Sustaining chlamydia screening is difficult

I read with interest the article on increasing opportunistic chlamydia screening in general practice.[1] Having heard the authors present this same research at the New Zealand Sexual Health conference in Dunedin in 2009, we undertook to replicate their intervention in our practice in 2009–10. We audited six months of screening for chlamydia in 15–25-year-old patients and then introduced a number of measures to attempt to increase screening rates. These included a discussion of the Wellington research, a staff update session on chlamydia, an alert on all files of 15–25-year-old patients , ordering a large supply of patient information leaflets on chlamydia, and stocking each consulting room with chlamydia packs (male and female swabs, urine containers and patient information leaflets). The free sexual health consultation for under 25 years was available to be used to fund visits if patients had chlamydia testing or treatment.

We ran the intervention for three months, and thought we would be able to outperform the original study by increasing and sustaining higher rates of chlamydia screening—but we were wrong! Although our incentives for chlamydia screening were smaller than in the Wellington study (we awarded a chocolate fish each month to the clinician who performed the most tests) we were able to substantially increase our screening rates for the period of the intervention, particularly for males (see table). We also had a marked increase in chlamydia detection, finding eight times as many cases per month during the intervention. However a repeat audit post-intervention showed our rates had dropped back to that of the baseline period, as they did in the Wellington study.

It is interesting to reflect on the barriers to achieving high chlamydia screening rates in general practice. We have a well-informed and highly motivated team who demonstrated a useful clinical outcome (increased detection) by increasing our screening rates. In spite of this we have been unable to maintain vigilance. Why is this?

Table: Percentage of consultations with 15–25-year-old patients where chlamydia test done

	Female	Male
Initial audit period	8.3%	2.9%
During intervention	18.8%	18.9%
Post-intervention	9.7%	1.3%

Part of the effect may be due to the fact that we achieved quite high coverage rates during the intervention, so there were fewer patients attending who had not been offered testing. Making time for screening is also important—introducing a whole new topic into an unrelated consultation is often avoided when we are busy. Probably the most significant barrier, however, is the difficulty of introducing a sensitive subject (sex), when the patient has come about another problem altogether. This is particularly difficult in the context of a family general practice, where many of our adolescent patients have been known to us since birth, and are usually accompanied by their parents.

We would be interested to hear from practices who have found ways of overcoming these barriers and are maintaining good opportunistic screening rates.

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References

1. Lawton B, Rose S, Elley C, Bromhead C, McDonald J, Baker M. Increasing the uptake of opportunistic chlamydia screening: a pilot study in general practice. J Prim Health Care. 2010;2(3):199–207.

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