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Understanding patient choices for attending sexually transmitted infection testing services: a qualitative study

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ABSTRACT

Objectives To establish which aspects of sexually transmitted infection (STI) testing services are important to STI testing service users.

Methods 10 focus groups consisting of previous or existing users of STI testing services were conducted in community settings in the south east of England. Groups were quota sampled based on age, gender and sexual orientation. Data were analysed using Framework Analysis.

Results 65 respondents (58% men) participated. Perceived expertise of staff was the key reason for attendance at genitourinary medicine services rather than general practice. Although some respondents voiced a willingness to test for STIs within general practice, the apparent limited range of tests available in general practice and the perceived lack of expertise around sexual health appeared to discourage attendance at general practice. The decision of where to test for STIs was also influenced by past experience of testing, existing relationships with general practice, method of receiving test results and whether the patient had other medical conditions such as HIV.

Conclusions No one type of STI testing service is suitable for all patients. This is recognised by policymakers, and it now requires commissioners and providers to make services outside of genitourinary medicine clinics more acceptable and attractive to patients, in particular to address the perceived lack of expertise and limited range of STIs tests available at alternative testing sites.

INTRODUCTION

Testing for sexually transmitted infections (STIs) in the UK is mainly delivered through genitourinary medicine (GUM) outpatient services. Between 2003 and 2006, the number of sexual health screens carried out in GUM clinics in England, Wales and Northern Ireland rose by 40% from 659 752 to 920 877.¹ In parallel, the number of new STI diagnoses rose by 63% between 1997 and 2006,¹ meaning that access to STI testing services has become a major concern. The availability of accessible, comprehensive and confidential diagnostic and treatment services for STIs including HIV is key to limiting the associated morbidity and mortality. Although healthcare is complicated by the devolved nature of its provision, health authorities within the UK have responded by

encouraging alternatives to testing at GUM clinics. New initiatives include the provision of local STI diagnosis and treatment within primary care such as locally enhanced services for sexual health (LESSH).² LESSH services in primary care aim to expand provision of basic 'level one' services; however, the identification or quantification of LESSH service provision over and above usual care provided in general practice is difficult.³ New initiatives also include the implementation of the National Chlamydia Screening Programme (NCSP) in England which targets sexually active young people in a diverse range of settings.

Primary care and community-based settings potentially offer significant opportunities for early detection and management of STIs⁴ and already the NCSP has proved successful in screening young people for chlamydia outside of the GUM setting.¹ However, the impact of establishing LESSH in primary care is less clear. Little is known about why people visit different healthcare settings and whether investing in LESSH in primary care will encourage at-risk groups to test outside of traditional GUM settings.⁵

Despite the availability of qualitative studies about patient preferences for partner notification services⁶⁻⁷ and specific methods of testing for STIs,⁸⁻⁹ there are little qualitative data on patient preferences for STI testing services.¹⁰⁻¹¹ The aim of this paper is to establish which aspects of STI testing services are most important to previous or current service users. The results of this qualitative study were used to inform the design of a Discrete Choice Experiment (DCE).¹² Although recommended, the use of qualitative methods in the developmental phase of a DCE¹³ is rarely implemented.

METHODS

Design

Focus groups¹⁴ were chosen as they have the advantage of stimulating discussions through the interaction between group members and to raise issues that informants may not have thought about before.¹⁵ Ethical approval was granted by Brighton West Research Ethics Committee (08/H1111/86).

Participants and settings

Ten focus groups were conducted in Brighton, UK, August to October 2009. In order to seek a range of opinions we targeted eight distinct groups using

quota sampling based on age, sexuality and gender. A ninth group consisting of 'overseas students' reflected the demographic diversity of the region. The 10th group consisted of HIV-positive individuals of any age or gender. All participants were aged ≥ 16 years and had used STI testing services within the last 24 months. We aimed to recruit between six and eight people to each homogenous group. Participants were identified through local community and voluntary organisations, advertisements in the local press and word of mouth. Interested individuals emailed or telephoned the researcher who then assessed eligibility criteria and allocated the individual to the appropriate group. Recruitment was on a first come, first served basis until each group was filled to avoid recruiter bias. We stopped recruiting once the first eight eligible people in each group had contacted us. Individuals were asked to attend a community venue (The Terrence Higgins Trust, Young Peoples Centre, Brighton Women's Centre or Allsorts LGBT Youth Project) at a given time. The participants recruited from the four younger age groups were all youth group members.

