Accessibility and Acceptability of Public Sexual Health Clinics for Adult Clients in New South Wales, Australia.

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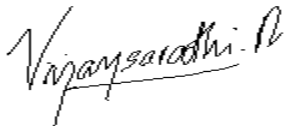
Declaration of authenticity

I hereby declare that this treatise is my own original work and contains no material previously published or written by any other person, without appropriate references.
No material content has been accepted for award of any other post graduate qualification at The University of Sydney or any other educational institutions.
Any contribution made by others with whom I have worked in the making of this treatise has been duly acknowledged.



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CONTENTS

Abstract

The objectives of this study were to examine the accessibility of public sexual health clinics (SHCs), identify the service preferences of clients and assess whether the services delivered by public SHCs were acceptable (suitable) to users' expectations. Participants were adult clients attending public SHCs in 4 different geographical regions of New South Wales (NSW). A self completed anonymous questionnaire survey was employed in this study and the data was collected over a two week period per clinic. The overall participation rate was 89%. Three hundred and two clients participated of which 68.2% and 31.8% were males and females respectively. Geographical proximity to residence or work was the single most common reason cited to choose a particular clinic by all clients. The main source of information about public SHCs for young and middle aged clients was their personal contacts, whereas for older individuals it was health professional's referral. Of the total sample, nearly 59% vs. 32% of clients used private and public transport to get to the clinic. About 80% of private transport users of the city and suburban clinics had indicated some difficulty with parking facilities. For more than two thirds of clients, the time taken to get to the clinic was less than 30 minutes. Overall, more clients preferred an appointment (56%) compared to a walk-in (32%) system. Nearly 65% of all clients preferred to attend the clinic during the weekdays and about 11% preferred weekends. Of those clients who had a preference for a time to attend a clinic, 83.3% attended clinic in their preferred time. Overall, more than one third (39%) of all clients preferred a same gender health care worker (HCW) whereas 13% of clients did not prefer a same gender HCW. Among clients who had a clear preference, more than 90% of all females and nearly 80% of overseas born males preferred a same gender HCW. More females (81%) than males (59%) were actually able to

have a consultation with a HCW of their preferred gender. The majority (79%) of clients preferred to consult the same doctor in the follow up visits and only a few clients (5%) preferred a separate male and female waiting room. The vast majority (97%) of clients had no difficulty with language during consultation. About 93% of clients had rated the services delivered by public SHCs to be either excellent or good. The public SHCs were found to be accessible and acceptable to the clients who currently utilise them. Designated parking spaces for the city and suburban clinic users and providing an option for female and overseas born male clients to select a HCW of their preferred gender need to be considered. Further research is required to examine accessibility and acceptability aspects of public SHCs for the potential clients who either currently use other services or do not access any form of services.

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List of tables Page no.

List of figures

List of appendices

Acronyms

ABS	Australian Bureau of Statistics
AIDS	Acquired Immunodeficiency Syndrome
CALD	Culturally and Linguistically Diverse
df	Degree of freedom
FPC	Family Planning Clinic
GPs	General Practitioners
GUM	Genitourinary Medicine
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
NES	Non-English Speaking
NSW	New South Wales
PIS	Participant Information Sheet
SH	Sexual Health
SHC (s)	Sexual Health Clinic (s)
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Diseases
STI	Sexually Transmissible Infections
TIS	Telephone Interpreter Service
WHO	World Health Organisation

Chapter 1 - Introduction

1.1 Background

Sexual health (SH) is a major aspect of health worldwide and an integral component of reproductive health. The World Health Organisation (WHO) defines it as –

> *a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled* [1].

An Australian report (2004) mentions that SH is a well recognised aspect of health even though there is limited information on the health of reproductive organs and of SH services utilisation [2]. Sexually transmissible infections is an important SH problem in Australia where 20.2% of males and 16.9% of females had reported that they had been diagnosed with an STI at some stage of their life [3].

The clients with SH problem(s) may attend sexual health clinics (SHCs), General Practitioners (GPs), Family Planning clinics (FPCs), Aboriginal Medical Service, specialist HIV clinics, infectious disease physicians or gynaecologists [4]. In NSW, there are 43 public SHCs funded by the State Government[5]. These clinics deliver free, confidential, anonymous and high quality services

through multidisciplinary teams including venereologists, sexual health physicians, sexual health nurses, sexual health counsellors [6]. Psychologists are another important team member.

A number of SH services are provided at public SHCs which mainly include care and treatment for sexually transmissible infections (STI) such as HIV, gonorrhoea, syphilis or chlamydia.

Contact tracing (*the process of identifying contacts of a person with an infectious disease in order to inform them of their exposure, assess the risk of transmission and if appropriate provide screening and treatment* [7]), SH promotion (*the holistic process of enabling individuals and communities to increase control over the determinants of sexual health, and thereby managing and improving it through their lifetime* [8]), training, professional development and consultancy for health care workers (HCW) as well as research and collection of surveillance data are some or all of the services also delivered by public SHCs [6].

Most of the public SHCs are found within hospital grounds or in a premise where other health care services are delivered, although few stand alone clinics are present. The public SHCs functions only during weekdays, mostly between 9:00am and 5:00pm. Few clinics have extended hours of functioning and exclusive evening sessions. On weekends and after hours, clients are recommended by the SHC to access the Emergency Department of a specific hospital or a GP/medical centre in the nearby area. The SHCs consult with clients by both set appointments and walk-in system; however, an individual clinic may have its own preference and encourage its clients accordingly.

To cater to the needs of Culturally and Linguistically Diversified (CALD) clients, the SHC can arrange for a Telephone Interpreter Service (TIS) or accredited personal interpreters for assistance with interpretation and at no cost to the clients. The clinics also provide a wide range of information on sexual health in the form of pamphlets and fact sheets.

1.2 Rationale

SHCs and GPs are the two major providers of SH services in Australia [4]. Grulich et al. mention that the GPs are the most common source of treatment rather than SHCs [3]. Apart from the increased availability of GPs when compared to the public SHCs, it is important to specifically examine the factors on accessibility, acceptability and satisfaction with services that underpins current levels of utilisation of public SHCs. Gulliford and co-workers (2002) reported that access measured in terms of utilisation of services is dependent on the accessibility and acceptability of services and not merely on adequacy of supply [9].

Research was done in the past to identify the variables that were related to utilisation of GPs/private practices in Australia and also in overseas countries. Accessibility and acceptability of services which included continuity of care, evening and weekend availability of service, personal choices of the GP(s) and lack of awareness about existence of other choices were some of the reasons identified [10-15]. The survey of public Sexually Transmitted Disease (STD) clinics (1983) and the evaluation of SH services within Australia (1997) mainly focussed on the functioning of SHCs but did not examine the clients' needs and preferences in regards to service delivery [16,17]. In 2005, a study done by Family Planning Victoria identified the barriers to accessing sexual health clinical services in Victoria (Australia) [18]. The study made 11 recommendations of which one was concerned with satisfaction of service users. These satisfaction ratings may be related to a number of underlying variables. Two of the important variables that might contribute significantly to levels of satisfaction are issues concerned with accessibility and also acceptability.

Accessibility aspects examine the access to the clinic by private and public modes of transport, parking facilities, time taken to travel as well as flexible mode of booking consultation (appointment or walk-in) and availability of services on weekends and after office hours.

Acceptability features relating to satisfaction may primarily be concerned with the personal choices of the clients for same gender health care worker (HCW), continuity of care with the same doctor as well as waiting room considerations and effective communication between client/HCW during consultation. A more detailed description of these variables associated with utilisation and/or satisfaction of health care services in terms of accessibility and acceptability are discussed in detail in the following chapter (Chapter 2 – Literature review).

Thus, the current study was undertaken in response to the foregoing issues concerning accessibility and acceptability as factors that may influence satisfaction of current users with the services delivered by public SHCs. The findings of this study may firstly be useful in modifying and/or improving current services. The findings may also be used in future research to examine the barriers to utilisation of public SHCs in NSW by the potential clients who currently access other service providers or indeed those not accessing any form of services.

1.3 Objectives

The objectives of this study were to examine the accessibility (*convenience*) of attending public SHCs; identify the service preferences of clients and assess whether the services delivered by public SHCs are acceptable (*suitable*) to users' expectations.

1.4 Research question

Are the services delivered by public SHCs in NSW, accessible and acceptable to the current users?

Chapter 2 Literature Review

The current study is concerned with the factors that underpin utilisation of public SHCs and clearly a number of identifiable features of quality health care. Accessibility and acceptability are considered to be important attributes of quality health care services along with equity, effectiveness, efficiency, optimality and legitimacy [19]. Chen and Hou (2002) suggest that two major reasons for having had unmet health care needs are related to issues concerned with acceptability and accessibility of health services [20].

A review of international studies mainly examined issues regarding accessibility of services for consumers, their preferences in sexual health services delivery and also examined issues related with utilisation of a particular health service provider (high preference/attendance with GPs). The sexual health clinics are called by various names: Genitourinary Medicine (GUM) clinics in the United Kingdom (UK) and Sexually Transmitted Disease (STD) clinics in the United States of America (USA).

A study on consumers' views on GUM services in UK was done by Munday (1990) with 300 patients who attended the service. The study identified issues concerned with accessibility and acceptability of service for the consumers. The accessibility issues identified were that the majority of users preferred the clinic to be sited away from the main outpatient department and also preferred an appointment system and evening clinics. The acceptability concern in this study was that nearly 50% of women wished to be examined by a female doctor [21].

Rogstad (1991), in his study on patients' assessment of and suggestions for a GUM service in the UK with a larger sample size of 1000 consecutive attendees mainly examined acceptability issues. Forty six percent of women and 33% of men preferred to be seen by a doctor of their

same sex. The majority had preference to see the same doctor at each visit. Most of the women and men preferred separate waiting rooms. Regarding accessibility, 38% of patients requested evening clinics and the majority had preference for an appointment system [22].

McCarthy and co-researchers (1992), in their study on a women-only clinic for HIV, GUM and substance misuse services found that the main reasons for attendance at these services was related to the availability of female doctors and staff, the presence of a female waiting area and the greater convenience of an evening clinic [10].

Gunneburg and co-workers (1996) did a quantitative study to determine the accessibility of GUM services by women attending family planning clinics (FPC). Ninety eight women who attended FPC were equally divided and referred to get tested at either a GUM or a FPC. The purpose of this randomised split and referral to a GUM service was to establish the rates of attendance at the two different facilities. The attendance rate was significantly higher with those who were referred to a FPC clinic. The study noted that women in the UK were less likely to attend GUM clinics, but further research was recommended to determine the reasons for low utilisation [23].

In 1995, Hope et al. reported a questionnaire survey on accessibility of GUM clinics. Five clinics, each from different regions of the UK were included with a sample size of nearly 300. Most (87%) attendees took less than 30 minutes to get to the clinic. Sixty six percent used public transport with variations between locations. The most common reasons for choosing a clinic were recommendation by others and proximity to their residence. Nearly 77% of patients attended the clinic in their preferred part of the day and most of them found the clinic staff friendly. The authors concluded that the clinics were physically accessible and recommended further work on acceptability of service in relation to expectations of patients [24].

