Managing genital infection in community family planning clinics: an alternative approach to holistic sexual health service provision

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Objective: To pilot and evaluate sexually transmitted infection (STI) management in community family planning clinics (FPCs).

Methods: Number of STI tests taken, positive results, infections treated, contacts traced/treated, referrals to specialist services and time from testing to treatment were documented as well as age and sex of the population tested.

Results: STI tests taken increased from 233 to 308/month and male clients seen increased from 114 to 147/month across all clinics. Chlamydia prevalence rates in one large clinic increased from 6.7% to 11.9%. 82% of those with STIs in this clinic were treated. Of 44 clients treated for chlamydia, 84% had partner notification performed, 0.43 contacts were treated for every client with chlamydia and referrals to specialist services decreased. 70% of STIs were detected in clinic users under the age of 25 and 45.5% of clients tested under the age of 16 had an STI. Before STI treatment was available at FP clinics 52% of clients with STIs attended specialist services after referral and time from testing to treatment was 19 days. Managing STIs in the community increased treatment rates to 82% with a testing to treatment time of 10 days.

Conclusions: The management of uncomplicated genital infection in community FPCs working in partnership with specialist services is a feasible and effective approach to holistic sexual health service provision.

In the United Kingdom sexually transmitted infections (STIs) are traditionally managed in specialist genitourinary medicine (GUM) clinics but the increasing incidence of STIs means that specialist services lack capacity to meet demand.1-3 Long waiting times and a reluctance to travel to an unfamiliar service4 result in poor attendance rates (for example, 52%) when those with STIs diagnosed in community clinics are referred for treatment. Community based services for the management of uncomplicated genital infections are a possible solution to this problem5 but their effectiveness and accessibility is untested.

METHODS

Population studied

This study took place in an outer London family planning service in Lewisham, consisting of 11 community family planning clinics (FPCs) providing 42 doctor sessions a week (36 327 client attendances in 2001–2). The local population has high rates of infection. Over one quarter of all cases of chlamydia infection and nearly one third of all cases of uncomplicated gonorrhoea in London were diagnosed in the boroughs of Lambeth, Southwark, and Lewisham.6 Data on STI rates are available from GUM clinics only.

Policies before and after the change in STI service

In the past these community clinics have offered testing for chlamydia, gonorrhoea, trichomonas, genital warts, genital herpes and vulvovaginal candidal infections, and treatment for symptomatic candidiasis and bacterial vaginosis. Gonorrhoea and trichomonas testing were performed respectively on endocervical and high vaginal swabs sent to the laboratory in transport medium. Chlamydia testing at the time of the study was performed on endocervical swabs using Micro-trak II enzyme Immunoassay (EIA).

From November 2001 we introduced treatment for chlamydia, trichomonas, genital warts, genital herpes and from September 2002 treatment of pelvic inflammatory disease (PID). Partner notification was client led; clients were counselled about the consequences of untreated infection, advised to contact current/previous sexual partners at risk and provided with contact slips. Testing and treatment were offered to male partners of female clients with infection (direct microscopy for acute male urethral discharge was not available). Gonorrhoea and complicated cases were referred to GUM clinics. The treatment of gonorrhoea was not included because clients could not be actively pursued if they failed to attend for follow up. This policy is under review.

The new services were advertised only in a newsletter to local general practitioners (GPs). They required new clinical guidelines, paperwork, drugs and training for staff. Clinical guidelines were based on national guidelines modified for community settings. Drugs are stocked in the clinics and prescription charges are not levied for STI treatment. Some staff had extensive GUM experience but those without experience attended recognised training courses.

AIMS AND ANALYSIS

This paper presents the evaluation of the first 6 months of this new service. The evaluation aimed to test the feasibility of managing STIs in community FPCs, document demand for this service, describe the population using the new service in terms of age, sex, and STI prevalence and document the proportion of infections treated and the effectiveness of partner notification.
From December to May 2001–2 and 2000–1 the numbers of microbiological tests taken, infection treatments given, men tested/treated, and clients referred to GUM services were collected from all Lewisham clinics.

From December to February 2001–2 and 2000–1 the numbers and results of swabs taken, treatments given, GUM referrals, partner notifications performed and the time between testing and treatment were collected from the largest clinic site in Lewisham, the Waldron Health Centre, open for 39 hours/week (12 752 client visits in 2000–1). The six clients with multiple infections. Of the population of clients over 30 and the under 16s accounted for three of 45% of clients under 16 tested had a STI compared to 10.3% of the population tested rose from 6.7% to 11.9%. Predictably, 135% (from 17 to 40) and as a result chlamydia prevalence in the number of clients testing positive for chlamydia rose by chlamydia swabs taken increased by 34% (from 252 to 337), trichomonas, four had gonorrhoea alone, one had gonorrhoea and chlamydia, three had chlamydia and gonorrhoea, three had chlamydia and trichomonas, four had gonorrhoea alone, one had gonorrhoea and trichomonas, four had trichomonas alone, nine had genital warts, and four had genital herpes). The number of chlamydia swabs taken increased by 34% (from 252 to 337), the number of clients testing positive for chlamydia rose by 135% (from 17 to 40) and as a result chlamydia prevalence in the population tested rose from 6.7% to 11.9%. Predictably, 45% of clients under 16 tested had a STI compared to 10.3% of clients over 30 and the under 16s accounted for three of the six clients with multiple infections. Of the population tested during December–February 2001–2, 6.2% (22/356) were men who accounted for 10.3% (7/68) of those with STIs, which was to be expected as were offering testing and treatment to male partners of female clients with infection (table 1).