Procedure

Focus groups lasted approximately 1 h, each group had two moderators (AP and either CL or a doctoral student), with a lead moderator directing the majority of the discussion and the other moderator organising the equipment, taking notes and ensuring coverage of the topic guide. AP and CL have extensive experience of moderating. A topic guide was used (online Supplementary document 1).¹⁶ Each session opened with broad questions relating to knowledge of STIs, in order to stimulate thinking about the subject area and to facilitate group discussion. The topic guide encompassed perceptions of testing, likes and dislikes with existing services and suggestions for improvements. Participants were encouraged to draw on their experiences but were assured that they did not have to share confidential information. Focus group discussions were digitally recorded with informed consent. A gratuity of £20 was offered to each participant.

Analysis

Data were analysed by AP and CL using a Framework Analysis Approach.¹⁷ This was chosen over more inductive methods, such as grounded theory, because there was both a need to explore inductively the original accounts of the respondents while achieving preset aims and objectives.¹⁸ Framework Analysis is a matrix-based approach to qualitative data analysis,

which uses verbatim transcripts. This technique involves identifying recurring and important themes based on a combination of a priori issues introduced by the moderator/interviewer, emergent themes and recurring attitudes or experiences. Major themes arising from the data were compared and contrasted between groups. This ensured that the diversity of the participants' experiences was encapsulated. Coding and analysis were done by hand.

Validity

Validity/credibility of the focus group findings was ensured by discussion between the coresearchers (AP and CL) about interpretation of the data and the classification of supporting quotes into themes.

RESULTS

Sixty-five participants took part. Focus group and socio-demographic characteristics are summarised in tables 1 and 2. Two of the groups fell short of our target number of participants because some respondents did not attend. We report the four major themes to emerge from the discussions (see subheadings). There was no discrepancy of any note between the coresearchers interpretation of the data. Patients' preferences did not appear to be clearly related to characteristics such as gender and sexual orientation, although differences due to age or experience emerged.

Where do I want to get tested?

The pros and cons of testing in a variety of healthcare settings proved the main focus of discussions in all groups but the decision to choose a particular venue was multifaceted.

GUM clinics

Among the majority, perceived expertise and specialism was the key reason for attendance at a GUM clinic versus attending a general practitioner (GP).

"I think at the end of the day a General Practitioner is just that, a General Practitioner. It would be very nice of course if they could have these skills and competencies to be accessible... in this area [STIs] but you know a specialised GUM clinic I suppose is the ideal situation." [Group 8: Older MSM]

In contrast, every group criticised the overcrowded environment of GUM clinics, which also raised concerns about anonymity and discouraged attendance. However, comments

Table 1 Composition of each focus group

Focus group number	Participants	Venue	Mean age (range) in years	n	Gender
1	Heterosexual females (≤ 24 years)	Young Persons Centre	18 (16–23)	6	Female
2	Heterosexual males (≤ 24 years)	Young Persons Centre	21 (19–24)	7	Male
3	Heterosexual females (> 24 years)	Women's Centre	32 (25–45+)	7	Female
4	Heterosexual males (> 24 years)	Medical Education venue	36 (25–59)	7	Male
5	WSW (≤ 24 years)	Allsorts LGBT Youth Group	21 (16–24)	7	Female
6	MSM (≤ 24 years)	Allsorts LGBT Youth Group	22 (19–24)	8	Male
7	WSW (> 24 years)	Terrence Higgins Trust	36 (29–42)	4	Female
8	MSM (> 24 years)	Terrence Higgins Trust	37 (26–51)	7	Male
9	Overseas students	Terrence Higgins Trust	23 (16–28)	5	Male (3) Female (2)
10	Individuals infected with HIV	Terrence Higgins Trust	51 (37–65)	7	Male (6) Female (1)
	Total		30 (16–65)	65	27 Female 38 Male

MSM, men who have sex with men; WSW, women who have sex with women.

Table 2 Socio-demographic characteristics of 65 participants

	N (%)
Male	38 (58%)
Ethnicity*	
White British	51 (78)
White other	4 (6)
Asian British	1 (2)
Black	1 (2)
Mixed race	6 (9)
Other	2 (3)
Sexuality	
Heterosexual	30 (46)
Homosexual	25 (39)
Bisexual	10 (15)
Employment status†	
Student	12 (18)
Employed	22 (34)
Self-employed	1 (2)
Unemployed	25 (39)
Homemaker/retired	2 (4)
Highest educational qualification†	
No qualifications	4 (6)
GCSE/O' level	12 (18)
A level	8 (12)
NVQ/diploma	17 (26)
Graduate	17 (26)
Postgraduate	6 (9)

*Other categories were included on the proforma but not endorsed.

