basic example used by one of us in our PhD research.[1]

In response to Dr Guest's reference to content analysis, we would like to raise one more methodological question, namely: 'When does qualitative research really become quantitative research?' Content analysis as outlined in this month's article is obviously a qualitative research method. However, there are other forms of content analysis, such as those used in media studies where one can ask: 'Which paper, *The Daily Planet* or the *Evening Herald*, offers its readership more on sexual health?' One can approach this question by defining what is 'sexual health' and subsequently simply measuring space dedicated to the topic (column centimetres). This would constitute content analysis as a quantitative approach. However, if one studies differences in the tone and underlying message of two papers, each article needs to assessed and allocated into a theme. This would constitute content analysis as a qualitative approach.

We concede that we have not covered the whole range of qualitative methods nor possible sampling strategies; instead we covered the most commonly used methods in the reproductive health field. For example, we have not included: (a) action research, (b) participatory action research, (c) discourse analysis, (d) conversation analysis, and so on. Finally, we welcome the reference to fora for innovation in this field provided by Dr Guest, which is indeed much broader than typically portrayed in medical and health science journals.

Edwin van Teijlingen, Med, PhD
Reader in Public Health, Public Health and Dugald Baird Centre, University of Aberdeen, Aberdeen AB25 2ZD, UK. E-mail: van.teijlingen@abdn.ac.uk

Emma Pitchforth, BSc, PhD
Department of Health Sciences, University of Leicester, Leicester, UK

Maureen Porter, MSc, PhD
Department of Obstetrics and Gynaecology, University of Aberdeen, Aberdeen, UK

Karen Forrest Keenan, MA, MLitt
Public Health and Department of Medical Genetics, University of Aberdeen, Aberdeen, UK

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News Roundup

Mobile phone technology to the rescue

The youth of today spend large amounts of time texting each other on their mobile phones. Brook have utilised the fashion and the technology to give young people access to information about sexual health. The new service gives young people instant access to information on a range of topics, including sexually transmitted infections, contraception and counselling, as well as details of their nearest Brook Centre or young people's clinic, all via their mobile phones. Brook introduced the service to compensate for the postcode lottery that affects the amount of information that young people can access. By texting BROOK HELP to 81222, users will receive a menu of options, giving them access to automated information on key sexual health topics or details of their nearest young people's sexual health service. This is in addition to their comprehensive website at http://www.brook.org.uk.

Depo-Provera and bone density again

Just in case anyone did not see the information from the Committee for Safety of Medicines,[1] their current advice on Depo-Provera® is as follows:

- In adolescents, Depo-Provera may be used as first-line contraception but only after other methods have been discussed with the patient and considered to be unsuitable or unacceptable.
- In women of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use for more than 2 years.
- In women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered.

It has gradually become clear that, for some women, bone loss occurs during the time they are using Depo-Provera and recovers by a variable amount after stopping the method. This is particularly undesirable in adolescents who have yet to attain their peak bone mass. The highest risk for low bone mass is in those (young) women who smoke, eat a poor diet and do not exercise. Unfortunately, this group of (young) women is also most likely to find combined oral contraceptives difficult to manage in a reliable way.

Depo-Provera gives very reliable contraception with few risks to health. It can give valuable breathing space for a disorganised young woman, not ready for a pregnancy, but not yet in control of her life sufficiently to take oral contraceptives regularly or contemplate a longer-acting method like an implant. Discuss all the methods of contraception and help the woman to choose the method that has the least risks for her at that phase of her life. It would be a pity if fear of low bone mass resulted in unwanted pregnancy.

Using Depo-Provera long-term has always been a minority choice in the UK. We need to ensure that women have all the facts and can make an informed choice about their continuing contraception. You might like to refresh your mind with all the discussion points from the Faculty of Family Planning and Reproductive Health Care[2,3] and a review of the recent papers discussing this topic will appear in a future issue of the Journal.

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1 http://medicines.mhra.gov.uk/ourwork/monitorsafequalmed/safetymessages/Depo-Provera_letterhealthprofs_181104.pdf.
2 http://www.ffprhc.org.uk/meetings/factreview.pdf.
3 http://www.ffprhc.org.uk/YoungPeople.pdf.

Keep taking the medicine

Bandolier examines compliance with medication in an interesting article that includes looking at compliance with contraception.[1] An analysis of perfect and imperfect use of a patch and oral combined contraception had pregnancy as an outcome.[2] Perfect use was defined as 21 consecutive days of either the patch or taking the oral contraceptive. Information was obtained from diary cards on an ongoing basis. I was amazed at the number of 'perfect' cycles – but then this was a clinical trial, not real life. Imperfect use increased the pregnancy rate by between five and ten times, although the total number of pregnancies was small in each group. This reminds us that contraception which is not dependent on human activity or memory works better every time.

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1 http://www.jr2.ox.ac.uk/bandolier/band127/b127-4.html.
2 Archer DF, Cullins V, Creasy GW, Fisher AC. The impact of improved compliance with a weekly contraceptive transdermal system (Ortho Evra®) on contraceptive efficacy. *Contraception* 2004; **69**: 189–195.

Ideological constraints on women's health

A National Protocol for Sexual Assault Medical Forensic Examinations[1] was published in September 2004 by the US Department of Justice, Office on Violence Against Women. No mention of emergency contraception is made in the document. Detailed and extensive advice on the identification and prevention of sexually transmitted infections (STIs) is included. The only mention of the pregnancy risk is the following:

"Recommendations at a glance for health care providers to evaluate and treat pregnancy:

- *Discuss the probability of pregnancy with female patients.*
- *Administer a pregnancy test for all patients with reproductive capability.*
- *Discuss treatment options with patients, including reproductive health services."*[1]

It is feared that the document has been influenced by the desire to avoid controversy with the anti-abortion groups in the USA who believe that life begins at conception and that the prevention of implantation (which might be produced by emergency contraception) is murder.

Other instances of the difficulties produced by the anti-abortion pressure groups and the support given to them by President Bush are well documented.[2] The Emergency Plan for AIDS Relief provided by the USA exists in parallel with the Global Fund to fight AIDS, Tuberculosis and Malaria from the United Nations. The president's programme has been criticised as diverting funds from the Global Fund, and organisations that receive funds from the programme are usually required to agree not to be involved in abortion provision or counselling. This is difficult in countries where women may only have access to one clinic that provides all health care for them whether that is contraception, abortion or treatment for AIDS. The expected changes in the composition of the Supreme Court will help to push forward a review of abortion legislation. Social policies emphasise fundamentalist views on sexuality, including the promotion of abstinence as the only means of preventing pregnancy.[3] It is feared that women's health will suffer and unwanted pregnancies will increase.[4]

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3 Perrin KK, DeJoy SB. Abstinence-only education: how we got here and where we're going. *J Public Health Policy* 2003; **24**: 445–459.
4 Girard F. Global implications of US domestic and international policies on sexuality. IWGSSP Working Papers, No. 1. New York, NY: Columbia University, 2004. http://www.mailman.hs.columbia.edu/cgsh/IWGSSPWorkingPaper1English.pdf.

Collated and reported by **Gill Wakley**, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance GP, Writer and Lecturer, Abergavenny, UK