Hope et al. (1997) also did a study on acceptability of GUM clinics to homosexual and bisexual men using a cross sectional survey of men using "gay" venues in the UK with a sample size of 848 attendees. The acceptability of the service was assessed using a range of indicators like friendliness of clinic staff and ease of communication with the doctors, nurses and health advisors. The study identified the need to improve acceptability of the service and also found that men who need to use the GUM service were found not to be using it [25].

McClean et al (1997) conducted a study in a large city in UK that aimed to examine the relationship between information and views held by first time service users before obtaining help from a GUM service and also the study examined the accessibility of services. The two main sources of information in this study were the General Practitioners (GPs) and personal contact with other service consumers. Most service users (92%) were in favour of increased availability of information about GUM clinics mainly through written media and GPs [26].

Fisk and Julian (1997) did an audit on GUM clinic's acceptability in 120 patients and found that the majority used cars and they located the clinic easily. More females (40%) than males (27%) preferred a same sex doctor. Seventy two (60%) of consumers preferred an appointment system [27].

Bell and Rogstad (2000) identified the length of time spent in the clinic to be a main obstacle for off-street sex workers in a questionnaire survey done in saunas and massage parlours in the UK. Other reasons cited were difficulty to get to the clinic as well as dislike of needles and examinations [28].

In 2002, Malu and co-investigators did an audit to evaluate the accessibility of attending GUM clinics in London and Plymouth using a questionnaire survey involving 958 attendees of the clinic. The key findings were that the majority of the service consumers used public transport in London and whereas private transport was used more in Plymouth. The journey time was less

than 30 minutes for attendees in both cities. Sixty eight percent of the attendees from both sites were either full time or part time employed while others were unemployed/students. The study found both the clinics to be accessible and convenient for the users [29].

Evans and co-researchers (1996) in the UK did a qualitative study to assess users and potential users' views on provision of GUM services. Although the participants commented positively on many aspects of the service, many of them emphasised initial difficulty in finding the clinics. Many women and Caribbean men strongly expressed the need for single sex clinics [30].

In 2001, Dixon-Woods and co-workers did a qualitative study of women's views to choose and use services for sexual health with 37 women. It was found that a simple referral system; as well as appropriately communicating and understanding staff were important. Confidentiality was also a priority issue for women [31].

A qualitative survey of young persons was done by McAllister and co-researchers (2002) to determine the accessibility and acceptability of a sexual health service in a city centre pharmacy in UK. The timing and location of the service were the most commonly quoted reasons for attendance [32].

A large Colombian survey by Valendia et al. (2003) with a sample of nearly ten thousand homes was done to evaluate the reasons for non utilisation of the health care services. The majority (64.7%) of people reported reasons associated with quality problems. Amongst these reasons, the most important were those related to accessibility of services such as distance to travel, lack of money, lack of credibility in the health agents [33].

Jones et al. (2001) did an evaluation program that compared Milwaukee's STD clinic with the USA National Standards for Health Care and found accessibility by public transport, clean and

comfortable waiting rooms with educational materials, effective clinician – patient interactions and mode of consultation were the key features of basic services and accessibility [34].

The 2003 Sexual Health Relationship strategy of Scotland mentions that accessibility and acceptability as important issues for the sexual and reproductive health services and the way the services was delivered was important to all age groups of the population. The strategy also mentions that access to same sex GPs and nurses and availability of same sex practitioners can influence the outcome of sexual health interventions [35].

Review of Australian studies: In 1983, a nation wide survey of services that offered free care for STDs was done by Bradford et al. This survey included all 20 public STD facilities Australia wide. The study found that almost all clinics were located in the major cities, leaving vast rural areas not serviced by public clinics. Inadequate opening times, lack of facilities in some clinics for treating both men and women and insufficient staff were some of the other findings. It was concluded that the facilities studied were inadequate in several respects to meet the needs of the population [16].

An evaluation of sexual health services within Australia and New Zealand was done in 1993 by Marks et al. involving all SHCs (public and private) in both countries. It was reported that the number of clinics had increased with marked urban predominance of clinics in Australia. Compared to the 1983 survey, this study found an increase in the number of doctors and nurses at these clinics while the number of patients seen annually was similar to the past study [17].

A study on accessibility of general practice in rural Australia by Humphreys and co-researchers (1997) found that social accessibility or acceptability considerations were more important than geographical proximity. Elder people, in particular attributed most significance to acceptability

and continuity of care. Young and middle aged people, particularly men living in isolated communities ranked geographical proximity as the most important factor [11].

Mindel and Tenant-Flowers (1998) mention that GPs and SHCs were the two major providers of sexual health in Australia and discuss the advantages and disadvantages of both. GPs were found to offer patients convenience and continuity of care whereas SHCs offer anonymity, specialist expertise, readily available diagnosis, treatment, counselling, surveillance and contact tracing all on one site. Feeling embarrassed and being uncomfortable discussing sexual 'indiscretion' and anxiety about disclosure of confidentiality with attending GPs were mentioned as reasons for not attending GPs [4].

A *Women's Health* study by Schofield and others (2000) was done in Australia with a study sample of over fourteen thousand women aged 18-23. The objectives were to examine the associations of self reported STI, socio-demographic, lifestyle, health status, health service use and quality of life factors. The study found that the factors associated with use of family planning clinics included unemployment, current smoking, having had a Pap smear in the last 2 years, not having ancillary health insurance, having consulted a hospital doctor and having higher stress and life events score. It was also found that the factors associated with the use of SHCs were younger age, lower occupation status, being a current or ex-smoker, being a binge drinker, having had a Pap smear, having consulted a doctor, having poor mental health and having a higher life event score [36].

Hyndman and co-workers (2001) investigated the accessibility and spatial distribution of general practice services by levels of social disadvantage in the catchment areas in Perth, Australia. All 459 general practices were surveyed. Access factors were defined as the distance to the nearest practice, provision of Sunday and evening services, ease of making same day appointment, bulk

billing and whether the practice offered a choice of gender of doctor. It was concluded that the overall picture of accessibility was favourable, although variations were found within different socioeconomic groups [12].

In 2003 Hyndman and co-researchers reported a study in Perth which looked at the attractive factors that influence the choice of general practices and found such variables as 'easy to make an appointment', 'nearby pharmacy', 'bulk billing', 'punctuality of the doctor' and 'opened on all Sundays' were some of the key factors [13].

A review of sexual health clinical services in Victoria was done by Family Planning Victoria in 2005. One of the objectives of the review was to examine access to services for individuals with special needs. The identified barriers to accessing sexual health clinical services were grouped under social, structural, financial, informational, geographical and attitudinal and knowledge related issues. The study mentions a list of performance indicators specifically for state funded sexual health clinics. Accessibility and consumer satisfaction (percentage of patients satisfied with the service and ability to feedback on areas for improvement in the clinic) were two important performance indicators [18].

The findings of the Australian studies were similar to that of the international studies regarding more utilisation of GPs and private practices. What does appear to be lacking in the Australian literatures was an examination of acceptability aspects related to consumer satisfaction with SHC services. There was one study done by Family Planning Victoria which examined accessibility but did not examine acceptability issues. It seems important to address both accessibility and acceptability issues in one study as there may well be an interaction with both that is not seen when we examine one key predictor or variable associated with consumer utilisation and satisfaction of sexual health services.

The literature has identified accessibility issues such as flexible appointment systems [12,13,21,22,27] ; ability to attend the clinic in the preferred time [24,32] ; functioning of evening clinics[10,21,22] and access to service on weekends[12,13]. The other accessibility issues are travel time and ability to access by public/private transport modes [24,27,29] and location of clinic [21,32].

The important acceptability issues identified in the literature were preference for a same gender HCW [10,21,22,27], availability of same sex clinics [30] and availability of separate waiting rooms for males and females [22].The other acceptability issues were continuity of care with the same doctor [22] and ease of communication with doctors/nurses [25,31,34]. Reasons for choosing a particular service [24], sources of information about the service [26] and length of time spent at the clinic [28] were few other issues assessed in the past studies.

Thus the current study is undertaken to examine whether the same factors mentioned appears to influence the utilisation of public SHC facilities in NSW.

Chapter 3 Methods

Approval for this research was granted by the following Human Research Ethics Committees and a copy of approval letter is attached (appendix A)

South Eastern Sydney and Illawarra Area Health Service (SESIAHS) – Eastern section

University of Wollongong + SESIAHS – Illawarra section

Sydney West Area Health Service – Nepean and Westmead campuses.

3.1 Design

The study was a survey using a self-administered anonymous questionnaire.

3.2 Sample

The target population was adult (18 years and above) clients attending public SHC(s). The study sample was recruited from 4 clinics located in different geographical locations within NSW. Sample size needed to have sufficient power to establish a statistically significant difference was determined to be 43 subjects at each clinic using *WinEpi* computer software package. The output of the sample size calculation is attached (appendix B).The sampling period was two weeks in each clinic, covering all working days.

Subjects

All adult attendees of public SHC during the sampling period were included, irrespective of the services provided within a particular clinic for which they attended. The only eligibility criterion was the age of participants (18 years or above), as the study was aimed only at adults. Clients attending for follow-up visits during the sampling period in the same clinic were not approached.

Public SHCs in NSW

There are 43 public SHC(s) in NSW which are classified under 3 regions namely: *Sydney City and suburbs*; *Sydney Outer metropolitan* and *Rural NSW* [5]. The 'Region – *Sydney City and Suburbs*' was further classified by the researchers as two separate regions namely *'Sydney City'* and *'Sydney Suburban'* for more precise comparisons. Only in this report, the region *'Sydney City'* includes clinics within 5 kilometre radius of Sydney Central Business District (CBD) and *'Sydney Suburban'* includes clinics within metropolitan Sydney but a beyond 5 kilometre radius of Sydney CBD. The classification of regions and number of public SHCs in each region within parentheses are mentioned below -

Region A: (R-A) Sydney City [5]

Region B: (R-B) Sydney Suburban [9]

Region C: (R-C) Sydney Outer metropolitan [4]

Region D: (R-D) NSW Rural areas [25]

Study clinics

One clinic per region was decided to be surveyed. The R-A and R-D clinics were invited to participate by contacting the Directors/Managers of the clinics using 2005 Public Sexual Health Clinics Register. The R-B and R-C clinics were selected by the researchers. This could have resulted in selection bias of clinics. The name of the clinics are not mentioned anywhere in this report as negotiated with the Directors/Managers of the participating clinics, in order to maintain anonymous participation of the clinics.

3.3 Procedure

All attendees over the sampling period were approached in the waiting area by the investigator(s). The participant information sheets (PIS) (appendix C) were given after a brief description of the purpose and nature of the study. Those who were eligible and willing to participate were then given the questionnaires. On completion of both sections, the questionnaires were returned in a sealed envelope in order to assure anonymity and confidentiality for the respondents.

An accredited personal interpreter service was used for those non-English speaking (NES) clients who requested assistance with completion of questionnaires. Log sheets were maintained for individual days of data collection (appendix D), to measure the approach and participation rates for clinics. The summary of data collection is attached (appendix E). The target sample of 43 per clinic was achieved in 3 out of 4 sites and not in the R-D clinic.

