

Demographics, Sexual Risk Behaviours and Uptake of Screening for Sexually Transmitted Infections among Attendees of a Weekly Women-only Community Clinic Program

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ABSTRACT

Objectives: Vancouver's DTES represents a high-risk neighbourhood, in which there exist a number of community clinics and outreach programs. The purpose of this study was twofold: 1) to describe the population of women attending a weekly women's program with respect to demographics, risk behaviours and prevalence of STI, and 2) to assess the uptake of STI screening in this setting.

Methods: A cross-sectional survey was undertaken during a weekly community clinic-based women's program from October to December, 2004. Women were recruited at the start of the program each week and were invited to provide urine samples for chlamydia and gonorrhoea screening.

Results: Among 126 respondents, the median age was 42 (36-49), more than half (52%) self-identified as White and 40% as Aboriginal ethnicity. Forty percent were currently involved in the sex trade. Two thirds reported a Pap smear in the past year, while 14% had not accessed sexual health care (Pap smear, STI or HIV testing). Among the 92/126 (74%) women providing a urine sample, the prevalence of chlamydia and gonorrhoea was 2.2% and 0.0%, respectively.

Conclusion: The majority of women accessing this program were over 35 years of age, and while nearly half were currently involved in the sex trade, cross-sectional screening did not reveal a substantial prevalence of STIs. Women who were not regular program attendees reported less sexual health care, and represented the only two cases of chlamydia found. Innovative programs that better serve the needs of populations that remain unable or unwilling to seek sexual health care in its current formats are needed.

Key words: Sexual health care; sexually transmitted infections; women

La traduction du résumé se trouve à la fin de l'article.

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Acknowledgements: The authors acknowledge the dedicated staff and volunteers of the community clinic, and especially the participants who gave both their time and support.

Support: Individual funding: Michael Smith Foundation for Health Research; Technical support: BC Centre for Disease Control Laboratory.

Sexually transmitted infections (STIs) remain a significant health problem in terms of direct costs, long-term complications and increased risk of more serious infections such as HIV.¹⁻³ While the rates of STIs had declined during the 1980s and 1990s, a shift occurred at the end of the 1990s, raising concerns about inadequate prevention efforts, increasing risk behaviours, and the impact of STIs on HIV transmission.^{4,5}

In addition to being at higher risk for infection biologically, women are also more prone to long-term morbidities due to STIs.^{1,3,6} The high rates of asymptomatic infections can make it difficult to detect and treat STIs among women who are not regularly accessing sexual health care.⁶ These problems can be magnified in populations of vulnerable women living in low socio-economic communities such as Vancouver's Downtown Eastside (DTES), where poverty, drug addiction, homelessness, mental illness and the inherent dangers of sex work overshadow sexual health concerns.⁷⁻⁹

Advances in technology, such as nucleic acid testing, have allowed for innovative ways of accessing high-risk communities for sexual health care, including urine samples and self-swab sample collection among women.¹⁰⁻¹² While regular access to full sexual health services should be encouraged, limited clinic hours and long wait times present barriers to care for many women, while others simply do not want to undergo a full exam.⁹ Regular screening of identified high-risk women has been shown to be effective in many low- and middle-income countries where there is high prevalence of STIs.¹³ In industrialized cities, methods of STI control such as presumptive treatment, mass treatment and targeted screening in areas of concentrated risk have been tried with varying success.¹⁴⁻¹⁷ Targeting identifiable risk groups for screening is logical; however, several studies in the US have also reported high rates of STIs when sampling more generally from low-income neighbourhoods.¹⁸⁻²⁰ In communities where there are multiple risk factors, sexual health initiatives that focus on sex worker (SW) or illicit drug using populations may miss women who are linked into high-risk sexual networks through their partners.^{21,22}

In this study, we partnered with a local, centrally located, community clinic in

Vancouver's DTES offering a weekly program for women in order to first, describe the demographics, sexual behaviours and STI prevalence of women accessing the program, and second, assess uptake of urine screening in this venue. While there are many community clinics and outreach programs serving the more visible high-risk populations (e.g., injection drug users, street sex workers), the clinic program offers more general services (food and social activities), thereby drawing a broader sample of women from this neighbourhood in which to assess risk behaviours and STI prevalence.

