Evaluation of Sexual Health Program: Client Survey

Alexandria Kells

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Dr. Darlene Steven

Lakehead University

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Abstract
{ TC "Justification for the Study" \f C \l "1" }

The purpose of this study was to examine the opinions of current clients of the sexual health clinics operated by the Simcoe Muskoka District Health Unit (SMDHU) concerning the existing delivery of clinic service. The SMDHU is mandated to provide contraceptive and sexually transmitted infection (STI) services for vulnerable groups, including adolescents. Contraceptive services are limited to those aged 20 and younger, while STI services are provided for all ages. The SMDHU has targeted the adolescent population for its sexual health services, particularly its birth control services, as youth are among those at highest risk of negative consequences associated with unplanned pregnancies and STIs.

Study objectives were to determine the types of service that the clients of the sexual health clinics felt they required; to determine which aspects of service the clients perceived as most important; and to determine the level of client satisfaction with the clinic locations, service availability, confidentiality, as well as staff attitudes and knowledge.

A survey was developed by the researcher to obtain information from clinic clients including demographics, the specific needs that prompted a clinic visit and the reasons for choosing the sexual health clinic to meet these needs. Respondents were asked to choose and rank the most important aspects of clinic service and to evaluate satisfaction with wait time, clinic location, ease of access, staff attitudes, confidentiality and satisfaction with treatment received. Open-ended questions included the opportunity to provide an opinion about the clinic location and a question asking what was most and least liked about the clinic visit.

Data were collected from 161 clinic clients over a 12 week period, with participants from each of the seven clinic locations. The age of respondents ranged from 13 to 63 years of age with a mean age of 22 and a median age of 20 years. The majority of clinic visits were made for STI testing or treatment (59.6%), with 36% seeking birth control, and 6.2% of clients wanting counselling or information. The proportion of STI visits increased with client age, while younger clients were more likely to attend clinic for birth control services.

The most important and best liked features of the clinic service were found to be the availability of a female provider, the respectful, non-judgemental attitudes of clinic staff, the comfortable clinic atmosphere, confidentiality and the ability to receive the desired care or treatment. Overall client satisfaction was high. The majority of participants were pleased with the clinic location, the speed of service, the availability of clinic appointments, the level of confidentiality and the care received. Most survey respondents indicated satisfaction with staff attitudes, knowledge and behaviour.

Study recommendations include strengthening community partnerships to better co-ordinate delivery of sexual health services, increasing the advertising of clinic services, and expansion of services to Huntsville. In order to continue to provide services in an appropriate and sensitive manner, the sexual health program must continue to support staff development through in-services and opportunities for staff to attend conferences dealing with adolescent sexuality.

Further research should include surveying youth and adolescents in the community to assess the level of awareness of clinic service, the accessibility of current clinic locations, and the perceived sexual health needs of the target population. Another important area for

future research is to evaluate the outcomes of sexual health clinic service including increased knowledge and intent to practice safer sex.

Acknowledgements

I would like to thank the sexual health clinic clients for their participation in this study. By taking the time to complete a survey and offer their opinions about the existing sexual health services, it is hoped that these services may be improved to better serve the residents of Simcoe County and the District of Muskoka.

A warm thanks to the health unit staff for their assistance. The program assistants and public health nurses were always helpful and co-operative. Without their willingness to recruit and accommodate survey respondents, this project would not have been possible. The evaluation team members, Dr Deborah Hardwick (Evaluation Specialist), Stephanie Wolfe (Clinical Epidemiologist), Ellen Hartwick (Sexual Health Program Manager), and Anne McCarthy (Nurse Practitioner) were all incredibly supportive. Their advice, suggestions and the encouragement helped me beyond measure.

Last but certainly not least I want to thank my supervisor and mentor, Dr Darlene Steven (Professor at Lakehead University School of Nursing and Master of Public Health Program) for her support, guidance and encouragement not only with this project but throughout the Masters in Public Health Program.

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Statement of the Purpose{ TC "Statement of the Purpose" \f C \l "1" }

There are challenges in the delivery of sexual health services across the geographically large and primarily rural area served by the Simcoe Muskoka District Health Unit (SMDHU). Equitable access is one of the greatest of these challenges, particularly when the target population for this service is comprised of adolescents and young adults. Since 2001, there have been significant changes in sexual health clinical service delivery. For example, the number of clinics was expanded from 2 to 7 locations, and the SMDHU merged with the Muskoka District Health Unit. With that merger, Simcoe and Muskoka saw changes in services and service delivery. This survey is being conducted as part of a larger evaluation of these changes and the sexual health program. The purpose of the client survey is to determine the extent to which the sexual health clinic services provided by the SMDHU are meeting the perceived needs of its clients.

Objectives of the Study{ TC "Objectives of the Study" \f C \l "1" }

To determine the types of service that the clients of the sexual health clinics feel they require.

To determine which aspects of service delivery are perceived as the most important to the clients of the sexual health clinics.

To determine the level of client satisfaction with the clinic locations, service availability, confidentiality, and staff attitudes and knowledge.

Conceptual Framework

The organizing framework for this study is Pender's revised health promotion model (HPM; Pender, 2002; Pender, Murdaugh, & Parsons, 2002). This model outlines the influence of individual characteristics and experiences, as well as behaviour-specific cognition and affect on health-promoting behaviours (see Figure 1).

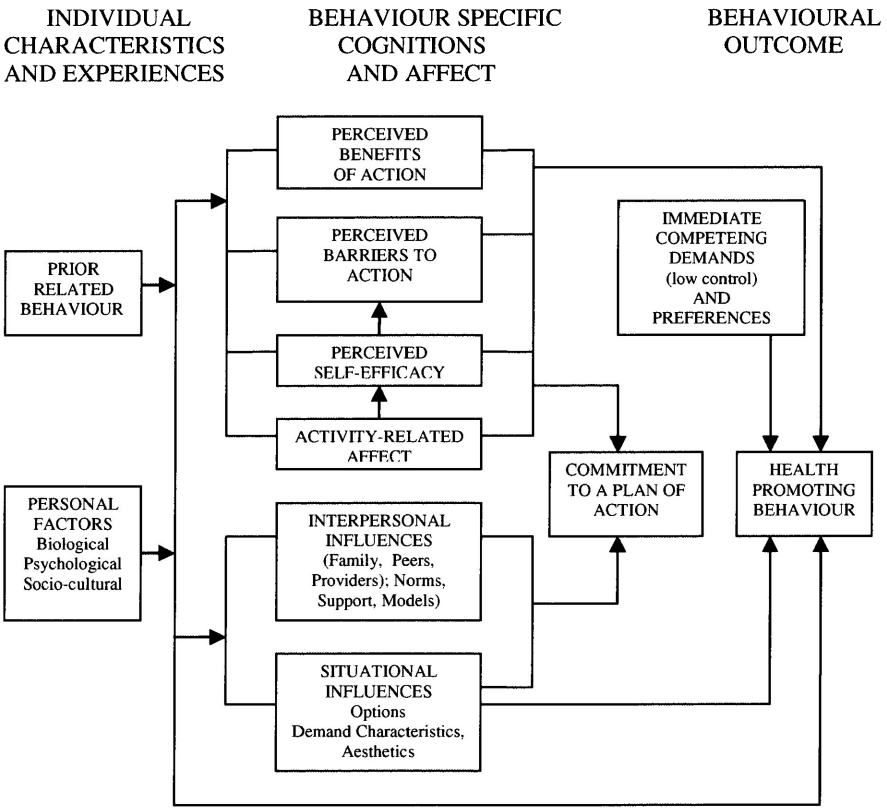

Figure 1. Pender's revised health promotion model.{ TC "*Figure 1.* Pender's revised health promotion model." \f B \l "1" }
Source: Pender (2002).

According to the HPM, individual characteristics are the sociocultural beliefs and biological and psychological characteristics unique to each person. These characteristics, along with the prior related behaviours and experiences of the individual, are powerful influences on the level of motivation a person requires before adopting or rejecting a particular health-promoting behaviour (Pender et al., 2002).

Regarding sexual health behaviours, prior experiences may include such factors as the age of first sexual experience, the number of sexual partners, previous experience with contraception, involvement in high-risk behaviours such as alcohol or drug abuse, and personal history of sexual abuse or violence. Personal factors influencing sexual health behaviours may include beliefs about sexuality; sexual identity and orientation; and the individual's personality, genetic makeup, and physical and cognitive abilities. These characteristics and experiences interact with interpersonal and situational influences to shape behaviour.

Interpersonal influences include the positive or negative effects of family, friends, and role models, as well as the perceived norms within the community and other significant people, including health care providers. Social support is another interpersonal influence that can play a significant role in promoting a healthy lifestyle. When individuals are part of a supportive social group, they may be able to access resources that will help them to accomplish their personal health goals. Situational influences include such factors as perception of available options, accessibility of resources, and features of the surroundings that may impact behaviour (Pender, 2002).

The HPM (Pender, 2002) describes four behaviour-specific variables that influence the level of engagement in health-promoting behaviours: (a) perceived benefits of action, (b) perceived barriers to action, (c) perceived self-efficacy, and (d) activity-related affect. Perceived benefits of action are positive mental images concerning the personal consequences of adopting a particular behaviour. Perceived barriers to action are real or imagined impediments that may reduce the commitment to a plan of action. Perceived self-efficacy is the individual's belief in the ability to make a behaviour change

or adopt a health lifestyle. Activity-related affect refers to the subjective feelings experienced before, during, and after an activity. These variables, in combination with interpersonal and situational influences, determine one's commitment to a plan of action. This commitment can be modified by competing demands, over which an individual has little control, and preferences, over which the individual has a higher level of control (Pender et al., 2002).

This framework is useful in understanding the complexity and interrelated nature of the variables that impact health service utilization and effectiveness. Interpersonal and situational influences play important roles in determining if those who might benefit from clinic attendance will seek service. For example, if clients perceive clinic services to be acceptable and easy to access, it is more likely that they will make the effort to attend clinic and possibly to follow through with advice or treatment.

Behaviour-specific variables are powerful motivators that are, in many cases, amenable to change, thereby allowing service providers the opportunity to encourage their clients to engage in positive behaviours. Before they can commit to a health-promoting behaviour such as practising safer sex, it is crucial that the clients see the personal benefits to doing so and have an adequate perception of their ability to put the desired behaviour into action. Clients who doubt their ability to follow through with an action plan such as using a particular method of contraception correctly are unlikely to succeed. Perceived barriers can be addressed by a skilled clinician through exercises in problem solving or role-playing. Addressing perceived barriers in this way is often useful in helping clients deal with relationship issues such as negotiating sexual limits. Activity-related affect may include the clients' subjective feelings associated with clinic

attendance. If the clients feel welcome, secure, and supported, they will have positive feelings related to the clinic visit and be more likely to commit to health-promoting behaviours.

These four variables are interrelated, and they all have direct and indirect influences on behaviour. For example, positive affect toward a behaviour results in fewer perceived barriers and greater perceived self-efficacy, leading to an increased likelihood of commitment to action and actual performance of the desired behaviour (Pender, 2002).

CHAPTER 2: LITERATURE REVIEW{ TC "CHAPTER 2: LITERATURE REVIEW" \f C \l "5" }

Introduction{ TC "Introduction" \f C \l "1" }

A critical review of current literature is the basis for the survey. The review starts with a definition of sexual health. It includes an overview of the sexual health status of Canadians, particularly of Canadian youth; an examination of trends in sexual behaviour, sexually transmitted infections (STIs), and teen pregnancy; and a review of the evidence concerning knowledge of sexuality among secondary school students. Factors commonly identified as influencing the accessibility and acceptability of sexual health services are discussed, as are common barriers and facilitators to clinic access. Finally, studies and guidelines outlining interventions shown to be effective in reducing sexual health risks are reviewed, and common elements among them are identified.