3.4 Materials - Questionnaire: (appendix F)

The questionnaires were in English and had questions on baseline demographics, accessibility and acceptability. The questions were chosen based on literature review, understanding of difference in functioning and service delivery among different SHCs, advice of Directors or Managers of SHCs and also from expert opinion of key Researchers. There were two sections to be completed, one before and the other after consultation. The latter section had questions relevant to the consultation on the day of participation. Most questions were closed ended and few were open ended questions. A separate space at the end for suggestions and additional comments was provided. The questionnaire had to be modified for the R-D clinic as the HREC did not approve the question on ‘Ethnic background’.

3.5 Data analyses

The data was coded, entered and analysed using SPSS software version 11.5 [37]. Descriptive statistics (proportions or percentages) were used to describe demographics. Chi-squared (2-sided) and Fisher's Exact (1-sided) statistics were used to test significance of the difference observed in the findings. The significance level was set at 0.05. For all statistical analyses that compared clients of individual clinics, R-D clinic data was excluded due to insufficient sample size (n = 10). Binary logistic regression analysis was also used to determine the preference of clients for same gender HCW.

Chapter 4 Results

Three hundred and two clients participated in the study and the participation rate was 89%.

The demographic details of the participated clients from individual clinics are presented in table 1.

Age group: Of the total sample, 73.5% were either middle (26-49 years) or old (above 50 years) adults and the remainder were young adults (18-25 years). The proportion of middle and older adult groups was high in the R-A (90%) clinic when compared to the proportion of same groups who attended R-B (61.1%) and R-C (72.1%) clinics. The proportion of young adults was observed to be high in R-B (38.8%) and R-C (27.9%) clinics when compared to the R-A (10%) clinic.

Gender: Of all attendees, more than two thirds (68.2%) were males and 31.8% were females. The proportion of male clients was very high in R-A (94.5%) clinic when compared to the proportion of males who attended R-B (54%) or R-C (46.5%) clinic. The balance in the proportions of male and female clients was found to be more even in R-B and R-C clinics when compared to R-A clinic.

Employment status: The proportion of employed (either full time or part time) clients in the total cohort was 60.7%. Of the remaining, 16% were unemployed, 12% and 11.3% were retired and students respectively. The proportion of unemployed and retired clients together was comparatively high in R-A (44.1%) clinic when compared to the proportion of the same groups in R-B (15.1%) or R-C (28.6%) clinic.

Highest education status: Ninety six percent of all attendees reported at least secondary level of education with no major differences observed between individual clinics.

Usual language spoken at home: English was found to be the spoken at home by 88.4% of all respondents while 11.6% were non-English speaking (NES) clients. The proportion of NES clients was higher in R-B (17.3%) when compared to R-A (9.1%) or R-C (2.3%) clinic. The list of languages spoken at home by clients is attached (appendix G).

Country of birth: Of total participants, more than two-thirds were born in Australia (68.9%) and the remaining 30.1% were born overseas. The proportion of overseas born clients' was observed to be nearly same in R-A (35.5%) and R-B (33.8%) clinics but higher when compared to R-C (14%) clinic. The list of countries of origin of clients is attached (appendix H).

SHC users: Nearly 71.5% of all clients were repeat attendees of the same SHC (the clinic attended on the day of participation). Of the rest, 20.9% were first time users of public SHCs and 7.6% had used other SHCs in the past.

Ethnic background: Overall 81.8% of clients were Caucasians and the remaining 18.2% were non-Caucasians (Asians, Aboriginal and Torres Straight Islanders and other ethnic groups). The proportion of non-Caucasian group was found to be high in R-B (25.4%) clinic when compared to R-A (12.7%) or R-C (9.3%) clinic.

Table 1: Baseline demographics of clients who attended public sexual health clinics in NSW (*n* = 302).

Region codes	A *n* (%)	B *n* (%)	C *n* (%)	D *n* (%)	Overall *n* (%)
Total participants	**110** (100.0)	**139** (100.0)	**43** (100.0)	**10** (100.0)	**302** (100.0)
Age group (years)					
18-25	11 (10.0)	54 (38.8)	12 (27.9)	3 (30.0)	80 (26.5)
26-49	74 (67.3)	68 (48.9)	23 (53.5)	4 (40.0)	169 (56.0)
above 50	25 (22.7)	17 (12.2)	8 (18.6)	3 (30.0)	53 (17.5)
Gender					
Male	104 (94.5)	75 (54.0)	20 (46.5)	7 (70.0)	206 (68.2)
Female	6 (5.5)	64 (46.0)	23 (53.5)	3 (30.0)	96 (31.8)
Employment status					***n* = 300**
Full Time	33 (30.3)	68 (48.9)	7 (16.7)	6 (60.0)	114 (38.0)
Part Time	20 (18.3)	29 (20.9)	18 (42.9)	1 (10.0)	68 (22.7)
Unemployed	27 (24.8)	15 (10.8)	6 (14.3)	0 (0.0)	48 (16.0)
Retired	21 (19.3)	6 (4.3)	6 (14.3)	3 (30.0)	36 (12.0)
Student	8 (7.3)	21 (15.1)	5 (11.9)	0 (0.0)	34 (11.3)
Missing responses	1	--	1	--	2
Highest education status					***n* = 299**
Primary	7 (6.4)	5 (3.7)	0 (0.0)	0 (0.0)	12 (4.0)
Secondary	42 (38.2)	42 (30.9)	13 (30.2)	6 (60.0)	103 (34.4)
TAFE	26 (23.6)	33 (24.3)	12 (27.9)	2 (20.0)	73 (24.4)
Undergraduate	18 (16.4)	30 (22.1)	11 (25.6)	1 (10.0)	60 (20.1)
Postgraduate	17 (15.5)	26 (19.1)	7 (16.3)	1 (10.0)	51 (17.1)
Missing responses	--	3	--	--	3

Table continues on next page.

Table 1 continues.

Region codes	A *n* (%)	B *n* (%)	C *n* (%)	D *n* (%)	Overall *n* (%)
Total participants	**110** (100.0)	**139** (100.0)	**43** (100.0)	**10** (100.0)	**302** (100.0)
Language spoken at home					
English	100 (90.9)	115 (82.7)	42 (97.7)	10 (100.0)	267 (88.4)
Other	10 (9.1)	24 (17.3)	1 (2.3)	0 (0.0)	35 (11.6)
Country of birth					
Australia	71 (64.5)	92 (66.2)	37 (86.0)	8 (80.0)	208 (68.9)
Other	39 (35.5)	47 (33.8)	6 (14.0)	2 (20.0)	94 (31.1)
Clinic user					
First time users	15 (13.6)	32 (23.0)	14 (32.6)	2 (20.0)	63 (20.9)
Repeat users – same clinic	82 (74.5)	102 (73.4)	25 (58.1)	7 (70.0)	216 (71.5)
Repeat users – other clinics	13(11.8)	5(3.6)	4 (9.3)	1 (10.0)	23 (7.6)
Ethnic background					***n*=291**
Caucasian	96 (87.3)	103 (74.6)	39 (90.7)	N/A	238 (81.8)
Asian	9 (8.2)	23 (16.7)	1 (2.3)		33 (11.3)
Aboriginal and Torres Straight Islanders	1 (0.9)	0 (0.0)	1 (2.3)		2 (0.7) 18 (6.2)
Other	4 (3.6)	12 (8.7)	2 (4.7)		1
Missing response	--	1	--		

n – Number (count) N/A - Not available**.**

The reasons given for choosing a particular public SHC by different age groups of the clients is shown in the Figure 1. Geographic proximity of the clinic to home or work was reported as the reason by more young (48.6%) and middle (59.9%) aged adults when compared to older individuals (39.6%). Whereas health professional's referral was the reason for more old aged (39.6%) adults when compared to young (21.4%) or middle (20.4%) aged adults. For 30% of young adults and for nearly equal proportions of middle (19.7%) and older (20.8%) aged adults, the clinic they attended was the only clinic known (limited information). These observed differences were tested to be significant (χ^2 = 11.39 df: 4 p = 0.023). Those who responded with non-specific reasons (n = 22) are not included in the figure below or in the statistical analysis. There were 10 missing responses.

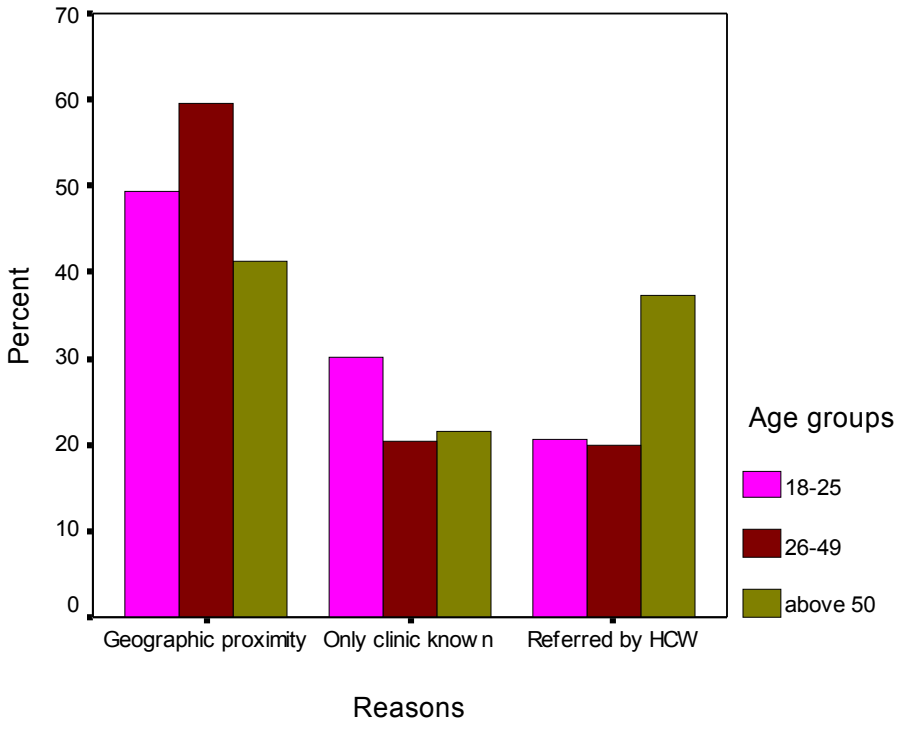

Figure 1: Reasons given for choosing a particular public sexual health clinic by different age groups of clients (n = 270).

Figure 2 shows the different sources of information about a particular public SHC for different age groups of clients. Personal contacts were the source of information for slightly higher proportions of young (55.7%) and middle (53.6%) aged clients when compared to older (36.2%) adults. Whereas, health professional's referral was responded by a higher proportion of old (59.6%) age adults when compared to young (28.6%) or middle (32.5%) aged clients. Media (including internet), was reported by more young (15.7%) and middle (13.9%) aged adults than older (4.3%) age group individuals. These differences were found to be significant by chi-squared statistics ($\chi^2 = 14.66$ df: 4 $p = 0.005$).Clients who responded with non-specific sources of information ($n = 24$) are not included in the figure or in the statistical testing.There were 10 missing responses.

