Women's health: potential for better coordination of services

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Abstract

Objective: To determine the proportion of women attending a genitourinary medicine clinic (GUMC) who are in need of contraception and the proportion of women attending a family planning clinic (FPC) who may require screening or treatment for sexually transmitted disease (STD).

Design: Cross-sectional survey.

Setting: A large FPC (17 600 attendances by women a year) and a large GUMC (20 060 attendances by women a year) in an inner London health district.

Subjects: All clients attending the two clinics in consecutive weeks (356 GUMC and 335 FPC). In addition a non-random cluster of other women attending the same clinics later in the year were interviewed in depth (21 GUMC and 20 FPC).

Results: Of women at the GUMC 10.4% (95% CI 7.2-13.6) were at risk of unwanted pregnancy and not using contraception. Women aged under 20 years and women not registered with a general practitioner (GP) were more likely to be in this group. A further 13.8% may have been using contraception unreliably as they were not obtaining contraception from a GP or FPC. Of women at the FPC 1.8% (95% CI 0.3-3.2) complained of symptoms of genitourinary infection. In-depth interviews showed

that some women assumed the staff at both clinics would counsel them in all aspects of sexual health.

Conclusions: The opportunities presented at GUMCs to reduce the incidence of unwanted pregnancy and the opportunities presented at FPCs to reduce the incidence and prevalence of STD should not be missed.

Introduction

There are 270 000 new female cases a year seen at GUMCs in England¹ and 2 500 000 visits by women to FPCs.² Although some women at each type of clinic are in need of the services provided by the other, Department of Health guidelines do not mention the contribution GUMCs could make to reducing numbers of unplanned pregnancies³ and, except with reference to AIDS,⁴ the contribution FPCs could make to reducing the prevalence⁵ and long term sequelae of genitourinary infections.⁶⁻⁹

We have described the number and characteristics of women presenting such opportunities at two clinics. We have asked the women whether it would be appropriate for GUMCs to ask about their contraception, and for FPCs to ask about their risk of sexually transmitted disease, in order to propose acceptable coordination of these services.

Subjects and methods

The survey was carried out in two large clinics in the Parkside Health District in London: the Raymede Family Planning Clinic, where there were 17 600 visits by women in 1987, and the St Mary's Genitourinary Medicine Clinic, where there were 20 060 visits by women in the same period.

The subjects were all women attending the GUMC in one week and all women attending the FPC in the following week, in the spring of 1989. Three hundred and sixty three women attended the GUMC and 348 attended the FPC, equivalent to 2% of the previous year's attendance in both cases. No women attended more than once in the week, and no women came into both samples. 356/363 (98%) of attenders at the GUMC and 335/348 (96%) of attenders at the FPC agreed to participate.

... Women were invited to respond to a questionnaire

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administered by an interviewer before their consultation with the doctor, nurse, or health adviser. The questionnaire covered demographic information, contact with relevant health services, contraceptive method, obstetric history, history of genital tract pathology and STD and the reason for attending. After the consultation the diagnostic outcome, and medical history were extracted from the clients' notes by the two medically qualified authors. The data were analysed using SPSS-X at St Mary's Medical School.

During a week at each clinic later in the summer, a third of women were invited to participate in an in-depth semi-structured interview to describe their experience of being asked questions about their sexual health and their attitude to such questions. The protocol was to interview every third woman attending, but this proved not to be feasible with one interviewer. The women's replies are presented to illustrate rather than to quantify the issues. Twenty one women agreed to in-depth interviews at the GUMC and 20 women at the FPC.

Results

The women attending the two clinics were similar in age, country of origin, education attained, method of contraception, and history of termination of pregnancy (table 1). The significant differences were that more women at the FPC had ever had a child while more women at the GUMC had a history of genital tract pathology or STD (table 2). Genital tract

pathology was defined as candidiasis, bacterial vaginosis, urinary tract infection, abnormal cervical smear, or pelvic inflammatory disease. STD was defined as syphilis, gonorrhoea, HIV, genital warts, genital herpes, trichomoniasis or chlamydia infection.

Most of the women were in contact with a GP as well as attending the clinic (table 3). Of women at the GUMC 73.0% and of women at the FPC 83.9% were registered with a GP and 67.3% at GUMC and 66.1% at FPC had visited a GP within the last year. But these are open access clinics not requiring referral from a GP and 65.2% of women at GUMC and 63.8% at FPC had referred themselves. Of attenders at the GUMC 25.3% and of attenders at the FPC 20.6% were making their first visit to this clinic. The only significant difference in use of services by the two groups of women was that a higher proportion of women at the FPC were registered with a GP.

