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How and why do South Asians attend GUM clinics? Evidence from contrasting GUM clinics across England

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ABSTRACT

Background Improving access to sexual healthcare is
a priority in the UK, especially for ethnic minorities.

Though South Asians in the UK report low levels of
sexual ill health, few data exist regarding their use of
genitourinary medicine (GUM) services.

Objectives To describe reasons for attendance at GUM
clinics among individuals of South Asian origin relative to
patients of other ethnicities.

Methods 4600 new attendees (5% South Asian;
 $n=226$) at seven sociodemographically and
geographically contrasting GUM clinics across England
completed a questionnaire between October 2004 and
March 2005, which were linked to routine clinical data.

Results South Asians were more likely than other
groups to be signposted to the GUM clinic by another
health service—for example, in women 14% versus 8%
respectively ($p=0.005$) reported doing so from a family
planning clinic. These women also reported that they
would be less likely to go to the clinic if their symptoms
resolved spontaneously compared with other women
(51% vs 31%, $p=0.024$). However, relative to other
clinic attendees, no differences in the proportions of
South Asians who had acute STI(s) diagnosed at clinic
were noted. Furthermore, South Asian men were more
likely to report as their reason for attendance that they
wanted an HIV test (23.4% vs 14.8%, $p=0.005$).

Conclusion Despite having similar STI care needs to
attendees from other ethnic groups, South Asians,
especially women, may be reluctant to seek care from
GUM clinics, especially if their symptoms resolve. Sexual
health services need to develop locally-delivered and
culturally-appropriate initiatives to improve care
pathways.

INTRODUCTION

The Health Protection Agency has reported that
minority ethnic groups in the UK generally bear
a disproportionate burden of poor sexual health and
considers improvement of access to services as a key
priority.¹ Though our ability to assess equity of
services is limited by a lack of comprehensive ethnic
monitoring, it is well recognised that access to
preventive services by ethnic minorities is poor.^{2,3}

South Asians (Indians, Bangladeshis, Pakistanis)
account for nearly half of all ethnic minorities in the
UK⁴ and while it is recognised that nationally South
Asians report lower levels of sexual ill health when
compared with their White and African counter-
parts,⁵ there is a paucity of research exploring their
utilisation of sexual health services. Few data exist

for this population group, as limited respondent
numbers prevent detailed analyses in many studies.⁶
Although GUM clinics have witnessed marked
increases in activity,⁷ this does not seem to have
translated to the South Asian population. A recent
study from a single centre reported that despite
South Asians comprising 29.9% of the total local
population, their utilisation of the local GUM
Service was well below that of other local minority
populations,⁸ yet during the same period nearly
a quarter of the total contacts annually attending
the contraceptive service were of South Asian
ethnicity (Fox L, personal communication, 2008).

We therefore sought to describe the characteris-
tics and reasons for attendance at GUM clinics
among individuals of South Asian origin relative to
patients from other ethnic groups.

METHODS

Population and sampling

Seven GUM clinics across England were purpo-
sively recruited, representing contrasting demo-
graphic, geographic and service configuration
characteristics likely to affect sexual health needs
and use of services. These included a London clinic,
large provincial cities with single and multiple
clinics, a city with a substantial Asian population
and clinics serving rural populations. Full details of
the survey have previously been published.¹⁰
Briefly, all new patients were given written infor-
mation about the study by the receptionist and
invited to complete a short, 22-item self-comple-
tion pen-and-paper questionnaire in English.
Regrettably, resources were not available to trans-
late the questionnaire or to provide translation
facilities. This questionnaire asked patients about
the reasons for their current consultation and
contact with other health services before atten-
dance at the GUM clinic. In order to protect
confidentiality, questionnaires were anonymous
apart from the clinic number used to link the
questionnaire to the clinic's routine database (and
later removed) to obtain data on the patient's
gender, age, ethnicity, STI diagnosis/es made at
that clinic visit and whether any STI was likely to
have been homosexually acquired. Data collection
took place from October 2004 to March 2005. The
denominator for each clinic was estimated as the
number of new clinic numbers issued minus, if
applicable, those issued in the week in November
2004 when the Department of Health conducted
its Waiting Time Survey, as questionnaires were not
distributed during this week.⁷

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Statistical analysis

We compared South Asian patients relative with patients from other ethnic groups, by gender, and determined statistical significance using the χ^2 statistic for categorical variables and the Mann–Whitney statistic for continuous variables (because of the skewed distributions of the variables considered). Analyses were undertaken using the survey commands in STATA 9.0 to take account of clustering by clinic.¹¹ Statistical significance is considered as $p < 0.05$ for all analyses.

