A critical review of the literature on family planning services with specific reference to the respective roles of general practice and clinic based services

This report was commissioned by Fife Health Board and was carried out by Fife Health Research
Fife Health Research

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1. Summary

1.1 There are no randomised control trials (RCTs) comparing family planning services provided from general practice with those provided from family planning clinics.

1.2 In the absence of RCTs there is some evidence that in general family planning services are staffed by people more highly trained in family planning methods and offer a wider range of contraceptive methods than general practice. However, where general practice staff are trained in family planning methods there are no differences between them.

1.3 The unique contribution of family planning clinics is in offering choice to those men and women who prefer not to attend their own general practitioner, particularly for those who wish anonymity.

1.4 If the health board continues to see the availability of choice as a feature of its services for family planning, offering these through both general practice and the family planning clinics ensures that this is accomplished.

2. Introduction

The Acting Director of Public Health (ADPH) of Fife Health Board has asked for a review of the literature on family planning services, excluding specific services for teenagers, as part of the Board's work towards a sexual health policy.

3. Aim

The aim of this report is to review the literature on family planning services with a view to determining the relative merits and respective roles of general practice and clinic based services. The ADPH particularly wishes to know whether each has a unique contribution and, where their services overlap, whether one service is better than the other.

4. Objectives

The specific objectives of this report are to answer the following questions:

4.1 Are there any RCTs comparing family planning services provided from general practice with those provided from family planning clinics and, if so, which do they show are better?

4.2 In the absence of RCTs is there any information which shows that family planning services provided from general practice are better or worse that those provided from family planning clinics?

4.3 What is the unique contribution of family planning clinics?
5. Methods


6. Literature review

6.1 Historical perspective of family planning services

In March 1921 Marie Stopes opened the first British birth control clinic in Holloway but it was not until 1930 that active campaigning had managed to secure relatively positive results. In that year the Ministry of Health permitted local authorities to provide contraceptive facilities to married women on limited medical grounds. Brooke Advisory Centres came into being in 1964 to provide for young unmarried people who, it was felt, were not being adequately catered for by existing family planning services. In 1967 the public family planning clinics started to provide contraceptive advice on medical and social grounds regardless of marital status and in 1974, on the re-organisation of the health service, the clinics were fully incorporated into the National Health Service (NHS). Use of the service increased rapidly, with the percentage of women ever married making use of general practitioner or family planning clinic services in England and Wales increasing from 23% in 1970 to 35% by 1979. Just over half of these attended their own general practitioner. Family planning was seen to have three principal benefits in contemporary society, a benefit to the individual health of mothers and children, including emotional and economic, benefits to the community at large of having healthy mothers and children which came from planned families, and the avoidance of unintended pregnancies.

6.2 Operations research issues

Workers in operations research have examined in some detail family planning services in different countries throughout the world. Bernhart investigated the specific role of management of family planning programmes and operations research. Within this context the major problem facing family planning services in Fife is that of overcoming marginal effectiveness. Bernhart noted that even when uptake is high, people can drift in and out of programmes, and groups that remained unprotected were at high maternal risk. While this problem is most acute within the context of teenagers in Fife it is also a problem affecting those beyond their teenage years. Townsend has reviewed the results of operations research in improving the effectiveness of family planning programme components and reached a number of conclusions, some of which are particularly relevant in the present context (Table 1).
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<table>
<thead>
<tr>
<th>Table 1: Some key components from operations research on effective family planning services</th>
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<tr>
<td>Female service providers are often viewed as more acceptable to clients than males. The actual performance of female providers is often better than that of male providers in clinics, and differs little from that of males at the community level.</td>
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<tr>
<td>Greater access to contraceptives increases use, but there are many ways to increase access, including new delivery systems, improved referral, and efforts to listen to the needs of clients.</td>
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<tr>
<td>Expanding the choice of methods available to users increases overall contraceptive use. Choice affects not only acceptance, but also continuation.</td>
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In recent years the importance of consumer choice has come to the fore, although not to the exclusion of other quality-of-care issues. The key issue would appear to be the degree of trust, rapport and confidence which is established between the individual seeking advice and the health care worker.