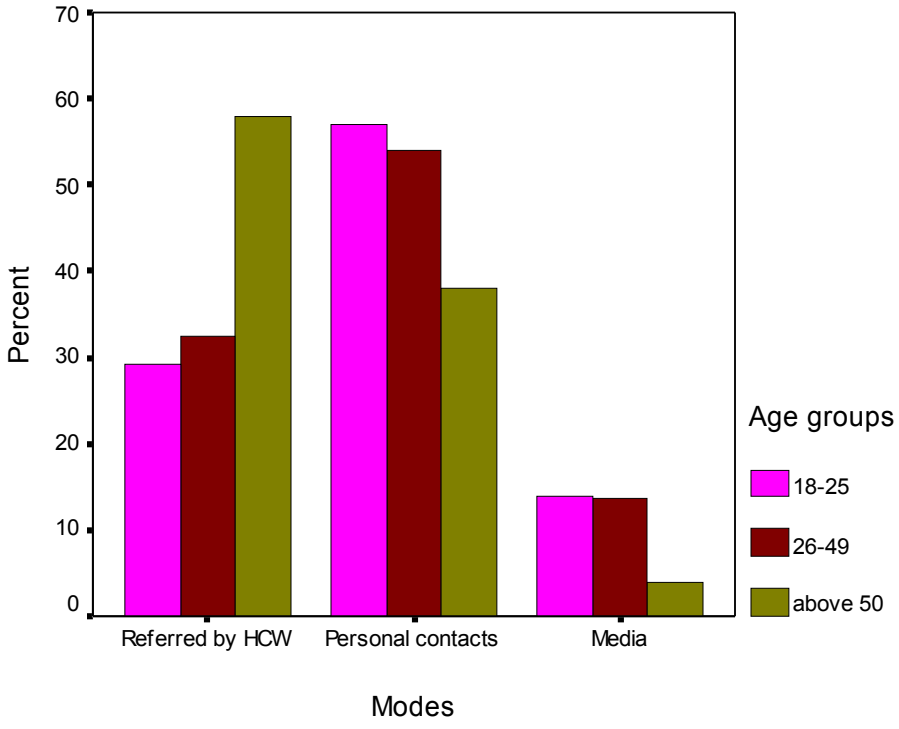

Figure 2: Sources of information about a particular public sexual health clinic by different age groups of clients (n = 268).

The modes of transport used by clients of public sexual health clinics and the time taken to travel from home/work to a particular clinic is displayed in the Table 2. Overall 58.7% of clients used private transport while the remaining 32% and 9.3% of clients used public and other modes respectively. More clients (46.8%) in R-A clinic used public transport while 36.7% of clients used private transport. In contrast majority of clients in R-B (64.5%) and R-C (86%) used private transport while 31.2% and 4.7% of clients of respective clinics used public transport. All clients of R-D clinic used private transport. There were 2 missing responses.

Table 2: Modes of transport used by clients of different public sexual health clinics (n=300).

Modes of transport		**Private** *n* (%)	**Public** *n* (%)	**Others** *n* (%)	**Total** *n* (%)
Regions	**A: City**	40 (36.7)	51 (46.8)	18 (16.5)	109 (100.0)
	B: Suburban	89 (64.5)	43 (31.2)	6 (4.3)	138 (100.0)
	C: Outer metro	37 (86.0)	2 (4.7)	4 (9.3)	43 (100.0)
	D: Rural	10 (100.0)	0 (0.0)	0 (0.0)	10 (100.0)
	Total	176 (58.7)	96 (32.0)	28 (9.3)	**300**

Time taken to get to clinic from home or work was compared between private and public transport users and the results are shown in Table 2A. The majority (70.5 %) of clients who used private transport had reported less than or 30 minutes travel time. Whereas the majority (59.6%) of clients who used public transport and 40.4% of those who used private transport had reported more than 30 minutes travel time. Using Fisher's Exact test the differences observed in the travel time and the mode of transport were found to be significant ($p < 0.001$).

Table 2A: Time taken to get to the clinic from home or work for private and public transport users of public sexual health clinics (n=272).

Modes of transport		**Private** *n* (%)	**Public** *n* (%)	**Total** *n* (%)
By approximate time taken	Less than or 30 minutes	155 (70.5)	65 (29.5)	220 (100.0)
	More than 30 minutes	21 (40.4)	31 (59.6)	52 (100.0)

The feedback on parking facilities given by clients of public sexual health clinics who used private mode of transport are shown in Table 3 after recoding**.** The original responses were either easy or difficult to finding parking spaces' and adequate or inadequate parking spaces. These responses were recoded as '**some difficulty**' if the original response was either difficult to find and/or inadequate parking spaces. '**No difficulty**' was coded when the original response was either easy to find and/or adequate parking spaces. The recoding was done as the meaning of the original responses (finding and adequacy of parking spaces) could not be separated.

The majority of private transport users of R-A (80%) and R-B (79.7%) clinics had expressed some difficulty with parking facilities. In contrast 86.5% of private transport users of R-C clinic reported no difficulty. This difference was found to be significant ($\chi^2 = 53.04$ df: 2 $p < 0.001$). R-D clinic is not shown in the table or included in the statistical test due to insufficient sample size. There were 15 missing responses.

Table 3: Feedback given on parking facilities by private transport users of different public sexual health clinics (*n*=151).

Feedback on parking facilities		**No difficulty** *n* (%)	**Some difficulty** *n* (%)	**Total** *n* (%)
By regions	**A: City**	8 (20.0)	32 (80.0)	40 (100.0)
	B: Suburban	15 (20.3)	59 (79.7)	74 (100.0)
	C: Outer metro	32 (86.5)	5 (13.5)	37 (100.0)

The preferred days to attend public SHC for clients of different employment status is shown in Figure 3. The weekdays were predominantly preferred by 82.2% of employed (full time or part time) and 91.4% of non-employed (unemployed, retired and students) clients. However 17.8% of employed and 8.6% of non-employed clients did prefer weekends to attend the clinic. Clients who responded no preference (*n*=73) are not shown in the figure below. There were 2 missing responses.

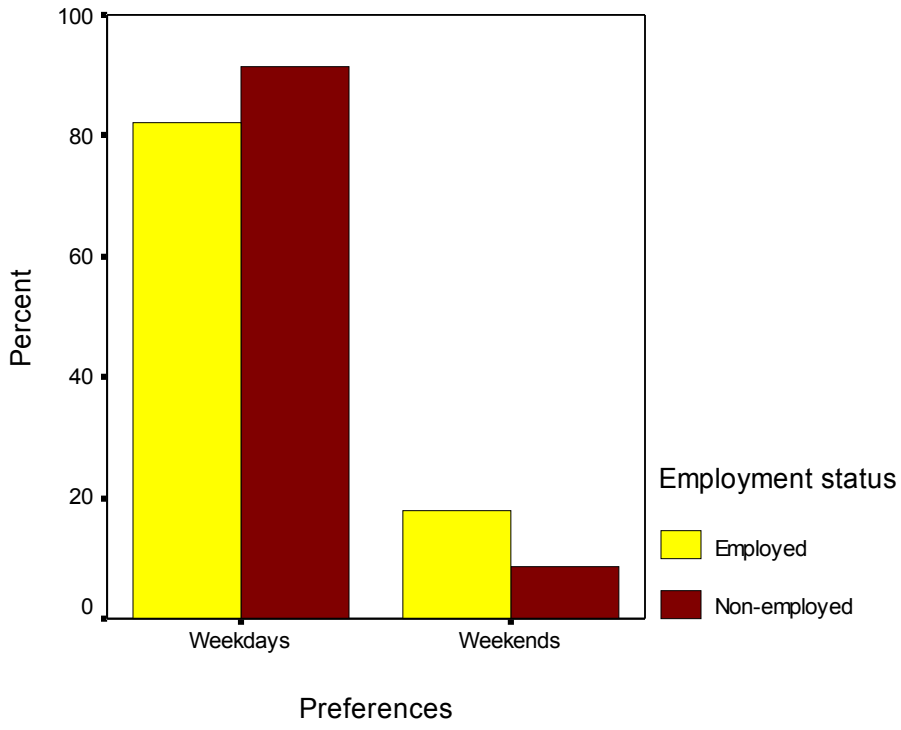

Figure 3: Preferred days to attend public sexual health clinic by different employment status of clients (n = 227)

The preferred and actual time of attendance at public SHCs for either full time or part time employed clients is shown in Table 4. The majority (92.2%) of employed clients who preferred to attend during office hours [8am-4pm] did actually attend the clinic in their preferred time. Of those who preferred to attend after office hours [4pm-8pm], only 47.6% of them actually attended in that time slot while the remaining 52.4% attended during office hours. This difference was found to be significant by Fisher's Exact test ($p < 0.001$). Employed clients who had no preference (n=38) were not included in Table 4 or in the statistical analysis.

Table 4: Preferred time to attend public sexual health clinics and actual time of attendance by employed clients (n=144).

		Actual time of attendance		
		During office hours n (%)	After office hours n (%)	**Total**
Preferred time to attend	During office hours	94 (92.2)	8 (7.8)	102 (100.0)
	After office hours	22 (52.4)	20 (47.6)	42 (100.0)
	Total	116	28	**144**

The preferred and actual time of attendance at public SHCs by non-employed (unemployed, retired and students) clients is shown in Table 4A. The majority (92.9%) of non-employed clients who preferred to attend during office hours [8am-4pm] did actually attend the clinic in their preferred time. Of those who preferred to attend after office hours [4pm-8pm], one half (50%) actually attended in that time slot while the other half (50%) attended during office hours. This difference was found to be significant by Fisher's Exact test (p = 0.012). Non-employed clients who had no preference (*n*=28) were not included in Table 4 or in the statistical analysis.

Table 4A: Preferred time to attend public sexual health clinics and actual time of attendance by non-employed clients (*n*=90).

		Actual time of attendance		
		During office hours n (%)	After office hours n (%)	**Total**
Preferred time to attend	During office hours	78 (92.9)	6 (7.1)	84 (100.0)
	After office hours	3 (50.0)	3 (50.0)	6 (100.0)
	Total	81	9	**90**

The preferred mode booking consultation (appointment/walk-in) for clients of individual study clinics is shown in Figure 4. More than two thirds of clients in R-A (74.3%) and R-C (82.1%) clinics preferred an appointment system. In contrast, nearly equal proportions of clients in R-B clinic had a preference for either an appointment (49.6%) or walk-in system (50.4%). The R-D clinic is not included due to insufficient sample size. Among the three clinics compared, 33 clients had no preference and there were 2 missing responses.