RESULTS

Sample characteristics

In total, 5322 questionnaires were completed with response rates ranging across the seven clinics from 17.8% to 70.1%, thought to be due to reception staff not offering questionnaires to all new patients. As previously reported,¹⁰ there was no evidence of any differences between patients who completed the questionnaire and those who did not, with respect to routinely collected data on gender, age, ethnicity and whether or not STI(s) were diagnosed. Four thousand six hundred questionnaires (86.4%) could be linked to routine clinic data, resulting in a sample of 2255 men and 2345 women.

Two hundred and twenty-six of the 4600 patients (4.9%) were of South Asian ethnicity. However, there was substantial variation in this proportion by clinic sample (range: <0.1% to 38.1%), reflecting the variability in the proportion in the populations of

the primary care trust in which each clinic is located that was South Asian (range: 0.2–29.9%).⁹

South Asian patients were no different from patients of other ethnic groups in terms of age, achieved qualifications, childcare responsibilities, employed or at college during clinic opening hours, GP registration or reported previous STI diagnosis/es (table 1). However, South Asian men were more likely to report living with a partner/spouse relative to men from other ethnic groups (40.2% vs 27.6%, $p = 0.005$).

How patients found out about the clinic

The most commonly reported means of finding out about the clinic was from a GP or a nurse at the GP's surgery (table 2), with no overall differences by ethnicity or gender. However, South Asian women were more likely than women from other ethnic groups to report finding out about the GUM clinic from the Family Planning clinic (13.7% vs 7.6% $p = 0.005$). Fewer South Asians reported that 'a friend told me about [the clinic]', with 16.8% of South Asians and 28.8% of all patients reporting this source of information ($p = 0.0052$, with no significant gender differences).

Interestingly, almost a quarter of South Asian women (23.3%) reported that the study GUM clinic was not their nearest clinic, in contrast to 12.3% of other women ($p = 0.004$) and 11.7% of South Asian men ($p = 0.025$). Despite this, no significant difference in travel time to clinic was noted (median: 30 min, interquartile range: 30 min), even after controlling for clinic.

Table 1 Sociodemographic characteristics of South Asian clinic attendees in relation to clinic attendees of other ethnicities, by gender

| Characteristic | Denominator | Males | | | Females | | |
|--|--------------------------|-----------------|------------------------|---------|----------------|------------------------|---------|
| | | South Asian 131 | Other ethnicities 2124 | p Value | South Asian 95 | Other ethnicities 2250 | p Value |
| Age, grouped | <20 | 3.1% | 5.4% | 0.187 | 9.4% | 16.8% | 0.146 |
| | 20–24 | 28.9% | 30.1% | | 28.2% | 33.5% | |
| | 25–29 | 21.1% | 24.8% | | 27.1% | 20.6% | |
| | 30–34 | 21.1% | 12.7% | | 17.7% | 10.9% | |
| | 35–39 | 11.7% | 11.0% | | 11.8% | 8.1% | |
| | 40–44 | 7.8% | 7.2% | | 3.5% | 4.8% | |
| | 45+ | 6.3% | 8.7% | | 2.4% | 5.2% | |
| Age, median (lower and upper quartiles) | | 27 (22, 35) | 28 (23, 35) | 0.105 | 25 (20, 32) | 24 (20, 30) | 0.079 |
| Lives with partner/spouse | | 40.2% | 27.6% | 0.005 | 32.2% | 24.5% | 0.183 |
| Childcare responsibilities | | 12.5% | 10.1% | 0.374 | 14.8% | 17.2% | 0.462 |
| Works/at college when the clinic is open | Yes, every day | 53.4% | 62.6% | 0.115 | 54.7% | 53.2% | 0.119 |
| | Yes, some days | 20.3% | 21.8% | | 19.8% | 28.3% | |
| | No | 26.3% | 15.6% | | 25.6% | 18.5% | |
| Highest qualification* | Degree/higher degree | 47.4% | 36.7% | 0.154 | 55.0% | 40.8% | 0.093 |
| | A levels | 9.5% | 18.4% | | 6.7% | 21.2% | |
| | GCSEs/O levels | 11.6% | 18.8% | | 11.7% | 17.8% | |
| | NVQs/other qualification | 20.0% | 19.1% | | 18.3% | 15.3% | |
| | None | 11.6% | 6.9% | | 8.3% | 4.9% | |
| Registered with a GP | | 86.4% | 87.3% | 0.798 | 93.9% | 92.8% | 0.766 |
| Previous STI diagnosis/es | Yes | 4.3% | 15.9% | 0.113 | 11.0% | 18.8% | 0.296 |
| | Not sure | 6.8% | 4.8% | | 3.7% | 3.7% | |
| | No | 88.9% | 79.3% | | 85.4% | 77.5% | |

*Among patients aged at least 21.