Some women at each clinic needed the services provided by the other. Women at the GUMC were classified as being at risk of unwanted pregnancy if (1) they were not using contraception (2) they were not pregnant or wanting to be (3) they were not sterilised or infertile and (4) they had had heterosexual intercourse in the last two months. Of 356 women 37 (10.4%, 95% CI 7.2-13.6) were at risk of unwanted pregnancy. Women under 20 were more likely to be at risk than older women (29.6% versus 8.8%, $p < 0.01$) and women not registered with a GP were more likely to be at risk than those who were

Table 1 Similarities of women attending the two clinics

	GUMC		FPC	
	No.	(%)	No.	(%)
Total of women	356		335	
Age (years)				
< 20	27	(7.6)	37	(11.0)
20-34	281	(78.9)	249	(74.3)
35+	48	(13.5)	49	(14.6)
Total	356		335	
Place of origin				
United Kingdom	211	(59.8)	203	(60.8)
Europe	48	(13.6)	38	(11.4)
Other	94	(26.6)	93	(27.8)
Total	353		334	
Education				
"O" level or less	179	(51.1)	174	(52.9)
"A" level/further education	151	(43.1)	142	(43.2)
Other	20	(5.7)	13	(4.0)
Total	350		329	
Work				
Employed outside the home	225	(63.7)	220	(65.7)
Unwaged	81	(22.9)	70	(20.9)
Student	47	(13.3)	45	(13.4)
Total	353		335	
Contraception				
Steroids (oral/injected)	144	(40.7)	167	(49.9)
Barrier (diaphragm/condom)	95	(26.8)	77	(23.0)
Other	31	(8.8)	25	(7.5)
None	84	(23.7)	66	(19.7)
Total	354		335	
History of termination of pregnancy				
Yes	91	(28.1)	114	(34.2)
Total	324		333	

Table 2 Differences in women attending the two clinics

	GUMC		FPC		Difference in % (95% CI)
	No.	(%)	No.	(%)	
Total of women	356		335		
Had child(ren)**†					
Yes	52	(16.0)	95	(28.4)	12.4 (6.1–18.7)
No	274	(84.0)	239	(71.6)	
Total	326		334		
Genital tract pathology history*					
Yes	283	(79.5)	200	(59.7)	19.8 (15.2–26.5)
No	73	(20.5)	135	(40.3)	
Total	356		335		
Sexually transmitted disease history*					
Yes	161	(45.2)	55	(16.4)	28.8 (22.3–35.5)
No	195	(54.8)	280	(83.6)	
Total	356		335		

* $p < 0.05$.

†Information missing for 30 women at GUMC and one woman at FPC.

Table 3 Use of services by women attending the two clinics

	GUMC		FPC		Difference in % (95% CI)
	No.	(%)	No.	(%)	
Total of women	356		335		
Registered with a GP*					
Yes	260	(73.0)	281	(83.9)	10.9 (4.8–17.9)
No	96	(27.0)	54	(16.1)	
Total	356		335		
Visited GP within a year†					
Yes	237	(67.3)	218	(66.1)	
No	115	(32.7)	112	(33.9)	
Total	352		330		
Self-referred to clinic‡					
Yes	232	(65.2)	192	(63.8)	
No	124	(34.8)	109	(36.2)	
Total	356		301		
New to clinic					
Yes	90	(25.3)	69	(20.6)	
No	266	(74.7)	266	(79.4)	
Total	356		335		

* $p < 0.001$.

†Information missing for 4 women at GUMC and one woman at FPC.

‡Information missing for 34 women at FPC.

registered (16.7% versus 8.1%, $p < 0.05$). None of these women received contraceptive supplies at this visit, and it was not clear from their notes how many were referred to another source of professional advice on contraception.

Of those who were using contraception, 49/270 (18.1%) were not receiving their contraception from an FPC and had not visited their GP in the last year. As the GUMC was apparently their sole contact at this time with a potential source of medical advice on contraception, their contraception may have been unreliable and the number of women at the GUMC at risk of unwanted pregnancy may be underestimated.

