In this issue

The history of involuntary sterilisation brings reproductive justice into focus

Involuntary sterilisation has a dark history that remains relevant for contemporary medical and legal professionals. To learn from the past, we need to recognise historical injustices, and be aware of those that continue. In this editorial, Rowlands and Amy describe contexts in which sterilisations have been carried out without proper consent or under coercion. They consider the harm that has occurred, particularly to vulnerable populations, incarcerated peoples, and women of colour, and conclude that challenging the attitudes that underlie these human rights violations remains an important part of achieving reproductive justice. *See page 239*

Mifepristone effectiveness is not reduced by intramuscular DMPA given 24–48 hours later

Achieving effective contraception without delay following abortion is an important goal, but a randomised controlled trial in 2016 found an association between intramuscular depot medroxyprogesterone acetate (IM DMPA) given at the time of mifepristone administration for early medical abortion (EMA), and a slightly increased risk of continuing pregnancy compared with those not receiving it simultaneously. Reassuringly, a case-control study of almost 5000 women undergoing EMA reported here finds that those who received DMPA 24–48 hours after mifepristone were no more likely to experience continuing pregnancy than women receiving other methods of contraception, or none at all. A linked editorial (*page 235*) welcomes this new evidence, emphasising the importance of convenience and choice in contraception after abortion. *See page 242*

Might a user-informed video about the LNG-IUS reduce discontinuation and improve patient satisfaction?

Recognised side effects from the levonorgestrel intrauterine system (LNG-IUS) are common reasons given for discontinuation within the first 12 months of use. As anticipatory counselling regarding expected side effects may reduce method discontinuation and improve patient satisfaction, the authors describe the development of an educational video. They collaborated with clinicians and LNG-IUS users and plan to pilot the use of this video among patients on the day of their LNG-IUS insertion. *See page 248*

Ineffective postpartum contraception threatens adequate birth spacing in China

In China, unintended pregnancy rates among postpartum women are relatively high. An interview-based study with over 500 mothers in Hunan Province reported here explores contraceptive prevalence, chosen methods and factors affecting their use, using globally validated Unicef questionnaires. While two-thirds of women reported using contraception, most chose condoms, with only 10% using long-acting reversible contraception (LARC). Many believed breastfeeding to be a reliable method of contraception, while a third were using no postpartum contraception. *See page 254*

Implanon is favoured in rural upper Egypt, but counselling is not always adequate

In Egypt, Implanon has a lower first-year discontinuation rate than injectables and intrauterine devices (IUDs), but there remains room for improvement. A mixed-methods community-based study in Assiut Governorate asked clients and providers about their attitudes towards Implanon. Women's choice of this contraceptive was strongly influenced by their social networks, as well as their husbands' education and the method's cultural acceptability. While few Implanon users discontinued in the first year, two-thirds of discontinuation was due to side effects, especially the inconvenience of bleeding during prayers and for sexual relationships. Contraceptive discontinuation rates are important service indicators, and counselled women are more likely to tolerate menstrual irregularity, yet only a third of women received counselling at health centres before Implanon insertion. Aziz and co-authors conclude that improving family planning counselling services and offering Implanon for long-term contraception would improve continuation and cost effectiveness. *See page 260*

Patient and public involvement faces special challenges in sexual healthcare, but can be achieved

Patient and public involvement (PPI) is increasingly recognised as central in healthcare, but achieving this in sexual health is challenging due to the sensitive nature of the field, and lack of evidence as to what should be done and how. An audit involving 18 local sexual health services using thematic analysis found wide variation in practice, and misunderstanding. PPI is often methodologically misunderstood, poorly resourced, implemented late, based on narrow methods such as focus groups, and poorly communicated and implemented. The authors identify common areas for improvement, including clear definitions of 'what PPI is for', defined evaluation measures, and a sufficient range of different options for patient involvement, including those which respect potential embarrassment and the need for anonymity. In a first editorial (*page 237*) the journal's new PPI Editor, Linda Pepper, introduces herself, and highlights some of the challenges in involving patients in research and practice. *See page 267*

Teenage parents respond favourably to a targeted support programme

Teenage parents and their children are at risk of poorer outcomes than both older mothers and their peers, so effective support for this group is vital. Using focus groups, 18 vulnerable teenage parents attending a holistic, family-centred support programme in Durham were asked about their experiences. Most reported feeling supported, and less socially isolated, as a result of the programme, highlighting free transport and childcare onsite as essential elements. The programme appeared effective at increasing participants´ emotional and social capabilities, their engagement in education and employment, and their children's social development. *See page 272*

Intrauterine contraception is most effectively provided at the time and place of abortion