6.3 Family planning services in the UK

Family planning services within the UK are provided both by general practitioners and by clinics, both of which have been the subject of recent reviews, as has the community based family planning service within Scotland. Specialist services for young people are also provided by organisations such as Brooke Advisory Centres and others, which have also been examined in detail. These descriptive studies support the view that no single ideal model of family planning and pregnancy counselling service provision exists, a conclusion reaffirmed by a consumer opinion study of 367 clients attending family planning clinics in Nottingham District. A survey within the Benarty area of Fife confirmed this view. The latter showed women's preferences for where they wished to obtain various services if they have different kinds of problems (Table 2). Most preferred to use their general practitioner for family planning services but a percentage did not.

<table>
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<tr>
<th>Table 2: Percentage of women in Benarty survey who would prefer to attend each service with different problems</th>
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<tr>
<td></td>
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<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Contraception</td>
</tr>
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<td>Pregnancy</td>
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<td>Sexual relationships</td>
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6.4 Randomised control trials comparing family planning clinics and general practice

Regrettably no RCTs exist to allow us unequivocally to draw inferences on the relative merits of general practice and family planning clinic based
services. In the absence of these we have to rely on descriptive studies which have examined the range of services provided by both outlets and the views of consumers. There are three significant reports of direct relevance to this question and these will now be discussed in detail.

6.5 The Family Planning Association Report\textsuperscript{14}

This is a report of two research projects carried out in England. The first, a study of National Health Service Family Planning provision and the second a consumer survey.

6.5.1 The prospective study of family planning provision was undertaken in 1978/79 and involved 9,030 new patients attending 57 family planning service outlets in Torbay, Nottingham and Scunthorpe. The aim was to follow up these women for 12 months to document their experiences. The study group consisted of women making their first visit for contraception for at least two years or women who had had a recent pregnancy. Information was collected at each visit throughout the following year and a questionnaire was sent to women who failed to turn up for appointments. Most of the women (5,770) attended one of 35 area health authority community clinics. The remainder comprised 2,555 attending a private family planning association clinic and 715 women who attended one of 18 general practices.

The author notes that this study was being conducted against the backdrop of two main trends, one of expansion in general practice and the other of diversification in family planning clinics. Although general practice accounted for the larger proportion of family planning care the author notes that the choice of method was more restricted in general practice than in clinics with general practitioners tending to prescribe the pill much more than clinics. Whilst many general practitioners claimed to provide a comprehensive service there was evidence that this potential was not always fulfilled in practice. The survey did however show some evidence that general practitioners who had attended a family planning training course offered a less restricted choice.

This was a good study and allowed a number of conclusions to be drawn.

As far as services were concerned, general practitioners saw more patients overall but offered less choice of methods. They prescribed the pill to 84% of all patients seeking family planning compared with 55% of those seen in family planning clinics. In younger women the differences were more marked with general practitioners prescribing the pill to 96% of those aged under 25 with no children compared with 78% in clinics. All general practitioners offering a family planning service provided the pill but only 49% fitted intra-uterine devices and even fewer (43%) fitted the cap. General practitioner training seemed to increase consumer choice and 71% of clinic-trained general practitioners fitted intra-uterine devices compared with 25% of those with no such training. Clinics offered more thorough medical checks and in the case of oral contraceptive users general practitioner medical examinations were sometimes seen as insufficient and inadequate.
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Women who sought contraceptive advice from their general practitioner tended to be younger, more likely to be single, more likely to be spacing rather than delaying or stopping childbearing and were more likely to be first time users of contraception. For new attenders 48% of those going to their general practitioner had not recently used contraception compared with only 21% at clinics.

As far as movement between provision outlets was concerned those attending general practice were more likely to be self-referred; clinic attenders tended to be referred by others. Trained general practitioners were more likely than untrained general practitioners to refer patients to clinics. Patients transferring from general practice to clinics tended to have important but not necessarily urgent method problems needing more attention and advice. Patients transferring from clinics to general practice tended to have acute problems needing immediate treatment or advice.

Women who chose clinics preferred the anonymity of the clinic setting, the avoidance of discussion of sexual matters with the family doctors, a non-disease orientated setting for what was essentially a health problem, the specialist knowledge and experience offered by the clinics with the chance to discuss related problems such as sexual matters and the greater chance of seeing a woman doctor. On the other hand women who chose their general practitioner preferred the more familiar setting of the surgery, the personal attention of their family doctor and his or her knowledge of their medical history, the continuity of care offered by the family doctor and the absence of an exclusive emphasis on sexual matters.