†Missing data.

about the physical environment frequently referred to the subjective experience of undergoing a sexual health check: the environment was often a proxy for the stigma of sexual activity and infections.

"[The worst thing is ...] The environment I think really. The environment of the place. The stigma that goes with it. As far as I'm concerned ... the problem of the environment isn't necessarily the building as such, it's the atmosphere created by what it's there for." [Group 3: Older Heterosexual ♀]

"Because if you go into a sex clinic you'd be called a slag wouldn't you—by all your friends." [Group 1: Younger Heterosexual ♀]

"The atmosphere is just so unpleasant for me ... I'd rather be careful than have another appointment in these places ... My thinking was that if it's too pleasant people will be more cavalier!" [Group 10: People with HIV]

STI testing in primary care settings

Attending general practice for STI testing was preferable for some people and appeared to be more so for those with limited prior experience of STI testing and those with a good relationship with their GP. The general practice setting also had the advantage of a generic waiting room as highlighted in the following quote:

"... if you're in a general waiting room, nobody knows exactly what you're there for, so if you're seen it would be better than being in a specific building ... you feel a little bit awkward when you're with the GP talking, but at least that's only one awkward situation rather than a whole build-up as well." [Group 4: Older Heterosexual ♂]

Many of the younger men and women preferred to visit their general practice as it was a place they were familiar with. One

respondent highlighted the perception that unless the practice offered a dedicated sexual health service, the range of tests available could be limited.

"My personal preference would be to have them at GP surgeries... [but] the problem with GPs surgeries at the moment they can do, I think it's level one STI testing, they can't do the full range like the [local GUM clinic] can and so you can't get a full screening. Whereas if they could do a full screening you could attend your GP's surgery." [Group 6: Younger MSM]

Although many of the younger people attended a GP for testing, this was less common among older groups, whose overriding desire was for a specialist service (see first quote provided by Group 8: older MSM). This view was apparent in other groups such as those with HIV and thus ongoing contact with specialist health services and overseas students.

"My GP is supposed to know something about sexual health but to be honest I'm not sure they do ... I just wouldn't have the faith. That's why they send people off to consultants - because they're the ones who know about these things." [Group 10: People with HIV]

"If it's through your GP it's good that he can rule out other diseases or pathologies but it's not really good because it's not as specialised..." [Group 9: Overseas Students]

Some of the reluctance to attend general practice was because of the lack of time to be examined and talk through the issues.

"I wouldn't go to my GP personally because they're so pushed for time. You go for an appointment with the doctor and it's like they have a ten minute slot It just seems like it's all so rushed". [Group 3: Older Heterosexual ♀]

What STIs do I want to test for?

Access to a comprehensive range of tests was a significant consideration and a serious concern among users of limited services (eg, those provided by the NCSP). However, this was not always sufficient to override other considerations affecting the choice of testing service discussed above. Most participants assumed that a full range of STI tests would be available at any GP offering sexual health services, as well as at GUM services. A few participants suggested that only GUM clinics would test for all STIs that was one advantage over other testing sites.

"What I like about the clinic and the service they provide there is, yeah, all right it takes two hours—but they are empathetic, they're thorough and comprehensive ..." [Group 3: Older Heterosexual ♀]

How long will I have to wait?

Three different types of 'waiting time' were identified and discussed by participants: 'waiting' until the next available appointment between arrival and being seen at the testing site and for the test results. Waiting in any form was universally unpopular; however, some people indicated their preference to wait in a drop-in centre for several hours to be seen the same day rather than wait several days for an appointment. Conversely, for some people long waits, particularly at the GUM drop in service, were not tolerated and had negative repercussions for some:

Female 3: *You can wait for ages* [at the local GUM clinic].

Female 2: *When it gets really ... [busy]*

Female 3: *If you go for the drop in. You can wait up to like 2 hours I think. I've waited with [my friend] that long.*

Moderator: *Have you ever been tempted to leave?*

Female 2: *Oh yeah, plenty of times.*

Moderator: *Have you ever left?*

Female 2: *Yeah. I thought f-k this, I'm going now and didn't bother telling them.* [Group 1: Younger Heterosexual ♀]

Waiting for results was consistently identified as the most stressful type of waiting, although some participants accepted it as an inevitable part of the clinical process with the least opportunity for change.

"... all you're doing is waiting on the results ... it's like you're just playing the game: is it positive, is it negative, is it positive, is it negative ... and it'll just keep going round in your head." [Group 6: Younger MSM]

How do I get the results? Is 'no news good news'?