Sexual Health{ TC "Sexual Health" \f C \l "1" }

Definition of Sexual Health{ TC "*Definition of Sexual Health*" \f C \l "3" *}*

The World Health Organization (WHO, 2004) acknowledged the complexity of the issue of sexual health, which encompasses such issues as HIV/AIDS, STIs, unplanned pregnancies, abortion, infertility, and sexual dysfunction. In consultation with a group of experts in the field of sexuality, the WHO established a working definition of sexual health:

> Sexual health is a state of physical, emotional, mental and social well-being in relation 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 (Section 2, ¶ 5).

Adolescent Pregnancy Rates{ TC "*Adolescent Pregnancy Rates*" \f C \l "3" *}*

Rates of adolescent pregnancy are often used as a general indicator of sexual and reproductive health (McKay, 2006). In Canada, the rates of adolescent pregnancy have been steadily declining since 1974, when Statistics Canada began collecting these data. Between 1974 and 2003, the pregnancy rate among females ages 15 to 19 dropped from 53.9 per 1,000 to 32.1 (Statistics Canada, 2004). In 2003, the adolescent pregnancy rate for Ontario was lower than the national average, at 27.4, whereas the rate of pregnancies among females ages 15 to 19 in Simcoe County and the District of Muskoka was slightly higher than the provincial average, at 29.5 per 1,000 (SMDHU, 2007; see Table 1).

Table 1{ TC "Table 1" \f A \l "3" }

Adolescent Pregnancy Rates (per 100,000 population ages 15-19 years) 2000-2003{ TC "*Adolescent Pregnancy Rates (per 100,000 population ages 15-19 years) 2000-2003*" \f A \l "3" *}*

Year	Canada	Ontario	Simcoe-Muskoka
2000	38.0	32.7	30.7
2001	36.1	30.4	30.9
2002	33.9	28.7	31.7
2003	32.1	27.6	29.5

Source: SMDHU (2007).

It is difficult to make comparisons between countries because data often are collected and presented differently; however, Canada is ranked as having a moderate rate of adolescent pregnancy when compared with other industrialized countries (Dryburgh, 2002). According to McKay (2006), the combined birth/abortion rate in Canada has remained dramatically lower than that of the United States, England, and Wales, and that

"after a decade of declines in all three countries, Canada's rate in 2003 remains less than half the rate in either the U.S. or England and Wales" (p. 161).

Prevalence and Incidence of Chlamydia{ TC "*Prevalence and Incidence of Chlamydia*" \f C \l "3" }

Chlamydia is the most common reportable STI in Canada, with the highest rates occurring in females ages 15 to 19 and 20 to 24 (Public Health Agency of Canada [PHAC], 2005). Because it is more common in adolescents, the rates of chlamydia often are used as "monitors of the magnitude of STI infection in adolescents and of trends in infection rates" (McKay, 2004, p. 71). Although it is a common infection among the general population of adolescents in Canada, the rates of chlamydia are the highest among certain adolescent subpopulations, including Aboriginals, street youth, and those who are socioeconomically disadvantaged. Females account for 75% of reported chlamydia infections, a circumstance that may be the result of better screening and case finding among females rather than an accurate reflection of the distribution of infection (McKay). The Centers for Disease Control and Prevention (CDC, 2006) suggested that increased rates of chlamydia may reflect an expansion of testing and an increased sensitivity of diagnostic tests, along with possible true increases in disease.

The rate of chlamydia in the area served by the SMDHU is lower than the Ontario and the Canadian rates. In 2004, the rate of chlamydia per 100,000 population in Simcoe and Muskoka was 115, compared to 165 in Ontario and 192 in Canada (SMDHU, 2007). The incidence is considerably higher in the United States, where the rate of chlamydia in 2004 was 348 per 100,000 (CDC, 2006; see Table 2).

Table 2{ TC "Table 2" \f A \l "1" }

Incidence of Chlamydia in Canada, Ontario, and Simcoe-Muskoka per 100,000 population (2000-2004){ TC "*Incidence of Chlamydia in Canada, Ontario, and Simcoe-Muskoka per 100,000 population (2000-2004)*" \f A \l "1" }

Location	2000	2001	2002	2003	2004
Canada	152	161	179	190	192
Ontario	126	136	150	156	165
Simcoe-Muskoka	84	96	108	132	115

Source: SMDHU (2006).

Sexual Health and Canadian Adolescents{ TC "*Sexual Health and Canadian Adolescents*" \f C \l "3" }

In 2002, the Canadian Youth, Sexual Health and HIV/AIDS Study was conducted to update data concerning the sexual health of Canadian youth (Boyce, Doherty, Fortin, & Mackinnon, 2003). Survey questions from a previous study, the Canada Youth and AIDS Study of 1989, were modified to include the concepts of sexual health and healthy sexuality. For this study, a sample of more than 10,000 students in Grades 7, 9 and 11 was selected from every Canadian province and territory, with the exception of Nunavut. A systematic, stratified sampling method was used to ensure representation from various groups, including public and separate school students; students instructed in both English and French; and students from rural and urban areas, schools of various sizes, and different geographic locations. A final random selection was made to choose one class per grade in each sampled school.

The surveys were comprised of three basic components: psycho-social-environmental determinants, sexuality variables, and sexual health. For students in Grade 7, the survey consisted of a single, three-item question concerning sexual experiences. For those in Grades 9 and 11, the survey included those same items as well as questions about oral sex and sexual intercourse. Potential determinants of sexual health were selected based on previous research, which showed a possible link among sexual behaviours, risk behaviours, and sexual health outcomes (Boyce et al., 2003).

Comparing findings between the 1989 study and the 2002 study, Boyce et al. (2003) noted a decline in the proportion of Grade 9 students who reported having had sexual intercourse. Although the rate of Grade 11 girls who reported having had sexual intercourse was unchanged between the two studies, fewer males in Grade 11 reported having had sexual intercourse in 2002. These findings did not support the assumption held by some that recent cohorts of adolescents are more likely to have had sex than adolescents did in previous years (Boyce et al.). The average age of first sexual activity remained unchanged at 15 years.

In terms of positive adolescent sexual health, the study found that most of the students reported the rare use of harmful addictive drugs and a happy home life. Most of the respondents were familiar with condom use, and more than one quarter of them used both a condom and birth control pill at last intercourse (Boyce et al., 2003, p. 2). Less encouraging were findings of the increased use of alcohol and a lack of student use of health services that provide education about the prevention of STIs. Student scores in questions dealing with general knowledge about sexuality were lower in 2002 than they

were in the earlier study. Confidence levels related to coping skills and self-esteem also were lower.

In summary, Boyce et al. (2003) highlighted the need for a comprehensive focus on the sexual health needs of Canadian adolescents. This focus "must go beyond an exploration of the knowledge, attitudes and behaviour of youth, to an exploration of the contexts under which they engage in sexual activities and the belief systems that inform both positive and negative actions" (Boyce et al., p. 3).

Accessibility, Availability and Acceptability of Services{ TC "Accessibility, Availability and Acceptability of Services" \f C \l "3" }

Clinic location and hours of service were mentioned frequently in the literature as important considerations for youth. The provision of sexual health services in a convenient area, perhaps in a nontraditional setting such as a school, a drop-in centre, or a local mall, can help adolescents access services (Elliott & Larson, 2004; Evans, Wright, Goodbrand, Kilbreath, & Young, 2002; Hayter, 2005; Hock-Long, Herceg-Baron, Cassidy, & Whittaker, 2003; Metcalf, 2004; Mulchahey, 2005).

Confidentiality has been identified by many researchers as a key component in promoting access to sexual health services (Elliott & Larson, 2004; Hayter, 2005; Hock-Long et al., 2003; Mulchahey, 2005; Parkes, Wight, & Henderson, 2004; Sanci, Sawyer, Kang, Haller, & Patton, 2005). Sanci et al. found concerns about confidentiality to be so important that nearly 1 in 10 adolescents in the United States reported not visiting a health care provider in the previous year because of the fear that parents would find out about the visit. According to Ontario law, adolescents are able to consent to medical care

as long as they meet the requirement of the Health Care Consent Act (Government of Ontario, 1996), which states that a person is capable of consent if he or she

> Is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. (Chap. 2, sec. 4.1)

Kennedy and McPhee (2006) conducted one-on-one interviews with 12 females ages 13 to 16 concerning their perceptions of the confidentiality of health services in one district of Nova Scotia. The participants in this qualitative study were randomly selected from sex education class lists in two schools. One of the selected schools was located in an urban area where there was access to a youth health centre; the other was a rural school without access to a youth health centre. Six girls from each school were randomly selected and invited to participate in the study. Semistructured interviews were taped, and a grounded theory approach to analysis was used. There was consistency among the participants in the identified reasons for accessing health services. These reasons were related to sexual health and relationship issues, including birth control, concerns about pregnancy, STIs, relationships, abortion information, and sexual bullying. Confidentiality was found to be a key concern. The interviewed adolescents typically viewed traditional health services as less confidential, and many expressed the concern that their parents would find out about their sexual activity. Generalizability of the findings from this study was limited because the participants were drawn from only two schools in a small geographical area; however, the study contributed to the field of knowledge concerning appropriate service delivery. The findings supported the need for research at the community level to identify local needs and provide services tailored to the needs and concerns of youth.

Hayter (2005) used a descriptive, cross-sectional study to assess the views of youth ages 13 to 18 who attended sexual health outreach clinics located in youth clubs in a region of the United Kingdom (UK). Questionnaires were distributed to 250 service users, with a 60% response rate. The survey questions focused on client perceptions of the confidentiality, accessibility, and appropriateness of services, and the approachability and attitudes of clinic staff. In addition, 20 service users, at least 1 from each clinic, provided additional information through semistructured interviews. Quantitative analysis of the survey data was used to carry out descriptive and correlation analyses among the key variables. Qualitative interview data were analyzed using a thematic content approach. The results of the study showed that the majority of visits were related to contraception or relationship issues, with concern about STIs ranking fifth in reasons for attending clinic. The responses to questions seeking views on the attitudes of staff were positive, with 90% agreeing that staff treated them with respect. When asked about future sexual activity, nearly 80% of the respondents reported that the clinic visit had made them think about safer sex, and more than 80% indicated an intent to use contraception.

Hayter's (2005) findings generally supported the practice of situating clinics in areas where young people meet for social and recreational reasons. Analysis of the interviews found that the clients appreciated the respectful, nonjudgemental attitudes of clinic staff and the friendly, informal atmosphere. An issue identified through the interviews highlighted one problem with locating clinics in youth clubs, namely, a concern about confidentiality. Several respondents commented that others could see them seeking advice or service and might overhear private conversations. Although this study was conducted in the UK and included a relatively small number of participants, the use

of interviews in addition to survey data to glean a better understanding of the views and beliefs of participants added strength to the conclusions. Hayter concluded that targeted sexual health services have a clear effect on adolescent sexual health and that service providers should continue to develop services that are confidential, user friendly, and accessible.