6.5.2 The second part of this report documents the results of a consumer survey carried out in three phases. In the first phase 22 focus groups were conducted, each comprising eight men or women at a particular stage of their reproductive lives. The interviews took place in Exeter and Liverpool. On the basis of these focus group discussions a questionnaire was constructed and a quota sample of the national population aged between 18 and 44, numbering 2,076, interviewed individually in January 1985. In the third phase of the study a self-administered questionnaire was completed by 464 women attending family planning clinics in Exeter and Liverpool in February 1985. The aim of this work was to determine the views of potential users of family planning services with particular reference to provision in clinics in general practice.

The general practitioner was most often the first mentioned source of family planning advice with 51% mentioning the general practitioner and 40% first mentioning clinics.

There was a high expectation that general practitioners would provide a comprehensive range of family planning methods, even although they may not offer some of them and relied heavily on the pill. Among respondents who mentioned the clinic or general practitioner as their first choice of family planning supply these were equally represented with 52% mentioning the clinic and 48% their general practitioner. Given a free choice the overall preference for source of supplies were clinic 32%, general practitioner 29% and chemist 33%. Respondents expected the clinic to provide a full range of contraceptive methods and although a large proportion expected the full
range from their general practitioner fewer expected this in relation to the intra-uterine device, diaphragm, condom and spermicides. The method expected from their family doctor most frequently mentioned was the pill and this was held for both women 93% and men 89% across the country.

A comparison of the general practitioner and the clinic showed that clinic attenders were more likely to be delaying their first pregnancy (54%), or not wanting any more pregnancies (26%); only 5% were spacing their pregnancies. The disadvantages of the clinic compared to general practice included difficulty in finding it, inconvenient hours, insufficient privacy, long waiting times, formal clinical atmosphere and a limited knowledge of personal medical history. Advantages of the clinic compared with general practice included wider choice of methods, access to specialist expert advice, more thorough tests and follow up, greater likelihood of seeing a women doctor, more time available for discussion and greater privacy. Those attending general practice were more likely to walk to the surgery (44%) than those attending a clinic (25%). The general practitioner was an important source of information about the clinic and an important point of referral to it. A majority of respondents believed that general practitioners should have more training in family planning provision, should advertise family planning services more openly and should have a women doctor available for consultation in all group practices.

The two studies reported above showed that family planning clinics and general practitioners provide alternative and complementary methods of family planning, whereas general practice is heavily weighted towards oral contraception. Clinics offered a wider choice, particularly to older women and to women at different stages in their reproductive life cycle. Clinics provided an alternative environment for women who are reluctant to discuss sexual matters and contraceptive needs with the family doctor. The clinic provided a more impersonal atmosphere where it was possible for the women to preserve a greater degree of anonymity, a fact which may be particularly important in the case of young women who had just commenced sexual activity. Clinic personnel had time and skills to enable them to engage in counselling about sexual relationships and couples were able to attend the clinics together. Finally clinics performed both an important training function in passing on family planning skills to general practitioners and at the same time a specialist referral centre where general practitioners could refer women with particular problems of contraceptive care.

6.6 The Portsmouth and South East Hampshire Report

This study involved a quota sample from the seven most heavily used health authority family planning clinics and seven general practitioner surgeries offering contraceptive services located close to these clinics. Each clinic and practice was assigned a target quota of questionnaires. Practice and clinic support staff were issued with an allotted quota of questionnaires and asked to give one to each woman attending the outlet for contraceptive purposes until the quota was used up. At the end of the survey 569 forms were returned from family planning clinics and 100 from those attending general practice. Because of the somewhat idiosyncratic
nature of the sampling process it is difficult to know what reliance can be placed on the figures and in particular it is not possible to work out confidence intervals for the results.

Single women who had never married were much more likely to attend a family planning clinic (45%) than general practice (25%). 84% of women attending their family doctor were on the pill whereas 55% attending the family planning clinic were.

Women were generally very satisfied with the outlet they normally attended for family planning with 94% saying they were highly satisfied with their general practitioner service and 93% with their family planning clinic. However, a number of women were surveyed at a clinic or general practice when they normally attended the other for contraceptive advice. In these circumstances all the women surveyed in general practice who normally attended a family planning clinic were satisfied with the service provided by their general practitioner. However of the 83 women surveyed at a family planning clinic who normally attended their general practitioner only 59% of these were highly satisfied with the service given by the family planning clinic. The reasons for this were not explored. When women were asked why they attended one rather than the other there were significant differences in three circumstances: the availability of women staff in family planning clinics was mentioned by 19% of women as being an important factor as was the ability to obtain contraceptive supplies at the same place; for users of the general practitioner service the personal attention of their own doctor was an important issue.