Table 2 How patients found out about the clinic, by gender and whether of South Asian ethnicity

| Denominator | Males | | | Females | | |
|---|------------------------|-------------------------------|--------------|-----------------------|-------------------------------|--------------|
| | South Asian (%) 131 | Other ethnicities (%) 2124 | p Value — | South Asian (%) 95 | Other ethnicities (%) 2250 | p Value — |
| 'How did you find out about this clinic?' | | | | | | |
| 'I found it in the phone book' | 8.4 | 9.7 | 0.521 | 9.5 | 7.4 | 0.303 |
| 'I found it on the internet' | 6.9 | 10.2 | 0.010 | 6.3 | 6.0 | 0.909 |
| 'My GP or the nurse at the GP surgery told me about it' | 38.9 | 28.7 | 0.089 | 33.7 | 32.1 | 0.797 |
| 'I heard about it at the family planning Clinic' | 0.8 | 1.4 | 0.457 | 13.7 | 7.6 | 0.005 |
| 'I saw an advert in a newspaper or magazine' | 3.1 | 1.0 | 0.127 | 0.0 | 0.8 | 0.511 |
| 'I picked up a leaflet' | 0.0 | 2.4 | 0.353 | 1.1 | 2.4 | 0.414 |
| 'My partner told me about it' | 12.2 | 13.7 | 0.736 | 8.4 | 10.8 | 0.238 |
| 'A friend told me about it' | 16.8 | 22.4 | 0.047 | 16.8 | 24.4 | 0.019 |
| 'Told about it by a family member' | 2.2 | 1.5 | 0.195 | 0.0 | 3.9 | 0.525 |

*Response options listed in the order they were presented in the patient questionnaire.

Why patients went to clinic

Symptoms were the most frequently cited reason for going to clinic for all patients (table 3). This reason was reported by a higher proportion of South Asian women than other women (61.3% vs 51.6% respectively, although not statistically significant: $p=0.160$) and South Asian men (46.3%, $p=0.039$ for gender difference). The next most commonly cited reason for attendance was for a check-up, reported by 36.8% of all patients with no significant differences by gender or ethnicity. A third reason, 'I wanted to have an HIV test,' was reported by a higher proportion of South Asian men than men from other ethnic groups (23.4% vs 14.8%, respectively, $p=0.005$), and a higher proportion than both Black African and Black Caribbean men (17.9% and 15.9%, respectively). Although few patients reported 'I was contacted by a clinic/health advisor,' a larger proportion of South Asian women gave this reason for attendance than women from other ethnic groups (6.5% vs 2.5%, $p=0.003$).

Time taken and time prepared to wait to get into clinic

There was no difference by ethnicity (or gender) in either the number of days patients with symptoms had taken to seek care (median 7 days); the proportion who reported seeking care from other healthcare professionals (including their GP) prior to going to the study GUM clinic (40.4%); or the number of days taken to be seen at the study clinic from first seeking care (median 5 days). In response to the question: 'how long would you be prepared to wait for an appointment at a clinic like this one?' the median response for all patients was 7 days, and this did not differ significantly by ethnicity for men, but South Asian women reported less willingness to wait, 3.5 days on average. South Asian women also were more likely to report that they would not go to see anyone if they had to wait longer than the time they were prepared to wait (17.8% vs 6.8% other women, $p=0.017$), and also they would not attend if their symptoms had gone away on their own (68.8% vs 49.5%, $p=0.024$).

Table 3 Reasons for going to the GUM clinic by gender and whether of South Asian ethnicity

| Denominator | Males | | | Females | | |
|---|------------------------|-------------------------------|--------------|-----------------------|-------------------------------|--------------|
| | South Asian (%) 131 | Other ethnicities (%) 2124 | p Value — | South Asian (%) 95 | Other ethnicities (%) 2250 | p Value — |
| 'Why did you come to the clinic?' | | | | | | |
| 'I have (or had) symptoms (eg, itching, discharge)' | 46.3 | 51.0 | 0.332 | 61.3 | 51.6 | 0.160 |
| 'My partner had (or had) symptoms' | 44.1 | 46.9 | 0.643 | 9.1 | 11.9 | 0.348 |
| 'My partner has been diagnosed as having an infection and I needed to come to the clinic' | 9.0 | 11.3 | 0.466 | 3.9 | 10.3 | 0.121 |
| 'I was contacted by a clinic/health advisor' | 4.5 | 1.5 | 0.001 | 6.5 | 2.5 | 0.003 |
| 'I did not have symptoms but wanted a check-up' | 31.5 | 35.2 | 0.318 | 31.2 | 38.8 | 0.164 |
| 'I wanted a HIV test' | 23.4 | 14.8 | 0.005 | 15.6 | 12.3 | 0.412 |
| 'GP advised me or told me to go' | 0.9 | 1.3 | 0.574 | 1.3 | 2.8 | 0.364 |
| Hospital referral | 0.9 | 0.3 | 0.372 | 1.3 | 0.3 | 0.281 |
| (Emergency) contraception/pregnancy tests | NA | NA | NA | 2.6 | 2.1 | 0.758 |

