In this issue

Two tenacula cause equal pain and bleeding on IUD/IUS insertion

Anything that makes effective contraception more acceptable for people who need it interests us at the journal. So what about the type of forceps used to grasp the cervix when inserting an intrauterine device (IUD) or intrauterine system (IUS) – does this make any difference to pain or bleeding? Apparently not, according to a randomised controlled trial (RCT) in this issue. Reporting on a comparison of Littlewoods forceps with a single-toothed tenaculum, Speedie *et al*. find no significant difference in outcomes between the two groups apart from higher mean visual analogue scale scores for pain 10 minutes after insertion in the tenaculum group. And as the authors point out, even this statistical difference may not be *clinically* significant given pain scores were already very low. ***See page 241***

In a linked editorial (***page 239***), Rebecca Allen observes that tenaculum type seems to be joining a slew of interventions found relatively ineffective in a recent Cochrane systematic review. These include nonsteroidal anti-inflammatory drugs (NSAIDs), some topical lidocaine agents, and misoprostol for cervical ripening. So, how *can* we counsel women and help them through the IUD insertion process?, Allen asks.

Prescriptions of contraceptives for non-contraceptive use are increasing, in the UK

Those contraceptive pills which occupy the grey area in prescribing between contraception and non-contraceptive uses such as treatment for acne or hirsutism, subject to more restrictive prescribing guidelines, can risk either being used inappropriately, or underused where they *are* appropriate. Data on how contraceptives are used outside their product licence are generally limited, so we were interested in the retrospective analysis in this article which tries to address this, using the UK primary care database, The Health Improvement Network (THIN). Looking at the diagnosis or indication recorded in connection with new prescriptions of pills containing cyproterone acetate, levonorgestrel (LNG) and drospirenone (DRSP), respectively, from 2002 to 2010, the authors report a marked increase over time in acne or hirsutism as recorded factors, and a huge drop from 33% to 8% in the proportion where contraception was the only recorded reason. In fact, by 2010, one-third to one-half of new users of products containing DRSP or LNG did not have a record indicating use for contraception at all, while many had records for hormone-responsive conditions only. This may, suggest the authors, mark improved adherence to stricter prescribing guidelines. But we cannot rule out the possibility of a shift in recording practices. ***See page 247***

In a linked commentary (***page 254***), Laura Percy welcomes the trend this article presents, while cautioning readers against over-interpretation of a database study with unavoidable limitations: the data may be incomplete, cannot account for contraception prescribed through other sources, focus on just a few preparations, and do not measure adherence to UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) prescribing guidelines.

Australian women frequently report non-contraceptive reasons for changing contraception

On the theme of overlap between contraception and other areas of experience, we know that side effects are commonly reported reasons for changing contraception, but lack evidence from women's own perspectives. This qualitative study from Australia uses thematic analysis to explore young women's explanations for their recent changes in contraception. Women reported both contraceptive and non-contraceptive reasons for switching, but it was most strikingly the non-contraceptive effects such as relationship and other medical factors which featured most frequently in their accounts. Commenting, Kumiyo Inoue (***page 263***) highlights the influence of sociocultural factors on the significance women attach to side effects, suggesting these findings challenge the reader to reconsider 'truth' from the perspective of the experiencer. It's a useful reminder, if we needed one, that when it comes to choice of contraception, technical advantages and disadvantages need to be seen in the (influential) context of a woman's wider experience. ***See page 256***

Dual use contraception is advised for serodiscordant couples, but is hard to achieve

Because almost half of incident HIV infections occur in long-term heterosexual couples, World Health Organization guidelines recommend the dual use of condoms and an alternative contraceptive in HIV-discordant heterosexual couples. But how well is this adhered to? Two articles in this issue, one from Africa, one from South America, make sobering reading. ***See pages 264 and 271***

Dual contraceptive use is low in HIV-serodiscordant Kenyan couples

A qualitative study from two large HIV-serodiscordant cohorts in Nairobi reports disappointing results. Interviewing 12 men and 12 women from serodiscordant couples where individuals had disclosed their HIV status to each other, the authors find that few couples reported dual method use. Men, especially HIV-seropositive men, reported more condom use than women, especially HIV-seronegative women – who reported the least condom use. Both sexes agreed that men had a dominant role in decisions about condom use and contraception, and side effects were cited as an influence on decision making. However, other factors such as male preference, desire for children, and fears of dual use being misunderstood as evidence of unfaithfulness also featured. Given all these biopsychosocial barriers to adoption of dual use, we may need to look to biomedical HIV prevention methods to reduce HIV transmission in serodiscordant heterosexual couples, suggest the authors. ***See page 264***

Two-thirds of women in Brazil use dual protection, but few of these use condoms consistently

In Brazil, where 79% of cases of HIV in women occur in women of reproductive age and 55% of all pregnancies are unintended, syndemic HIV and unintended pregnancy also pose a challenge. Presenting data from a decennial, nationally representative household survey of women of reproductive age, Tsuyuki

et al. found that two-thirds of women using contraception used dual protection. However, consistent condom use was reported by only 27% of dual-use users. Use of dual methods was associated with predictable factors such as education, geographical region, and number of children. Consistent condom use was associated with condom use at sexual debut, lack of desire for further children, and using condoms exclusively. The authors conclude that HIV and family planning (FP) services should focus on completed families, single individuals, and on sexual debut as a time to promote dual use. ***See page 271***

ID-Migraine™ and VARS help us make a vital distinction: migraine with, or without, aura?