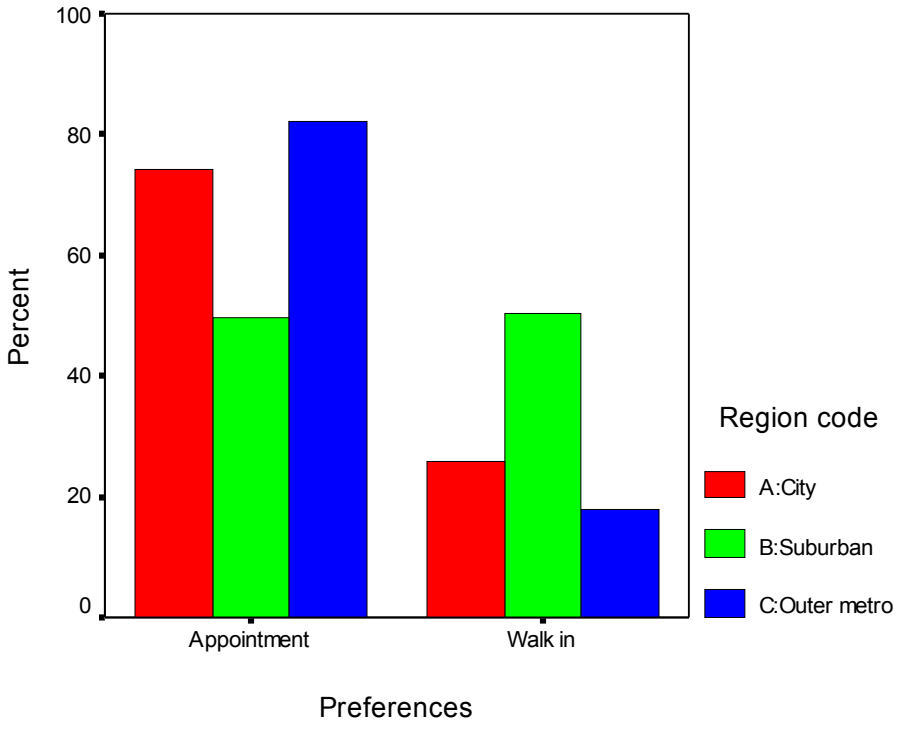

Figure 4: Preferred mode of booking consultation by clients of individual clinic (n = 257).

The results and analyses of preference of clients for a same gender HCW are shown in Tables 5, 5A-D.Overall 38.7% of clients preferred and 13.2% of clients did not prefer a same gender HCW. The remaining 48.1% of clients (n=145) had no clear preference and so not included in any of the above mentioned tables or in the statistical analyses.

Binary logistic regression (LR) analysis was done to examine the preference to consult a same gender HCW by different three variables chosen by *a priori* logic. These variables were age group, gender and country of origin of clients. The LR model (Table 5 and appendix I) shows that only gender ($p < 0.001$) and country of birth ($p= 0.024$) of clients to be significant predictors. The age group of clients was found to be non-significant ($p= 0.885$) and so dropped out of any further analyses.

Table 5: Logistic regression analyses examining the interaction of gender and country of birth of clients with preference for same gender health care worker.

	Parameter estimates (+/- standard errors)	Degree of freedom	Significance
Final variables in the model			
Constant [a]	3.886 (1.228)		
Gender of the client	-2.868 (0.648)	1	0.000
Country of birth	-1.085 (0.483)	1	0.025
Age	0.050 (0.342)	1	0.885

[a] The constant is a measure of the response or dependent variable with the effects of predictor variables removed.

In order to determine the individual and interactive aspects of gender and country of birth variables, further analyses examining both gender and country of origin were undertaken. More females than males (95.7% vs. 57.5%) had a preference for the same gender HCW (Table 5A). Using the Fisher's Exact test this difference was found to be significant ($p < 0.001$).

Table 5A: Preference to consult a same gender health care worker by gender of the clients who had preference (*n*=157)

Preference for same gender HCW		Yes n (%)	No n (%)	Total
Gender of the clients	**Males**	50 (57.5)	37(42.5)	**87** (100.0)
	Females	67 (95.7)	3 (4.3)	**70** (100.0)

A bivariate split of the 157 clients by country of origin (Australia vs. overseas) showed that 84.6% of overseas born clients and 69.5% of the Australian born clients preferred same gender HCW (Table 5B). This difference was found to be significant by Fisher's Exact test ($p = 0.03$).

Table 5B: **Preference to consult a same gender health care worker by country of birth of the clients who had a preference (*n*=157).**

Preference for same gender HCW		Yes n (%)	No n (%)	Total
Country of birth of clients	**Australia**	73(69.5)	32 (30.5)	**105** (100.0)
	Overseas	44 (84.6)	8 (15.4)	**52** (100.0)

Further sub analysis of male clients using the bivariate split based on country of birth with a specific preference for same gender HCW showed 79.3% of males born overseas and 46.5% of Australian born males preferred a same gender HCW (Table 5C). This difference was significant by Fisher's Exact test (p = 0.003).

Table 5C: Preference to consult a same gender health care worker by country of birth of male clients who had preference (*n*=87)

Preference for same gender HCW		Yes n (%)	No n (%)	Total
Country of birth of male clients	**Australia**	27 (46.6)	31 (53.4)	**58** (100.0)
	Overseas	23 (79.3)	6 (20.7)	**29** (100.0)

When a similar sub analysis was done for female clients it was found that vast majority of females, either born in overseas (91.3%) or in Australia (97.9%) preferred a same gender HCW (Table 5D). Using the Fisher's Exact test no difference in preferences was found between the two groups of females (p = 0.25).

Table 5D: Preference to consult a same gender health care worker by country of birth of female clients who had preference (*n*=70)

Preference for same gender HCW		Yes n (%)	No n (%)	Total
Country of birth of female clients	**Australia**	46 (97.9)	1 (2.1)	**47** (100.0)
	Overseas	21 (91.3)	2 (8.7)	**23** (100.0)

The proportions of clients consulted or not consulted by HCWs of their preferred gender are presented in Table 6. The matching was done after excluding clients who responded 'no preference' (n =145). The matching combined three individual variables namely gender of the client, their preference for same gender HCW and the gender of the HCW whom they consulted on the day of survey. The method of matching is attached (appendix J).

From Table 6 it can be noticed that overall 68.6% of clients were consulted by a HCW of their preferred gender (matched) while the remaining 31.4% of clients were not (mismatched). More female than male clients (81.2% vs. 58.6%) had their preference matched. The proportion of clients not consulted by a HCW of their preferred gender was higher among male (41.4%) than female (18.9%) clients. These differences were found to be significant by Fisher's Exact test (p = 0.002). There was 1 missing response.

Table 6: Matching of clients' preference for a same gender health care worker and the actual gender of the health care worker who consulted on the day of survey (*n* = 156).

Preferred and actual gender of the HCW		Matched *n* (%)	Mismatched *n* (%)	Total
Gender of the clients.	**Males**	51 (58.6)	36 (41.4)	87 (100.0)
	Females	56 (81.2)	13 (18.8)	69 (100.0)
	Total	107 (68.6)	49 (31.4)	**156**

The majority (79.1%) of clients preferred to consult the same doctor in their follow up visits while 1.7% of clients (*n*=5) did not prefer. The remaining 19.2% of clients (*n*=58) had no specific preference. There was 1 missing response.

The vast majority of clients either did not prefer (46.4%) or had no preference (48.3%) for a separate male/female waiting rooms while the remaining 5.3% of clients (*n*=16) preferred it. There were 2 missing responses.

Of the total sample, 97.3% of clients had no difficulty while the remaining 2.7% of clients (*n*=8) had difficulty with language during consultation with a doctor or a nurse. In the latter group, only one client reported great difficulty. There was 1 missing response.

The approximate length of time spent by clients at public sexual health clinics are shown in Figure 5A (waiting time) and Figure 5B (consultation time). [Waiting time is the time between registrations at reception and being called in for consultation]. The majority of clients responded less than or 30 minutes of waiting (77.2%) and consultation (85.4%) time while the remaining clients reported more than 30 minutes of waiting (22.8%) and consultation (14.6%) time respectively. There were 10 missing responses in each variable.

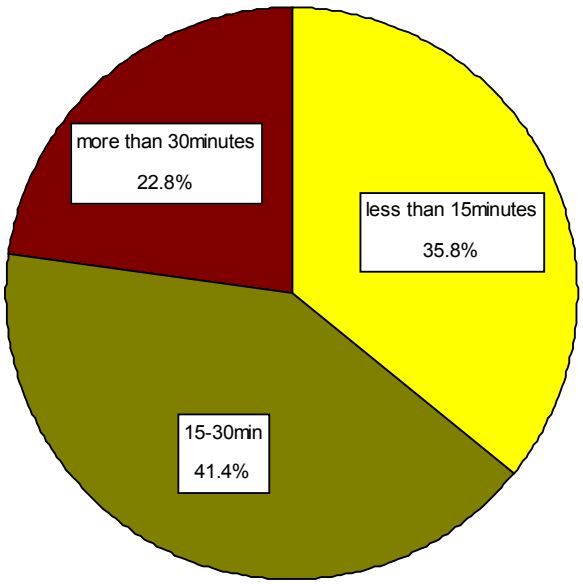

Figure 5A: Waiting time in public sexual health clinics (n=292).

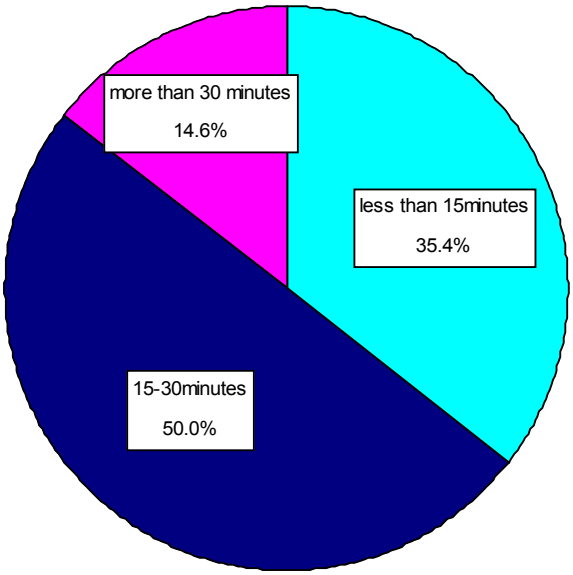

Figure 5B: Consultation time at public sexual health clinics (n=292).

The overall impression on public sexual health clinic services of clients is shown in Figure 6. Of the total sample, 93.1% of clients responded that the services delivered by public SHCs to be either excellent or good. The remaining 5.6% (*n*=17) and 1.3% (*n*=4) of clients responded the services to be either satisfactory or poor respectively.

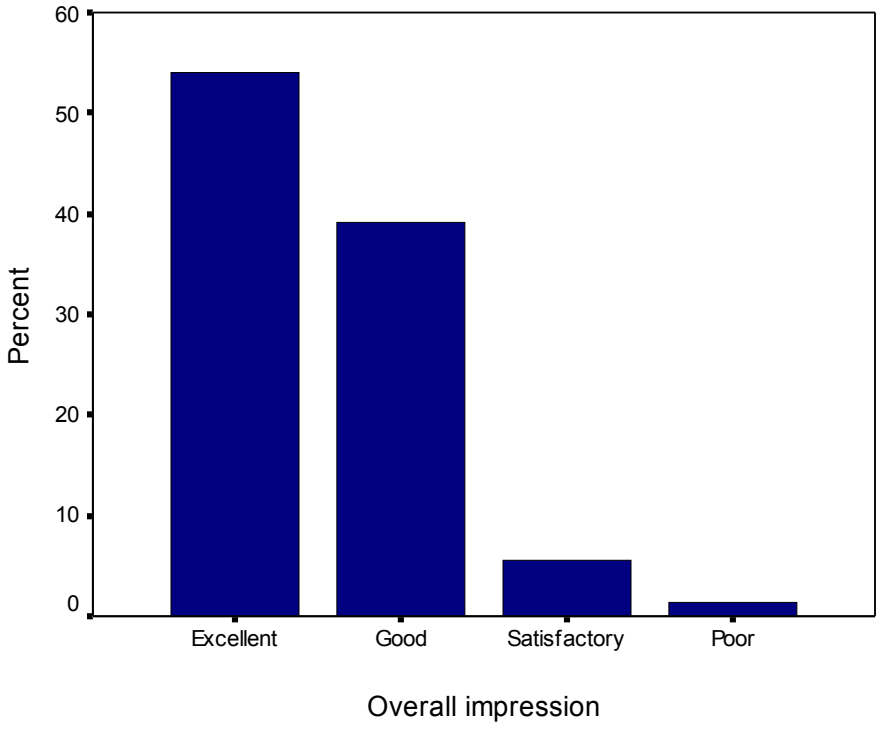

Figure 6: Overall impression about public sexual health clinic services given by clinic users (n=302).

