

Accessibility of genitourinary medicine clinics

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Objectives: to examine and compare the accessibility and acceptability of a range of genitourinary medicine (GUM) clinics.

Design: five GUM clinics representing different types of locations in the West Midlands Region were selected. All patients attending over the sampling period were included, with data collected by anonymous self completed questionnaire.

Results: 297 completed questionnaires were obtained from 360 attendees; 87.4% of attendees had taken 30 minutes or less to get to the clinic, and 66% had used public transport, with variations found between locations. The majority (72.5%) of attendees visited the clinics during their preferred part of the day. Examination of narrower time preferences showed that those wanting to visit in the evening were less likely to be seen during their preferred time than those wanting daytime visits (32% compared with 90%). Of the attendees 98.6% found clinic staff to be friendly and 97.5% did not feel they were being judged because of their sexual activities. The most common reasons for choosing a clinic were recommendation (38.2%) and proximity (36.4%).

Conclusions: the clinics were generally found to be physically accessible, although clinic opening hours need to be reconsidered. Further work is needed on the acceptability of the service in relation to expectations.

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Introduction

Genitourinary medicine (GUM) clinics in the United Kingdom are in the forefront of the fight against sexual transmitted diseases and HIV infection. It is believed that up to 90% of cases of sexual transmitted diseases in the country are seen at these clinics and 8.3% of men and 5.6% of women have attended a clinic at least once.¹

GUM clinics provide a free and confidential specialist service. Being based on self referral they need to be easily accessible. There is some stigma attached to attending GUM clinics so that taking time off work or studies may be difficult; either because the employee is embarrassed to ask, or is concerned about colleagues reactions or the prejudices of the employer.^{2,3}

Attendance rates at GUM clinics in the West Midlands region in the late 1980s were among the lowest in the United Kingdom, and were half those for the Thames Regions (South East England and London).⁴ The National Survey of Sexual Attitudes and Lifestyles also found regional differences in reported clinic attendance.¹ The reason(s) for this difference are not known, but may reflect differences in need (levels of sexually transmitted diseases); greater use of non-specialist services for treatment of STDs such as private clinics or general practitioners; travel to attend clinics in other regions; a lower level of service uptake and thus possibly more untreated cases; or a combination of these factors. Low attendance rates may also be related to the accessibility and acceptability of the service.

Opening hours can make accessing clinics a problem for some attendees.⁵ A number of studies have shown that patients prefer evening sessions.^{6,5} The "Monks Report",⁷

expressed concern that half of the clinics in the study had no evening sessions, even though such opening is specified in the Venereal Disease Regulations of 1916. Allen and Hogg,⁸ in their study of Work Roles and Responsibilities in GUM clinics, noted difficulties over the location and sign-posting of a number of the clinics they studied. There has been little work on clinic acceptability except that it has been suggested that there needs to be an awareness and acceptance of minority cultures if they are to be accessible to such groups.^{9,10}

This paper reports on the accessibility and acceptability of a number of GUM clinics in the West Midlands Region of the United Kingdom, which was examined as part of a wider survey of GUM services.

Methods

Five genitourinary medicine clinics, representing different types of locations in the West Midlands Region, were selected for inclusion in the survey. The clinic locations were classed as follows:

Central—close to the centre of large city with good access by public transport (near to major transport hubs) and by road.

Suburban—situated in a metropolitan suburban area. The site is some distance from the nearest urban centre, fairly accessible by car, and accessible by bus.

Metropolitan—on the edge of a medium sized industrial town in a metropolitan conurbation, and accessible by bus and car.

New-town—situated in a new-town near to a large conurbation. Access by road is good, with a large car park. Access also possible by bus.

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Table 1 Time taken to get to clinics and the modes of transport used

Clinic location	Time taken to get to clinic (%)			Transport used (%)	
	under 15 minutes	15 to 30 minutes	over 30 minutes	private transport	public transport or walk
Central	21 (31)	30 (45)	16 (24)	26 (38)	42 (62)
Suburban	26 (44)	28 (48)	5 (9)	41 (70)	18 (31)
Metropolitan	29 (52)	25 (45)	2 (4)	46 (81)	11 (19)
Newtown	29 (56)	20 (39)	3 (6)	39 (75)	13 (25)
Rural	23 (38)	26 (43)	11 (18)	42 (70)	16 (30)
All clinics	128 (44)	129 (44)	36 (13)	194 (66)	100 (35)
χ^2		p = 0.0084			p = 0.0000

Rural—situated near to the centre of county town that is surrounded by agricultural areas and smaller dormitory towns. Accessible by car, bus and train.

