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Procedure for Health Visitors in promoting positive Sexual and Reproductive Health to ante-natal and post-natal mothers in Newham.

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Version Control Summary

Version	**Date**	**Author**	**Status**	**Comment**
1.0	May 2016	Hazel Thomas	First Version	This document provides guidance for Health Visiting Teams/ Services.

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Introduction

1. This procedure is written to provide guidance for Health Visiting Teams in making referrals of antenatal & postnatal mothers to Sexual and Reproductive Health services. This document has also been developed to provide evidence-based information and to support collaborative and partnership working to ensure that accessible, high quality interventions are available to those requiring them.

1.1 Sexual health matters to antenatal & postnatal mothers. It is therefore, important to have appropriate support and services in place to promote good sexual & reproductive health. Sexual health for antenatal & postnatal mothers covers the provision of advice and services relating to contraception, intimate personal relationships, and the prevention of sexually transmitted infections (STI's).

1.2 Improving the sexual health of antenatal & postnatal mothers aims to reduce inequalities in health and promote better sexual health outcomes. Antenatal & postnatal mothers provided with knowledge / information will be able to make informed and responsible choices about contraception, relationships and sex, pre and post-delivery and beyond.

1.3 Good quality, accurate and evidence based information can play a crucial role in facilitating antenatal & postnatal mothers to understand how to improve their sexual and reproductive health and wellbeing and reduce unplanned pregnancies.

1.4 Early intervention informs behaviour change and is a key part of preventative mediations. At 6-8 weeks post-partum mothers will have a postnatal / physical review with their GP. Contraception advice may also be provided at this appointment, some women however may have resumed sexual activities before this time.

2. Purposes:

2.1 The purpose of this procedure is:

2.2 To provide information and guidance for Health Visiting Teams through reproductive and sexual health training updates and by raising awareness.

2.3 To detail the referral process and support improvement of antenatal & postnatal mothers experience increasing their knowledge and understanding.

2.4 To support antenatal and postnatal mothers to make informed choices about their sexual and reproductive health, contraception and well-being.

2.5 To promote integration and partnership working with Health Visiting Teams and Sexual and Reproductive Health Services (SRH) to improve sexual health for antenatal and postnatal mothers and to reduce the rate of STI's and unplanned pregnancies.

3. Duties:

3.1 To ensure that this is circulated to all Health Visitor Managers and Team Leaders and for them to ensure that it is read and adhered to by all Health Visitors.

3.2 Training aims to enable the Health Visiting Team to recognise antenatal and postnatal mothers with sexual ill health including perineal trauma from birth, Female Genital Mutilation (FGM) and sexual violence. Sexual ill health can cause relationship difficulties and self-

esteem issues which may impact on the mother's emotional and mental health in addition to her parenting capacity.

3.3 Health Visiting Duties – Health Visitor Teams have a key role in antenatal and postnatal mother's sexual health promotion and prevention through the Healthy Child Programme (HCP) which commences from the ante-natal period to 5 years (0-5 years). It is therefore important to increase the knowledge of health visiting professionals because of the direct contact they have with mother from the antenatal period to up 5 years. This is a unique position of trust and enables a professional working relationship to be developed and established.

4. Guidelines: The Faculty of Sexual and Reproductive Health (FSRH) provides clear guidelines for health professionals to adhere to and are as follows:

4.1. Health professionals should create opportunities for women and/or their partners to raise issues relating to postnatal sexual issues such as perineal care and dyspareunia, body image and mental well-being, and should know where to refer if appropriate.

4.2. Health professionals should allow opportunities for time alone with women in the antenatal and postnatal period, and should know how and where to access information and support for individuals affected by sexual and domestic violence including Female Genital Mutilation (FGM).

4.3. Health professionals should find opportunities during both the antenatal and postnatal period to discuss all methods of contraception.

4.4. Health professionals should assess a woman's postpartum contraceptive needs by taking account of her personal beliefs/preferences, cultural practices, sexual activity, breastfeeding pattern, menstruation, medical and social factors.

5. NICE Guidelines:

5.1 The National Institute for Clinical Excellence (NICE) identifies that the new birth visit and the follow-up visit at 6-8 weeks are prime opportunities to discuss sexual & reproductive health matters

6. Training:

6.1 In order to meet the requirement identified above Health Visiting Teams will engage in the training opportunities provided referring to Sexual and Reproductive Health services where appropriate.