METHODS

Between October and December 2004, an interviewer-administered survey and urine screen was carried out among 126 women attending a weekly program exclusive to women (including transgendered individuals) held at a local community health clinic. The three-hour evening program offers women a safe place to access food and health care, as well as to take part in various social activities. Women were invited to take part in the study at the start of each evening. Although there was no overt advertising for the study, snowball sampling through word-of-mouth was used to recruit women into the study. Participants were asked to indicate where they heard about the study, and how often they attended the clinic program.

The 27-item survey was an extension to the Community Health and Safety Evaluation (CHASE) concurrently being carried out in the community.²³ The CHASE survey covered demographics and health care use, and the extension gathered data on women's use of and contact with other services in their community (including outreach programs, outreach workers and street nurses), as well as their self-reported patterns of sexual behaviour and drug use, and use of sexual health care services such as annual Papanicolaou (Pap) smears and testing or treatment for STIs.

For sexual behaviour, a regular partner was defined as someone who the participant had been having sex with more than once a month for at least three months; a casual partner was someone who the participant had been having sex with once a month or less, or for a duration of less than

three months; and a client was someone who the participant had traded sex with for money, drugs, food or shelter. For each partner type, frequency of condom use (never, less than ½ the time, ½ the time, more than ½ the time, always) was asked.

Study coordinators read through the consent form with participants. Participants were not excluded if they did not provide a urine sample. Treatment for positive STI results was provided through the clinic under established STI testing and treatment protocols. Participants received \$10 remuneration for completing the survey. Urine samples were tested by the BCCDC provincial laboratory using nucleic acid amplification techniques (NAAT) as per standard protocols.²⁴ The study was approved by the University of British Columbia Behavioural Research Ethics Board.

Demographics and drug use behaviours were described for the participants of the women's program and comparison was done between those providing and those not providing a urine sample for STI screening, as well as between those who reported being regular or occasional program attendees and those who reported being first-time attendees. Dichotomous variables were compared using the chi-square test for significance, and continuous variables using the Kruskal-Wallis test.

RESULTS

Table I describes the demographics of the participants. Overall, the majority of women were over 35 years of age, although current sex workers were significantly younger [Median(IQR): 39 (35, 45) versus 43 (38, 49); $p=0.03$]. More than half of the participants self-identified as White (52%), while 40% identified as Aboriginal. Approximately 70% of the women had ever traded sex, with a significantly higher proportion of Aboriginal women reporting this (76% versus 59%, $p=0.02$). There were no significant differences between those who provided urine for STI screening and those who did not, although there was a higher proportion reporting regular, casual and multiple partners among those tested.

Table II compares those who had attended the program previously to those who had not, the latter group most likely

representing women who were recruited into the study through word-of-mouth. First-time attendees were younger, and were more likely to report injection and non-injection drug use. Overall, 78% of women reported having a regular doctor, while 80% reported sexual health care in the past year. First-time attendees were more likely to report having a regular partner and were significantly less likely to report sexual health care.

Differences in consistent condom use by partner type were similar among both program attendees and non-attendees. Consistent condom use with clients was reported by nearly 80% of participants; however, with regular or casual partners this dropped to 23% and 29%, respectively. When examining condom use by sex work status, active SW were found to report marginally higher rates of condom use with regular partners as compared to non- and former SW (35% versus 14%; $p<0.10$).

Ninety-two (73%) of the 126 participants submitted a urine sample for STI testing. There were no positive gonorrhoea screening tests, and two positive chlamydia tests (2.2%). Excluding those who did not report any sexual activity in the past six months, the prevalence increases to 2.6% (2/78). Both chlamydia cases identified were among first-time program attendees (2 of 21 providing a urine sample), resulting in a prevalence of 9.5% among this group.