The sampling at each clinic took place over a number of days during a two week period, all parts of the day that the clinic opened being covered. All those attending during the sampling period were offered inclusion in the survey. Attendees were approached in the waiting area by a research worker of the same gender and were given a letter explaining the survey and their consent to take part sought. The anonymity and confidentiality of the survey were emphasised. Those who agreed to take part were provided with a self administered questionnaire, asked to complete it during their visit and return it sealed in the envelope provided, before leaving. For those attendees who were unable to complete the questionnaire themselves assistance was given and confidentiality from others maintained by using an office.

The questionnaire covered issues related to health advice, demographics, reason for attending and nature of the visit, as well as the clinics' physical accessibility and its acceptability to attendees. The questionnaire was piloted in a GUM clinic. Data was coded in to a Fox Pro database and chi square analysis was undertaken using SPSSPC +.

Results

Completed questionnaires were received from 297 of the 360 attendees approached, a response rate of 82.5%, with no differences between the clinics.

Physical accessibility

The length of time taken by the attendees to get to the clinic was obtained using with a structured response question. Most (87.4%) took less than 30 minutes to reach the clinic (table 1), but this varied between clinics, with more people taking over 30 minutes to reach the clinic in the central location than the others. When asked how they got to the clinic 65.5% of the attendees said they used private transport

(car, motor-cycle or peddle-bicycle (n = 194)) whilst the remainder used public transport (n = 88) or walked (n = 12). The proportion using private or public transport also varied between clinics, those attending the centrally located clinic being most likely to use public transport (table 1).

Of the attendees 41.6% had "taken time off work or studies" and 22.6% of them "found it difficult to make time to come to the clinic". There were no differences here between the clinics. Nor were there any differences for attendees responses to finding the clinic "easy to get to" and "easy to find at the hospital", 88.9% and 86.4% respectively said yes to these questions.

Attendees were asked what was the best part of day for them to attend. Of these, 72.5% preferred p.m. and 18.4% a.m., with the remainder saying anytime. There were no differences between clinics.

When actual time of attendance was compared with preferred time it was found that 77.5% of the sample had visited the clinics during their preferred part of the day (table 2). If narrower time periods are examined a similar pattern was found for those wanting to attend during the day-time, but not for those wanting to visit in the evening: 90% of those whose preferred time was before 16:30 h had attended before 16:30 h, but only 32% of those wanting to be seen at 16:30 h or later had attended at this time (table 3).

Acceptability

There were two questions relating to the acceptability of the clinics: whether the attendees found the clinics to be friendly (98.6% did); and whether they felt that the clinic staff thought badly of them because of their sexual activities (97.5% did not). These responses did not differ from attendees at the different clinics.

Reasons for choice of clinic

Attendees were asked why they chose a particular clinic, more than one response being possible to this structured question. The most common reasons were that the clinic was recommended (38.2%), and it was the nearest

Table 2 Preferred part of the day for attendance compared to actual attendance

Time period of actual attendance	Preferred time to attend clinic (%)		
	a.m.	p.m.	a.m. and p.m.
a.m.	35 (69)	47 (23)	6 (23)
p.m.	16 (31)	156 (77)	20 (77)

Table 3 Preferred time and actual time of attendance: evening compared to daytime

Time period of actual of attendance	Preferred time to attend (%)	
	before 16:30 h	16:30 h or later
before 16:30 h	182 (90)	53 (68)
16:30 h or later	20 (10)	25 (32)

Table 4 Reason for choosing a clinic

Clinic location	Why did you choose to come to this clinic? (%)				n
	nearest to where you live	nearest to where you work	only one known	recommended	
Central	17 (25)	7 (10)	22 (32)	27 (40)	68
Suburban	15 (25)	1 (2)	6 (10)	34 (58)	59
Metropolitan	27 (47)	7 (12)	11 (19)	12 (21)	57
Newtown	21 (40)	7 (14)	9 (17)	22 (42)	52
Rural	29 (48)	5 (8)	16 (27)	18 (30)	60
All clinics	187 (36)	27 (9)	64 (22)	113 (38)	296
χ^2	p = 0.0079	p = 0.2028	p = 0.0284	p = 0.0009	

clinic to where they lived (36.4%). Variations were found here between the clinics (table 4). Those attending the clinics in Metropolitan, New-town and Rural locations were more likely to give as a reason that the clinic was nearest to where they lived. Over half of those attending the Suburban clinic said that recommendation was involved in the choice of clinic.

First time visitors compared with those who had previously visited the clinic

No significant differences were found between those who had visited the clinic before (n = 203) and those who were visiting the clinic for the first time (n = 91) for the any of the factors examined.