6.2 The sexual and reproductive health service will provide training for all Health Visiting teams. This training is to have a health promotion focus and will include:

6.3. Revision of the FSRH and NICE guidance to demonstrate rationale and enable awareness.

6.4. Information regarding services provided and clinic times and locations.

6.5. Provision of information regarding specific contraception methods available

6.6. Provide an opportunity for case discussion.

6.7 Training will run annually at all four localities; a one hour session will be delivered during team briefs.

7 Audits:

7.1 The SRH services will audit the outcomes of direct referrals received by them

7.2 The SRH service will provide feedback on status of attendance for all referrals received.

7.3 The nature of SRH service provision requires that the content of these consultations in relation to the audit remain confidential.

8. Intervention Plan

8.1. Following appropriate training Health Visiting teams will implement the following interventions:

8.2. Antenatal visit – discussion around sexual health & well-being and previous contraception use including whether current pregnancy was planned or unplanned. Referral to SRH services if appropriate using referral form (appendix A). Provision of clinic times and locations factsheet (Appendix B).

8.3. New birth visit and two week follow up visit – Discussion around sexual health & well-being, future contraception requirements and the resumption of sexual activity. Referral to SRH services if appropriate. Provision of contraception methods summary factsheet (Appendix C).

8.4. Subsequent contacts – review of current sexual and reproductive health needs. Referral to Sexual & Reproductive Health services if required. Ensure client has factsheet (appendix C) and is aware that she can self-refer at any time.

8.5. For those service users who are transferred in sexual health and well-being should be discussed at first contact, interventions then to be delivered as above depending on antenatal / postnatal stage.

9. Monitoring

9.1. As part of the implementation plan all members of staff will be required to sign to confirm that they have received an electronic copy of the Procedure and that they will comply with procedure.

10. References

British Medical Association (2011*) Female Genital Mutilation: Caring for patients and safeguarding children Guidance from the British Medical Association* London. British Medical Association http://www.scie-socialcareonline.org.uk/female-genital-mutilation-caring-for-patients-and-safeguarding-children/r/a11G000000180qPIAQ [accessed 5/4/16]

Department of Health (DH) A Framework for Sexual Health Improvement in England. March 2013

Department of Health (2009) *Healthy child programme: pregnancy and the first five years of life*. London: Department of Health.

Department for Education and Department of Health. (2016) *Female genital mutilation, Schools: statutory guidance and Violence against women and girls*. London. Home Office. http://www.scie-socialcareonline.org.uk/female-genital-mutilation-caring-for-patients-and-safeguarding-children/r/a11G000000180qPIAQ [accessed 5/4/16]

Faculty of Sexual & Reproductive Healthcare (FSRH) Postnatal Sexual and Reproductive Health. London, UK: FSRH 2009.

National Institute for Health and Clinical Excellence (NICE) Postnatal Care: Routine Postnatal Care of Women and Their Babies [CG 37] July 2006. http://www.nice.org.uk/guidance/CG37 [accessed 20/2/16]

Appendix A

Sexual & Reproductive Health Services Referral Form

Date Referred:-	Referred by:-
Patient Surname:-	Patient First Name:-
Address:-	Contact Numbers:-
Consent to Refer: -	Nationality:- Interpreter Required:-
Date of Delivery:-	

Reason for referral:-

Contraception Advice / Provision [ ] **Sexual Health Advice** [ ]

STI screening [ ] **Dyspareunia** [ ]

Other [ ]

Additional Information:-

Please complete all fields and email to newham.cash@nhs.net or fax to 020 8586 5008

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Appendix B

Newham Community Sexual & Reproductive Health Services

Clinics	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
West Beckton Health Centre **2 Monarch Drive, E16 3UB** **(off Fulmer Road)** **262, 473, 147 bus routes and Docklands Light Railway Prince Regent Station**		SHINE Drop in for under 24's 3:30 – 6pm		Appointme nt only 6:30 – 8pm		
Shrewsbury Centre **Shrewsbury Road, E7 8QP** **238, 325, 376 bus routes and East Ham Tube Station**		Appointment only 6:20 – 8pm	Appointment only 6:20 – 8pm	SHINE Drop on for under 24's 5 – 6:30pm	Appointment only 9:30 – 11:30am	
Lord Lister Health Centre **121 Woodgrange Road, E7 0EP** **58, 308, 330 bus routes and Forest Gate Rail Station**			Appointment only 1:45 – 3:30pm SHINE Drop in for under 24's 3:30-4:15pm			
West Ham Lane Clinic **84 West Ham Lane, E15 4PT** **69, 262, 276, 473, 241, 238, 104 bus routes and nearest tube Stratford Station**	SHINE Drop on for under 24's 4 – 6:30pm	Appointment only 6:30 – 8pm	SHINE Drop on for under 24's 4 – 6:30pm	Appointme nt only 6:30 – 8pm		SHINE Drop on for under 24's 9:30 – 11:30am
Appleby Centre **63 Appleby Road, E16 1LQ** **Docklands Light Railway Royal Victoria Station**	Appointment only 1:45 – 3pm					