Migraine aura, with or without migraine headache, is an independent risk factor for ischaemic stroke, and an absolute contraindication to the use of combined hormonal contraception (CHC). But migraine *without* aura is not a risk factor and CHC may therefore be used. The problem is to distinguish between the two, particularly because visual symptoms are common in both types. Diagnostic uncertainty, practitioner anxiety, or even ignorance of the migraine types may have prevented many young women from being prescribed CHC that might otherwise have suited them. If you are ever in doubt, a review article in this issue from one of the UK's foremost authorities on migraine in relation to contraception makes essential reading. Anne McGregor takes us through two simple, evidence-based, differential-diagnostic tools – the ID-Migraine™ and the visual aura rating scale (VARS). While ID-Migraine offers the three best predictors for diagnosing migraine without aura – photophobia, disability and nausea, VARS screens for specific visual symptoms of migraine aura. ***See page 280***

Commenting from the perspective of a patient treated for migraine at a time when the links between aura and ischaemic strike were not yet established, Karen Charlesworth welcomes the author's attempt to aid safer prescribing practice of CHC for migraine sufferers (***page 287***). She goes on to ponder how practitioners can operationalise these hybrid scales in their own differential diagnostic practice.

Embedding routine HIV and STI screening in an abortion service

The UK Royal College of Obstetricians and Gynaecologists advises that all women attending abortion services should be screened for *Chlamydia*, and risk-assessed and screened for other sexually transmitted infections (STIs), including HIV, as appropriate. British HIV Association (BHIVA) guidelines also recommend the routine offer of an HIV test to all attendees at abortion clinics. But how to achieve this? This 'Better Way of Working' article describes how one abortion service in an area of rising STI incidence succeeded in embedding routine HIV and STI screening for all women. Following this initiative, women have been routinely offered screening, and uptake of HIV testing has risen to levels equivalent to those achieved by the co-located sexual health service (73%). Lessons on implementation and monitoring shared here should be of value to abortion providers in appraising their STI screening practice. ***See page 288***

Chemsex is a rapidly emerging public health concern

Sexualised drug use with novel psychoactive agents such as crystal methamphetamine is on the rise amongst men who have sex with men in the UK and Europe. This poses novel personal and public health concerns, which are addressed in two articles in this journal issue: Alastair Macfarlane, winner of the 2016 Margaret Jackson Essay Prize, presents an overview of the epidemiology of chemsex in the UK, and considers the sexual health and mental health consequences of these agents. He poses tough questions as to how the health service might best be placed to help individuals who develop problematic substance use. He proposes that sexual health services are seen as appropriate venues for health seeking amongst the men affected, but there is a skills gap with many sexual health providers being ill-equipped to deal with the broad range of issues. ***See page 291***

In his linked commentary (***page 295***), David Stuart, Substance Use Lead in one of the busiest sexual health services in London and lead for clinical services developed for men having problematic chemsex, asks provocative questions as to the nature of the problem. As Stuart states: "You can't remove the sex from the chemsex … Make that gay sex, include HIV, and chemsex becomes something that requires some untangling before an effective public health response can be mounted".

A doctor grieves her vocation

In a howl of practitioner pain, new columnist Abi Berger laments what she sees as the replacement of curiosity, relationships, and all that feels most meaningful in UK primary care with protocols. Sound familiar? See it from a different angle? Send us your thoughts. ***See page 297***

Then and now: developing priorities in SRH

Comparing this journal's interests of 25 years ago to the world agenda in 2016, our International Advisory Editor, Professor Lindsay Edouard, draws attention to the perceived threat to FP services in the UK in 1991 due to "turmoil in the National Health Service (NHS)". How little have things changed. But there was also substantial involvement of British sexual and reproductive health (SRH) practitioners overseas. The great Dr Libby Wilson, whose obituary we publish in this issue (***page 301***), worked in Sierra Leone after her retirement. Twenty-five years on, the United Nations has placed Sexual and Reproductive Health prominently among the targets for health and gender goals of the 2030 Agenda for Sustainable Development. Professor Edouard reminds us that SRH is at last gaining the recognition it deserves on the world stage. ***See page 298***

Venus

Finally, our new evidence sleuth, Venus, brings us snippets from the cutting edge of contemporary sexual health research. Some of the new studies may seem familiar – confirming that the hunt for the elusive G spot continues unabated, while testosterone levels remain a poor predictor of clinical erectile dysfunction – others less so. New evidence suggests the IUS is less frequently discontinued than the subdermal contraceptive implant, and one article discusses the pros and cons of the ever-controversial PrEP (pre-exposure HIV prophylaxis) – the subject of an ongoing High Court appeal in the UK, where the NHS declined to fund it. Venus finishes on a high note, with well-deserved congratulations to the Royal London Hospital for launching the first maternity clinic offering fully integrated specialist support to women who have suffered sexual trauma – a trailblazing service poignantly named 'My Body Back'. ***See page 302***