Chapter 5 Discussion

The baseline demographics of this study shows above 60 percent of all attendees were employed men in their middle and old age group. However, the R-A clinic had a much higher proportion of male (94.5%) clients, mostly in their middle and old age group (90%). This demographic pattern of R-A clinic was consistent with the finding of a previous study done in the same clinic [38]. Also, the proportion of unemployed and retired adults was found to be slightly higher in the same clinic. The possible reason for this pattern of attendees of R-A clinic is that it mainly caters to the needs of HIV/AIDS clients who are predominantly homosexual men in their middle and older age group.

More than 80% of all clients were Caucasians, speaking English as their first language. Nearly one-third of all attendees were overseas born clients mostly from the UK, New Zealand and China and this was found to be representative of the general population of NSW [39]. The proportion of repeat users of the same public SHC (the clinic that was attended on the day of survey) was nearly 74% in both R-A and R-B clinics, whereas in R-C clinic it was about 58%. One possible reason could be the increased availability of clinic services in R-A and R-B clinics (5 days a week) compared to R-C clinic (3 days a week).

Reasons for attending and source of information about public SHCs

The two main reasons to choose a particular public SHC, indicated by all clients were geographic proximity to home or work and health professional's referral; this was similar to the finding of an international study[24]. Personal contacts (social network) and health professional's referral (GPs and other clinics) were reported as two main sources of information by over two thirds (69%) of all clients. This finding concurs with a study reported by McClean et al. (1997) in the UK [26]. Media (television, radio, newspapers, magazines and internet) appears to be a source of information for

slightly higher proportion of young and middle than older aged adults, and may be due to less access to internet by older individuals. These details may be of use in the promotion of sexual health of specific adult groups within the general population.

Accessibility of public SHCs for current users

The accessibility factors identified and discussed in this study focussed on access to the clinic by private and public modes of transport, parking facilities for private transport users, and time taken to travel (from home or work) to get to the clinic.

Public transport was mainly used by clients of R-A and R-B clinics, whereas the vast majority of clients in R-C clinic used private transport. The most likely reason for this difference is the increased availability of public transport in R-A and R-B areas compared to sparse or non-availability of public transport facilities in the R-C area. A similar pattern was noticed in a study done in the UK comparing clinics in a larger city (London) with a smaller city (Plymouth) where more clients of the London clinic used public transport and those of the Plymouth clinic used private transport [29].

In regards to parking facilities, about 80% of private transport users of R-A and R-B clinics had some difficulties with parking, either finding the parking location inadequate or issues concerned with enough parking spaces. It, therefore, appears important to be aware that a proportion of clients may need better signage to find parking areas. There may also be a need to consider more designated parking spaces, particularly for the users of R-A and R-B clinics.

Travel time was less than 30 minutes for more than 80% of all clients irrespective of their mode of transport and this was congruent with the past studies [24,29]. Travel time was more than 30 minutes for the remaining clients. It might have been expected that those who indicated more than 30 minutes would have a significant distance to travel, but upon examination of the data it was found that a

majority of users in each clinic came from the same or nearby locality (this result is not displayed in the report as it may be identifying the individual clinic). Also among those who reported more than 30 minutes travel time, 40% and 60% were private and public transport users respectively. Therefore, there may be number of reasons explaining the unexpected time spent travelling for these individuals that is not focussed singularly on either travelling by private or public transport. There may be a long distance between the train stations/bus stops or parking area and the clinic, difficulty in finding the clinic due to signage issues or congested traffic conditions mainly during peak office/school hours.

Clients' preferences related to convenience of attending public SHCs

It was found that above 80% of clients, irrespective of their employment status, preferred weekdays with only 18% of employed clients preferring the weekends. It is of importance to note that all public SHCs function only during the weekdays and so the actual proportion of clients who prefer and attend other service providers during weekends is not known due to limitations of the current study. Opening for a few hours of functioning either on Saturday or Sunday may be of benefit to full time employed clients.

On examining the preferred time to attend clinic, more than 90% of clients who preferred attending during office hours and nearly 50% of clients who preferred after office hours were able to attend the clinic in their preferred time. The most likely reason for this difference in the proportions could be the limited hours of functioning of public SHCs after office hours. However, few clinics have exclusive evening sessions and extended working hours. A study by Hope et al. (1996), reported a similar finding as nearly 90% of those who preferred to attend before 4:30pm had actually attended in their preferred time, whereas only 32 % of those wanting to be seen at a time later than 4:30pm had attended at this time [24].

Preference for an appointment system was indicated by majority of participants in many past studies [21,22,27]. Similarly, in this study over two thirds of attendees of R-A and R-C preferred an appointment system where the clinics mainly functions by set appointments. Equal proportions of clients of R-B clinic preferred an appointment and walk-in system where the clinic functions by both. It, therefore, appears the public SHCs to have booking systems congruent with its clients' preference.

Clients' preferences related to acceptability issue

More than half the participants had a specific preference to consult a same gender HCW. The proportion of females who preferred a same gender HCW was higher than that of males and this was found to be consistent with numerous studies done in the past [21,22,27]. This clearly suggests that having a same gender HCW is more of an acceptability issue for female rather than male clients. When the study examined the preference for same gender HCW in relation to the country of origin of clients, it was found that 79.3% of men born overseas compared to 46.5% of men born in Australia preferred a same gender HCW. It is of importance to note that about 23% of the male population of NSW were born in overseas countries [39]. By matching it was found that a higher proportion of female than male clients were consulted by a HCW of their preferred gender. The most likely reason for this difference is the high proportion of female HCWs in the study clinics and in particular, two of four study clinics had only female HCWs. Another reason could merely be a coincidence (chance) when the proportion of female HCWs was high.

A separate waiting room for males and females was preferred by only few clients in this study. In contrast, Rogstad (1991) reported most of his study participants preferred a separate waiting room [22]. However, in this study no clinic had a separate waiting room for males and females. The majority of

clients preferred to consult the same doctor in their follow up visits. However, the study did not actually establish whether the clients consulted the same doctor or not on the day of participation.

About 19% of NSW population speaks languages other than English [38]. Effective communication is important in the care of all patients and language plays an important role. Hence, this study investigated language difficulties between clients and HCWs. The study found that the majority of clients utilising the public SHC had no language difficulty. Only a few clients reported language difficulty and the reasons for difficulty may be due to the NES background of clients, difference in English accent and/or use of medical terms by the HCWs. Most NES clients who participated were able to complete the questionnaire by themselves whereas only two NES clients completed the questionnaire with interpreter assistance. Few other NES clients refused to participate in spite of interpreter assistance. However, the reason for non participation is not known.

Length of time spent per visit in public SHCs

Very little information is currently available in the literature with regards to the duration of time spent in SHC. The exact time spent by an individual client per visit was not measured in this study, but was calculated from the responses given by clients to the questions on approximate waiting and consultation time. The estimated average time spent by majority of clients was between 30 minutes and one hour which includes both waiting and consultation time.

Summary of evaluation of clients' preferences and current services delivered by public SHCs

The majority of clients preferred weekdays and all public SHCs were found to be open on weekdays, although the number of days and working hours differ among clinics. A high proportion of clients were found to attend clinic in their preferred time. The mode of booking consultation by individual

study clinics was found to be congruent with its clients' preference. The majority of clients (both males and females) had a consultation with a HCW of their preferred gender. Whenever possible, public SHCs tried to fulfil client requests to consult a same gender HCW or the same doctor. However, at present there is no organised or structured provision for the clients to select a HCW of their preferred gender or to select the same doctor in the follow up visits. The current infrastructure of public SHCs with no separate waiting rooms for males and females was not an issue for vast majority of clients. All participated public SHCs were found to acknowledge the importance of identifying language barriers and provide assistance with interpretation for those who request.

Overall impression about public SHC services

The majority (90%) of clients responded with either excellent or good regarding clinic services. However, the study did not specifically examine the degree of satisfaction with the individual or overall services delivered by public SHCs. One common suggestion given by clients of R-A and R-B clinics was to improve parking facilities and the frequent comment was about the length of waiting time.

Limitations

A limitation of this study arises in relation to comparing accessibility and acceptability issues between current users and those who do not use public SHCs. Another limitation is that there is insufficient data from a rural clinic which restricted comparisons between rural and urban clinics. The R-B and R-C clinics were selected on the basis of convenience and this may have resulted in bias. Due to these latter two reasons, the findings may not be generalisable to other public SHCs in NSW.

Recommendations

Further research is required that examines the accessibility and acceptability of public SHCs for those who access other services and also targeting the population that do not access any form of services. Also, more consideration should be given concerning accessibility of rural public SHCs where transport, infrastructure, personnel and other factors could be quite different. Additionally, the research instrument needs more focus on clients' attitude, although in this study clients were asked a question about their impression re services. Although the proportion of NES clients with language difficulties is smaller, having research tools in a few most commonly spoken languages may be of use to examine more NES clients.

Chapter 6 Conclusion

Public SHCs were found to be accessible by both private and public modes of transport. The travel time to clinic for clients of this study is similar to the findings of other international studies. One important finding in regards to accessibility was the difficulty with parking facilities, particularly for the clients of city and suburban clinics. Provision of designated parking spaces for clients of these clinics needs to be addressed.

Public SHCs are also found to be acceptable for those who utilise them by evaluating the identified preferences of clients and the services delivered by public SHCs. One key acceptability issue identified in this study was the preference for a same gender HCW and provision should be made for clients to select a HCW of their preferred gender. This appears to be particularly important for females, although an unexpected finding in this study related to a similar desire for a same gender HCW identified for males born overseas.

Overall, clients appeared to hold either excellent or good impressions regarding the services delivered by public SHCs. Therefore, one can suggest that the level of general satisfaction regarding accessibility and acceptability of services was reasonably high.

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Appendix A

HREC approval letters

1. The South Eastern Sydney and Illawarra Area Health Service
2. The University of Wollongong + SESIAHS – Illawarra Section
3. The Sydney West Area Health Service – Nepean campus
4. The Sydney West area Health Service – Westmead campus

SOUTH EAST HEALTH
South Eastern Sydney Area Health Service

RESEARCH ETHICS COMMITTEE - Eastern Section

Room G71, EBB
Cnr High & Avoca Strs
RANDWICK NSW 2031
Tel: 9382 3587
Fax: 9382 2813

26th October 2005

Dr Vijayasarathi Ramanathan
13/32 Tennent Parade
HURLSTONE PARK
NSW 2193

Dear Dr Ramanathan

Re: Accessibility and acceptability of public sexual health clinics (SHC) for adult clients in New South Wales, Australia. Ref: 05/282

The Research Ethics Committee at it's meeting on 25th October 2005considered and **approved** the above study.