DISCUSSION

This weekly program is conducted in a community considered to be at high risk for STIs and aims to attract marginalized women who may not attend regular clinics. As shown, the participants were mostly over 35 years of age, self-reported as of Aboriginal or White ethnicity, were unemployed and reported a high prevalence of substance use (80% non-injection drug use, 40% injection drug use). In addition, the population included a high proportion of both current and former SW. The cross-sectional prevalence of chlamydia and gonorrhoea was low, which may not be surprising given the age of the population; however, one may have expected to see higher rates among current SW. A comparison by program attendance indicated that while

TABLE I
Demographics of 126 Participants and Comparison of 92 Providing Urine Samples for STI Screening to 34 Not Providing Samples for Screening

	Total (N=126)	Urine Test (N=92)	No Urine Test (N=34)	p-value
Gender % (N)				
Female	96.8 (122)	97.8 (90)	94.1 (32)	0.292
Transgender	3.2 (4)	2.2 (2)	5.9 (2)	
Median age (IQR)	42 (36, 49)	43 (36, 49)	42 (38, 48)	0.897
Ethnicity % (N)				
White	52.4 (66)	51.1 (47)	55.9 (19)	0.826
Aboriginal	39.7 (51)	41.3 (38)	35.3 (12)	
Education % (N)				
<High school	59.5 (75)	58.7 (54)	61.8 (21)	0.755
High school	40.5 (51)	41.3 (38)	38.2 (13)	
Employment % (N)				
Any	5.6 (7)	94.6 (87)	94.1 (32)	0.922
None	94.4 (119)	5.4 (5)	5.9 (2)	
Drug use % (N)				
Injection	39.7 (48)	40.7 (37)	36.7 (11)	0.698
Non-injection	81.8 (99)	80.2 (73)	86.7 (26)	0.427
Alcohol	41.6 (52)	39.1 (36)	47.1 (16)	0.422
Sexual partners % (N) (past 6 mos)				
Regular partner	57.9 (73)	62.0 (57)	47.1 (16)	0.133
Casual partner	20.6 (26)	23.9 (22)	11.8 (4)	0.135
>1 partner	45.6 (57)	49.5 (45)	35.3 (12)	0.157
Sex work % (N)				
Never	30.2 (38)	30.7 (27)	35.5 (11)	
Former	26.2 (33)	26.1 (23)	32.3 (10)	0.562
Current	38.1 (48)	43.2 (38)	32.3 (10)	
Attendance at weekly women's program % (N)				
Never	23.8 (30)	22.8 (21)	26.5 (9)	0.670
Sometimes/Regularly	76.2 (96)	77.2 (71)	73.5 (25)	

TABLE II
Demographics, Sexual Behaviours and Sexual Health Care Among Participants, Comparing Regular/Occasional Program Attendees to First-time Attendees

