

Experiences of and attitudes to contraceptive services among a sample of attenders at general practices in Dublin

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Summary

The aim of this pilot project, using quantitative and qualitative methods, was to gain insights into contraceptive service utilisation by studying the experiences and attitudes of a sample of women using general practice for contraception services in Dublin.

Keywords

contraception, general practice, Ireland

Key message points

- Over time and changing circumstances, women tend to shift from using specialist contraceptive services to general practice care.
- Contrary to GP concerns, the majority of women would welcome the doctor or practice nurse raising the issue of contraception.
- A minority of women entitled to free GP care because of their low economic status, still use fee-paying services; lack of access to a female practitioner may be the reason.
- Continuity of care is a valued feature of GP contraceptive services; contrasting with specialist centres, where perceived anonymity is paramount.

Background

More than 90% of Irish general practitioners (GPs) claim to offer a contraceptive service¹ yet over 50% of Irish women do not find contraceptive advice accessible² and the abortion rate continues to rise.^{3,4} A study amongst attenders at specialist family planning services indicated scant knowledge and utilisation of general practice for contraception,⁵ while little is known of women who *do* avail of this service. This pilot project focuses on a sample of Dublin women as service users, and provides baseline information in this context.

Method

Ten practices chosen opportunistically were used to target 500 consecutive female attenders of childbearing age. An anonymous self-administered questionnaire was used to gather quantitative data. Audiotaped in-depth interviews with volunteers among the respondents provided qualitative data, which was transcribed and analysed. The quantitative data was analysed using EPI-INFO (v6.04a).

Results

A list of practices comprising a mix of doctor gender, practice size and composition of fee- and non-fee-paying patients was compiled. The first 10 practices approached agreed to participate, with a target of 50 respondents each. All consecutive female attenders of childbearing age were offered a questionnaire, which was returned in a sealed envelope or by free post. This quantitative data gathering

measure yielded a valid response rate of 84% (398 respondents). Among these, 115 (29%) indicated willingness to be interviewed by supplying name and contact details.

From among these, a purposive sample of eight women was drawn to represent diversity of sexual and contraceptive experience and social background. Qualitative data from this sample was gathered using in-depth interviews, conducted confidentially in the respondents' homes, audio taped, transcribed and analysed using a framework technique.⁶

Quantitative data

Of the 398 respondents, 72 (18%) indicated they were not sexually active or not using contraception; 33 (8%) got supplies from their chemist. In the past, 154 respondents (39%) had used specialist service providers: Well Woman or Family Planning Centres; 57 (14.3%) continue to access contraceptive services there ('specialist attenders'), 86% of whom indicate they have a regular GP. Women regularly attending their GP for contraceptive services ($n = 236$, 'GP attenders') are the group of particular interest. Their demographic and other characteristics are summarised in Table 1 and are compared with the 'specialist attenders' group. In Ireland roughly a third of the population, the poorest section of the community, are General Medical Services (GMS) eligible, with free access to primary care and drugs. Specialist attenders paid for services received. GP attenders differ significantly from specialist attenders in the following respects: they are more likely to be GMS eligible (58% vs.42%) and have children (72% vs.42%), and less likely to have a job (44% vs.67%) or to be married (46% vs.58%) ($p < 0.05$ in all respects).

Differences between GP and specialist attenders regarding access to, and requirement for, a female practitioner are not significant, but specialist attenders with GMS eligibility ($n = 24$) are less likely than GP attenders with GMS eligibility ($n = 137$) to have access to a female GP (16% vs. 40%) ($p = 0.027$).

Assessment of satisfaction with the service received indicated that 74% of GP attenders were satisfied. There is a delay between the onset of sexual activity and contraceptive behaviour for both groups, a phenomenon observed in other studies.⁵⁻⁸

Asked if they felt it was appropriate for the GP or practice nurse to inquire of all women if they needed advice on contraception, 73% of all respondents agreed that it was, while 80% and 92% of GP and specialist attenders, respectively, said that such an inquiry, directed to them personally, would be welcome.

Table 1 Demographic and other characteristics of GP and specialist attenders

Characteristics:	GP attenders n = 236	Specialist attenders n = 57
GMS eligible	137 (58%)	24 (42%)
Median age (range) (years)	28 (17-50)	30 (16-52)
Have a job	104 (44%)	38 (67%)
Weekly income:	n = 228	n = 56
< £200	176 (77%)	40 (72%)
>£200	52 (23%)	16 (28%)
Marital Status:	n = 235	n = 55
Married /co-habit.	109 (46%)	32 (58%)
Single, no partner	124 (54%)	33 (60%)
Children:		
None	67 (28%)	32 (58%)
One or more	169 (72%)	23 (42%)
Have access to female GP	112 (47%)	20 (35%)
Male doctor acceptable for contraception	165 (70%)	42 (74%)
Female doctor only for smear	110 (47%)	25 (44%)
Mean age first sexual intercourse (years)	18.86 (SD = 2.9)	18.8 (SD = 3.1)
Mean age at which contraception initiated (years)	20.08 (SD = 3.7)	19.54 (SD = 3.2)

Qualitative data

Continuity of care and an established relationship with the doctor is a valued feature of general practice, and contrasts with a perception of specialist services providing ‘anonymity’. Anonymity is important to some women at the outset of sexual activity, while continuity of care is linked with increasing confidence in lifestyle choices. Discussing sex and contraception with the family GP who “..knew me as a little girl..” makes some women uncomfortable. A GP recommended by their peers is preferred by some young women. Facilities and procedures affording optimum dignity and privacy are paramount to women where pelvic examination is required, and GP surgeries are sometimes found wanting in this regard. A perception exists of female practitioners being more sympathetic than male because they have the same biological functions and problems; this facilitates discussion and minimises embarrassment for some women.

Discussion

Methodological factors impose some limitations on the findings: opportunistic rather than random selection of general practices; respondents with special needs were not catered for; qualitative data provided useful supplementary information without wider claim to generalisability, but the sample is small. A ‘satisfied-user’ bias cannot be out-ruled. Despite assurances of confidentiality and anonymity, patients completing a questionnaire in such settings may feel that future care is jeopardised by unfavourable responses. Because it excludes men, the study may also inadvertently reinforce the view that contraception is the sole responsibility of women. However, given the dearth of information that exists in the Irish context, the findings can inform and may encourage further study.

Satisfaction ratings expressed by GP attenders are acceptable and similar to other patient groups and settings.^{9,10} The influence of doctor gender, well documented elsewhere,¹¹⁻¹⁴ remains an important issue for many women. Specialist centres (staffed almost exclusively by female practitioners) are still the preferred option for

some women among whom are those who, although eligible for free GP care, do not have access to a female GP. The unmet needs of this vulnerable group must be of concern. The endorsement by respondents of the GP or practice nurse initiating inquiry regarding contraception may be reassuring to practitioners, whose concerns about its acceptability may have deterred them from broaching the subject with their patients.

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