Eighty two per cent of those with chlamydia, trichomonas, genital warts, or genital herpes diagnosed at the Waldron Health Centre were treated. Before the introduction of the new service all of these (62) would have been referred to GUM clinics. Referrals to specialist services were appropriate, for example, for HIV testing. Initially clients with suspected PID were referred to GUM clinics but when delays between referral and treatment were reported, treatment for PID was introduced into community clinics to minimise risk of complications. Of the 44 clients treated for chlamydia or as chlamydia/non-specific urethritis contacts, 84% (37) had documented evidence of partner notification protocols completed. Of the remaining seven clients, two declined contact slips, one client’s notes were unavailable for analysis, and four had no recorded discussion of partner notification. For every index client treated for chlamydia 0.43 contacts were treated; 13 partners attended FPCs for treatment and six attended GUM clinics or GPs. The median test to treatment time for the 52 clients treated for trichomonas or chlamydia was 10 days.

**RESULTS**

The number of swabs taken for STIs in all Lewisham clinics increased significantly from an average of 233 to 308 per month (p = <0.05) in the first 6 months of the new service. During this time (December–May 2001–2) 194 clients were treated for chlamydial infection with smaller numbers treated for primary genital herpes (11), genital warts (22), and trichomonas (16). The number of men using community family planning services increased from an average of 114 per month to an average of 147 per month (p = 0.149). Despite the increase in the number of swabs taken and infections detected the number of clients referred to specialist services decreased significantly from an average of 28 to 17 per month (p = <0.05).

At the Waldron FPC between December–February 2000–1 and December–February 2001–2 the number of STI detected increased from 26 to 68 (35 clients had chlamydia alone, two had chlamydia and gonorrhoea, three had chlamydia and trichomonas, four had gonorrhoea alone, one had gonorrhoea and trichomonas, four had trichomonas alone, nine had genital warts, and four had genital herpes). The number of chlamydia swabs taken increased by 34% (from 252 to 337), the number of clients testing positive for chlamydia rose by 135% (from 17 to 40) and as a result chlamydia prevalence in the population tested rose from 6.7% to 11.9%. Predictably, 45% of clients under 16 tested had a STI compared to 10.3% of clients over 30 and the under 16s accounted for three of the six clients with multiple infections. Of the population tested during December–February 2001–2, 6.2% (22/356) were men who accounted for 10.3% (7/68) of those with STIs, which was to be expected as we were offering testing and treatment to male partners of female clients with infection (table 1).

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**DISCUSSION**

The management of uncomplicated STIs in community FPCs is feasible and effective. The new service, working in partnership with local GUM clinics, delivers semi-specialist STI management services in an environment that is familiar (in local health centres) and accessible (44% of clinics provided after 5 pm at 11 clinics in Lewisham). Demand for STI management services in this context is high with uptake increasing despite no advertising to clients.

We do not know whether clients using the new service would otherwise have accessed specialist GUM clinics, primary care, or remained undiagnosed and untreated. The increase in chlamydia prevalence rates documented (from 6.7% to 11.9%) suggests that either the population now being tested is new to the service or the uptake of testing among existing high risk clients has increased. Most community family planning clinics record low average chlamydia prevalence rates (5.1%, range 3–7) compared to that in GUM clinics (16.4%, range 7–29). The increasing chlamydia prevalence documented in this study may reflect an increasing prevalence in the local population but almost double the prevalence in 1 year is unlikely and inconsistent with national trends.

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>Under 16</th>
<th>16–19</th>
<th>20–24</th>
<th>25–29</th>
<th>30+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients tested</td>
<td>11</td>
<td>84</td>
<td>87</td>
<td>61</td>
<td>107</td>
</tr>
<tr>
<td>Number of clients being tested for STI (n = 356)*</td>
<td>(3.1%)</td>
<td>(23.6%)</td>
<td>(24.4%)</td>
<td>(17.1%)</td>
<td>(30.1%)</td>
</tr>
<tr>
<td>Number of clients with STI detected (n = 62)</td>
<td>5</td>
<td>21</td>
<td>17</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>% of clients tested who were positive for STI</td>
<td>(8.1%)</td>
<td>(33.9%)</td>
<td>(27.4%)</td>
<td>(12.9%)</td>
<td>(17.7%)</td>
</tr>
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*Age unknown 6 (1.7%)
Treating infections in the community clinics where they are diagnosed is more effective than referral to GUM clinics. Eighty two per cent of those with positive results were treated in community clinics compared to 52% referred to specialist services.9 The average time from testing to treatment in the new service is 10 days compared to 19 days when clients were referred to specialist services. The partner notification strategy adopted appears adequate with the 0.43 contacts treated for every index client comparing favourably with the national contact tracing standard of 0.5.10 The new service reduces GUM workload by referring fewer clients for treatment despite the increasing number of clients diagnosed with STI.

ACKNOWLEDGEMENTS
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CONTRIBUTORS
JE and PB jointly designed the study, analysed the data, and wrote the paper; JP provided statistical analysis; JE and JC collected the data; JE and LB planned and implemented the service; LB commented on drafts of the paper.

REFERENCES
4. Evans J. Should we be testing for STI in south east London community family planning clinics? Dissertation submitted as part of the requirements for the Membership of the Faculty of Family Planning, 2001.