General contraception and sexual health clinic times are shown, please call 020 8586 5147/5148 to book an appointment. Additional clinic times are available for Implant and Coil fittings

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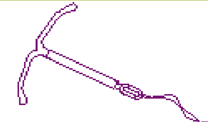
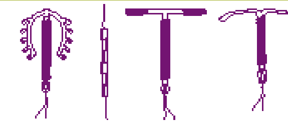
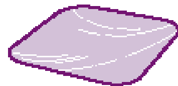
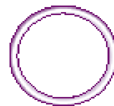
Appendix C

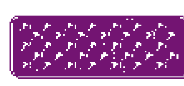
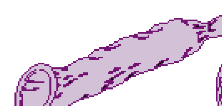
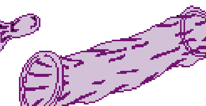
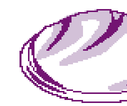
Methods with no user failure – they do not depend on you remembering to take or use them

	Contraceptive injection	Implant	Intrauterine system (IUS)	Intrauterine device (IUD)
What is it?	• An injection of progestogen.	• A small, flexible rod put under the skin of the upper arm releases progestogen.	• A small, T-shaped, progestogen-releasing, plastic device is put into the uterus.	• A small plastic and copper device is put into the uterus.
Effectiveness	• Over 99%.	• Over 99%.	• Over 99%.	• Over 99%.
Advantage	• Lasts for eight or 12 weeks – you don't have to think about contraception during this time.	• Works for three years but can be taken out sooner.	• Works for five years but can be taken out sooner. Periods usually become lighter, shorter and less painful.	• Can stay in 5–10 years depending on type but can be taken out sooner.
Disadvantage	• Can't be removed from the body so side effects may continue while it works and for some time afterwards.	• It requires a small procedure to fit and remove it.	• Irregular bleeding or spotting is common in the first six months.	• Periods may be heavier, longer or more painful.

Methods with user failure – you have to use and think about them regularly or each time you l

	Contraceptive patch	Contraceptive vaginal ring	Combined pill (COC)	Progestogen-only pill (POP)	Male condom	Female condom	Diaphragm/cap with spermicide
What is it?	• A small patch stuck to the skin releases estrogen and progestogen.	• A small, flexible, plastic ring put into the vagina releases estrogen and progestogen.	• A pill containing estrogen and progestogen, taken orally.	• A pill containing progestogen, taken orally.	• A very thin latex (rubber) or polyurethane (plastic) sheath that is put over the erect penis.	• Soft, thin polyurethane sheath that loosely lines the vagina and covers the area just outside.	• A flexible latex (or silicone device, with spermicide, is into the vagina to the cervix.
Effective only if used according to instructions ... Effective only if used according to instructions ... Effective only if used accord							
Effectiveness	• Over 99%.	• Over 99%.	• Over 99%.	• Over 99%.	• 98%.	• 95%.	• 92–96%.
Advantage	• Can make bleeds regular, lighter and less painful.	• One ring stays in for three weeks – you don't have to think about contraception every day.	• Often reduces bleeding, period pain and premenstrual symptoms.	• Can be used by women who smoke and are over 35, or those who are breastfeeding.	Condoms are the best way to help protect yourself against sexually transmitted infections.		• Can be put in ar before sex.
Disadvantage	• May be seen and can cause skin irritation.	• You must be comfortable with inserting and removing it.	• Missing pills, vomiting or severe diarrhoea can make it less effective.	• Late pills, vomiting or severe diarrhoea can make it less effective.	• May slip off or split if not used correctly or if wrong size or shape.	• Not as widely available as male condoms.	• Putting it in can sex. If you have se extra spermicide is