In conclusion this survey of attenders seeking contraceptive advice at both health authority family planning clinics and general practitioner surgeries reinforced the findings of other studies. However because of the method of carrying out the survey it is difficult to be more specific about its findings.

6.7 The Wessex Report

On the basis of 19 focus groups held throughout Wessex three questionnaires were drawn up, one for general practitioners, one for family planning clinic doctors and one for family planning clinic nurses. Each of the three questionnaires were designed with a similar structure and incorporated questions on information about the range of services offered, an evaluation of possible changes in provision an assessment of providers perceptions of family planning provision and basic information about experience and training. The aim was to survey a systematic sample of 541 general practitioners and carry out a census of 98 doctors and 137 nurses working in family planning clinics in Wessex. The survey was carried out by post in the early 1990s and the overall response rate was 78% for general practitioners, 80% for family planning doctors and 87% for family planning nurses.

From the training point of view the survey showed that 33% of general practitioners in the Wessex region did not currently hold the Joint Committee on Contraception (JCC) Certificate or its equivalent and that 35% of long term providers of family planning service among general practitioners had not attended a refresher course in the previous five years.
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All family planning clinic doctors in the sample had the required qualification and in addition around 50% had attended further training courses on general counselling skills, all the family planning clinic nurses held the appropriate certificate of competence.

As far as the provision of services was concerned most general family planning services were offered by the majority of providers. However the more specialised services were offered by more family planning clinic doctors than general practitioners. These included the fitting and checking of intra-uterine devices, the fitting of diaphragms and caps and psycho-sexual counselling.

The survey also asked these providers about the groups of people for whom they gave family planning services. The client group most often seen by family planning clinic doctors and nurses was the single teenage woman. Female and younger general practitioners tended to see these teenage women and women without children more frequently than their male and older colleagues in general practice. Holders of the JCC Certificate were also more likely to see all types of clients than their counterparts without certification.

In the focus group discussions with consumers, a number of suggestions to improve the service emerged, which were generally received very positively, although a higher percentage of family planning clinic doctors were prepared to offer the services suggested.

As far as perception of family planning provision was concerned, the focus groups produced a number of views and problems with the way in which family planning services were delivered. When these views were put to the general practitioners, family planning clinic doctors and family planning clinic nurses there was general agreement among all providers that requirements for good family planning services include clear written instructions, updating for doctors and nurses and counselling skills. However the focus groups had raised the issue that effective counselling to young and single people needed an atmosphere which was not best provided in a general practice surgery or clinic environment and that many young people find the surgery and clinic intimidating. The general practitioners family planning clinic doctors and nurses disagreed with this.

In summary this study showed that more family planning clinic professionals than general practitioners offered the full range of specialist family planning services. It also showed that increasing formal training in family planning among general practitioners improved the range and probable quality of the services available. Discussion in the focus groups with clients showed that this was associated with increased consumer satisfaction. Consumers' suggestions for improvements to family planning services were generally positively received. The authors of this report concluded that the roles of family planning clinics and general practitioners were complementary and that consumer needs would be best met by continuing the dual system of provision.
7. Conclusion

These descriptive studies incorporating the views of consumers show the range and quality of family planning services which people wish to have. Not all of these are currently being provided both by family planning clinics and general practice, although with adequate training, general practitioners offer the same range of service as clinics. Important though they are, one must be circumspect about placing undue reliance on "wish lists" produced as a result of consumer surveys where people are asked if they want a particular service. Experience in Fife has shown, both with a women's health bus,\textsuperscript{17} and with a women's drop-in service,\textsuperscript{18} that it is essential to introduce these services on a pilot basis in the first instance and thoroughly evaluate them before they become routinely offered.

In summary the unique contribution of general practice lies in the intimate knowledge of personal medical history whereas that of family planning clinics is anonymity. The two provide alternative and complementary services and, if the health board continues to see the availability of choice as a feature of its services for family planning, offering these through both general practice and the family planning clinics ensures that this occurs.

Dr Ian G Jones
Medical Director
15 May 1995

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8. References