This study has been allocated the reference number **05/282.** This reference must be quoted in all correspondence with the Committee.

Please note that any approval relates to the ethical content of the trial, and individual arrangements should be negotiated with the Heads of Departments in those situations where the use of their resources is involved.
This study must be conducted in accordance with the National Health and Medical Research Council of Australia and Good Clinical Research Practice. It is the responsibility of the Chief Investigator to furnish the Human Research Ethics Committee with a progress report every 12 months for the duration of the study and a final report on completion of the study. Any advertising or media articles must be submitted for ethics approval prior to media release. The Committee must be notified of any Serious Adverse Events or Unexpected Events that occur in relation to this study. This approval is valid for 5 years.

You may now commence the study and the Committee wishes you well.

Yours sincerely

S Fawcett

Sue Fawcett
Research Ethics Coordinator
Human Research Ethics Committee - Eastern Section

SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH

Research Directorate

Telephone: 02 4253 4800
Facsimile: 02 4253 4823
Ref: HE05/268
FINAL APPROVAL

Dr Vijayasarathi Ramanathan
13/32 Tennent Pde
Hurlstone Park NSW 2193

Dear Dr Ramanathan

ETHICS NO: HE05/268
TITLE: "Accessibility and acceptability of public sexual health clinics for adult clients in NSW, Australia"

The South Eastern Sydney & Illawarra Area Health Service has received and noted notification dated 31 October 2005 from the Joint Human Research Ethics Committee of the University of Wollongong and Illawarra Area Health Service of ethics approval for the above named study.

Approval Date: 10 November 2005

Expiry Date: 9 November 2006

Please remember that your research should be conducted in accordance with the NHMRC National Statement on Ethical Conduct in Research on Humans http://www.nhmrc.gov.au/publications/synopses/e35syn.htm and the NSW Health Privacy Manual http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_593.pdf Please note that this policy was updated in September 2004 and you and your staff should make yourselves familiar with the provisions of the Health Records Information and Privacy Act.

Should you require any further information please do not hesitate to contact Prof. Anthony Hodgson, Level 8, Block C, Wollongong Hospital, Ph: 4253 4800.

Best wishes for the conduct of the study.

Yours sincerely

Ms Sue Browbank
General Manager, Northern Illawarra Hospital Group

DATE:

cc Ms Eve Steinke, Ethics Officer, University of Wollongong
Professor Anthony Hodgson, Joint Director of Health Research.

SYDNEY WEST
Area Health Service

HUMAN RESEARCH ETHICS COMMITTEE- NEPEAN CAMPUS

Court Building, level 1
P.O Box 63
Penrith NSW 2751

Tel: 47 34 3441
Fax: 47 34 1365
Email: Ethics@wahs.nsw.gov.au or
CoutinM@wahs.nsw.gov.au

mc

November 21st 2005.

Dr. Vijayasarathi Ramanathan
Postgraduate Student
13/32 Tennent Parade
Hurlstone Park NSW 2193

Email: vram4831@usyd.edu.au

Dear Dr. Ramanathan,

Re: Project No. 05/070: Accessibility and Acceptability of Public Sexual Health Clinics (SHC) for Adult Clients in NSW, Australia – Dr. Vijayasarathi Ramanathan, Dr. Melissa Kang, Dr. Eva Jackson, Dr. Virginia Furner and Dr. Sarangapany Jeganathan

Thank you for your response dated 17/11/05 along with the required amendments.

As all matters raised by this HREC have been addressed, we are pleased to inform you that your project now has final approval.

This approval is valid for a period of twelve months from the date of this letter.

Conditions of the approval of your study are that the Committee be kept informed of:

1. Any serious or unexpected adverse events involving participants, if relevant to your study.

2. Changes to the research protocol (including if the project is not commenced, or is delayed in commencement by more than six months from the date of this letter; or is discontinued and giving reasons)

3. All current SWAHS/Nepean Hospital policies pertaining to the project must be fully complied with. These policies include, *Duty of Care, Infection Control and Occupational Health and Safety.*

4. The Committee is to be provided with immediate reports of any unforeseen events that might affect the ethical acceptability of the project.

5. Please note that a Progress Report should be submitted to this HREC as well as a Final Report, on completion of the project.

The project approval becomes operative when the attached copy of this letter is signed, dated and returned to Marietta Coutinho, Ethics Officer, at the address mentioned on this letterhead.

Please quote the HREC study number (05/070) in all correspondence and telephone enquires relating to your study.

The HREC wishes you success with the project.

Yours sincerely,

Dr. Colleen-M Cook
Chair, SWAHS HREC-Nepean Campus.

CC: Dr. Melissa Kang, Division of General Practice, PO Box 154, Westmead NSW 2145.
Dr. Eva Jackson, Staff Specialist, Blue Mountains Sexual Health and HIV Clinic, Locked Bag 2, Katoomba NSW 2780.
Dr. Virginia Furner, Director of Clinical Services, 150 Albion Street, Albion Street Centre, Surry Hills NSW 2010.
Dr. Sarangapany Jeganathan, Manager Research Unit, 150 Albion Street, Surry Hills NSW 2010

I accept, acknowledge and will comply with the conditions of approval for this project.

Vijaysarathi M ..... 24.11.05 .....

Chief Investigator/Designated Researcher (Date)

SYDNEY WEST AREA HEALTH SERVICE *(Westmead Campus)*

HUMAN RESEARCH ETHICS COMMITTEE

Research Office, Clinical Sciences
Westmead Hospital Campus
Westmead NSW 2145

Telephone: 02 9845 8183
Facsimile: 02 9845 8352
Email: researchoffice@westgate.wh.usyd.edu.au

In reply please quote:

HS/pme

7 December, 2005

Dr Vijayasarathi Ramanathan
13/32 Tennent Parade
HURLSTONE PARK NSW 2193

Dear Dr Ramanathan

Research Proposal: Accessibility and Acceptability of Public Sexual Health Clinics (SHC) for Adult Clients in NSW, Australia

Thank you for your letter dated 21 November 2005 together with a copy of Participant Information Sheet (PIS) approved by use by Nepean Campus Human Research Ethics Committee (Ref. Project No. 05/070) and Participant Information Sheet (PIS) Version 2 dated 6/12/05 for submission to the Westmead Campus Human Research Ethics Committee, all for the above study.

Thank you also for forwarding a copy of the original ethics application together with the details and signatures of all the researchers involved in this study and the questionnaire you wish the participants to complete.

On review of the abovementioned documents, the Committee finds it has no ethical concerns and they are therefore approved. They will be held on file in the Research Office with your original proposal. Attached for your records is an approved copy of Participant Information Sheet (PIS) Version 2 dated 6/12/05 and the Questionnaire to be used by participants.

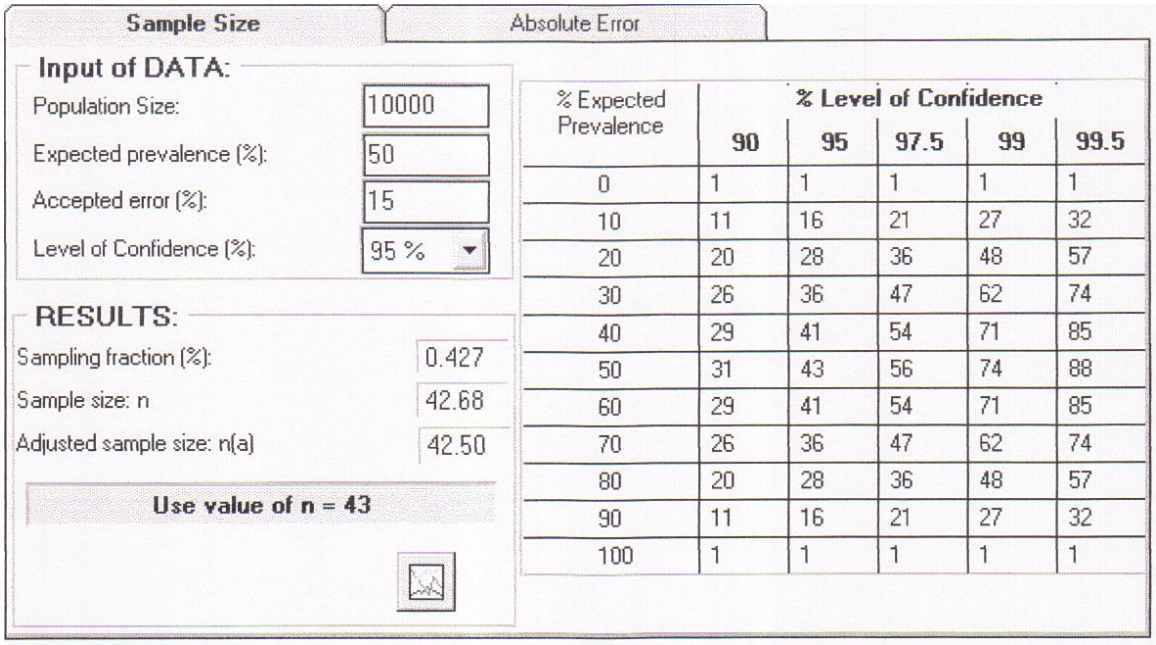
Would you please ensure that any amendments to this study are brought to the attention of the Human Research Ethics Committee. The Committee would also appreciate you advising when you commence and complete the study, as well as an Annual Research Report and any articles which may be published as a result of this study.

Yours sincerely

Dr Howard Smith
Secretary
Sydney West Area Health Service
Human Research Ethics Committee

Appendix B

Study sample size calculation output.



% Expected Prevalence	% Level of Confidence				
	90	95	97.5	99	99.5
0	1	1	1	1	1
10	11	16	21	27	32
20	20	28	36	48	57
30	26	36	47	62	74
40	29	41	54	71	85
50	31	43	56	74	88
60	29	41	54	71	85
70	26	36	47	62	74
80	20	28	36	48	57
90	11	16	21	27	32
100	1	1	1	1	1

Appendix C

SOUTH EASTERN SYDNEY ILLAWARA AREA HEALTH SERVICE

Room G71,EBB ,corner of High and Avoca street, Randwick, NSW 2031

Accessibility and acceptability of public sexual health clinics for adult clients in New South Wales, Australia

INFORMATION FOR PARTICIPANTS

The survey is done to evaluate the convenience and appropriateness of the sexual health services for adult clients attending public sexual health clinics (SHC).

Dr. Vijayasarathi Ramanathan, Dr.Melissa Kang, Dr. Eva Jackson, Dr.Virginia Furner and Dr.Sarangapany Jeganathan and Dr.Katerina Lagios are conducting the study.

All aspects of the study, including results, will be strictly confidential and only the investigators above mentioned will have access to information on participants.

A report of the study will be submitted to the University of Sydney for award of degree and may be submitted for publication, but individual participants will not be identifiable in such a report.

We cannot and do not hold that you will gain any benefit by participating in this study however it is an opportunity to express your opinion of the service you receive.