	Program Attendees (N=96)	First-time Attendees (N=30)	p-value
Gender % (N)			
Female	97.9 (94)	93.3 (28)	0.183
Transgender	2.1 (2)	6.7 (2)	
Median age (IQR)	43 (38, 49)	39 (35, 45)	0.036
Ethnicity % (N)			
White	61.5 (59)	56.7 (17)	0.640
Aboriginal	38.5 (37)	43.3 (13)	
Education % (N)			
<High school	61.5 (59)	53.3 (16)	0.130
High school	38.5 (37)	46.7 (14)	
Employment % (N)			
Any	92.7 (89)	100.0 (30)	0.128
None	7.3 (7)	0.0 (0)	
Drug use % (N)			
Injection	34.4 (32)	57.1 (16)	0.031
Non-injection	77.4 (72)	96.4 (27)	0.022
Alcohol	37.5 (36)	53.3 (16)	0.124
Sexual partners (past 6 mos) % (N)			
Regular partner	52.1 (50)	76.7 (23)	0.017
Casual partner	22.9 (22)	13.3 (4)	0.258
>1 partner	45.3 (43)	46.7 (14)	0.893
Median number of clients (IQR)*	16 (3, 50)	10 (4.5, 40)	0.989
Sex work % (N)			
Never	32.6 (29)	30.0 (9)	
Former	27.0 (24)	30.0 (9)	0.941
Current	40.4 (36)	40.0 (12)	
Consistent condom use† % (N)			
Regular partner	26.5 (13)	18.2 (4)	0.446
Casual partner	38.9 (7)	25.0 (1)	0.601
Clients*	78.4 (29)	66.7 (8)	0.412
Median years involved in sex trade (IQR)*	12.0 (4.0, 20.0)	6.0 (3.0, 17.5)	0.530
Have a regular doctor % (N)	79.2 (76)	73.3 (22)	0.502
Sexual health (past year) % (N)			
Pap smear	75.0 (69)	56.7 (17)	0.056
STI test or treatment	53.1 (51)	23.3 (7)	0.004
Neither	14.7 (14)	36.7 (11)	0.009

* Among active SW only
 † Among those reporting partner type
 boldface p<0.05; bold italics p<0.10

most women agreed to STI screening (92/126 provided a sample), the only STIs were found among women who were first-time attendees, likely present solely for participation in the study. This, combined with the lower proportions of first-time attendees reporting regular sexual health care, indicates the need not only to continue but to bolster outreach screening programs, such as those offered through the Street Nurse program, in order to increase service utilization among these higher risk populations that are not connecting with current programs.

While a diverse group of women partake of the services offered through this venue, ethnic minorities other than First Nations and young women did not figure prominently in the sample. Asian women involved in the sex trade in this area are more likely to work out of private establishments and are less likely to connect with community services; innovative programs to provide services to these more hidden populations of women are currently being implemented.²⁵ Of the subset of attendees who were active SWs, there was a trend towards reaching a more established group who had been involved in the sex trade for an extended time (≥10 years), were not highly active in the sex trade (Median 10 partners in past 6 months, IQR: 4 to 50) and who may have already been well connected with services and outreach workers in the area. Other studies have identified groups of youth and young adult women involved in the sex trade in this area, however these women were not apparent in the clinic sample.^{26,27} Issues of stigma and fear of authorities may be more prominent in youth and in street sex workers, and programs that are tailored specifically for these populations are probably better suited to connect these women to care.

Condom use was highest among sex worker-client partnerships, but dropped off for non-paying partners. Partner-specific condom use patterns have also been noted in other SW populations.^{28,29} This is of particular concern in a community with high levels of IDU, as even monogamous couples may be risking infection with HIV. Condom use with regular or casual partners was also low among non- and former SWs.

The proportion of women reporting pap smears did not differ substantially as com-

pared to studies in the US and Canada which report a range from 55% in the past year to 85% in the past three years.³⁰⁻³² Previous studies in BC have found lower rates of cervical screening among Aboriginal women, however this was not the case among the women's program participants.³³ Of note, sexual health care was significantly lower among first-time attendees. The lack of sexual health care among these women has important implications for their own health – both from long-term complications and from increased susceptibility to other infections – as well as for public health, as every untreated infection represents additional cases that might have been found through partner tracing or that might have been prevented.

The level of uptake of urine screening was similar to that in other studies, which have reported levels ranging from 72 to 84% among women and young adults.³⁰⁻³² Despite this, and the variety of risk factors, there were not high rates of STIs. Had STI screening uptake been 100%, and assuming a similar prevalence of STI among women who did not provide a urine sample, there would still only have been a total of 2.7 cases (95% CI: 0.3-9.6) uncovered in this setting. It is unclear why some women did not agree to provide a urine sample, although distrust of authorities may have played a role. Chlamydia is a reportable infection in BC and requires partner tracing, which was indicated in the consent form and may have led some women to avoid testing. Additionally, while providing a urine sample is less physically intrusive than other specimen collection methods, it may be viewed as more personally intrusive and more traceable than simply providing verbal information for the survey.