DiCenso et al. (2001) solicited the opinions of adolescents concerning sexual health services and ways to improve service delivery in two Ontario regions. In this qualitative study, sexual health services were described as health promotion, health education, counseling, and birth control clinic services. In each of these regions, all students in Grades 9 and 11 at one rural and one urban high school were potential participants. Of the 1,190 eligible participants, 84 students were randomly selected and invited to participate in 1.5-hour, same-sex focus groups. In total, 49 female and 35 male students participated. Topic areas included sources and quality of sexual health information, knowledge and use of sexual health services, gender differences, factors that influence sexual behaviour, and suggestions for improving sexual health services. Three main themes dominated the participants' comments: (a) the limited availability of sexual health information, (b) a lack of knowledge about the existence of services, and (c) the existence of a social environment where healthy sexual decision making is not encouraged.

Based on information obtained from this study, DiCenso et al. (2001) made several recommendations regarding the delivery of sexual health services. These included suggestions that there be improved advertising for clinic services, an expansion of counselling services, the availability of low-cost contraception, and clinic locations and

hours designed with adolescents' needs in mind. The researchers concluded that much needs to be done to improve the quality of sexual health services for adolescents. The strengths of this study included the recruitment of participants from different areas of the province, as well as youth from rural and urban areas. An independent review of the transcripts by two members of the research team provided additional strength. A poor response rate, particularly from male students, was the major study limitation.

According to SMDHU (2007) data, there are 29,065 adolescents ages 15 to 19 in Simcoe County and the District of Muskoka. Table 3 shows the population of youth in the various communities, highlighting those communities where there are sexual health clinics. As shown in the table, there are clinics in some areas where the population of youth is relatively small, but in other areas with more adolescents, there are no clinic services available. For example, in Muskoka, there are three communities: Gravenhurst, Bracebridge, and Hunstville. Gravenhurst, with only 635 adolescents ages 15 to 19, has a clinic, but Hunstville, with 1,200 adolescents in the same age range, has no clinic service. This inequity in the availability of sexual health services is a concern for the SMDHU and the Sexual Health Program in particular.

Table 3{ TC "Table 3" \f A \l "1" }

Population by Sex for Ages 15 to 19 in Simcoe and Muskoka, 2001{ TC "Population by Sex for Ages 15 to 19 in Simcoe and Muskoka, 2001" \f A \l "1" }

Municipality	Population female	Population male	Population total
Simcoe Muskoka	12,210	14,855	29,065
Adjala-Tosorontio	370	395	765
*Barrie	3,425	3,465	6,890
*Bracebridge	525	515	1,040
Bradford	790	860	1,650
*Collingwood	555	565	1,120
Clearview	484	494	980
*Essa	575	625	1,200
Georgian Bay	65	60	125
*Gravenhurst	305	330	635
Huntsville	610	590	1,200

Innisfil	870	985	1,855
Lake of Bays	100	85	185
*Midland	590	565	1,155
Moose Point	5	5	10
Muskoka Lakes	160	175	335
New Tecumseth	840	915	1,755
*Orillia	955	980	1,935
Oro Medonte	610	730	1,340
Penetanguishene	270	275	545
Ramera	275	265	540
Severn	360	360	720
Springwater	585	665	1,250
Tiny and Tay	555	575	1,130
Wasaga Beach	280	340	620

*clinic site Source: SMDHU (2007).

Barriers to Access{ TC "*Barriers to Access*" \f C \l "3" *}*

The review of the literature pointed to several factors that serve as barriers to accessing sexual health services. A lack of knowledge and skill in talking about sexual matters comprise one significant barrier. Adolescents who have not been provided with adequate and correct information concerning sexuality, including information about contraception and STIs, may be unaware of the risks and possible consequences of their behaviour (Dehne & Riedner, 2005; Mulchahey, 2005). In addition, information about the availability and nature of sexual health services should be provided to adolescents. According to Hock-Long et al. (2003), "Youth may delay seeking service because they have inadequate or incorrect information regarding the location of services and their eligibility for care" (p. 145).

The costs associated with sexual health services also may present a barrier to access in some situations. Hock-Long et al. (2003) found that youth in countries with universal health care systems, such as the UK, Canada, and most western European countries, face fewer financial barriers to service than those living in the United States. For many American adolescents, access to service is limited by the type and extent of health insurance and drug plan coverage. The Canadian health care system allows for easier access to service, but in some cases, access is still limited because many adolescents are unable to afford transportation to clinic or the costs associated with the purchase of contraceptives (Elliott & Larson, 2004; Hock-Long et al.).

Elliott and Larson (2004) investigated perceived health care needs, foregone care, barriers to care, and associated risk factors in a nonurban population of adolescents in a midwestern county in the United States. Surveys and interviews were conducted with

1,948 Grade 10 students ages 15 to 17. The surveys included demographic data and questions related to the types of health care each student had perceived as needed in the past year, the health care received during that same time, and the perceived barriers to receiving care. The respondents were asked about the risk factors and personal involvement in behaviours that were likely to affect their health.

After Elliott and Larson (2004) summarized the survey results, they held focus group discussions to better understand the survey findings. Quantitative analysis of the survey data, including frequencies and descriptive analyses, was followed by correlation and regression analyses. Interpretation of these results was aided by information and insights from the focus groups. Elliott and Larson analyzed the qualitative data from the focus groups by identifying themes and interpreting the findings. Nearly half of the sample reported foregoing necessary care in the last year, particularly those living in midsized and rural communities. Those most likely to have not sought care participated in risky behaviours such as drug use, were sexually active, and experienced peer pressure to behave in ways that might cause harm. Five common reasons for missing needed care were identified as the following:

> Anxiety, including fear of what the health care provided would do; embarrassment; and concerns about confidentiality.
>
> Lack of access to care, including problems with transportation; inability to pay for care; not knowing where to go for care; not having someone to accompany the adolescent; and time. The lack of access was a particularly important barrier with respect to sexual health care, where problems with geographic access resulted in considerable foregone care.

A belief that he or she could take care of the problem without intervention.

A lack of parental support for the adolescent seeking care.

A feeling of helplessness or hopelessness concerning health care.

Elliott and Larson (2004) concluded that a coordinated effort involving communities, families, health care providers, schools, policymakers, and adolescents is required to address these barriers. The strengths of this study were in the design, which included adolescents both in and out of school; the identification of specific barriers to care; and the identification of changes needed to address the issue. The findings may not have been applicable a in other settings or to other age groups beyond those ages 15 to 17. The findings also may have been limited because the conclusions were based entirely on self-reports.

Effective Interventions{ TC "*Effective Interventions*" \f C \l "3" }

There is a need for a more rigorous evaluation of interventions focusing on adolescent reproductive health service delivery. Past evaluations were primarily descriptive, with indicators including clinic volume and client satisfaction. More research is needed to evaluate such outcomes as changes in knowledge, attitudes, and behaviours, as well as the impact of services on rates of STIs and unplanned pregnancies (Dehne & Riedner, 2005; Matika-Tyndate, 2001; Metcalfe, 2004).

The Registered Nurses Association of Ontario (RNAO, 2002) developed a best practice guideline outlining approaches likely to be successful with adolescents. The recommended approaches are comprehensive, facilitative, and supportive; the adolescents are involved in program design and implementation; and staff receive adequate training in dealing with adolescents. This document was one of several sources strongly

recommending the use of a theoretical model as the basis of programs aimed at changing the sexual behaviours of adolescents (Jemmott & Jemmott, 2000; McEvoy & Coupey, 2002; McKay, 2000).

There is evidence on the effectiveness of certain interventions. A systematic review done by the Cochrane Collaboration found evidence supporting the importance of educational interventions in improving sexual health and preventing HIV and STIs, particularly when the information is complemented by sexual negotiation and skills development (Shepard, Weston, Peersman, & Napuli, 1999). This review was done to determine the effectiveness of health education to promote sexual risk reduction behaviours among women in order to reduce the transmission of the human papilloma virus (HPV). Thirty studies met the initial inclusion criteria, including 8 methodological qualities deemed likely to identify studies from which potentially reliable conclusions could be drawn. Following critical appraisal, 20 of the 30 studies were excluded, primarily because there was a lack of equivalence between intervention and comparison groups at baseline measurement.

All studies showed a favourable effect on sexual risk reduction outcomes, most commonly expressed as an increase in condom use during intercourse (Shepard et al., 1999). This positive effect was generally sustained for a 3-month period. Common elements of successful educational interventions included multiple intervention sessions, with the use of activities such as skills development, motivation building and attitude change. Effective interventions tended to be guided by theoretical constructs, with most studies using an established theory of behavioural change. Other successful programs displayed sensitivity to local culture and context, and addressed issues of power

imbalances in relationships. Shepard et al. recommended greater integration between sexual health risk reduction and prevention of cervical cancer. They also identified areas for future research, such as long-term randomized controlled trials with equivalent study groups and research with longer postintervention outcome measurement and effective intervention components.

McKay (2000) reviewed the literature supporting the development and implementation of effective HIV and STI interventions for different populations. Interventions aimed at adolescents, street youth, STI clinic patients, women, heterosexually active men, men who have sex with men, and communities were studied. Interventions that produced behaviourally effective outcomes commonly incorporated theoretical models and specific training in behavioural skills, facilitated consistent condom use, used strategies that were community and culturally appropriate, involved peer educators or community opinion leaders, helped clients to create personal sexual health plans, and were appropriate in the duration of intervention. Another element mentioned in McKay's study, as well as those done by other researchers, was the use of staff specifically trained in adolescent-friendly approaches and STI diagnosis and care (Dehne & Riedner, 2005; McKay; Metcalfe, 2004; RNAO, 2002).

Efforts focusing on the highest need groups as well as the behaviours most amenable to change are likely to produce the best results. Jemmott and Jemmott (2000), in a meta-analysis of 21 studies, concluded that certain behaviours are more likely than others to be influenced by interventions. They found greater success in interventions aimed at increasing condom use and reducing the number of sexual partners, whereas efforts promoting abstinence or frequency of intercourse were largely ineffective. Groups

most likely to benefit from targeted interventions include adolescents, the homeless population, those with mental health problems, and other marginalized groups (Matika-Tyndale, 2001; McKay, 2000).

Summary{ TC "Summary" \f C \l "1" }

The literature review confirmed the need for a comprehensive focus on sexual health for Canadians and Canadian youth in particular, including clinical services that are available, accessible, and acceptable to adolescents. To meet this need, consideration must be given to clinic locations and hours of service, along with the provision of information to adolescents about the clinics, the services offered, and ways to access services. Clinic staff should receive training specific to sexual health and must be friendly, knowledgeable, and approachable, displaying an open and nonjudgemental attitude toward adolescents. To reduce barriers to care, it is important that such issues as a lack of knowledge regarding STIs and contraception, financial concerns including the need for free or low-cost medications, and problems arranging transportation to clinic be addressed. It is of the utmost importance to ensure confidentiality, an issue that adolescents frequently report as a major factor in their decision to make and attend a clinic appointment.

The literature presented interventions more likely to be successful when information is complemented by strategies designed to develop skills in sexual negotiation, increase motivation, and change attitudes toward sexually risky behaviours. Sexual health clinic services should be targeted toward specific populations, showing sensitivity to local culture and context. Including clients in program design, implementation, and evaluation facilitates the responsiveness of the programs to local

needs and issues, thus helping to ensure that sexual health services meet the needs of the target populations.

CHAPTER 3: NEEDS ASSESSMENT{ TC "CHAPTER 3: NEEDS ASSESSMENT" \f C \l "5" }

This assessment was done taking into consideration the following areas: client needs, organizational needs, and political considerations. Each is discussed in detail in this chapter.

