As the UK faces extraordinary political uncertainty, much of the world faces austerity, and sexual health services are squeezed in many places, much of the new evidence in this journal issue relates to resources, and relationships. Wherever cost is a high priority in sexual health, it is unsurprising to find a focus on long-acting reversible contraception (LARC) – a group of methods with high cost-effectiveness, but also questions over acceptability and suitability in certain groups. One trial in HIV-infected individuals in this issue addresses the vexed question of whether LARC may increase HIV transmission, while other studies reassure us that missing intrauterine device (IUD) strings following postpartum insertion may reappear in due course, and confirm clear health benefits for disadvantaged women from free intrauterine system (IUS) access. Finally, both a subjective account and objective evidence remind us, if we needed it, of the power of strong, effective clinical relationships in delivering healthcare which is both acceptable and effective.

Early evidence suggests trials of the effects of hormonal contraception on HIV acquisition are possible

The possibility that hormonal contraception, particularly injectable depot medroxyprogesterone acetate (DMPA), increases the risk of HIV acquisition has been discussed for more than 30 years. Hofmeyr and colleagues set out to investigate this possibility in their open-label randomised controlled trial of the levonorgestrel IUS (LNG-IUS) – a group of methods with high cost-effectiveness, but also questions over acceptability and suitability in certain groups. One trial in HIV-infected individuals in this issue addresses the vexed question of whether LARC may increase HIV transmission, while other studies reassure us that missing intrauterine device (IUD) strings following postpartum insertion may reappear in due course, and confirm clear health benefits for disadvantaged women from free intrauterine system (IUS) access. Finally, both a subjective account and objective evidence remind us, if we needed it, of the power of strong, effective clinical relationships in delivering healthcare which is both acceptable and effective.

Providing free LNG-IUS to low-income women promotes women’s health

What are the overall benefits of the provision of an effective LARC method free of charge in a country where contraception would normally have to be paid for? Ferreira et al in Brazil analysed the likely outcomes of a 9-year programme in which the levonorgestrel IUS (LNG-IUS) was provided at no cost to over 15 000 women. Using a mathematical modelling programme they estimated the number of live births and unsafe abortions averted, together with the associated potential maternal morbidity, maternal mortality and child mortality, resulting in averted Disability Adjusted Life Years (DALY). They found that almost 900 unintended pregnancies were prevented over the 9-year period. They concluded that in low-resource settings, the averted DALY and the additional health benefits of the LNG-IUS make its provision an effective policy for the promotion of women’s health. See page 181

IUD strings, sometimes invisible following postpartum insertion, may reappear later

Insertion of an IUD immediately after delivery is an increasingly important approach to the provision of effective long-acting contraception. In India, postplacental IUD insertion is encouraged by the government, with training and incentives for service providers. However, an area of concern is that the strings of IUDs inserted postplacentally may not be visible at the cervical os soon after the birth, particularly following insertion at caesarean section (CS). In their prospective study of almost 350 postplacental IUD insertions, Dewan et al found that strings were not visible at 6 weeks in 40% of the women, particularly if insertion was at CS. However, over time an increasing proportion of the strings became visible. The authors provide useful guidelines for monitoring the continuing presence of IUDs with non-visible strings, and emphasise that counselling and reassurance about the location of IUDs helps to improve continuation rates. See page 186

YouTube information on contraceptive implants is low grade, but seldom actually wrong

Information abounds in this digital age, but quality is difficult to measure. Chang and colleagues sat down with a box of popcorn and reviewed more than 100 clips about single-rod contraceptive methods, from patient and provider perspectives, posted on the video-sharing site, YouTube. They objectively and systematically reviewed the reliability and quality of the information presented. The majority (76%) of videos were patient testimonials, which were of lower Global Quality Score than professional provider videos, but often they were of greater longevity on the site, and viewed more frequently. Of patient-produced videos, 61% described positive experiences of the method, and misinformation was fortunately rare. Clinician engagement with digital information is key to drive a quality agenda. See page 195

Abuse is associated with both abortion, and denied access to reproductive health care, in a multiply disadvantaged group

We know little about how sex workers are affected in armed conflict, particularly around access to safe abortion services and relationships to violence, criminalisation, coercion, and reproductive health and rights. This community-based, cross-sectional study explored factors associated with lifetime abortions among female sex workers (FSWs) in Gulu District northern Uganda; and separately modelled lifetime exposures to incarceration and living in internally displaced persons (IDP) camps on coerced and unsafe abortions. Some 62/400 FSWs had ever accessed an abortion. Childhood mistreatment and/or abuse at home and workplace violence by clients were both linked to increased experience of abortion. FSWs frequently experienced denial or impeded access to sexual and reproductive healthcare (SRH). Lifetime exposure to incarceration showed increased odds of coerced abortion, and living in IDP camps was positively associated with unsafe abortion. Safe, voluntary access to reproductive choice for marginalised and criminalised populations of FSWs is urgently needed. See page 201

Childbearing aspirations in people living with HIV infection reflect concerns other than just HIV treatment and transmission

