

**UK centres for Implanon® removal**

*Mea culpa* – when writing the article on the UK provision for removal of non-palpable contraceptive implants<sup>1</sup> 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 Lincolnshire 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**

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**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 documentation done. The patient subsequently again reported with a positive pregnancy test and opted for a termination of pregnancy.<sup>1</sup>

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 offered and also in view of the remote possibility of litigation following failure of the method, it should be mandatory for the practising doctor to also get involved and appropriately counsel, and to adequately document such an episode.<sup>2,3</sup>

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**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,<sup>1</sup> 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 academic accreditation 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**

- Mann S, Wilkinson C. Reviewing the National Sexual Health and HIV Strategy. *J Fam Plann Reprod Health Care* 2008; **34**: 211–212.

**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.<sup>1</sup> I would like to applaud the authors' comments within this article relating to 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! I am sure that 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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- Mann S, Wilkinson C. Reviewing the National Sexual Health and HIV Strategy. *J Fam Plann Reprod Health Care* 2008; **34**: 211–212.

**Sexual health of South Asians in the UK**

I was interested to read the comprehensive review article by Griffiths *et al.*<sup>1</sup> and the discussion on sexual knowledge and behaviour, contraceptive behaviour, and sexually transmitted infections (STIs) and HIV in the South Asian population. There is very scant if any information on ethnicity and abortions. Though abortion statistics have been available from 1968 from the Registrar General and from 1974 from the Office for Population Censuses and Surveys OPCS/Office of National Statistics (ONS), it was not until 2005 that ethnicity was included in data collection. Our unpublished data in Waltham Forest (for 2006) show that of a total of 1257 abortions, >50% of abortion requests were from Asian, black and mixed-race women, though only 35% of women in our population are categorised as mixed-race, Asian or black. Some 31% of abortions were in white British, Irish and other white women compared to 24% in black and 19% in Asian women. Being a black, Asian or mixed-race woman emerged as an important risk factor for induced abortions. However, we did not study other ethno-cultural variables such as social class, deprivation and educational status.

Chlamydia screening has not been discussed by the authors. In 2007, the English National Chlamydia Screening Programme (NCSP) performed over 270 000 screens in under-25-year-

olds and the overall positivity rate was 9%. The positivity rate in young Asians was less than 5%.<sup>2</sup>

Again, there is little if any information on ethnicity and teenage births. However, in a recent study of teenage births to ethnic minority women, Pakistani and Bangladeshi women were much more likely to have been teenage mothers compared to white women, but Indian women were below the national average.<sup>3</sup>

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**Reply**

We thank Dr Sunanda Gupta for comments relating to our review of the sexual and reproductive health of South Asians in the UK.<sup>1</sup> We agree there is a paucity of detailed data on ethnicity and abortion and on ethnicity and teenage births. In 2002, the abortion notification form (HSA4) was revised to allow for the recording of ethnicity, as self-reported by the women involved. This information was not previously recorded. In 2007, of the 198 499 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.<sup>2</sup>

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 can nevertheless have socioeconomic and educational implications. More recently, however, there has been a marked decline in early parenthood in South Asian groups in Britain, with all groups having lower than average incidence of teenage motherhood.<sup>3,4</sup>

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.<sup>5</sup> Although the observed differences in positivity are consistent with ethnic variations in sexual behaviour noted in the National Survey of Sexual Attitudes and Lifestyles (Natsal 2000),<sup>6</sup> we should also consider that the differences observed to date may be influenced by other factors. For example, screening is not yet national and may be missing areas and local ethnic groups with higher/lower positivity. Differences in health care-seeking behaviour/service access between ethnic groups will also mean some groups are screened more than others.<sup>5</sup>

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