Client Needs{ TC "Client Needs" \f C \l "1" }

The sexual health clinics operated by the SMDHU offer services aimed at reducing rates of STIs and unplanned pregnancies. Youth face a disproportionately high risk of negative outcomes associated with sexual activity, and STIs and unplanned pregnancies can cause significant health, economic and social problems for adolescents (Hellerstedt & Radel, 2005; WHO, 2004). Because of the vulnerability of this age group, clinic services are focused on, and in the case of contraceptive care, services are limited to clients 20 years of age and younger. Clinic promotion is targeted toward the adolescent population, although clients of all ages are seen for the testing and treatment of STIs.

Health services have been acknowledged internationally as a vital element to improving sexual and reproductive health. Such services should include prevention, diagnosis, and treatment of STIs, including HIV; prevention of cervical cancer; contraceptive care; and care during pregnancy and childbirth. In addition, to be effective, the services need to be "available, accessible, acceptable and appropriate for adolescents" (Bearinger, Sieving, Ferguson, & Sharma, 2007, p. 1225). In some of the sexual health clinics run by the SMDHU, the number of clients being seen, particularly the number of adolescent clients, has been lower than expected. This raises questions about the availability, acceptability, and appropriateness of services offered in these locations.

Prior to 2007, data collected by the SMDHU describing clinic use did not include information about client age or gender. Rather, clinic visits were categorized according to those clients attending for STI concerns, birth control concerns, and counselling visits. Birth control clients have tended to be younger because of the exclusion from the clinic of older clients seeking contraception. This policy, along with anecdotal reports from staff, indicated that in general, birth control clients are younger than STI clients. As Table 4 illustrates, birth control visits sharply declined between 2002 and 2006, STI visits increased, and counselling visits remained relatively stable.

Table 4{ TC "Table 4" \f A \l "1" }

Sexual Health Clinic Visits, 2002-2006{ TC "*Sexual Health Clinic Visits, 2002-2006*" \f A \l "1" *}*

Visit Type	2002	2003	2004	2005	2006
STI visit	925	575	1030	900	1225
Birth control	1300	1370	810	700	520
Counselling	780	580	860	590	785

Source: SMDHU (2007).

The rates of adolescent pregnancy in Simcoe County and Muskoka have declined in recent years, as they have across the country, for a variety of reasons, including socioeconomic factors, improved access to confidential reproductive health services, increased availability of contraceptives, and improved sexual health education (Dryburgh, 2002; Langille, 2007; Matika-Tyndale, 2001). Despite this progress, efforts to reduce the rate of adolescent pregnancy is a worthwhile and realistic goal. Pregnancy

carries a high risk of maternal and infant morbidity and mortality (WHO, 2004). Parenting during adolescence limits the life chances of young mothers, and both pregnancy and abortion can lead to long-term physical and emotional health problems (Hayter, 2005).

Although pregnancy rates have fallen in Canada, rates of STIs, particularly chlamydia, remain "unacceptably high" (McKay, 2004, p. 76). The negative outcomes associated with STIs can be serious. For example, pelvic inflammatory disease (PID) resulting from untreated chlamydia is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain (Macdonald & Brunham, 1997; WHO, 2004). Due to a variety of biological, developmental, and behavioural reasons, adolescents have a disproportionately high risk of acquiring STIs, including HPV, chlamydia, gonorrhea, and herpes (McKay; Society of Obstetricians and Gynaecologists of Canada, 2004). In adolescent girls, the physical immaturity of the cervix makes it less able to combat infection, leading to a risk of PID that is 10 times higher in a 15-year-old female than in a 24-year-old female (Metcalfe, 2004).

The role of health care services, including sexual health clinic services, is an essential component in the prevention of unplanned pregnancies among adolescents, as well as the diagnosis and treatment of STIs, including HIV and AIDS (Bearinger et al., 2007).

Organizational Needs{ TC "Organizational Needs" \f C \l "1" }

The area served by the SMDHU includes Simcoe County and the District of Muskoka, located in southern Ontario and bordered by Georgian Bay on the west and Lake Simcoe on the east (see Appendix A). Simcoe County has an area of almost 5,000

square kilometres and a population of 377,000 (Statistics Canada, 2001). There are two cities, Barrie and Orillia, with the remainder of the county comprised of a mixture of small towns and rural areas. In the District of Muskoka, there are only 50,000 permanent residents spread out over an area of 2,500 square kilometres (Statistics Canada). With no cities and only a few smaller centers, this also is a predominantly rural area.

The SMDHU is required under the Mandatory Health Programs (Ministry of Health, 1997) to provide clinical services in order to address contraception, STIs, and blood-borne infections. Services are to include contraception counselling and the provision of contraceptives; pregnancy testing and counselling; screening for cervical cancer; counselling, diagnosis, treatment, and management of STIs; testing and referral for blood-borne infections; and provision of vaccines.

According to Romanow (2002), "Rural health initiatives should be designed to provide equity in access to health care and in health outcomes" (p. 165). In an effort to address the challenge of offering equitable, accessible service, the SMDHU opened several satellite clinic sites in smaller centres over the past 5 years, with plans to open another clinic site within the next year. In addition to clinics at the central office location in Barrie, sexual health clinics operate in six smaller communities across the district. There is a transportation fund that can be used to provide bus or taxi fare for clients who would otherwise be unable to attend sexual health clinics, however this fund is limited and is only used at the discretion of the public health nurses for clients who are deemed to be of higher risk.

The Mandatory Program Guidelines require monitoring of the progress toward achieving accessibility (Ministry of Health, 1997). This study, as part of an ongoing

evaluation of sexual health clinic services, will help to meet this mandatory requirement. In addition to meeting the mandatory guidelines, the evaluation may highlight needs that could require changes in program delivery or which could support the need for program expansion.

Political Considerations{ TC "Political Considerations" \f C \l "1" }

Canadians have high expectations of their health care services. As Romanow stated (2002), "Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth" (p. xvi). The PHAC (2005) identified as one of its primary goals the assurance that Canada is a country where "every person receives the support and information they need to make healthy choices" (p. 1). Sexual health clinic services play an important role in providing this support and information for Canadian youth. The need for sexual health services, particularly for adolescents, was acknowledged by the Society of Gynaecologists and Obstetricians of Canada (2004), which asserted:

> It is clearly necessary for all youth to receive educational and health services that prepare them for the reality and responsibilities of sexual behaviour. The lack of such programs infringes on the right of all young people to make informed choices about their health and places them at increased risk for significant negative health outcomes. (p. 597)

Appreciation for the importance of sexual health services has grown not only in Canada but also around the world. According to Dehne and Riedner (2005), the International Conference on Population and Development in Cairo in 1994 shed light on the need to recognize that adolescents have not only sexual and reproductive needs but also rights, including the right to a satisfying and safe sexuality.

CHAPTER 4: METHODS

Research Design{ TC "Research Design" \f C \l "1" }

The clinic survey was designed as part of the evaluation of the existing sexual health clinic services. According to Young (2005), evaluations are a "systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action" (p. 297). Although evaluations can and should be done on an ongoing basis, there are several types, depending on the stage and needs of the program. The type of evaluation described in this report is a formative evaluation, which is primarily concerned with improving and fine-tuning program operations.

A descriptive, correlational study design was chosen to allow the researcher to examine and explore the relationship among the variables without necessarily seeking to establish a causal relationship (LoBiondo-Wood, Haber, & Singh, 2005a; Loiselle, Profetto-McGrath, Polit, & Beck, 2004). According to LoBiondo-Wood et al., the advantages to correlational studies include the following:

> An increased flexibility when investigating complex relationships among variables.
> An efficient and effective method of collecting a large amount of data about a problem.
- A potential for practical application in clinical settings.
- A potential foundation for future, experimental research studies.
- A framework for exploring the relationship between variables that cannot be inherently manipulated (p. 270)

Although very practical and realistic, correlational studies also have disadvantages. The principal limitations to correlational studies identified by LoBiondo-Wood et al. include the following:

- The researcher is unable to manipulate the variables of interest.
- The researcher does not employ randomization in the sampling procedures because of dealing with pre-existing groups, and therefore generalizability is decreased.

  The researcher is unable to determine a causal relationship between the variables because of the lack of manipulation, control, and randomization. (p. 270)

Framework{ TC "Framework" \f C \l "1" }

A cross-sectional survey method was used for this study. Cross-sectional studies involve the collection of data at a single point in time; surveys obtain information regarding the prevalence, distribution, and interrelationships of variables within a population (Loiselle et al., 2004). Although cross-sectional studies are economical and easy to manage, Young (2005) stated that their major drawback is the difficulty establishing a temporal sequence.

In developing the survey questions, the researcher chose the variables on the basis of their relevance to the study objectives and research question, using Pender's (2002) HPM as a framework. The desired behavioural outcome or health-promoting behaviour sought in this study was the clients' attendance or continued attendance at clinic.

Individual Characteristics and Experiences{ TC "*Individual Characteristics and Experiences*" \f C \l "3" *}*

Demographic information such as age, gender, and school attendance fall into the category of what Pender (2002) referred to as personal factors; the category of prior related behaviours were explored through survey items concerning previous clinic use and age of first sexual intercourse.

Behaviour-Specific Cognitions and Affect{ TC "*Behaviour-Specific Cognitions and Affect*" \f C \l "3" *}*

These variables were explored through a number of survey items. The perceived benefits of attending clinic were addressed through questions about the reasons for attending clinic and for choosing the sexual health clinic to meet those needs. Further exploration of perceived benefits were examined in survey questions concerning the specific health teaching received during the clinic visit. Barriers to clinic attendance may be found in the responses to the questions about the ease or difficulty of getting to the clinic experienced by the survey respondent, as well as in the responses to the questions about wait times and clinic locations.

Activity-related affect may be evident in the responses to the questions about service satisfaction; some these same survey items offer insight into the client's interpersonal influences. For example, the level of parental support for clinic attendance is addressed indirectly in the list of potential reasons for choosing the sexual health clinic, which includes a possible reason of the client wanting to avoid parental knowledge of clinic attendance. The influence of peers or other significant people on a client's clinic attendance may be evaluated through the survey question asking about referral to the clinic by a friend, teacher, or health care professional. The category of situational influences described by Pender (2002) as an element of behaviour-specific cognitions and affect are included in the survey, and the client may identify concerns with the availability of options for desired services and the need for free or low-cost medications.

Immediate Competing Demands and Preferences{ TC "*Immediate Competing Demands and Preferences*" \f C \l "3" *}*

These influences on clinic attendance are difficult to address in a survey because someone who has an important competing demand may not attend clinic or may not take

the time to complete a survey form. The issue of preference was included in the survey design under the section exploring the reasons for choosing the sexual health clinic for service. For example, the researcher was interested in the number of survey participants who would indicate a preference for a female health care provider.

Study Sample{ TC "Study Sample" \f C \l "1" }

A convenience sample was utilized for this study. Convenience sampling is the use of readily accessible participants for the study. Although this sampling method makes it easier for a researcher to obtain participants, Haber and Singh (2005) identified its major disadvantage as a high risk of bias because "convenience samples tend to be self-selecting; that is, the researcher ends up obtaining information only from the people who volunteer to participate" (p. 288). The researcher did not recruit individuals who represent a particular target population, such as birth control clients or clients of a particular age. The researcher acknowledges that the findings derived from the study will have limited generalizability.