What shapes the desires to have children among people living with HIV? This qualitative study asked men and women living with HIV to describe their aspirations, hopes, concerns and experiences of having children. Many of the drivers were unrelated to HIV itself, and patriarchal, family and societal influences were very important. However, many participants raised concerns about the...
risk of horizontal and vertical transmission of HIV infection. Despite knowing about the substantial reduction in risk of transmission afforded by antiretroviral therapy (ART), none specifically discussed ART use in influencing their family planning decisions. Attending to the fertility needs of this population will therefore require an holistic bio-psycho-social approach, with a particular emphasis on the ability of ART to help people realise their family planning aspirations. See page 210

Quality of interaction with providers was a key determinant of satisfaction with FP services in Mozambique

Nowhere in international healthcare is the quality of clinician–patient interaction more central than in family planning (FP) – an area affecting both health and economics, where women are not ill, and treatment adherence depends on trust. A study using international (UNFPA) methodology documents satisfaction with, and quality of, provider–client interaction in family planning in Mozambique. It also documents the importance of FP uptake in reducing the maternal mortality ratio (MMR), which in Mozambique is high at 480/100,000 births. With a total fertility rate of 5.9 and contraceptive prevalence only 11%, Mozambique could potentially reduce maternal deaths by up to 30% by addressing unmet need for FP, according to the study’s authors. Importantly, women with a high level of provider–interaction were less likely to be dissatisfied. Those dissatisfied cited long waiting times, poor-quality provider–client interactions, including lack of questions and explanation before procedures, and insufficient supply of oral contraceptive pills: messages which may be easily recognisable in other settings. See page 222

Even legal abortion can be stigmatised, perpetuating illegal abortion, and maternal illness and death

Although legalisation of abortion has reduced maternal mortality worldwide, illegal abortions are not always unsafe and legal abortions not always safe, or convenient, or respectfully offered. Hence, when young women seek illegal abortion outside the formal healthcare system even in areas where it is legal, it is worth asking why. Ghana has liberal abortion laws, but abortion complications are still a large contributor to maternal morbidity and mortality. In this study, 18 women seeking care for complications from a self-induced abortion and 11 seeking care for an elective abortion were interviewed. Women self-induce abortion due to beliefs about illegality, negativity of healthcare workers’ attitudes, secrecy, and social stigma. Faced with an unwanted pregnancy, women consult individuals in their social network, and self-inducing abortion using procured medication has become normalised. See page 216

Birmingham’s sexual health ‘umbrella’ offers client-centred care for service users and security for staff

A reconfiguration of traditional sexual health services across Birmingham has been challenging, but rewarding. In a ‘Better Way of Working’ article, the team responsible charts the journey to a new, integrated model of care, with an enlarged scope and greater emphasis on prevention, from the perspective of staff and service users. A broad approach across traditional professional boundaries in a large geographical area is aimed at easing access to more client-empowered care. The service is to be audited, following public awareness campaigns. Other UK service providers may wish to submit letters commenting on their own experiences. See page 229

Any effective contraception is better than none, after ectopic pregnancy

Some medical myths die hard. In a Personal View article, Mansour and Percy remind us that a history of ectopic pregnancy can cause confusion in the minds of prescribers with insufficient experience in SRH, and summarise the documented risks of ectopic pregnancy with prescribed contraceptive methods. They remind us that intrauterine contraception is not contraindicated in women with this history, and that the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) classify past ectopic pregnancy as UKMEC Category 1, i.e. unrestricted for both copper-bearing IUDs and the 52 mg LNG-IUS. They also give reassurance regarding all methods of emergency contraception. See page 232

Cutbacks in sexual health services threaten practitioner training and patient care

Su Everett, a clinician and lecturer in UK sexual health services for 30 years, voices her concerns about the changes currently taking place in UK sexual health. Forcing services to compete against one another for contracts, and reducing training opportunities in contraception and sexual health for nurses both threaten patient care, Su argues. She encourages health professionals to voice their concerns, and actively oppose the reduction in services. See page 234

Awkward questions can drive efficacy in relationship-based medicine

This issue’s ‘Person in Practice’ article describes a trip ‘off-piste’ in the clinical consultation. Abi Berger highlights how asking what could be considered awkward questions in the consulting room can increase both efficiency and care quality at the same time, especially when it comes to sensitive and difficult topics such as sex. Taking the time, or perhaps finding the courage, to use knowledge of the patient and clinical intuition in this way, can actually speed up the consultation, she argues. Maybe she would say this – as a GP with additional psychotherapy skills. Maybe other readers with psychosexual or psychotherapeutic skills, or those who have read Balint on the doctor–patient relationship, would agree. Maybe such “extended history taking” skills, to borrow a well-known phrase coined by the famous doctor therapist, could be employed more widely. See page 237

Venus

In her quarterly sift through the literature Venus is more than usually attentive to men. She scrutinises their role in maternal health in Kenya, the sexual implications of male congenital pelvic abnormalities, and semen parameters in Scandinavian and Dutch men. But as always she also takes an interest in conception and abortion, highlighting LARC use and acceptance, and focusing on two especially topical areas in abortion provision: a mifepristone-misoprostol regimen for ultra-early medical abortion, and Irish women’s use of a telemedicine abortion service. See page 246