The researchers will use your input to recommend to the Department of Health, NSW to improve/modify current sexual health services.

Participation in this study is entirely voluntary: you are in no way obliged to participate and – if you do participate – you can withdraw at any time.

Refusal to participate does not in any way jeopardise your care.

When you have read this information, the investigator will discuss it with you further and answer any questions or concerns you may have. If you would like to know more at any stage, please feel free to contact Dr. Ramanathan on 0416 63 46 47 or email to vram4831@usyd.edu.au

Any person with concerns or complaints about the conduct of a research study can contact the Executive Officer, South Eastern Sydney Human Research Ethics Committee on (02)93823587

SYDNEY WEST
Area Health Service

THIS INFORMATION SHEET IS FOR YOU TOKEEP

Participant Information Sheet (PIS)

Title of project: *Accessibility and acceptability of public Sexual Health Clinics (SHC) for adult clients in New South Wales, Australia.*

Investigators: Dr.V.Ramanathan; Dr.M.Kang; Dr.E.Jackson; Dr.V.Furner; Dr.J.Sarangapany Dr. K.Lagios.

Introduction:

You are invited to take part in a research study of evaluation of current sexual health service offered through public SHC. Before starting to fill in the questionnaire it is important that you read

and understood this PIS, in order to decide whether or not you agree to be part of this research.

This PIS describes the purpose, procedure, risks and benefits of the study.

The information will be collected using self completed anonymous questionnaire and be held in confidential. Once you understand the study you will be given a questionnaire to complete, only if you agree to participate.

Aim of the study:

The research is done to evaluate the factors that may influence the convenience and appropriateness of the current public SHC service for adult clients in NSW.

Who will be invited to enter the study?

All adult (18 years and above) attendees of the public SHC during the period of study will be invited to participate in the study.

What will happen on the study?

The anonymous information provided by you will be analysed and used to recommend the NSW Department of Health and Aging to improve/modify the current service.

What are the known risks and benefits of the proposed study?

There is **NO** foreseeable risk involved in this study. We cannot and does not hold that you will gain any direct benefit by participating in this study; however it is an opportunity to express your valuable opinions and suggestions of the service you receive.

How long will it take to complete the questionnaire?
The estimated time to complete this questionnaire is approximately 10-15 minutes.

What are participants' rights?
You have the right to decide whether or not to participate in this study and you are also free to withdraw at anytime before completing the questionnaire.
This survey is anonymous and confidential and you cannot be identified in any way.

What if I decide not to go on the study?
If you decide not to participate or you wish to withdraw, it will not affect your current/future care and your further relations with Blue Mountains SHC in any way.

Complaints:
This study has been approved by Human Research Ethics Committee of Sydney West Area Health Service. If you have any concerns about the conduct of the study, you may contact the Ethics Officer at the Nepean Campus, Marietta Coutinho, Tel no. 4734 3441, Fax no. 47341365 or email: CoutinM@wahs.nsw.gov.au

Should you require more details about the study, please contact Dr.V.Ramanathan at 0416 63 46 47 or email: vram4831@usyd.edu.au

THIS SHEET IS FOR YOU TO KEEP

Appendix D **LOG SHEET**

Accessibility and acceptability of public sexual health clinics.

Day: **Date:**

Client No.	Session		Gender			Agreed	Disagreed (*)	Questionnaire Collected		Specific issues
	AM	PM	M	F	O			Yes	No	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
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20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										

*** It is not mandatory to give the reason(s) for not participating.**

Total clients attended per session:

Appendix E

Summary of data collection.

Region code	**Total attendance** (Count)	**Total approached** (Count)	**Total participated** (Count)	**Approach rate *** %	**Participation rate Ψ** %
A	143	124	110	87.0	90.0
B	243	163	139	67.0	85.0
C	43	43	43	100.0	100.0
D	10	10	10	100.0	100.0
Total	**439**	**340**	**302**	**77.4**	**89**

* Approach rate = Total attended / total approached X 100

Ψ Participation rate = Total approached / total participated X 100

Appendix F

Accessibility and acceptability of public sexual health clinics
for adult clients in NSW, Australia
Questionnaire

Date ☐☐/ ☐☐/ ☐☐☐☐ Time ☐☐ : ☐☐ am/pm

Age group	Gender	Post code (residence)
18 – 25 yrs ☐	Male ☐	☐☐☐☐
26 – 49 yrs ☐	Female ☐	
> 50 yrs ☐	Others ☐	

What is your current employment status?

Full time ☐ Part time ☐ Unemployed ☐ Retired☐ Student ☐

What is your highest educational status?

Primary ☐ Secondary ☐ TAFE ☐

Under Graduation ☐ Post Graduation ☐

What is the usual language spoken at your home?

English ☐ Other ☐ specify ……

What is your country of birth?

Australia ☐ Other☐ specify……

What is your ethnic background?

Caucasian ☐ Asian ☐

Aboriginal and Torres Strait Islander ☐ others ☐ *please specify*……..

Accessibility and acceptability of public sexual health clinics
for adult clients in NSW, Australia

Questionnaire

---

1 Have you attended sexual health clinics before?

No ☐ Yes, this clinic ☐ Yes, other clinics ☐

2 Reasons for choosing this clinic

Close to residence ☐ Close to work ☐ Only clinic known ☐ Referred by ☐ Health professional

Others …… ……

3 Time taken to get to clinic from home/work

Less than 15 minutes ☐ 15 – 30 minutes ☐ More than 30 minutes☐

4 Mode of transport

Private ☐ Public ☐ Others ☐

If private*, please comment on parking facilities at this clinic*

A) Easy to find ☐ Difficult to find ☐

B) Adequate space ☐ Inadequate space ☐

5 How did you find out about this clinic?

GP referral ☐ Other clinics ☐ Personal ☐ Media ☐ Internet ☐

Others, please specify…….

Accessibility and acceptability of public sexual health clinics
for adult clients in NSW, Australia

Questionnaire

---

6 Preferred days to attend the clinic?

Weekdays ☐ Weekends ☐ No preference ☐

7 Preferred part of the day to attend the clinic?

8-12noon ☐ 12 -4pm ☐ 4-8pm ☐ No preference ☐

8 Preference to consult a doctor?

by Appointment ☐ Walk in ☐ No preference ☐

9 Do you prefer being consulted by a health care worker of your own gender?

Yes ☐ No ☐ No preference ☐

10 Do you prefer to be consulted by the same doctor for subsequent visits?

Yes ☐ No ☐ No preference ☐

11 Do you prefer separate waiting rooms for males and females?

Yes ☐ No ☐ No preference ☐

Accessibility and acceptability of public sexual health clinics
for adult clients in NSW, Australia

Questionnaire

TO BE COMPLETED AFTER CONSULTATION

12 What is the approximate waiting time? (*between registration and consultation*)

Less than15 mins. ☐ 15 -30 mins.☐ More than 30 mins.☐

13 What is the approximate time taken for consultation?

Less than15 mins. ☐ 15 -30 mins.☐ More than 30 mins.☐

14 Did you have any difficulties with language during consultation with doctor/nurse?

No ☐ Yes, to some extent ☐ Yes to a great extent ☐

please specify difficulty ……..

15 What is the gender of the health care worker you consulted?

Male ☐ Female ☐

16 What is your overall impression about the service in this clinic?

Excellent ☐ Good ☐ Satisfactory ☐ Poor ☐

Additional comments /Suggestions:

……

……..

…….

Appendix G

List of languages spoken at home by clients.

Languages		Frequency	Percent
	English	267	88.4
	Arabic	3	1.0
	Basso	1	.3
	Burmese	1	.3
	Cantonese	3	1.0
	Chinese	8	2.6
	Croatian	1	.3
	French	1	.3
	Hindi	2	.7
	Indonesian	2	.7
	Malay	2	.7
	Not specified	1	.3
	Philippine	1	.3
	Serbian	1	.3
	Swahili	1	.3
	Spanish	2	.7
	Tagalong	1	.3
	Tamil	1	.3
	Thai	2	.7
	Vietnamese	1	.3
	Total	**302**	**100.0**

Appendix H

List of countries where clients were born.

	Frequency	Percent
Australia	**208**	**68.9**
Africa	1	.3
Algeria	1	.3
Argentina	2	.7
Belgium	1	.3
Burma	1	.3
China	10	3.3
Colombia	1	.3
Congo	1	.3
Croatia	1	.3
Denmark	1	.3
Egypt	1	.3
Fiji	1	.3
France	2	.7
Germany	2	.7
Gordon	1	.3
Hong Kong	1	.3
India	4	1.3
Indonesia	3	1.0
Ireland	1	.3
Kenya	1	.3
Lebanon	1	.3
Liberia	1	.3
Malaysia	2	.7
Malta	1	.3
Not specified	5	1.7
New Zealand	12	4.0
Philippi	3	1.0
Singapore	1	.3
South Africa	1	.3
Thailand	2	.7
Trinidad	1	.3
Turkey	1	.3
UK	21	7.0
USA	2	.7
Vietnam	2	.7
Zambia	1	.3
Total	**302**	**100.0**

Appendix I

SPSS logistic regression output - Preference for a same gender HCW.

Case Processing Summary

Unweighted Cases(a)		N	Percent
Selected Cases	Included in Analysis	157	52.0
	Missing Cases	145	48.0
	Total	302	100.0
Unselected Cases		0	.0
Total		302	100.0

a If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
yes	0
no	1

Block 0: Beginning Block

Classification Table(a,b)

Observed		Predicted		
		preference to be consulted by HCW of same gender		Percentage Correct
		yes	no	
Step 0	preference to be consulted by HCW of same gender yes	117	0	100.0
	Overall Percentage			74.5

a Constant is included in the model.
b The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	-1.073	.183	34.339	1	.000	.342

Variables not in the Equation

			Score	df	Sig.
Step 0	Variables	AGE	1.905	1	.168
		GENDER	29.880	1	.000
		BIRTHCOU	4.172	1	.041
	Overall Statistics		34.173	3	.000

Block 1: Method = Enter

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	40.321	3	.000
	Block	40.321	3	.000
	Model	40.321	3	.000

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	137.881	.226	.334

Classification Table(a)

Observed			Predicted		
			preference to be consulted by HCW of same gender		Percentage Correct
			yes	no	
Step 1	preference to be consulted by HCW of same gender	yes	96	21	82.1
	Overall Percentage				77.1

a The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1(a)	AGE	.050	.342	.021	1	.885	1.051
	GENDER	-2.868	.648	19.602	1	.000	.057
	BIRTHCOU	-1.085	.483	5.043	1	.025	.338
	Constant	3.886	1.228	10.014	1	.002	48.710

a Variable(s) entered on step 1: AGE, GENDER, BIRTHCOU.

APPENDIX J

Matching – Clients' preferred gender of HCW and the actual gender of the HCW consulted on the day of survey.

The matching was done without including 'no preference' response.

Gender of client	Response	Preferred gender of HCW	Actual gender of HCW	Score
Male	Yes	Male	Male	Matched
Male	No	Female	Female	Matched
Male	Yes	Male	Female	Mismatched
Male	No	Female	Male	Mismatched
Female	Yes	Female	Female	Matched
Female	No	Male	Male	Matched
Female	Yes	Female	Male	Mismatched
Female	No	Male	Female	Mismatched