While STI rates of 2-5% are typical of screening studies carried out among at-risk populations,^{14,34-36} the low number of bacterial STI found in this study may be attributed to the population characteristics (i.e., over 35 years of age), as well as to timely access to care in this population through local clinics and intensive public health efforts. Although the utility of urine screening in this venue is not apparent, the women's program could be used to improve the knowledge and awareness of sexual health and STI issues in this population, and remains a good access point for

care and treatment. This reaffirms other research that has highlighted the need for programs targeting high-risk women to be specific to the location, as conditions and barriers vary widely.³⁷

There are limitations to the study. The generalizability of the results is restricted to an older, service-connected population of women from the community. There is a potential for under-reporting on sensitive topics such as drug use and sexual behaviours, although the high proportions reporting these behaviours indicate that most women were comfortable disclosing this information. There is also a potential for misreporting of sexual health check-ups either due to forgotten events or over-reporting of the desirable behaviour; however, the proportions receiving care were similar to those reported in other studies.

While screening high-risk populations may be beneficial for improving the sexual health of individuals and of the community, it is apparent that this type of intervention needs to be more carefully evaluated according to the setting through which it is offered. In high-risk populations where care is widely available and accessible, the utility of screening programs needs to be evaluated and potentially tailored in order to better serve the needs of particular populations that remain unable or unwilling to seek sexual health care in its current formats.

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Received: May 21, 2007
Accepted: February 19, 2008

RÉSUMÉ

Contexte : Plusieurs cliniques communautaires et programmes d'approche sont implantés dans le quartier défavorisé de Downtown Eastside à Vancouver, où la population est particulièrement vulnérable. Notre étude avait deux objectifs : 1) décrire le profil démographique, les comportements à risque et la prévalence des ITS dans la population féminine fréquentant un programme hebdomadaire pour femmes et 2) évaluer l'utilisation des tests de détection d'ITS dans le cadre de ce programme.

Méthode : Enquête transversale menée dans une clinique communautaire dans le cadre d'un programme pour femmes organisé un soir par semaine d'octobre à décembre 2004. Des participantes, recrutées au début du programme chaque semaine, étaient invitées à donner un échantillon d'urine pour la détection du chlamydia et de la gonorrhée.

Résultats : Sur les 126 répondantes, dont l'âge médian était de 42 ans (36-49), plus de la moitié (52 %) disaient être blanches, et 40 % disaient être autochtones. Quarante p. cent travaillaient dans le commerce du sexe. Les deux tiers disaient avoir subi un test de Papanicolaou au cours de l'année antérieure, tandis que 14 % n'avaient reçu aucun soin de santé sexuelle (ni frottis vaginal, ni test de détection d'ITS ou du VIH). Chez les 92 femmes sur 126 (74 %) ayant fourni un échantillon d'urine, la prévalence du chlamydia et de la gonorrhée était de 2,2 % et de 0 %, respectivement.

Conclusions : La majorité des participantes avaient plus de 35 ans, et la moitié travaillaient dans le commerce du sexe; malgré cela, l'enquête transversale n'a pas révélé une prévalence importante d'ITS chez ces femmes. Celles qui ne participaient pas régulièrement au programme avaient reçu moins de soins de santé sexuelle, et c'est chez elles que l'on a décelé les deux seuls cas de chlamydia. Il faudrait créer des programmes novateurs pour mieux répondre aux besoins des populations qui ne peuvent ou ne veulent pas recevoir de soins de santé sexuelle tels qu'ils sont dispensés actuellement.

Mots clés : soins de santé sexuelle; infections transmises sexuellement; femmes



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