Do women with HIV infection consult with their GPs?

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SUMMARY

In a cohort of 106 HIV-positive women, 86 (81%) were registered with a general practitioner (GP) and 71 (83%) had a GP who was aware of their HIV status. GPs were primarily consulted for perceived non-HIV-related problems and prescriptions. This is encouraging. However, primary and secondary care services should aim to increase the proportions of HIV-positive individuals with access to primary care.

Keywords: HIV; women; primary health care.

Introduction

WOMEN now make up 40% of those infected with HIV worldwide, and 15% of those infected in the UK. Anonymous antenatal HIV seroprevalance studies suggest that the majority of women (87%) in England and Wales are unaware that they are HIV positive.[1] This may change since HIV testing is becoming more streamlined into medical care. An early diagnosis of HIV infection is now critical to maximize the best use of a combination of antivirals. Early diagnosis in women also offers the possibilities of reducing vertical transmission.[2]

In future, GPs may have more contact with HIV-positive individuals,[3] especially since treatment centres now encourage a more active role for primary care. Previous studies have examined both access and attitude to primary care in homosexual men with HIV.[4] We were interested in investigating whether women with HIV consulted with their GP and, if so, for what reasons.

Method

Over a four-month period, 106 consecutive HIV-positive women in an established clinic at the Royal Free Hospital, London, completed a questionnaire with a clinic doctor. This dedicated clinic is held weekly and is attended by a stable cohort of HIV-positive women. Women were asked basic demographic details: if they were registered with a GP, whether the GP was aware of their HIV status, and if they had visited their GP in the past year. Questionnaires were entered onto a database and responses were summarized using statistical analysis software (SAS Cary NC, 1990).

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Results

The median age of the women was 32.5 years (range 20–63), and the majority had been infected by heterosexual sex (n = 95, 90%). Fifty (47%) were black African, and 48 (45%) were Caucasian. Thirty-four (32%) women had a current sexual partner, of whom 14 (41%) were HIV positive. Forty-six (43%) women had, between them, a total of 87 children currently living with them, and 10 women had three or more children. Eight (9%) children were known to be HIV positive.

Eighty-six (81%) women were currently registered with a GP, and 71 (83%) reported that their GP was aware of their HIV status. Of those unregistered, 11 stated that they had recently moved, eight stated they would rather use hospital services only, and three had recently arrived in the UK. Of the women not registered with a GP or who had not disclosed their HIV status, nine were not ready to do so, eight had fears over confidentiality, three had not seen their GP since diagnosis, and two were unsure of the GP's reaction. In the preceding 12 months, 70 (81%) women who had registered with a GP had consulted him or her. Women were more likely to disclose their HIV diagnosis to their GP if they had a symptomatic disease (P<0.0001, chi-squared test). The main reasons for consultation are listed in Table 1.

Forty-six (43%) women had changed their GP in the last year. The main reason given for this was that they had moved house (39), although six women stated that they had had a bad experience with their previous GP. Black African women were less likely to have changed their GP in the preceding year (P = 0.0034, chi-squared test).

Conclusion

In this clinic population where involvement with primary care services is actively encouraged, most women had registered with a GP who was also aware of their HIV status. Women most often consulted their GP for perceived non-HIV-related matters or prescriptions.

A significant number of women changed GPs within the previous year, usually because they were moving house. It is important for hospital doctors to encourage early re-registering with GPs, since continuity of primary care may be problematic with such women.

Some women were reluctant to either register or disclose their diagnosis to GPs. Secondary care services should facilitate registering and disclosure by offering women options such as writing to the GP, or clinic doctors speaking to GPs directly, or exploring with the female patients the implications of non-disclosure if they continued to see their GP.

In the past, various efforts have been made to formalize HIV 'shared care' between primary and secondary services.[6] These have been largely unsuccessful. One possible explanation for this came out of the work by Huby *et al.*[7] Here, the idea of 'parallel care' was raised. This is a concept whereby patients with HIV attend their GP with a different range of problems than those presented in hospital. Similarly, women in this cohort mainly attended their GP for perceived non-HIV-related matters.

When compared with the previous work on homosexual men with HIV,[4] this group of women are more likely to access their GP and disclose their HIV status. One possible explanation for

Table 1. Reasons for visiting GP in the previous year and HIV disclosure.

Reason for visiting GP*	Total number (70 women)	GP aware of HIV status	GP unaware of HIV status
Perceived non-HIV matter	44	39	5
Prescriptions	38	35	3
Perceived HIV-related matter	13	13	0
With children	19	17	2
For emergency visit	9	9	0
For support	7	7	0
Family planning	3	2	1
Other	8	7	1

* Some women visited their GP more than once in the year.

this is that women with HIV consult with their GP prior to HIV diagnosis. A previous study found that 65% of women recalled seeing their GP in the year before HIV diagnosis,[5] so they already had links with primary care. Wadworth's study was set in a genitourinary medicine clinic in 1992 where an active role for GPs may not have been encouraged.

There are two significant biases in this study which should be mentioned. Firstly, the ethnic bias in keeping with the distribution of HIV among women in England — black African women often have priorities other than their HIV disease such as refugee status, re-housing, and child care needs where GPs may have a role to play. Secondly, this study relied on the recalling of events over the past year. However, the data on disclosure could be confirmed by checking correspondence with GPs in hospital notes.

Complex medical histories, families with multiple infected members, and cultural issues mean that good communication between primary and secondary services is needed to maximize care. Women with an advanced disease were more likely to inform their GP of their diagnosis, reflecting their increased need for community-based services. Results from this study are encouraging and suggest that most women with HIV in this cohort have established links with primary care services.

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