Letters to the Editor

Teen magazines

It's great to see such a comprehensive and considered piece[1] that talks to a range of people, particularly teenagers themselves, whose views are often left out of the debate. Young people will always find a way to read teen magazines – if they're not allowed them at home they'll probably go round to a friend's house!

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Reference
1 Quilliam S. 'Teen mags': helpful or harmful? *J Fam Plann Reprod Health Care* 2005; **31**: 77–79.

Cerazette® licence extension

I welcome the extension to the Cerazette® 'missed pill' licence up to 12 hours[1] as it facilitates concordance by offering a longer therapeutic window and minimises confusion in pill taking as the rule is similar to that of the combined oral contraceptive pill (COC). The extension of the missed pill licence for Cerazette offers better adherence as well as inhibition of ovulation,[2] and increases the contraceptive choices available to youngsters who cannot take the COC on account of medical risks or who cannot accept the invasiveness of long-term implants. Young girls worry that their mothers may suspect a pregnancy if they have amenorrhoea or gain weight on implants. Cerazette may also be used when clients are unable to provide their family medical history. I give below an account of a client who changed my prescribing habit.

It was at the end of a busy clinic when I saw this young 16-year-old girl, and the underlying message is undeniably imprinted in my memory. She accessed the clinic for emergency contraception and it is my usual practice to talk about future contraception. Her father had suffered from pulmonary embolism. She informed me that he was under 45 years old and gave no risk factors for venous thromboembolism (VTE).

I was impressed by the amount of medical information this young girl could give me and wondered whether my children of similar age would remember details of their parents' medical histories. I offered the patient a thrombophilia screen and with her consent gave her a letter requesting detailed medical information from her general practitioner. She was disappointed that I could not prescribe her pills with a longer therapeutic window similar to the ones her friends were taking. Progestogen-only contraceptive implants were unacceptable because of amenorrhoea and the progestogen-only pill was not acceptable because of concordance and efficacy issues. At the time I was accused of being overcautious and the general consensus was that I should have prescribed a COC.

A few months later I learnt that this girl had developed femoral vein thrombosis and was being treated at the local hospital with anticoagulants. This young client was so determined to get the COC that she went to another clinic, concealed the family history of VTE, and was prescribed COC. Surprisingly, she saw the same nurse, a very competent senior family planning nurse, who is very thorough and meticulous with history taking and other details and would not have missed out any relevant family history of clotting disorders. This girl deliberately concealed the facts in order to get a prescription of the COC.

I see many adolescents who are in care, or have been adopted, and hence cannot provide the medical history of their families. I am always reminded of this girl when I prescribe COC for the first time.

I acknowledge the lack of evidence on the safety profile of Cerazette to prescribe it routinely as the first-line pill or as a replacement pill for the COC, which regulates periods and mimics the natural cycle. Nonetheless, it is possible that as with progestogen-only emergency contraception, we may have enough evidence in future to change the prescribing habits of health professionals offering contraceptives to youngsters.

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References
1 Cerazette (UK SMC 03 Cera v1.3). *Electronic Medicines Compendium*, 8 July 2004. http://emc.medicines.org.uk/emc.
2 Korver T, Klipping C, Heger-Mahn D, Duijkers I, van Osta G, Dieben T. Maintenance of consistent ovulation inhibition with the 75-mug desogestrel-only contraceptive pill (Cerazette®) after scheduled 12-h delays in tablet intake. *Contraception* 2005; **71**: 8–13.

FPC prescribing

One of the issues raised at the Faculty's Current Choices Conference in November 2004 has become more pertinent in view of the changes to general practitioner (GP) out-of-hours work. It seems most family planning clinic (FPC) doctors are not able to prescribe on FP10s, and hence not able to complete patient care effectively. Does any one else find this a problem?

Take the following scenario. It's a Friday evening clinic, which is running late. A lady attends in whom you fitted an intrauterine device (IUD) 2 weeks ago. You diagnose a pelvic infection secondary to her IUD fitting. You write a letter to the GP, and she has to find time and energy to attend the out-of-hours clinic. Then she has to wait for a doctor's consultation and prescription. If the chemist is not local she may well have to wait till morning.