In the original plan every client who visited a sexual health clinic run by the SMDHU over a 6-week period was to be invited to participate in the study. In the study design the researcher estimated that there would be 450 potential participants, which is the average number of clients seen in the seven clinic locations over a 6-week period. From this number, the researcher expected that at least 250 clients would complete the survey, thus allowing for a 90% confidence interval with a 5% margin of error. During the course of the study it was determined that there were a large number of clients who visited several times during the data collection stage. Clients who were seen at the clinic on more than one occasion during this time were asked to participate only once. This

made estimation of the population size difficult. Clinic records showed the number of clinic visits and whether each client was a new or repeat client, but did not specify whether the client was visiting several times over the course of data collection or had visited at an earlier time. This over-estimation of population size may have contributed to a lower than expected response rate. With fewer than 100 surveys completed at the end of six weeks, the evaluation group decided to extend the period for data collection for a further six-week period. After 12 weeks, 161 surveys were completed. During this period of time, 1120 clinic visits were made and 344 of these visits were made by first time clients. An evaluation of population size is not included in the analysis of data.

Data Collection Instrument{ TC "Data Collection Instrument" \f C \l "1" }

Data were collected by means of a self-administered survey of clinic clients. Surveys or questionnaires have certain advantages. Sullivan-Bolyai, Grey, and Singh (2005) identified low cost, anonymity, and freedom from interviewer bias as advantages to this method of data collection.

The survey was divided into five sections. The first section obtained demographic information. In the second section, the participant was questioned about previous attendance at the clinic as well as the reason for the clinic visit, and in the third section the respondent was asked to identify reasons for choosing the sexual health clinic to meet his or her needs. In the fourth part of the survey, the client was asked to identify the three most important aspects of clinic service. Along with a list of items frequently mentioned in the literature as being important to sexual health clinic clients, there was opportunity for the participant to identify and explain personal choices. Respondents were asked to

complete the fifth section of the survey after the appointment was completed. This final section dealt with aspects of client satisfaction, including wait time, clinic location, ease of access, staff attitudes, confidentiality, and satisfaction with treatment received. For participants who identified a concern with any of these items, a space was provided for comments. The client was also asked to identify the specific health teaching received. The final question asked participants what was best and least liked about the clinic.

With a combination of check boxes, close-ended items, and open-ended items, the survey was designed to elicit quantitative and qualitative data. Quantitative studies are based on quantity and measurement, with data expressed numerically. According to Abramson and Abramson (1999), qualitative methods, where the results are expressed in words rather than numbers, are "especially useful in investigations of beliefs, perceptions and practices regarding health, the prevention and treatment of illness, and the utilization of traditional and other health care" (p. 167). Young (2005) described the ways in which qualitative methods complement quantitative research:

> As preliminary to quantitative research – to provide a description and understanding of a situation or behaviour, such as appropriate wordings for use in a survey questionnaire;
> As validation, part of a process of triangulation, comparing results from several methods to check for convergence, or studying the same phenomenon at different levels;
> - As an alternative to quantitative methods in studying complex issues;
> - To help explain quantitative results (pp. 238-239)

Validity and Reliability{ TC "*Validity and Reliability*" \f C \l "3" }

Validity refers to "whether a measurement instrument accurately measures what it is supposed to measure" (LoBiondo-Wood et al., 2005b, p. 330). Young (2005) distinguished between internal and external validity. Internal validity "refers to the degree to which inferences drawn from the study are correct for the actual groups of subjects

being studied" (Young, p. 231). External validity, or generalizability, "refers to the degree to which inferences drawn from the study may be applied to other groups" (Young, p. 231). Although both forms of validity are important in the evaluation of a study's credibility, internal validity is more important in this particular study because there is no intention of generalizing the results to other groups of clients in other settings. Threats to internal validity were identified by LoBiondo-Wood et al. as history, maturation, testing, instrumentation, mortality, and selection bias.

History can threaten validity when a specific event either inside or outside the experimental setting has an effect on the dependent variable (LoBiondo-Wood et al., 2005b). For example, in this study, a particular client's response to the question about satisfaction with the availability of an appointment may be influenced by such external factors as a power failure or staff illness that causes cancellation of the clinic. Maturation refers to the physical and developmental changes that occur over time in a participant. This type of bias occurs when study measurements occur over a period of time; this threat will not apply to the current study. Testing refers to the "effect of taking a pretest on the subject's posttest score" (LoBiondo-Wood & Singh, 2005a, p. 240). Because there is no pretest in this study, this threat to validity is not be a concern to the researcher. Instrumentation threats are "changes in the measurement of the variables or observational techniques that may account for changes in the obtained measurement" (LoBiondo-Wood & Singh, 2005a, p. 240). With no use of diagnostic instruments or collection of observational data, the risk of problems related to instrumentation in this study was primarily related to the differences that two members of the evaluation team could perceive in the analysis of the responses to open-ended questions in the survey. To reduce

this potential threat to validity, two members of the evaluation team compared their analyses of client responses to obtain consensus.

Mortality, which occurs when the participants are lost between two data collection points, was not an issue in this study because the data collection was completed at a single point in time. Selection bias occurs when precautions are not used to obtain a representative sample. LoBiondo-Wood and Singh (2005a) stated that "selection effects are a problem in studies in which the individuals themselves decide whether to participate in a study" (p. 241). It was acknowledged that the clients who chose to participate in the sexual health clinic survey may have differed significantly from those who chose not to participate.

Validity can be evaluated using three approaches: assessment of construct validity, criterion validity, and content validity. Construct validity refers to "the extent to which a measurement corresponds to some theoretical concepts" (Young, 2005, p. 230). No formal evaluation of construct validity was performed in this study.

Criterion validity is the extent to which a measurement correlates with an external standard. The researcher did not address this type of validity by attempting to correlate the survey findings with any external standards.

Content validity is "the extent to which a measurement incorporates the full scope of the phenomenon studied" (LoBiondo-Wood et al., 2005b, p. 330). The researcher used the theoretical framework presented by Pender (2002) to assist with the task of incorporating a wide range of potential variables in the proposed questionnaire in an effort to increase the content validity of the study. A preliminary assessment of the content validity of the survey instrument was conducted by piloting the survey with a

small group of clinic clients. Ten clients were asked to evaluate the clarity of the questions to ensure that the survey measures the desired areas of interest. The clients who participated in this pilot found a high degree of clarity to the questions. This was considered to indicate an acceptable degree of validity in the survey instrument.

LoBiondo-Wood et al. (2005b) defined reliability as "the extent to which the research instrument yields the same results on repeated measures" (p. 335). The main attributes of a reliable instrument are consistency, accuracy, precision, stability, and homogeneity. In order to maximize reliability, all sexual health staff members involved in the evaluation process received the same training. Program assistants, who played a key role in recruiting participation from clinic clients were brought together for a training session in which the study was explained and the script to be used for approaching clients was reviewed and practiced. Public Health nurses (PHNs) received ongoing information about the study during the planning stages at monthly team meetings. Once the survey instruments and supporting documents were finalized and approved by the Research Ethics boards of Lakehead University and the Simcoe Muskoka District Health Unit a training session was held to explain the role of the nurses in supporting client participation.

The concepts of validity and reliability can be applied to the quantitative and the qualitative aspects of the client survey. When used in the evaluation of quantitative research, validity, and reliability are treated separately; however, in qualitative research, these concepts often are described in terms that encompass both, such as credibility, transferability, and trustworthiness (Golafshani, 2003). The use of triangulation is a process recommended by Golafshani to test the validity and reliability of qualitative

research. Triangulation, which involves the corroboration of findings using multiple sources of information, can be used to test the validity of quantitative and qualitative findings (DiCenso, Guyatt, & Ciliska, 2005; Young, 2005). Many of the completed surveys contained comments that were similar in nature. Not only did different respondents share opinions about the clinic experience, consistency between responses to similar questions within individual surveys helped to validate the credibility of the survey instrument. This consistency in participant responses helps to corroborate the validity and reliability of study findings. To further increase the confidence of the researcher in the validity and reliability of the qualitative responses, two members of the research team reviewed the data in order to reach an agreement concerning the findings.

Data Collection Procedures{ TC "Data Collection Procedures" \f C \l "1" }

Ethical approval from Lakehead University and from the Simcoe Muskoka District Health Unit were sought prior to the collection of any data. The researcher submitted an application to each of these organizations outlining the purpose of the study and details of how the researcher intended to maintain standards of ethical research through the processes of informed consent, confidentiality, collection and storage of data. As one of the requirements of the Research Ethics Board of Lakehead University the researcher completed an on-line course that reviewed aspects of ethical research. Once ethical approval was obtained from both the Health Unit and Lakehead University, data collection commenced.

The participants in this study were solicited over a 12-week period. Each client who visited one of the sexual health clinics run by the SMDHU during this period was invited to participate. Program assistants approached each client on arrival to inform him

or her about the study; and provide anyone interested in participating with a cover letter (see Appendix B), consent form (see Appendix C), blank survey (see Appendix D), and two envelopes marked "survey form" and "consent form" in which clients were to place these forms. The program assistant provided a pen and clipboard to each participant. Participants returned the signed consent forms and the completed surveys to the program assistant, who placed these two items separately in a secure location.

Data Analysis{ *TC "Data Analysis" \f C \l "1" }*

Analysis of Quantitative Data{ TC "*Analysis of Quantitative Data*" \f C \l "3" *}*

Quantitative analysis was done by entering data onto an Excel document which was then transferred into an SPSS file.

Using the SPSS program, the data was summarized and organized by means of descriptive statistics. Abramson and Abramson (1999) advised starting the data analysis with frequency distribution of all variables. A separate table was prepared showing the frequency and percentage of responses to each question or category. Cross tabulation of variables was done where different responses were expected according to categories such as age, gender or clinic location. Calculation of descriptive statistics including mean, median, mode and standard deviation was done to better understand the data. Cross tabulations were done to examine the relationships between variables. Parametric tests such as the *t* test were used to measure the significance of differences in interval data. Null hypothesis tests of relationships assume that there is no relationship between variables. The chi-squared test was used to prove or disprove the null hypothesis in situations were an association between variables was in question. (Sullivan-Bolyai et al., 2005).

Analysis of Qualitative Data{ TC "*Analysis of Qualitative Data*" \f C \l "3" *}*

Responses to open-ended questions were entered onto the Excel worksheet using the exact words of the survey respondents. This information was transferred to a qualitative analysis package named Nvivo. The responses to various questions were categorized through the formation of "nodes". Each case or completed survey was coded to a node, titled by its record number. Demographic information was coded as "attributes" and assigned to the nodes. Responses to each question were coded into nodes, referred to as "free nodes". Within each of these nodes, common themes were further categorized and nodes would have various subcategories or "trees". As each free node was reviewed, additional categories or "tree nodes" were made to respond to specific questions of the data. Responses to questions such as those asking the most and least liked aspects of the clinic visit were reviewed in two ways. Two reviewers read each comment made by any of the respondents, agreeing on emerging themes and noting these themes. Then the question responses were re-examined after being divided according to clinic location using the Boolean feature of the Nvivo program. Once these responses were organized according to clinic location, themes were much clearer and a better picture of each clinic emerged. Quasi statistics were used, as the frequency of certain themes were tabulated. Finally, the researcher tried to "weave the thematic strands together into an integrated picture of the phenomenon under investigation" (Loiselle et al., p. 401).

CHAPTER 5: RESULTS

Demographics

A total of 161 clinic clients completed surveys over a 12 week period. Because the population of eligible participants was not known, the response rate was not calculated. Response rates between clinics varied. Barrie, with four clinics each week accounted for 33% of the surveys. Gravenhurst, with only 2 half day clinics each month accounted for 4.3% of the surveys. The other sites each with weekly clinics were Orillia with 22.3% of the total number of surveys, Midland with 17.4%, Bracebridge with 10.6%, Collingwood with 6.8% and Alliston with 5%. Females comprised 73.3% of survey respondents, 25.5% identified themselves as male and 2 individuals (1.2%) did not indicate gender. Of the 154 individuals who answered the question asking if this was the first clinic visit, 94 (58.4%) answered no, while 60 (37.3%) identified this as a first visit.

