UK centres for Implanon® removal

Mea culpa – when writing the article on the UK provision for removal of non-palpable contraceptive implants1 I forgot to include Dr Martyn Walling in Table 1. Martyn has the UK’s greatest experience in removing deep implants and is based at North Lindsey PCT, Orchard House, Greyleas, Sleaford NG34 8PP, UK. He is very happy to accept written referrals sent to this address.

Martyn has also been working as an independent practitioner, travelling the length and breadth of the UK, training doctors to locate and remove non-palpable implants.

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Reference

Editor’s note
An updated version of Table 1 in Dr Mansour’s article referred to above, which lists the UK referral sites for removal of deep/non-palpable contraceptive implants, appears on page 85 of this issue of the Journal.

Contraceptive failure with Depo-Provera®

I have a concern regarding the recent case report where a 28-year-old woman was given a subsequent (second) injection of Depo-Provera® by a practice nurse when she attended after 13 weeks, and when no precautions were advised, nor follow-up advice done. The patient subsequently again reported with a positive pregnancy test and opted for a termination of pregnancy.1

My personal feeling is that although by and large consultation times are often too short for practising doctors to cover all aspects of counselling at all times, when a patient is using a contraceptive method outside the terms of the product licence, to ensure that optimal service is obtained one would expect the doctor to also get involved and appropriately counsel, and to adequately document such an episode.2,3

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References

Reviewing the National Sexual Health and HIV Strategy

In response to the article entitled ‘Reviewing the National Sexual Health and HIV Strategy’ published in this Journal,1 I would like to endorse the authors’ comments with regard to the lack of standardised training for nurses in reproductive and sexual health care. As an educator in a Higher Education Institute (HEI), with experience of contributing to developing national education and training initiatives, I would like to express similar frustrations with the lack of national standards in sexual health training for nurses. With the increasing pressures on services, HEIs must develop innovative solutions to meet the sexual health education and training needs of nurses. Providing access to an online session for such a national ‘e-learning’ course could be one solution to meeting the standards in reproductive and sexual health service delivery.

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Reference

Reviewing the National Sexual Health and HIV Strategy

I write in response to the article entitled ‘Reviewing the National Sexual Health and HIV Strategy’, published in the October 2008 issue of this Journal.1 I would like to applaud the authors’ comments within this article regarding the lack of standardised training for nurses in reproductive and sexual health care. Since the demise of the National Boards, nurses and their employers have been left in a very unhealthy void as they are unable, with confidence, to ensure that either the training they are receiving, or the training that has been undertaken, is robust enough to ensure the provision of consistent, effective and evidence-based advice to clients. At least when a nurse presented with the (E)NB course certificates you knew what you were getting as many other nurses, and employers of nurses, would be overjoyed to see the new DFSRH online learning programme being able to be accessed and accredited for nurses as the new ‘gold standard’ for training in this area.

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Reference

Sexual health of South Asians in the UK

I was interested to read the comprehensive review article by Dr Sunanda Gupta on the National Chlamydia Screening Programme (NCSP), there are clear differences in ethnic variations in the South Asian population. There is very scant if any information on ethnicity and abortion. Though abortion data relate to the 1980s and early 1990s and show that Bangladeshi and Pakistani women had higher rates of teenage motherhood (with a majority of births within marriage) compared to white women. Although often culturally acceptable for these ethnic groups when within marriage, teenage motherhood nevertheless have socioeconomic and educational implications. More recently, however, there has been a marked decline in early parenthood in South Asian groups in the UK, and is associated with lower average incidence of teenage motherhood.1,4

Expanding upon the data presented by Dr Gupta on the National Chlamydia Screening Programme (NCSP), there are clear differences between ethnic groups in terms of positivity. Groups with the highest positivity include those of mixed, black Caribbean and other black ethnicity and those with the lowest positivity include those of Chinese and Asian/Asian British origin.5 Although the observed differences in positivity may be due to the recording of consistent, effective and evidence-based advice to clients. At least when a nurse presented with the (E)NB course certificates you knew what you were getting as many other nurses, and employers of nurses, would be overjoyed to see the new DFSRH online learning programme being able to be accessed and accredited for nurses as the new ‘gold standard’ for training in this area.

References
3 Berthoud R. Teenage births to ethnic minority women: Papel Trends 2011; 104: 12–17.

Reply

We thank Dr Sunanda Gupta for comments referred to above. Dr Sunanda Gupta mentioned in her excellent review of the National Chlamydia Screening Programme (NCSP) that there are clear differences in ethnicity and abortion and on ethnicity and teenage birth. In 2002, the abortion notification form (HASR) was revised to include the recording of ethnicity, as self-reported by the women involved. This information was not previously recorded. In 2007, there were 19 499 legal abortions that were recorded, 75% of women reported being white, 11% black or black British, and 8% Asian or Asian British. Interestingly, the percentage of previous abortions (where the woman has had one or more previous abortions in addition to the one recorded for 2007) also varies by ethnicity. Of those women having abortions in 2007, 31% of white, 48% of black/black British and 28% of Asian women, had previously had an abortion.7

In terms of teenage births, Berthoud’s 2001 data relate to the 1980s and early 1990s and show that Bangladeshi and Pakistani women had higher rates of teenage motherhood (with a majority of births within marriage) compared to white women. Although often culturally acceptable for these ethnic groups when within marriage, teenage motherhood nevertheless have socioeconomic and educational implications. More recently, however, there has been a marked decline in early parenthood in South Asian groups in the UK, and is associated with lower average incidence of teenage motherhood.1,4

Expanding upon the data presented by Dr Gupta on the National Chlamydia Screening Programme (NCSP), there are clear differences between ethnic groups in terms of positivity. Groups with the highest positivity include those of mixed, black Caribbean and other black ethnicity and those with the lowest positivity include those of Chinese and Asian/Asian British origin.5 Although the observed differences in positivity may be due to the recording of consistent, effective and evidence-based advice to clients. At least when a nurse presented with the (E)NB course certificates you knew what you were getting as many other nurses, and employers of nurses, would be overjoyed to see the new DFSRH online learning programme being able to be accessed and accredited for nurses as the new ‘gold standard’ for training in this area.

References
3 Berthoud R. Teenage births to ethnic minority women: Papel Trends 2011; 104: 12–17.