Although not the deciding factor over where to test, the method of notification of results was an area of concern. The most common preference was for a phone call to a mobile phone or a text message for negative results. The no-news-is-good-news policy, whereby people are not notified of negative results, was a major source of dissatisfaction and was consistently disliked across all groups because of uncertainty.

"They operate a sort of no-news-is-good-news-policy. So ... if you don't hear anything you don't know. [It should be] a good time for you, you should be able to be like: 'Brilliant!'; rather than just be a bit like: 'Well I presume I've not' ... It doesn't feel certain, and it's something you want to feel one hundred percent." [Group 4: Older Heterosexual ♂]

Female 4: *Yeah they don't ... they don't text you about the other ones so I guess if you don't hear from them it means you haven't got any of the other infections so but yeah, they only text you about Chlamydia.*

Moderator: *So do they text you if it's negative for Chlamydia still?*

Female 4: *They text you if it's negative or positive, yeah.*

Moderator: *Okay.*

Female 4: *But, yeah, like they don't text you the other ones so you just have to sort of assume you haven't got anything ...*

Moderator: *How does that make you kind of feel? Does that ... do you worry about it or ...?*

Female 4: *It would be nice to know if, you know, they would call you to say no you haven't got anything else either and just, rather than just assume by them not contacting you it means you haven't got anything else.*

[Group 3: Older Heterosexual ♀]

DISCUSSION

Statement of principal findings

Our findings suggest that there are a number of key factors that affect people's decisions about where to go for STI testing. The decision about whether to seek testing outside of traditional GUM services depended primarily on past testing experience (those with more limited experience were more likely to seek help from primary care), the relationship between patient and their GP and perceptions of the specialist nature of STI testing services. The majority of respondents considered sexual health, including conducting diagnostic tests, to be a specialist area, and therefore, their perception of who was appropriately trained influenced where they sought help. Although some respondents voiced a willingness to test for STIs within general practice, the perceived limited range of available tests and the perceived lack of expertise around sexual health appeared to discourage attendance. The decision of where to test for STIs also depended on whether the patient had other medical conditions such as HIV that were being managed by a specialist. Although younger patients appeared more willing to be tested in general practice than older patients, we did not find clear differences in preferences for services on the basis of sexual orientation or gender.

Relation to wider literature

Few qualitative studies have examined patient preferences for STI testing services.^{10 11} A recent interview study of patients who had originally sought STI tests within primary care found that people's expectations for comprehensive testing within the GP consultation were often not met, which lead to subsequent self-referral to GUM clinics.¹¹ Our study revealed that younger participants were more likely to assume that a comparable range of tests to those available at GUM clinics would be available in general practice. Our data also demonstrated that the perceived inability of primary care services to provide a full and comprehensive sexual health service hinders attendance for many other people. Indeed, it has been noted that a substantial percentage of new patients who seek care at GUM clinics have originally sought help in primary care.¹⁹ Our findings also indicate that in addition to comprehensive testing services, perceptions of who is providing this service appear to be equally important. This is similar to findings from a qualitative study of women seeking Chlamydia testing at GUM and family planning clinics which noted that 'users of specialist services often reject GP services for sexual health reasons associated with their relationship with their GP [and] their views on the quality of clinical care ...'.¹⁰ Unlike this study, ours contains the views of both men and women recruited from the community and not solely from GUM services and family planning clinics. Interestingly, we failed to establish any major gender differences with regards to preferences between sexual testing conducted by a specialist doctor or a GP which concurs with survey data.^{5 20}

Our data highlight the value in providing both drop-in (walk-in) services and fixed appointments as no clear preference was demonstrated among our sample. Access was not emphasised in these terms in the qualitative literature although it was noted in one study that all patients who had initially presented to primary care were given appointments within 48 h.¹¹ Conversely, in the study conducted in primary care, the difficulties with getting GP appointments were referred to.¹⁰ Waiting in relation to subsequent attendance at GUM services was not explored.¹¹ The value of continuing to offer walk-in services has been suggested previously, with survey data demonstrating that 44% of patients preferred a walk-in service with up to 2 h waits even if appointments could be made within 48 h.⁵ Other research with GUM clinic attendees have noted that the majority (62%) of patients would be happy to accept an appointment with the GP if they could be seen quicker.²⁰ However, it is unlikely that this would override factors that were rated more important such as access to a range of services and confidentiality.²⁰ Our results support the introduction of text messaging, especially as an alternative to the 'no-news-is-good-news' policy at GUM clinics that was consistently disliked in our sample and that is comparable to previous findings.²¹

