

The copper-bearing intrauterine device (Cu-IUD) is thought to act immediately by inhibiting sperm and ovum viability or preventing implantation.² The LNG-IUS has a different contraceptive mechanism of action that relies on hormonal effects on the endometrium, cervical mucus and uterine transport, and thus has a delayed onset.^{2,3} This is the rationale for advising additional contraception for 7 days if a LNG-IUS is inserted after Day 7.³ Although progestogen hormone can delay ovulation, the levels released from the LNG-IUS are insufficient to act in the same way as oral progestogen-only EC.

Therefore, as stated in CEU Guidance, we recommend that only copper-bearing devices should be used for EC.⁴

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Non-palpable implant removal

We were interested to read the comprehensive commentary on 'UK provision for non-palpable implants'¹ where the author recommends that "deep Implanon® removers" should remove at least 12 deep implants each year to maintain surgical skills.

The commentary did not elaborate on the basis for setting the standard at 12 removals per year or present the evidence to support the target. Deep (non-palpable) implants and difficult to remove implants (where attempts at removing using the push technique have failed) require different levels of competence and indeed the facilities required for removal may be different. Implanon was introduced in the UK in 1999. Of more than 150 000 implants fitted in the UK in 2007, the marketing company (Schering-Plough/Organon Laboratories) report a non-palpable rate of 0.69%, which, in absolute terms will be quite small numbers (Rakesh Patel, personal communication, 2009). We would like to suggest that if a competency target is to be used, definition of the competency area (non-palpable implants) and the referral pathway to national referral centres or individuals and the impact on access to such a service should be carefully considered. A large number of health professionals have acquired skills and experience in removal of deep implants and may not require removing 12 per year to maintain their skills.

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Reference

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Reply

Thank you for your interest in the commentary on UK provision for non-palpable implants.¹ Doctors often enquire about the number of 'deep' implant removals they should perform each year to maintain their competence. The setting of 12 deep removals a year is based on personal experience and discussion with trainees, who have undertaken the necessary ultrasound and surgical training to remove palpable implants. Anecdotally, location and implant removal times are longer in those who infrequently perform this procedure. If clinics are failing to see this number of women a year, then I would question whether the health professional can maintain their skills and suggest that referrals are centralised to a regional service.

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Contraception availability in China

When I started working in a small general practice in Nanjing in China, I was surprised to find out how limited was the choice of contraceptives. Many expatriate women would come to our clinic asking to be prescribed the same pills they had in their home countries but I was unable to obtain them from the local pharmacies. Having an interest in family planning and a desire to continue to advise and prescribe contraception, I decided to investigate the underlying reasons for the scarce contraceptive market.

The one-child policy it has adopted makes China a unique environment for family planning. It has been already reported that this policy may have contributed to the rapid economic growth.¹ However, it has also created an enormous pressure on women not to get pregnant. Chinese families traditionally disapprove of a child conceived out of wedlock and it can present a major administrative problem.

A lot of unmarried women opt for abortion if they get pregnant. In Cheng *et al.*'s study of 4547 young unmarried women seeking abortion, 47.7% of the current pregnancies were associated with non-use of any contraceptive method and 52.3% were related to contraceptive failure.² These findings support the idea that information on methods of contraception is not widely available to the target population.

In the 2006 survey of contraceptive knowledge of 8462 married couples, Chen *et al.* tested knowledge of eight methods of contraception, namely the intrauterine device (IUD), oral contraceptive pill (OCP), barrier

methods, injections, natural methods, withdrawal, vaginal douche ("irrigation") and the spermicidal sponge.³ They discovered that the majority of couples knew most about the irrigation method followed by the IUD, OCP, withdrawal, timing, injection and finally female condoms and sponges. Some 70.1% of couples were aware of more than five different contraceptive methods but condom use was the most familiar one.

Family Planning Bureaus (FPBs) are undertaking the task of delivering free contraception and information to women. Even though OCP can be obtained for free, there are a number of reasons why women do not want to take it.

1. There is a general belief that the side effects of the OCP outweigh its benefits and its use is discouraged.

2. Slim body image: it is important to be slim in Chinese culture and women are afraid of putting on weight after starting a hormonal method of contraception (HMC).

3. The importance of having regular periods makes progestogen methods an unpopular choice also.

When our clinic nurse tried to obtain information on OCP from the FPB she was told that this method is really not the best form of contraception. However, free OCP, condoms and implants were offered. Information on HMC is primarily available on the Internet.

We searched the information available on the Nanjing People Birth Control Bureau website⁴ and discovered a brief review of the main methods of family planning: OCP, IUD, injections and condoms, as well as information on sexually transmitted infections. Unfortunately, some of the facts were out of date and some were simply incorrect, such as the claim that OCP can treat HIV infection.

The most accepted and known forms of contraception are condoms, IUDs and natural methods. Before giving birth, condoms are the main method of contraception. After giving birth, IUDs are traditionally used.

The reasons for the reluctance to use HMC are a lack of information about the real side effects and an inability to make an informed choice. The FPB provides limited information and so advice is often sought from other family members and/or peer groups.

Another factor that should be taken into consideration is cultural shyness when it comes to talking about contraception. In general, Chinese women are reluctant to actively seek information on contraception from available resources. The present attitude of the public towards sex, contraception and sex education remains conservative. Current perceptions maintain the environment of false beliefs about the real advantages and drawbacks of HMC.

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LETTERS TO THE EDITOR

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