Socio-demographic differences

Women (n = 141) were more likely to say that they chose a clinic because of a recommendation than men (n = 155) (45.4% compared with 31.6%, p = 0.0148), and Black (n = 24) and Asian (n = 10) attendees were more likely to prefer to attend in the morning (34.2% compared with 15.9%, p = 0.0095). No other significant differences were found according to gender, ethnic group or sexual orientation for any of the factors examined, although the numbers of gay and bisexual men (n = 19) and people from black and Asian communities were small.

Those seeking work (n = 29) and housepersons (n = 29) were more likely to have a preference for morning attendance than those who were working or students (34.6% compared with 13.8%, p = 0.0002). No other differences were found between these groups. Black and Asian attendees were more likely to be seeking work (28.6% compared with 7.4%, p = 0.0001).

Discussion

This investigation has found that in general the five clinics studied were physically accessible as well as acceptable to attendees. Most reached the clinics in less than 30 minutes, found them easy to locate and found the clinic staff to be friendly and non-judgmental.

Around three-quarters of the attendees had attended during the part of the day they preferred, but examination of narrower time preferences showed that those who preferred to attend in the evening were least likely to be seen then. Most of those attendees giving preferred times of attendance in the evening wanted to visit the clinic between 17:00 and 19:00 h. Three of the clinics, at the time of the

study, were open up to 18:00 h on some nights of the week and one was open to 20:00 h one evening a week. These evening periods represented about one tenth of the actual clinic opening hours, yet evening opening was the *only* preferred time to visit the clinic given by over a quarter of the attendees (evening here is taken as 16:30 and after).

The need for evening sessions has also been shown by other studies. Munday⁶ found in a study of 300 attendees at a clinic in South East England, that the most common preference was for late afternoon and evening sessions, with late morning being least popular. Rogstad⁵ found in an investigation of 970 attendees at a clinic in Leicester, that 38% of the attendees wished to attend after 17:00 h. The "Monks Report" on the workloads of GUM clinics⁷ listed among its recommendations "In accordance . . . [with] the Venereal Diseases Regulations 1916 arrangements should be made for some sessions to be held after 5pm". Although most of the clinics in this study had such evening sessions, the number of sessions would appear to be inadequate.

Being unable to attend in the evening may interfere with a person's work or study. In this investigation over 40% of the attendees had to take time off work or studies and almost one quarter of the attendees had difficulty in making time to come to the clinic. Taking time off to attend clinics will mostly be through use of holiday entitlement or unpaid leave. Lim *et al.*² in a survey of attendees at a clinic in Belfast, Northern Ireland found that 64% of those attendees who were working (in employment or self employment) had taken time off, and that the majority (54%) of the employed attendees had taken leave to attend (27% took unpaid leave). These authors go on to argue that the attendees loss of income may be significant. They also found that very few employees had disclosed their visit to their employer.

The findings of this survey relate to the accessibility and acceptability of the clinics to those individuals who actually attended. Some of these had had problems in accessing the service but had they managed to overcome these. Those who have a GUM related health need, but do not attend, may have similar access problems to attendees, but which are not surmountable by them.

The main reasons for choosing a clinic were proximity and recommendation. Knowledge of alternatives was low, even though three of the clinics were within a couple of miles of an alternative. The survey also collected information on the attendees postal district of residence, which supports the claim of many of the attendees that they did choose their nearest clinic. Women attendees were more likely to cite recommendation as a reason for attendance than men, which may be related to accessing cervical cytology and other gender specific services. This is an area which might merit further investigation.

The location of the central clinic will partly explain the greater use of public transport by its attendees. This use of public transport

probably explains the longer access times for this clinic. The reliance of attendees at other clinics on private transport may indicate that for these clinics accessibility by public transport is poor, which may deter potential clients without access to private transport. This raises issues around equity of access.

An individual's views on whether the clinic staff were friendly or non-judgmental may be subjective and related to their expectations. If an attendee thought that the clinic staff might take exception to something, say their sexual orientation, and the staff were only slightly judgmental then that person would feel happy with the service; on the other hand if the same response was received by someone expecting a non-judgmental reaction they may view the service less favourably. No attempt was made to measure expectations of the attendees.

Access to GUM service by people from cultural minorities cannot be reliably established from this study owing to the small numbers of these groups included in the sample. The only difference found was a greater preference for morning sessions among black and Asian people, which may have been related to their higher levels of unemployment. The equity of both accessibility and acceptability to all socio-economic and cultural groups needs to be investigated more fully.

This study shows that the accessibility of GUM clinics, although generally good could

be improved by re-considering clinic opening times. This part of the study reports only on the needs of those who actually attend the clinics. Information is also required from those who may need to use a GUM services but do not do so.

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