Strengths and weaknesses of the study

A possible limitation of this study is that all the participants in our focus groups were current or previous users of STI testing services, and therefore, their preferences may differ from those with no experience of testing or those who choose not to test. We cannot comment on the distribution of testing services that participants had direct experience of as we wanted to limit the amount of personal data we collected about informants. We decided to recruit only those with recent experience of testing (within the last 2 years) as sexual health services are constantly evolving and we wanted respondents to be able to talk about their decisions and preferences from a current informed

perspective. Alternatively, this could be considered a strength. The participants recruited from the four younger age groups were all members of the youth groups where focus group testing took place, this may have influenced the nature of the group interactions, although it is not uncommon for focus groups to consist of people who know each other. The perspectives of black Caribbean and black African groups who are at disproportionately higher risk of STIs than other ethnic groups²² were not included as the recruitment region was not ethnically diverse (with a Black and Minority Ethnic population of only 5.7%).²³ This limits the generalisability of the findings to other areas. We did, however, recruit a heterogeneous group of overseas students representative of the local population that, although not considered a marginalised group, did bring the perspective of access to healthcare for non-British respondents.

Meaning of the study: implications for clinicians or policymakers

The National Strategy for Sexual Health and HIV²⁴ and the more recent Department of Health response document²⁵ highlight the need for improved access, patient information and choice in sexual health services. In order to alleviate pressure on GUM services and provide better access and choice to patients, enhanced sexual health services in community and primary care were developed,²⁶ which included LESSH within general practice. The missed opportunity to test within general practice has been highlighted elsewhere in the literature,²⁷ however, it has since been observed that signing up to locally enhanced services has not necessarily changed the number of tests performed in primary care or increased diagnoses.²⁸ Although these alternative services to GUM clinics have been introduced, it is important that patient and public understanding of what services are actually on offer align. Duplicate attendance at both primary care and GUM services due to lack of information about the range of tests available is unlikely to be a cost-effective strategy and is likely to lead to low satisfaction rates among patients. In relation to primary care, full packages of care or at the very least GP managed referrals to GUM clinics should be offered onsite to prevent patients from falling between services.¹¹

In 2006, the Department of Health introduced a 48-h appointment target for all patients attending GUM services.²⁹ While reducing the delay before an appointment may be a public health priority, our findings suggest that being seen within 48 h was not a universal priority. Moreover, our data illustrate how long waiting times in the drop-in GUM clinic may lead to people leaving the clinic without being tested. In relation to these targets, another of the high impact changes proposed by the DH to enable 48-h access to GUM services was to implement a text message result service to improve administrative efficiency and reduce follow-up appointments.²⁹ Our results support the introduction of text messaging. The feasibility and acceptability of text results would be equally applicable to testing services conducted in primary care and community settings. Further exploration is warranted.

Building capacity within primary care to provide the type of STI testing services that meet the needs of patients is a challenge. Providing what is considered by patients to be specialist care within general practice appears to be problematic and it is not yet clear whether a change in patient perceptions is required or whether a different service model would increase patients' willingness to engage with general practice for STI testing. The results of this qualitative study have been used to inform the attributes included in a DCE that will provide information on patient preferences by indicating how people trade off characteristics of different services. It is unknown as to the

Key messages

- ▶ Perceived expertise of the staff is the key reason for attendance at genitourinary medicine services compared with attending general practice.
- ▶ Where to test for STIs depends on past testing experience, relationships with GP and whether the person has other medical conditions necessitating specialist genitourinary medicine care.
- ▶ Waiting times and method of receiving results are also important factors when deciding where to test.

extent to which providing sexual health services poses challenges to the general practitioner, and further research into this area may clarify this perspective.

Conclusions

In conclusion, no one type of STI testing service is suitable for all patients. This is recognised by policymakers, and it now requires commissioners and providers to make services outside of GUM clinics more acceptable and attractive to patients, in particular to address the perceived lack of expertise and limited range of STIs tests available at alternative testing sites.

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Contributors AM and CL had the idea for the STI: Patient Preferences (STIPP) study. CL was the Principal Investigator and acts as guarantor of the paper. CL and AP devised the qualitative part of the study. AP and CL conducted the focus groups and the analysis of the transcripts. CL and AP wrote the first draft of the paper and both contributed to revised versions. AM, JC, DR, MF and HS contributed to the study design and to all revisions of the manuscript.

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