*Percentages sum to more than 100% as patients could report multiple reasons.

†Response options listed in the order they were presented in the questionnaire.

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STI diagnosis/es made at clinic visit

South Asian attendees were equally likely to be diagnosed with acute STI as patients of other ethnicities, with 38.2% of all men and 28.1% of all women diagnosed as having acute STI(s) (table 4). However, as observed in all ethnic groups, South Asian men were significantly more likely to have acute STI(s) diagnosed than South Asian women (35.9% vs 26.3% $p=0.009$). In terms of specific STIs, only one significant difference was observed in that a larger proportion of South Asian women were diagnosed as having Trichomoniasis than women of other ethnicities (4.2% vs 1.7%, $p=0.035$).

DISCUSSION

Our study of seven contrasting GUM clinics across England with varying ethnic populations provides evidence that South Asians, particularly women, tend to find out about and/or are referred to GUM services via their GP and/or family planning clinic. However, we also found that these women may cease to seek care if symptoms resolve spontaneously, and that they are less willing to wait for an appointment if they cannot get into the clinic quickly, suggesting that they may be vulnerable to incomplete care pathways. This is particularly important given that our clinic data suggest they are as likely to have an acute STI diagnosed as women from other ethnic groups and so are not simply 'worried well'.

Our results are consistent with other studies that have reported how GUM clinics are seldom the first port of call for South Asians seeking STI care, and that South Asian GUM attendees are less likely than other attendees to self-refer, instead being more likely to be referred from other medical services such as general practice or family planning.^{12 13} While higher referral rates may reflect higher attendance rates by South Asians at non-GUM services, others suggest that this healthcare-seeking behaviour reflects a low perception of sexual health risk among South Asians,¹⁴ their lack of awareness of GUM services^{15 16} and their association of GUM services with stigma, such that the anxiety of being recognised attending a clinic acts as a barrier to access.¹⁵ This in turn reflects how, for many South Asian communities, faith and cultural values prohibit premarital sex, and therefore dialogues around sexual health are deemed shameful, unnecessary and irrelevant.¹⁷ Behaviours which deviate from faith or cultural norms are often masked or hidden and may mean that individuals in need of sexual healthcare may

fail to access appropriate care.¹⁵ This may in part explain our finding that South Asians were less likely to find out about the GUM clinic via peers or social networks, as it is unlikely to be something that is disclosed to or discussed between friends or family. Furthermore, while general practice has been reported as the preferred service choice among some South Asians for sexual-health needs,¹⁵ concerns about the confidentiality of family GPs, particularly those of the same ethnic background, perceived as potentially disclosing information to other family members are real.^{16 18} Issues of trust, confidentiality and stigma may mean that some individuals prefer to seek care elsewhere (eg, family planning), or may fail to access any care at all.

In contrast to women, the reason for attendance at the GUM clinic was for HIV testing for a larger proportion of South Asian men compared with men of other ethnicities, which, to the best of our knowledge has not been observed in other studies. This may again reflect concerns about confidentiality or embarrassment about seeing their GP. The potential reasons (eg, perception of risk, increased HIV awareness) prompting this attendance among men warrants further investigation to ensure support of, and continuation of, this important healthcare-seeking behaviour.

It is important to acknowledge the limitations of our study. This paper follows the study's main paper,¹⁰ such that there was no *a priori* sample size calculation for these analyses, and having only 226 South Asians in our sample of 4600 patients may have meant that we did not have sufficient power to detect differences as statistically significant, especially comparisons of subgroups (eg, the analysis of sexual behaviour of those diagnosed as having an acute STI).

It is possible that some South Asians who were unable to read English may have been excluded from participating in the study, as the questionnaire was only available in English. While this may introduce some bias into the results, it is important to recall that we did not find any evidence of differences between patients who completed the questionnaire and those who did not, at least as far as routinely collected data on gender, age, ethnicity and whether or not STI(s) were diagnosed are concerned.¹⁰ A further consideration is our use of broad categories such as 'South Asian,' which may mask the heterogeneity of behaviours/attitudes and beliefs/faiths that exist between and within the different ethnic groups.