At the FPC 6/335 women (1.8%, 95% CI 0.3–3.2) complained of symptoms of genital tract infection

and were all referred to the local GUMC. The diagnostic outcome following referral is not known. Since many STDs are asymptomatic this is likely to underestimate the prevalence. However 55/335 women (16.4%, 95% CI 12.4–20.4) had a history of sexually transmitted disease which itself may indicate a risk for current asymptomatic infection. Among these 55 women there were 11 previous cases of chlamydia, five of gonorrhoea and 21 of trichomoniasis, all conditions which may be carried asymptotically.

The in-depth interviews provided insight into the way women viewed the services. At the GUMC most women interviewed would have had no objection to discussing contraception. One said "I think it would be helpful because if you're taking the wrong thing or

something that's not effective, there could be something that suits you". Indeed half of the women interviewed at the GUMC volunteered that they assumed the staff were trained in family planning and some assumed their contraception would be routinely checked. One woman stated "I think you get more detailed information here because they specialise in contraception and birth control."

At the FPC although few women said they would have objected to being asked about their past or present sexual relationships or any previous genitourinary infections, half considered such questions would be relevant only if they were at risk of infection ("if you've got lots of partners") and in fact these questions were not usually asked by the family planning staff. Some women assumed FPC staff were also qualified in genitourinary medicine. For some women at the FPC the stigma of possibly attending a GUMC remained. One said of her visit to a GUMC, "I was mortified by being there in the first place".

Discussion

The opportunity for GUMCs to identify women, particularly young women, in need of contraception has been shown by other studies. Twenty three per cent of new teenage women clients at another GUMC in London were not using reliable contraception.¹⁰ The same was true of 41% of teenagers attending a GUMC in the USA.¹¹ In our study 29.6% of teenagers and 10.4% of women of all ages were classified as at risk of unwanted pregnancy and a further 18.1% of women using contraception were not receiving medical advice. The contact with health professionals at the GUMC provided an opportunity for such advice. For those under 20 years old the opportunity was presented early in their reproductive lives.

Our findings support a policy of GUMC staff taking the opportunity to ask about contraception and to refer to FPCs and GPs where appropriate. In addition GUMCs should be able to offer emergency methods such as condoms and post-coital contraception.

The reciprocal need for genitourinary medicine care among women at FPCs has been documented elsewhere in terms of asymptomatic infection. Of 1000 women attending a FPC in Central London 0.4% had asymptomatic gonorrhea.¹² Of 300 women at three FPCs 4% had infection with *Trichomonas vaginalis*.¹³ The reported prevalence of asymptomatic cervical infection with *Chlamydia trachomatis* in women attending FPCs ranges from 2% to 7%.¹⁴ In our study 1.8% of women attending the FPC presented with symptomatic infection and 16.4% had a history of sexually transmitted disease. As women with a history of disease may be at increased risk of repeated episodes it may be appropriate for clinicians

to enquire further about recent sexual history with a view to referral.

At least one large contraception clinic already has on-site facilities for diagnosis of sexually transmitted diseases and genital tract pathology.¹⁵ However, this is unlikely to be feasible in the majority of clinics which are small and in shared premises. Accurate diagnosis prior to treatment is important. In the absence of on-site facilities FPC staff should identify women with symptoms of infection and arrange referral and treatment.^{14,16} Women at risk of asymptomatic infection should also be identified by the FPC and referred to a GUMC for screening, as suggested by Adler¹³ and Nabarro.¹² This recommendation is reinforced by our finding that in the in-depth interviews some women said they assumed screening was already occurring. In our study the GUMC was larger than the FPC, but in the total of clinics in England there are nine times more visits a year by women to FPCs than to GUMCs, and nine times more opportunities for advice and referral.

The importance of seeing this visit as an opportunity is underlined by the fact that in both clinics a third of women had not seen their GP within the last year while 25% of women at the GUMC and 21% at the FPC were visiting the clinic for the first time.

The similarity of the two groups of women is useful in describing GUMCs to the public and to staff, thereby reducing the stigma and resulting fear which many people have of attending such clinics. Over half of the GUMC attenders had never experienced an STD, the majority of consultations being for other genital tract pathology or screening.

We recommend that women should be clearly informed about the services provided at both types of clinic. Staff should attempt to identify women in need of services not available in their own clinic, and give appropriate advice and referrals. Implementation of these recommendations requires improved training for medical, nursing and reception staff at both types of clinic and interim counselling and contraceptive supplies at GUMCs. Staff at GUMCs should give special consideration to the contraceptive needs of women under 20 years of age.

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