This scenario causes extra journeys for patients, and will involve extra cost. As a result, advice is not taken and antibiotics are not sought in a timely fashion. The out-of-hours doctor may be busy, and is unlikely to be the patient's own GP. Keeping a selection of drugs on the FPC premises may mean wastage, as some will inevitably go out of date.

Most of us working in FPCs are actually employed by the local Primary Care Trust. By prescribing we can ensure a patient's care is effective, efficient and has continuity – this is surely in everyone's interests. Why duplicate work? Surely it makes sense to allow prescriptions to be written within a FPC setting.

In Swindon we can prescribe on FP10s, to which we add the patient's GP code. We don't use it often and we have agreed within our department which drugs we will be happy to prescribe. I do believe this enhances patient care.

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Range of qualitative research

I was glad to see your journal publish a series on qualitative research, and commend the authors for their concise summary of qualitative methodology in family planning and reproductive health care.[1–3]

I wish to make a few additional points, particularly with respect to the range of qualitative research methods. Qualitative research generates data with no inherent numeric value (images, sounds, words, etc.) and typically takes the form of text. Most definitions of qualitative research, however, fail to distinguish between the data themselves and the analyses performed on them.[4] The authors of your series discuss some of the more frequently used qualitative data collection methods – observation, in-depth interviews and focus groups – as well as some of the more common qualitative approaches to data analysis. Like many others in the field, however, they miss an ever-growing suite of quantitatively-oriented analytical methods that can be employed with qualitative data.

Qualitative data can be, and often are, quantified. Text or themes can be numerically coded and put into matrices, for example, and various data reduction techniques and statistical methods used. Content analysis, in which words or verbatim phrases are counted, also relies on statistical analyses. Likewise, observations can be quantified, and measured, for example, the number of behaviours, or the number of individuals engaged in an activity, in a specified time period. Advances in software permit efficient analyses of all of these types of data.

Sampling strategies beyond the typical purposive samples are also used in qualitative research. Sampling of an entire population (e.g. all decision-makers in a Ministry of Health) or simple random samples comprise two such examples. Appropriate sampling techniques and analytical methods permit qualitative inquiry to go beyond the formative or exploratory. With proper design and adequate datasets, qualitative research can be used to test hypotheses and data can be generalisable beyond individuals within a sample.

The authors of the series did a good job of covering the basics of qualitative research, but it would be remiss to leave your readers with the impression that this is indeed the full range of qualitative inquiry. It is an expanding and exciting field, much broader than typically portrayed in health science journals. I encourage interested readers to have a look at some of the forums for innovation in this field, such as *Field Methods Journal* or the Cochrane Qualitative Methods Network (http://www.iphrp.salford.ac.uk/cochrane/homepage.htm).

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References
1 van Teijlingen E, Forrest K. The range of qualitative research methods in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 2004; **30**: 171–173.
2 Forrest Keenan K, van Teijlingen E. The quality of qualitative research in family planning and reproductive health. *J Fam Plann Reprod Health Care* 2004; **30**: 257–259.
3 Forrest Keenan K, van Teijlingen E, Pitchforth E. The analysis of qualitative research data in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 2005; **31**: 40–43.
4 Bernard HR. Qualitative data, quantitative analysis. *Cultural Anthropology Methods Journal* 1996; **8**: 9–11.

Reply

We are glad to read that Dr Guest has valued our series of articles on qualitative methods in family planning and reproductive health and agree that it is an expanding and exciting field. We do appreciate that there is an increasing use 'of quantitatively-oriented analytical methods that can be employed with qualitative data'. Dr Guest will, of course, appreciate that our articles are meant to be (a) aimed at a broad audience and (b) merely an introduction to qualitative methods. This said, we have outlined one of these quantitative approaches in the qualitative methods paper appearing in this issue of the Journal (pp. 132–135).[1] Under the heading

'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.

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References
1 Pitchforth E, Porter M, van Teijlingen E, Forrest Keenan K. Writing up and presenting qualitative research in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 1995: **31**: 132–135.
2 van Teijlingen ER. A social or medical model of childbirth? Comparing the arguments in Grampian (Scotland) and The Netherlands. PhD thesis, University of Aberdeen, Aberdeen, UK, 1994.

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.

References
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.

References
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]

References
1 http://www.ncjrs.org/pdffiles1/ovw/206554.pdf.
2 http://www.ippfwhr.org/publications/pressreleases_e.asp.
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.

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