Early provision of LARC is a major factor in reducing the risk of further unplanned pregnancies following abortion. A randomised study from Finland of 605 women undergoing medical abortion gave the intervention group early appointments to return for IUD insertion at the hospital where their termination had been performed, while the control group had standard care and were advised to contact their primary healthcare centre for follow-up and IUD insertion. The intervention group proved significantly more likely to have had an IUD inserted by 3 months after their termination. There were few factors that predicted poor compliance with follow-up in the intervention group, and none at all in the control group. This study provides valuable data on planning provision of follow-up and contraception services after abortion. *See page 278*

Safe-abortion hotlines appear helpful in self-managed medication abortion over 12 weeks' gestation

Women worldwide face multiple barriers to accessing abortion care. Many self-manage using mifepristone and misoprostol or misoprostol alone outside formal healthcare settings. Using data from a safe-abortion hotline staffed by trained abortion counsellors in Indonesia, Gerdts *et al* examine the safety of medication abortions performed after 12 weeks of pregnancy using the hotline as a source of information and support. Results suggest that out-of-clinic models can be a safe alternative for women in need of abortions beyond 12 weeks' gestation in legally restrictive contexts. *See page 286*

Including LGBTQ people in research is complex, feasible, and overdue

Lesbian, gay, bisexual, transgender and queer (LGBTQ) people have often been excluded from research about abortion and contraception care, due to the complexity of finding the right gender identity measures, gender-neutral language, and formulating suitable questions. Happily, some researchers are now beginning to correct this unjust omission, such as this US survey which combined existing sexual orientation and gender identity measures with new reproductive anatomy questions to guide appropriate terminology and questions on sexual and behavioural risk, existing contraception and pregnancy intention. As well as modelling the inclusion of (LGBTQ) people in studies about pregnancy, this study highlights that LGBTQ people may feel validated by expanded gender identity options and SRH survey items that use gender-neutral terminology. *See page 292*

Same-day provision of specialist care in SRH services improves efficiency

One major reason for dissatisfaction with all health services is long waiting times. After a first consultation, 5% of the 150 patients a month seen at the SRH service at the Margaret Pyke Clinic in London require onward referral to a specialist clinic, and can face waiting times of up to 8 weeks. This Better Way of Working article illustrates how changing referral pathways led to better and faster access to contraception. Enabling same-day access to specialist care with ultrasound resources improved efficiency, and 85% of women referred via this new pathway did not require a return visit. They avoided bridging contraception while waiting for specialist review, and the higher 'did not attend' rates associated with appointments at later dates were avoided. Patients and staff gave positive feedback on this new system. *See page 299*

Hydrodissection facilitates the safe removal of deeply situated etonogestrel implants

Extracting an etonogestrel implant situated deeply below the muscle fascia is a challenge even to specialist practitioners if ultrasound shows it to be close to vital neurovascular structures. The open technique that is generally considered necessary still carries the risk of damage to the blood vessels and nerves. In this Better Way of Working article, Pillai describes her elegant application of the hydrodissection technique, in which small volumes of local anaesthetic injected under ultrasound control are used to separate tissue planes. The injection needle can then be used to underpin and raise the implant, permitting its safe removal by a conventional 'U' technique through a tiny 3 mm incision. Pillai describes the technique clearly, aided by excellent illustrations, and sets out its benefits. Importantly, she also provides valuable advice on training practitioners to use the method safely. *See page 303*

Traditional vs social media-based marketing of family planning innovations: case of Natural Cycles

Natural Cycles entered the contraceptive market in 2014, promoting a fertility awareness-based method of family planning. It claims to help women track their menstrual cycles using a digital thermometer and a mobile phone app. As a device – rather than a prescription drug – it is subject to different marketing rules to those required for other forms of contraception, and is marketed directly to young women directly via social media. Hough *et al* discuss the potentially confusing messages social media marketing strategies may present to adolescent women who comprise the target market. It is important for healthcare providers to be aware of these different marketing realities, and provide clients with objective and evidence-based information on all contraceptive options. *See page 307*

Small, empathic interventions can help make the unbearable bearable

Many of us have occasionally found ourselves 'on the other side of the fence', in the role of patient or relative. The insights we gain from these positions can change our own practice and increase empathy. In her latest column, Abi Berger highlights – this time from the perspective of a relative – some vital attitudes and practices on the part of clinicians which can help patients and relatives manage their own anxiety, and complement good technical care. *See page 310*

Venus

From the effects of DMPA on the heart, factors associated with low lying IUDs, and postal HIV testing, to the glycaemic effects of antipsychotic medication in pregnancy, Venus scans our diverse field for new information. Her offerings take in the biological, psychosocial, and even the epistemological: how come transgender people are excluded from research? And why and when in clinical practice is human contact preferable to a text message? *See page 318*