Age and gender

Participants ranged in age from 13 to 63 years. The mean age was 22.23 years while the median age was 20 years. Most of those who completed surveys were female (73%). According to information from the SMDHU (2008) 70% of the 217 clients seen in sexual health clinics across the district of Simcoe and Muskoka during July of 2008 were female and 51% of the total number of clients seen was under 20 years of age. This would indicate that the age and gender of survey respondents was fairly representative of the population of clinic clients.

Table 5

Frequency of age categories among survey respondents

Age (in years)	Males	Females	Total Number of Participants	Total percentage of Participants
18 and under	5	51	56	34.78
19 – 24	22	45	67	41.61
25 and over	14	22	36	22.36
No age given			2	1.24

N=161

The average age of clinic clients varied according to clinic location. The oldest clients were those seen in Barrie where the mean age of clinic clients was 25.74 years. The youngest clients were those seen in Alliston where the mean age was 17 years. An ANOVA showed that there was a significance in the difference in age between client group in the various clinics (df=6, Mean square = 216.487, F=4.167, Sig.= .001).

Table 6

Client ages according to clinic location

Clinic	N	Mean Age	Minimum Age	Maximum Age
Barrie	46	25.74	16	63
Collingwood	11	24.82	17	40
Orillia	31	21.90	14	39
Midland	28	20.32	13	31
Gravenhurst	7	18.29	17	20
Bracebridge	14	18.21	16	24

N=159

School attendance

Slightly more than half the respondents reported current school attendance with 89 of 161 participants providing a positive response to this question. Of these, 49 indicated secondary school while the remaining 40 attended a post-secondary institution.

Sexual Activity

Only 6 participants had not been sexually active prior to their clinic visit. For those who reported previous sexual activity, the age of sexual debut ranged from 7 to 23 years of age. The mean age of first sexual intercourse was 15.92 years for females (n=97) and 15.91 years for males (n=33). There was no statistical difference between male and female respondents. A t-test for equality of means showed a mean difference of .008.

Table 7

Age of first sexual activity by gender

	Levene's test for equality		t-test for Equality of Means						
								95% Confidence Interval of the Difference	
	F	Sig.	t	df	Sig. 2-tailed	Mean Difference	Std. Error Difference	Lower	Upper
Equal variance assumed	1.376	.243	.023	128	.982	.008	.375	-.733	.749
Equal variance not assumed			.022	51.248	.983	.008	.392	-.779	.796

N=146

Service Needs

Reason for visit

The sexual health clinics divide client visits into STI, contraceptive and counselling visits. The client survey included other categories. Under the broader

umbrella of contraception, survey respondents could choose birth control, annual exam and pregnancy testing. STI visits could include testing for infection, hepatitis or HPV vaccine, and treatment. The categories of condoms and counselling could refer to either contraception or STI. Participants were also able to indicate "other" and provide an explanation. Clients completing surveys were not limited to any particular number of responses to this question.

Testing for infection was the most commonly chosen response, with 74 (46%) of participants indicating this as a reason for the visit. The categories selected least often were hepatitis or HPV vaccine, and pregnancy testing. Each of these received only 2 responses. Several respondents wrote a reason for the visit that was also included in the predetermined choices, for example one client checked off the box marked "testing for infection" and then wrote "SH check for STDs" in the space for other reasons for the visit. Four clients wrote in that they had come for a post-abortion check-up, a category that was not included in the survey choices.

Table 8

Reason for visit

Reason for visit	Number of clients choosing this response
STI testing	74
Birth control	58
Annual exam	33
Treatment	22
Condoms	14
Counselling	10
Vaccination	2
Pregnancy test	2
Other	15

N=230

Chi-square testing was done to assess the association between age and reason for visit. Visits for STI testing and treatment were combined into a single category and clients were grouped according to age. It is clear from the Tables 9 and 10 that younger clients are more likely to attend for birth control while older clients are more likely to attend clinic for STI concerns. Counselling was not frequently selected as a reason for the visit, particularly among those younger than 19 years.

Table 9

Reason for visit by age category

Reason for visit	Participants who selected this reason (all ages)	Participants 18 and under who selected this (number and percentage of total clients in this age group N=56)	Participants 19-24 who selected this (N=67)	Participants 25 and over who selected this (N=36)
STI testing and/ or treatment	64	19 (33.93%)	37 (55.22%)	25 (69.44%)
Birth control	53	30 (53.57%)	21 (31.34%)	2 (5.6%)
Counselling	10	1 (1.79%)	7 (10.45%)	2 (5.6%)

N=159

Table 10

Chi- square test of reason for visit by age category

	STI testing and / or treatment			Birth control			Counselling		
	Value	df	*p*	Value	df	*p*	Value	df	*p*
Pearson Chi-square	12.286		.002	24.760	2	.000	4.116	2	.128
Likelihood Ratio	12.485		.002	28.382		.000	4.492	2	.106

N of Valid Cases	145	145	145

Reasons for choosing sexual health clinic to meet needs

The most commonly selected reason for choosing the sexual health clinic was the preference for a female health care provider. Over half of respondents chose this response. Cross tabulation of the 88 participants who selected this response was done according to age and gender. In the 18 and under age group, 37 of 51 females and no males gave this as a reason for choosing the clinic. Among those aged 19 to 24, 34 out of 45 females and 5 out of 22 males selected this response. In the over 25 year age category 11 out of 22 females and 1 out of 14 males identified this preference for a female clinician. The second most popular response to this question was discomfort with the client's regular health care provider. This was chosen by 62 (38.5%) of those surveyed.

Table 11

Reasons for choosing sexual health clinic

Reason	Number who chose this response	Percentage who chose this response
Preference for a female provider	88	54.7%
Uncomfortable talking about sexuality with regular provider	62	38.5%
Unable to get appointment with regular provider	42	26.1%
No regular health care provider	41	25.5%
Referred to clinic	39	24.2%
Unable to receive specialized care elsewhere	36	22.4%
Don't want parents or others knowing about visit	25	15.5%
Other reason	11	6.8%

N=344

For those who had been referred to the sexual health clinic, six identified a friend as the person who recommended the clinic; three identified a family member; and six participants were referred by a health care provider.

Among survey respondents who wrote in additional reasons for choosing the clinic, eight referred to the specialized service offered. As one participant commented, the clinic offers "anonymous testing, sexual disease testing all done by experts in the field." Six respondents identified a comfortable environment, including the contribution of staff in making clients comfortable. "I feel comfortable here and everyone has been very supportive" wrote one client. Three individuals chose the sexual health clinic for its location, convenience and speedy service.

Most important aspects of sexual health service

Some survey respondents did not complete this section as instructed. Rather than marking their choices as 1, 2 and 3, some respondents wrote "Yes" beside some, and in a few cases beside all of the potential responses. In cleaning up this data, it was decided to eliminate all cases where more than 3 responses were checked off, and in those surveys where 3 choices were marked but not ranked numerically, each selected choice was given a value of 2.

Confidentiality was ranked first in importance most frequently. Thirty five individuals (24.3%) identified this as most important, and a total of 68 respondents included confidentiality in the list of three most important factors. Being treated with respect was also ranked highly, and was also included in the top 3 choices 68 times. Respect was more often ranked as third in importance. Five of the six respondents who

indicated another aspect as being important identified the opportunity to see a female provider as first or second in importance, while the fifth participant wrote "Everyone is easy to talk to, I'm not too embarrassed to talk to anyone."

Table 12

Most important aspects of service delivery

Aspects of service	Number who ranked this # 1	Percent who ranked this # 1	Number who ranked this in the top 3
Confidentiality	35	24.3%	68
Being treated with respect	22	15.3%	68
Getting the care I need	21	14.6%	76
Receiving accurate information	11	7.6%	46
Availability of an appointment	8	5.6%	48
Affordable or free medication	5	3.5%	47
Not having to wait to be seen	3	2.1%	16
Being listened to	1	.7%	16
Other	3	2.1%	4

N=109

Satisfaction with Service

Clinic location

The majority of survey respondents identified the clinic location as being satisfactory. Of the 159 people who answered this question, 144 (89.4%) said the clinic location was good, while 15 (9.3%) said the clinic location was bad.

Wait time

Most clients who answered this question reported a wait time of less than 15 minutes (57.1%), while 24.2% waited 15 to 30 minutes and only 6.2% waited longer than 30 minutes. One person who waited less than 15 minutes considered this wait to be a

problem. Three of the thirty seven clients who waited 15-30 minutes considered the wait to be problematic, as did two of the seven clients who waited longer than half an hour.

Availability of clinic appointment

Most survey respondents (84.5%) were able to get an appointment at a convenient or satisfactory time. Of the 15 respondents who reported dissatisfaction with this, most complained about the limited hours of service. One client reported a three week wait for an appointment time while others found clinic hours unsuitable because of work or school schedules.

Other service issues

The survey included several questions which asked if there were problems with various aspects of the treatment received. One respondent said the staff did not treat him or her politely and with respect but did not elaborate on this response. Another client was not satisfied with the confidentiality of the visit but did not explain what caused this concern. There were no complaints about having the staff listen and pay attention and no one identified an issue with receiving the treatment or information sought.

Health teaching

Of the 147 people who answered the question that asked if health teaching had been received on the day the survey was completed, 110 people replied that it was received and 37 did not receive health teaching. Each of the 10 participants who had previously stated the reason for the clinic visit was for counselling or information did receive health teaching. The most common topic for health teaching was birth control, with 49 individuals indicating information about this topic was received.

Table 13

Health teaching received

Topic	Number of clients who received information about this topic	Percentage of clients who received information
Birth control	49	30.4%
HIV/AIDS	31	19.3%
Chlamydia and/or gonorrhea	30	18.6%
Medication or prescription	25	15.5%
HPV, genital warts, Gardasil vaccine	24	14.9%
Syphilis	20	12.4%
Hepatitis A, B and/or C	18	11.2%
Other teaching	17	10.6%

N=214

Qualitative Summary

Clinic location

Client comments about each of the seven clinic locations were reviewed individually. In Barrie, the sexual health clinic is located within the SMDHU office in the north end of the city, near an entrance to Highway 400. The clinic is located close to a bus stop, one block from a secondary school and approximately two kilometers from Georgian College. The 51 participants who liked this location frequently mentioned its proximity to the highway. Others thought it was easy to find and convenient, yet private

and discrete. As one participant remarked, he or she was "able to get here by bus and it is easy to go into the building without people knowing your exact reason." While convenience or proximity to home, work and school were frequently mentioned, several respondents were pleased that the clinic was not in their neighbourhood. "No one I know lives around here" wrote one client. "Out of the way, private" said another. Only three study participants wrote negative comments about the Barrie location. Two said it was too far from their homes, the third said "It can be confusing to locate the proper entrance as it is not facing the street."

The Bracebridge clinic is not part of the health unit building – the closest office of the SMDHU is in Gravenhurst, 18 km. to the south. The sexual health clinic is located in a small house one block from the downtown. The Bracebridge secondary school is within walking distance and the clinic is only one block from the downtown area. The 13 positive comments concerning the clinic location all referred its convenience. Five clients did not like the location. Each of these respondents stated the clinic was not in his or her home town. Four of the five mentioned living in Hunstville, 30 minutes away while the fifth participant did not specify a location, saying only " I live in another city."