In conclusion, our study found that South Asians attend GUM clinics for different reasons to people of other ethnicities:

Table 4 STI diagnoses made at the GUM clinic visit by gender and whether of South Asian ethnicity

| Denominator | Males (%; 95% CI) | | | Females (%; 95% CI) | | |
|-------------------------------|---------------------|---------------------------|--------------|---------------------|---------------------------|--------------|
| | South Asian 131 | Other ethnicities 2124 | p Value — | South Asian 95 | Other ethnicities 2250 | p Value — |
| Any acute STI* | 35.9 (23.6 to 50.4) | 37.6 (32.5 to 44.5) | 0.633 | 26.3 (18.3 to 36.3) | 28.2 (24.2 to 32.6) | 0.529 |
| Syphilis | 0 | 0 | NA | 0 | 0 | NA |
| Gonorrhoea | 4.6 (0.7 to 23.7) | 3.7 (2.8 to 4.8) | 0.757 | 0 | 1.8 (1.1 to 3.1) | 0.611 |
| Chancroid/LGV | 0 | 0 | NA | 0 | 0 | NA |
| Chlamydia | 8.4 (3.9 to 17.1) | 11.2 (8.1 to 15.2) | 0.247 | 12.6 (9.6 to 16.4) | 13.0 (9.8 to 17.1) | 0.865 |
| NG/NSU | 15.3 (10.7 to 21.3) | 16.5 (13.6 to 19.8) | 0.596 | NA | NA | NA |
| NG/NSI | 1.5 (0.3 to 8.7) | 1.0 (0.7 to 1.6) | 0.621 | 3.2 (0.8 to 11.4) | 4.2 (2.4 to 7.1) | 0.549 |
| Herpes simplex (first attack) | 1.5 (0.2 to 11.7) | 1.9 (1.0 to 3.6) | 0.824 | 2.1 (0.8 to 5.2) | 2.1 (1.6 to 2.7) | 0.985 |
| Genital warts (first attack) | 8.4 (4.3 to 15.6) | 9.5 (6.7 to 13.3) | 0.699 | 3.2 (0.4 to 21.0) | 8.8 (6.1 to 12.6) | 0.241 |
| Trichomoniasis | 0 | 0 | NA | 4.2 (1.1 to 15.3) | 1.7 (0.9 to 3.2) | 0.035 |

*Acute STIs are defined as infectious syphilis (KC60 codes: A1 and A2), uncomplicated gonorrhoea (KC60 codes: B1 and B2), complicated gonorrhoea (KC60 code: B5), chancroid/lymphogranuloma venereum (LGV)/donovanosis (KC60 codes: C1, C2 and C3); chlamydial infection (uncomplicated/complicated) (KC60 codes: C4a, C4b and C4c); uncomplicated non-gonococcal/non-specific urethritis in males (KC60 code: C4h); complicated non-gonococcal/non-specific infection (KC60 code: C5); herpes simplex (1st attack) (KC60 code: C10a); genital warts (1st attack) (KC60 code: C11a); trichomoniasis (KC60 code: C6a).

Key messages

- ▶ South Asians attending GUM clinics, particularly women, are more likely to be signposted there from other service providers (especially family planning).
- ▶ South Asian men attending GUM clinics are more likely to do so for HIV testing than other groups.
- ▶ South Asian women attending GUM clinics report attitudes to waiting that make them vulnerable to experiencing incomplete care pathways but have STI rates as high as other female attendees.
- ▶ To ensure completion of care pathways, GUM clinics need to engage with other sexual health service providers to ensure effective care pathways are in place, especially for South Asian women.

South Asian men were more likely to attend for HIV testing, which is encouraging. South Asian women were more likely to be referred to GUM from other healthcare settings, but, as they were also more likely to report that they may not continue to seek care if their symptoms resolve and/or they had to wait longer than they were prepared to do so to be seen, these findings have implications for facilitating STI care pathways. In particular, GUM services need to engage with other sexual healthcare providers to develop locally delivered and culturally appropriate initiatives to minimise the potential for experiencing incomplete care pathways.

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Competing interests None.

Ethics approval Obtained.

Contributors JD had the original idea for this analysis. JC was the principal investigator of the study and obtained funding from the Medical Research Council. Plans for analysis were led by CM, who undertook all data management and statistical work. CM wrote the first draft of the paper, and all authors contributed to subsequent drafts.

Patient consent Obtained.

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