Family planning in genitourinary medicine: an opportunistic service?

L Masters, H Nicholas, P Bunting, J Welch

Abstract

Objective—To evaluate and serve the need for contraception in those not using conventional sources of family planning services.

Setting—South London outpatient genitourinary medicine department at King's College Hospital.

Design and subjects—Prospective study of 200 women seen consecutively in the clinic by the same doctor (LM) during 1993. Women at risk of unwanted pregnancy were identified, and offered immediate contraceptive provision or referral.

Results—15 women (7.5%) were using no contraception, despite being sexually active and not wishing to conceive; of these two presented with an unwanted pregnancy. A further 23 women (11.5%) were not using their chosen contraception effectively, and another 20 women were unclear about contraceptive methods and wanted advice. Young women were most at risk; 14% of those aged 25 years and under were using no contraception. Eight women wished to defer contraceptive advice; of these four defaulted from follow up. Eighteen women (9%) wanted immediate contraceptive supplies. Ten of 18 returned a follow up questionnaire; all these women were satisfied with the contraceptive advice service received.

Conclusions—Absent or ineffective contraception is common in women attending an inner city genitourinary medicine clinic. Immediate provision of contraceptive education, advice and supplies is welcomed by patients.

exceed the national average for all age groups, and the termination of pregnancy (TOP) to live birth ratio is one of the highest in the country.⁴ We assessed the need for an "opportunistic" family planning service within the GU clinic, in which advice was offered to those most at risk of unwanted pregnancy, and follow up was arranged locally to make most economical use of existing services.

Methods

A structured interview was held with 200 women seen consecutively in the clinic by the same doctor (LM). Demographic information and details of sexual history and contraceptive practices were recorded. Compliance with contraception was assessed at interview and was defined as "good" (over 90% compliance), "partial" (70-90%) or "poor" (less than 70%).

A group of women at high risk of unwanted pregnancy was identified. They were those who were sexually active, without contraception, and who did not want to conceive. Contraceptive advice, supplies or referral were offered by the doctor where appropriate, especially targeting this "high risk" group. Advice and techniques were reinforced by a nurse with family planning training. Follow-up appointments with a general practitioner (GP) or family planning clinic were facilitated. Women given a new method of contraception were also asked to fill in a short feed-back questionnaire. Results from the structured interview were analysed using EPI. INFO and STATCALC programmes using chi square, *p* for significance at 0.05 level and odds ratios with 95% confidence intervals.

Results

Of 200 women seen, 94 (47%) were Caucasian, 79 (39.5%) black Caribbean, nine (4.5%) black African and 18 (9%) were of other origins. The majority were aged 30 years or under (table 1) and sexually active at

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Introduction

The *Health of the Nation*¹ white paper states amongst its objectives a need to ensure effective family planning services for those people who want them, and to reduce the rate of unwanted pregnancies. The specific aim is to halve the pregnancy rate in the under 16 age group by the year 2000. This is proving hardest to achieve in areas which are socio-economically deprived.² The Department of Genitourinary (GU) Medicine at King's College Hospital sees 19 000 women a year. Fifty six per cent of our population are socio-economically deprived.³ Conception rates

Table 1 Ages of participants

Age (years)	Frequency	%
Under 16	3	1.5
16-20	32	16
21-25	54	27
26-30	65	32.5
31-35	21	10.5
36-40	12	6
Over 40	13	6.5
Total	200	100

Department of Genitourinary Medicine, Kings College Hospital, London SE5 9RS
L Masters
H Nicholas
P Bunting
J Welch
Correspondence to: Dr L Masters

Table 2 Current sexual activity

	Frequency	%
Not sexually active	26	13
Trying to conceive	26	13
Using contraception	128	64
Proven infertile	4	2
At risk of unwanted pregnancy	15	7.5
Female partner only	1	0.5
Total	200	100

Table 3 Obstetric history

	Frequency	%
Never pregnant	69	34.5
Nulliparous with past miscarriage	8	4
Nulliparous with past TOP (including TOP and miscarriage)	37	18.5
Parous without TOP	50	25
Parous with TOP	36	18
Total	200	100

the time of interview (table 2). Fifteen women (7.5%) were classed as "high risk". Two of these were attending with an unwanted pregnancy. Twelve (80%) of the high risk group were under 25 years old ($p = 0.019$, odds ratio 5.02, confidence limits 1.25 to 28.76).