The Gravenhurst clinic is part of the local SMDHU office. The town is small enough that people from most of the municipality are able to walk there. The 5 clients who made positive comments about the clinic location said it was convenient and close to the high school. The only person who made a negative comment said that he or she lived in Hunstville, a 45 minute drive.

The Orillia clinic is part of the SMDHU office in Orillia. Located in a strip mall several blocks from the downtown area and from any of the three secondary schools in

the city, the office was not easy to access according to the four clients who had negative comments about the location. Twenty seven clients liked the Orillia clinic location. Several commented that the clinic was easy to find. What most people liked about this location was the fact that it is reasonably accessible, but private. As one participant stated, "I like it because it's not right in the middle of everything- people don't see where you're going- it's nicely hidden." The proximity to the highway received some positive comments, as did the availability of public transit.

The Collingwood clinic is located within the SMDHU office. It is on a four lane highway with no sidewalks and is not on a bus route. Of the six clients who commented on the clinic location, five said it was close and easy to find. The only person who made a negative comment about the clinic location said "it is a little inconvenient for some people who live in town."

The sexual health clinic in Midland is in the health unit building, close to the hospital and two blocks from the high school. There were no negative comments about this clinic location. Twenty three of the twenty four clients who made positive comments, found the location convenient. Those who liked the location mentioned its central location, its proximity to the hospital, school and bus route. Four clients mentioned the fact that it is somewhat secluded and private.

The sexual health clinic in Alliston is not part of the health unit building. It is on the main street, within walking distance of the high school. There were no negative comments about its location. Of the 8 comments made, 5 said it was close to school and the other 3 said it was easily accessible.

Least liked about the clinic visit

Relatively few respondents had anything bad to say about the clinic visit. Forty of the seventy seven comments made in the space allocated for what was least liked were that there was nothing that wasn't liked. One client described what was least liked as "Nothing. It's an amazing thing to have for the community." The responses to this question were examined according to clinic location.

Two negative comments were made by clients of the Gravenhurst office. One said the clinic hours were insufficient and the other said the clinic was far from where the client lived.

In Bracebridge the five negative comments concerned the distance of the clinic from the respondents' homes, the wait time and a crowded waiting room.

Barrie, the location with the greatest number of clinics, the most completed surveys, also had the greatest number of responses to this question. The most frequent complaint was the wait time, both to get in for an appointment and the time spent waiting to be seen once the client had arrived. Ten clients complained about the need for more clinic hours. According to one participant what was least liked was the "hours of operation and days to be treated that the clinic will run." Less frequent problems included the furniture and the music in the waiting room. There was one negative comment about a staff member who was perceived as being "abrupt."

Three clients from the Midland clinic did not like the wait time and three complained about the availability of clinic hours.

Clients who elaborated on what was least liked in the Orillia clinic mentioned the location (3 responses), the clinic hours (2 responses), and the fact that there are age restrictions for some services (1 response).

There were no negative responses from the Alliston clinic clients. The only response to this question from a Collingwood participant was that he or she did not like the requirement of providing a full name.

Best liked about clinic visit

By far, the majority of positive comments about the clinic visit were related to the attitude and competence of clinic staff (66 comments). One Barrie client found the staff to be "professional, funny, informative and courteous." Another wrote that staff was "respectful and non-judgemental." The best liked aspects of the clinic visit for another client was the "extraordinary service, knowledge of staff, fast treatment and diagnosis." Eighteen clients indicated that what was best liked was the availability of a female provider. Eighteen clients commented on the comfortable atmosphere of the sexual health clinic. As one respondent remarked, "I am treated with respect and feel comfortable discussing concerns or questions." Other aspects of service identified as best liked included the focus on specialized sexual health services (10 comments), confidentiality (18 comments) and the convenience or availability of service (17 comments). There were no significant differences between the comments made in the various clinics.

Table 14

Best liked about clinic visit

Best liked feature	Number of times chosen
Staff attitudes / competence	66
Female health care provider	18

Confidentiality	18
Comfortable atmosphere	18
Convenience / availability of appointment	17
Specialized service / focus on sexual health	10

N=147

CHAPTER 6: DISCUSSION

Analysis of the results of the SMDHU sexual health clinic survey confirms the value of the specialized services offered by these clinics. Study results corroborate many of the findings of other studies of sexual health needs and sexual health services across Canada and in other countries.

Study Findings

Comparing of study participants with other Canadian adolescents

Simcoe County and the District of Muskoka have seen similar trends in teen pregnancy and STI rates as the rest of Canada. Pregnancies among adolescents have declined since 2000, with the 2003 rate in Simcoe-Muskoka slightly lower than the Canadian rate of 32.1 at 29.5 per 100,000 teens ages 15 to 19 years. The incidence of chlamydia in Simcoe-Muskoka rose between 2000 and 2003, as it did in Ontario and in Canada. The Simcoe-Muskoka rate of 115 per 100,000 population is slightly lower than the national rate of 192. Clients attending the SMDHU sexual health clinics mirror adolescents across Canada in the age of first sexual activity. Boyce et al. (2003) reported the mean age of first sexual intercourse to be approximately 15 years. The SMDHU study found similar results among clinic clients with an average age of both male and female respondents of 15.89 years.

Comparing findings to the literature

Clinic location and hours of service were frequently mentioned in the literature as important considerations for youth seeking sexual health services. In the client survey these issues were often mentioned as an issue, particularly for those in the Muskoka area where clinic services are offered in only 2 of the 3 towns. Several clients seen in Bracebridge and Gravenhurst complained that they had to travel from Huntsville to receive service, identifying this as the least liked aspect of the clinic. This inequity in accessibility of service is an issue the health unit should address.

Kennedy and McPhee (2006) in their interviews of adolescent sexual health clinic clients in Nova Scotia found those interviewed typically viewed specialized sexual health services as more confidential than other health services. The SMDHU survey respondents voiced similar opinions, with 18 participants reporting the confidentiality of service to be the best liked aspect of the clinic visit. The importance of confidentiality cannot be over-stated as it was ranked as the most important aspect of sexual health services. In the client survey only one participant identified a concern with confidentiality. Unfortunately no details were provided.

The attitudes and behaviour of clinic staff were found in the literature review to be important to sexual health clients, particularly adolescents and young adults. The results of this study confirmed the importance of having staff who are competent, non-judgemental, approachable and respectful. The greatest number of responses to the question asking for the best liked feature of the clinic related to the sexual health staff.

Service needs

One of the objectives of the study was to determine the perceived service needs of clinic clients. STI testing was the most commonly selected reason for visiting the clinic (46% of clients) with birth control being the second most common service need (36% of clients). Thirty three clients (20%) indicated an annual exam as a reason for the visit and 22 (13.7%) were seeking STI treatment. Younger clients were more likely to attend clinic for birth control services. The percentage of clients seeking STI testing or treatment increased with each higher age category while the percentage of clients seeking birth control decreased as age category rose. This is significant in that it is an indicator of the changing characteristics and needs of sexual health clinic clients. It has been noted that since 2002, the SMDHU sexual health clinics have seen increasing numbers of STI visits and fewer birth control visits. This is due in part to the program mandate and policy which restricts birth control visits to younger clients, but there may be other interpretations as well. The higher proportion of STI visits may be a result of the increased rate of STIs, particularly chlamydia. Fewer birth control visits may indicate the availability of other community resources for birth control. Another possible interpretation of these results is that the younger clients who are the SMDHU target for birth control service are unaware of, or unable to access clinic services.

Only ten survey respondents indicated counselling or information was a reason for visiting the sexual health clinic. One hundred and ten participants reported receiving health teaching. While counselling is not often identified by clients as a reason for clinic attendance, it is considered by the clinic staff to be an important part of sexual health services, as well as one of the distinctive features of clinic service.

Important aspects of clinic service

The second objective of the study was to determine the aspects of service delivery that are perceived as the most important to the clients of the sexual health clinics. Clients were asked why they chose the sexual health clinic to meet sexual health needs. Responses to this question helped to identify the ways in which the sexual health clinics were seen to differ from other health services. The reason selected by the majority of respondents was the preference for a female provider (54.7%). The reason for the popularity of this response may be the discomfort felt by young female clients who are attending for a physical exam; however there were male clients who indicated a preference for a female provider as well. The second most frequently chosen response was that of feeling uncomfortable talking about sexuality with the client's regular provider. Most survey respondents found the clinics to be a safe and comfortable place to discuss sexual issues with respectful, non-judgemental and knowledgeable staff. This is in keeping with the literature which emphasizes the importance of staff attitudes in dealing with adolescents and young adults. The qualitative responses confirmed this, as the majority of clinic clients considered the attitudes and competence of clinic staff to be the best feature of the clinic.

When asked to rank the most important aspects of clinic service, survey respondents rated confidentiality as being most important aspect with 24.3% of respondents choosing this as their number one choice. Being treated with respect received the second highest number of responses rating it as most important (15.3%). Getting the required care received the third highest number of votes as being most important, and was chosen as one of the top three aspects by more respondents than any other choice.

The qualitative responses to the question that asked clients to identify the best thing about the clinic visit confirmed the importance of staff attitudes and behaviour, with 66 of 147 respondents commenting on the importance of this to the clinic experience. Confidentiality, the availability of a female health care provider, and a comfortable atmosphere were each mentioned by 18 survey participants.

To summarize, the most important and best liked features of the clinic service were perceived by clients as the availability of a female provider, the respectful, non-judgemental attitudes of clinic staff, the comfortable clinic atmosphere, confidentiality and the ability to receive the desired care or treatment.

Client satisfaction

Almost 90% of those who completed surveys were satisfied with the clinic location. This is a questionable indicator of the suitability of clinic locations to the target population as it only takes the opinions of those who were able to access clinics into account. There are large areas within Simcoe County and the District of Muskoka where clinic services are unavailable. Collingwood, with 1,120 young people between the ages of 15 and 19 has a sexual health clinic, but in the adjacent areas, including Clearview, Springwater and Wasaga Beach, with 2,730 young people in the same age group there are no sexual health services. The south part of Simcoe County has a growing population. There is only one clinic, in Alliston where the youth population is 1,200 (ages 15-19) and no service for nearby Bradford and Innisfil where there are 3,505 adolescents in the same age group.

There were comments from survey respondents in the Muskoka area, stating that they had travelled 30 to 45 minutes from Huntsville to seek clinic service. There are two

sexual health clinics in Muskoka, one in Gravenhurst where the adolescent population is 635 and the other, 17 kilometres away in Bracebridge where there are 1,040 people in the 15 to 19 year age group. Hunstville is more than 50 kilometres away and there are 1,200 adolescents there who have no sexual health clinic.

Wait time has been identified in the literature as a concern for many young people. There were very few complaints about wait time among survey respondents. Most clients (57.1%) waited less than 15 minutes before being seen and only 6.2% waited more than 30 minutes. Six clients considered the wait time to be an issue.

There was overall satisfaction with the availability of appointments with 84.5% of respondents able to get an appointment at a suitable time. Clients in the Barrie clinic reported most problems with arranging an appointment. The lack of clinic hours was the issue most commonly identified as the least liked aspect of the clinic service among Barrie clients. Of the 15 survey participants who were dissatisfied with the clinic hours 10 were from Barrie where there can be a wait of up to 3 weeks for an appointment.