Ten percent of the women said they had not been sexually active during the last three months, 73% said they had been in monogamous relationships, 12.5% said they had had two or more regular partners and 4.5% had had casual partners only. Seventy-three women (36.5%) had had at least one termination (table 3). Forty-five (22.5%) said that they did not want any more children.

Choice of contraception and compliance rates are shown in table 4. Twenty-three women (18% of those using contraception) were not using their chosen contraception effectively in addition to the 15 who were completely unprotected. There were no significant differences in either choice of contraception or compliance between ethnic groups. Most of those using contraception attended their GPs (45%) or family planning clinics (23%) for advice, but the pharmacist was the most popular source of condoms (16%). Nine (4.5%) were not registered with a GP. Fifty-eight women (29%) were unclear about contraceptive methods and needed advice, including the entire at risk group who were

Table 5 Contraception provided at clinic consultations

	Frequency
No contraception given	176
Condoms	8*
OCP/POP	3
Injectable progestogen	4
Cap	1
Female condom	3
Spermicides	2
Referred elsewhere†	3
Total	200

*Not including condoms given purely for safer sex in the presence of other contraception
†Referrals to ante-natal clinic or to family planning clinic/GP for IUCD insertion

using no contraception at all. Eighteen patients (9%) wanted contraceptive supplies at the first appointment. Eight preferred to wait until a follow up visit, but four then failed to return and three subsequently declined further contraceptive advice. Table 5 shows the range of contraception provided at these consultations.

Ten of the eighteen women (56%) given a new method of contraception returned the follow up questionnaire, and all these were satisfied with the family planning service they had received at the GU clinic.

Discussion

Our findings confirm other studies⁵ in finding that absent or ineffective contraception is common in GUM clinic attenders. Young women are most at risk of unwanted pregnancy, with 14% of those aged 25 and under using no contraception. The need for patient education is great, with 29% of women feeling unclear about contraceptive methods. Poor compliance leading to ineffective contraception was widespread: inadequate patient education was the major cause.

Such a substantial need for advice about contraception, and low attendance rates for specialist clinics,⁶ suggest that family planning expertise needs to be available in routine GU clinics as well as in designated family planning sessions. Such expertise can be provided in a variety of ways, by both doctors and nurses. Doctors in GU medicine training posts can readily also undertake the training necessary for the diploma in family planning, as can doctors in staff grade posts. Clinical assistants with a family planning background can continue to work in both fields, to the benefit of each specialty. Nurses with family planning training are well placed to educate and advise patients about their contraception, and, in our experience, value this extension of their roles. Health advisers can also make a major contribution by discussing contraception in addition to other aspects of sexual health.

Constraints on time may make it unfeasible to carry out some procedures, such as fitting a cap or a coil, in a busy GU medicine clinic, unless additional staff can be funded and made available. Initiating hormonal contraception for women at high risk of unwanted pregnancy is generally easier to achieve, and can be facilitated by enabling the nursing staff

Table 4 Choice of contraception and compliance

	Frequency	Compliance	
	No (%)	Good	Partial/Poor
No contraception/ not sexually active	72 (36)	—	—
Combined oral contraceptive pill (OCP)	62 (31)	56	6
Progestosterone only pill (POP)	7 (3.5)	4	3
Condom (male or female)	27 (13.5)	17	10
Cap	3 (1.5)	2	1
Intra-uterine contraceptive device (IUCD)	6 (3)	6	0
Sterilisation	11 (5.5)	11	0
Natural/withdrawal	4 (2)	3	1
Spermicide and condom	2 (1)	0	2
Injectable progestogen	6 (3)	6	0
Total	200 (100%)	105 (82%)	23 (18%)

to receive family planning training, so that they can provide most of the patient education required. Advising women who are using their chosen method of contraception ineffectively takes relatively little medical and nursing time, but is an important component of sexual health promotion.

Where appropriate we recommend giving family planning advice to patients at high risk of unwanted pregnancy, and initiating contraception, at the first visit, as our study showed little chance of a second opportunity. The women can then attend their GP or local family planning clinic for follow up but may need information about available services and help in making appointments. This approach was welcomed by substantial numbers of our patients, including over half those at greatest risk of unwanted pregnancy.

We feel that, especially in deprived areas,

opportunistic family planning could make a useful contribution to reducing unwanted pregnancy in young women.

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