The survey asked participants if there were any problems with being treated with respect, with confidentiality and with receiving the expected care or treatment. These are the three aspects of service that were ranked highest in importance among survey respondents and there were very few concerns identified. One client said there was an issue with being treated with courtesy and respect and another said there was a concern about confidentiality. In the qualitative remarks there was one comment about a staff member being seen as "abrupt" and one other comment about the person answering the phone being "rude." None of the survey respondents identified a problem with receiving the expected treatment, information or care.

The results of the clinic survey confirm a high degree of overall satisfaction with the clinic service. Problems are mostly around the need for more hours and for expansion of service into other locations.

Study Limitations

Although this study provided a great deal of information about the sexual health clinic clients, their needs and their opinions, there were several limitations to the study. The failure to capture the actual number of individual clients visiting the sexual health clinics over the 12-week period of data collection limited the researcher's ability to make calculations and generalizations about the overall population of clinic clients. The sample size was smaller than expected and this further limits the strength of the results. There is a bias to research that relies on self-selection of participants such as this survey where those who chose to respond may have differed significantly from those clients who did not complete a survey. The clarity of the survey instrument could have been improved. For example several clients misunderstood the question that asked respondents to rank the top three aspects of sexual health service and some of their answers were not included in the evaluation.

Those who attend clinic are those among the target population who are aware of the service, recognize the need for service, are able to make an appointment at a suitable time and are able to access the clinic. Many others might benefit from the services offered by the sexual health clinic but lack awareness of the service. Other potential clients may have had trouble making an appointment or finding transportation to the clinic site. Along with surveying clinic clients, it is important to seek input from young people in the communities throughout Simcoe County and the District of Muskoka.

Recommendations

The following recommendations are offered for the SMDHU and for the Sexual Health Program in order to complement the survey of sexual health clinic clients, to improve sexual health services offered by the Simcoe Muskoka District Health Unit and to promote healthy sexuality among targeted groups within Simcoe County and the District of Muskoka. The recommendations take place at the regional level, involving community partners as well as at the Sexual Health program level.

Policy

- Build partnerships and improve existing partnerships with community groups, family health teams, service organizations and schools to better coordinate sexual health services, including opportunities for shared clinic space in smaller communities where there are no existing clinic services
- To increase health promotion initiatives related to sexual health, including clinic advertising and information concerning birth control, emergency contraception, STI prevention and testing for adolescents and young adults
- To increase funding to allow for expansion of clinic services into Huntsville and to allow for increased hours of clinic service in Barrie where the wait time for a clinic appointment is highest

Program recommendations

- To develop a staff educational program for new sexual health staff that highlights the importance of staff attitudes and behaviours when dealing with the sexual health issues of adolescents and young adults

- To encourage and allow staff to attend conferences where adolescent sexuality and relating with adolescent clients is highlighted
- To seek ways of increasing the amount of money in the transportation fund through events such as raffles in order to allow more clients the opportunity to have bus or taxi fare to clinics
- To develop promotional materials that advertise clinic services, promote healthy sexuality and increase awareness of the need for STI testing

Future implications for research

- Proceed with plans to survey target populations in the community to assess the level of awareness of clinic service, the accessibility of current clinic locations, and the perceived sexual health needs of youth and adolescents in Simcoe County and the District of Muskoka
- To conduct further research on the outcomes of sexual health clinic service including increased knowledge and intent to practice safer sex

Conclusion

This study was designed to determine the perceived service needs of the clients of the SMDHU sexual health clinics; the aspects of service that are most important to these clients; and to assess the satisfaction with clinic locations, availability of service, confidentiality and with the attitudes and behaviour of clinic staff. The HPM was the basis for the theoretic framework as it considers the influence of individual characteristics and experiences, as well as behaviour-specific cognition and affect on health-promoting behaviours.

Client surveys were completed by 161 clinic clients in 7 locations across Simcoe County and the District of Muskoka. Respondents ranged in age from 13 to 64 with a mean age of 22.23 years. The majority of clients were seeking STI services, while birth control was the second most common reason for attending clinic. The need for STI testing and treatment increased with client age.

The most important and best liked features of the clinic service were found to be the availability of a female provider, the respectful, non-judgemental attitudes of clinic staff, the comfortable clinic atmosphere, confidentiality and the ability to receive the desired care or treatment. Overall client satisfaction was high. The majority of participants were pleased with the clinic location, the speed of service, the availability of clinic appointments, the level of confidentiality and the care received. Most respondents were quite happy with staff attitudes, knowledge and behaviour.

Recommendations include strengthening community partnerships to better co-ordinate delivery of sexual health services, increasing the advertising of clinic services and expansion of services to Huntsville. Program recommendations were to engage in staff development regarding adolescent sexuality, and to emphasize health promotion.

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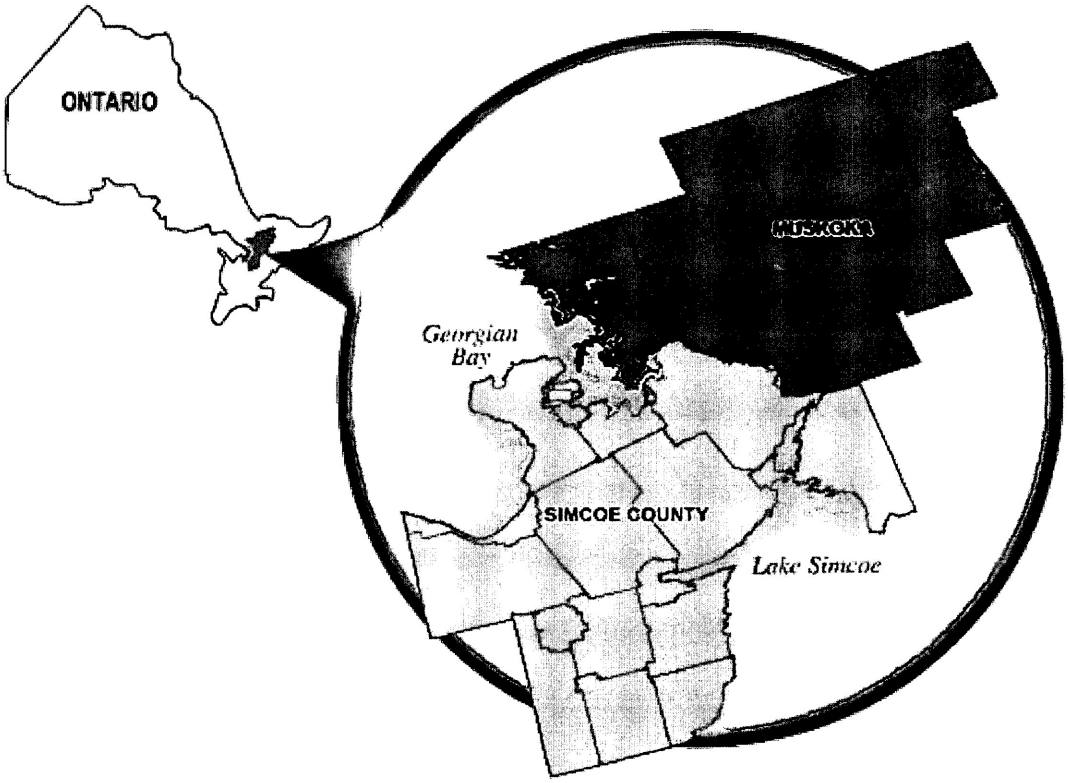
APPENDIX A: LOCATION OF SIMCOE COUNTY AND MUSKOKA IN ONTARIO{ TC "APPENDIX A: LOCATION OF SIMCOE COUNTY AND MUSKOKA IN ONTARIO" \f C \l "5" }



Source: SMDHU (2007).

APPENDIX B: COVER LETTER{ TC "APPENDIX B: COVER LETTER" \f C \l "5" }

Dear Potential Participant:

I am asking you to take part in a study about the sexual health clinic services at the Simcoe Muskoka District Health Unit, titled "Evaluation of the Sexual Health Program – Client Survey".

The overall purpose of this study is to see if the sexual health clinic services provided by the Simcoe Muskoka District Health Unit are meeting the needs of its clients. The objectives of the study are:

1. To find out what services the clients of the sexual health clinics feel they need.
2. To find out what things are most important to our sexual health clinic clients.
3. To ask about your satisfaction with the clinic location, the services we provide, the, confidentiality, staff attitudes and knowledge.

This survey is part of a research project I am doing as part of my Masters of Public Health Program at Lakehead University. It will also be used by the sexual health program as part of its evaluation of clinic services. Your answers may help us to provide better service to our clients.

Participation in this study is completely voluntary. You may choose to answer all of the questions, some of the questions or not to answer it at all. This will not make any difference to the care you will be given at the clinic.

The Sexual Health Clinic Survey will take about 10 minutes to finish. You can answer the first part of the survey while you are waiting to be seen, and then the last few questions at the end of your visit. When you finish the survey, please put it in the envelope and return it to the program assistant, who will place it in a private, secure place. No one will know what answers you have given as your name is not on the survey and it is kept separately from the consent form. If you would prefer to take the survey home to complete it, ask the program assistant for a stamp, and when you have completed the survey, drop it in the mail. Once we receive it, the survey will be locked up with the other surveys.

Anything you say will be kept private and will only be seen by the researcher and the people who help with evaluation at the Simcoe Muskoka District Health Unit. If the study is written up in a journal, no one who has answered the survey will be named. Completed surveys, consent forms and information will be safely stored in a locked location at the Health Unit during the study, then at Lakehead University for seven years before being shredded.

The findings of this study will be available to you on request once the study is complete. If you would like to learn more about the results of this study, please contact me at 705-721-7520 (ext 7267) or by e-mail, lexie.kells@smdhu.org You may also contact my

supervisor, Dr. Darlene Steven, at 807-343-8643 or Darlene.steven@lakeheadu.ca. You can also contact the Lakehead University Research Ethics board at 807-343-8283 regarding ethical approval for the study.

Thank you for participating in this study.

Sincerely,

Lexie Kells RN(EC) Nurse Practitioner
Simcoe Muskoka District Health Unit
Masters in Public Health (Cand)
Lakehead Universit955 Oliver Road
Thunder Bay, ON
P7B 5E1

Darlene Steven, RN PhD
Professor, School of Nursing &
Masters of Public Health Program
Lakehead University

APPENDIX C: CONSENT FORM{ TC "APPENDIX C: CONSENT FORM" \f C \l "5" }

The research is being conducted by:

Lexie Kells
Lakehead University
Master of Public Health Program
955 Oliver Rd.,
Thunder Bay, ON
P7B 5E1 (807) 983-3247

Lexie.kells@smdhu,org

My signature on this sheet indicates I agree to participate in a study by Lexie Kells evaluating the extent to which the sexual health clinic services provided by the Simcoe Muskoka District Health Unit are meeting the needs of its clients. I also understand that:

1. I am a volunteer and can withdraw at any time during the study.
2. There is no apparent risk of physical or psychological harm.
3. The information I provide will remain confidential.
4. All data will be kept secure and only accessed by the researcher.
5. I can receive a summary of the project upon request to Lexie Kells following completion of the project.

I have received explanations about the nature of the study, its purpose, and procedures.

Signature of Participant: _____ Date: _____

APPENDIX D: SEXUAL HEALTH CLINIC SURVEY{ TC "APPENDIX D: SEXUAL HEALTH CLINIC SURVEY" \f C \l "5" }

Part A 1. What is your age _____ 2. Your gender: ☐ female ☐ male

3. Do you attend school / college? ☐ no ☐ yes (if so what school) _____

4. Have you had sex ? ☐ no ☐ yes (if so, how old were you when you first had sex) ____

Part B 1. Is this your first visit to this clinic? ☐ no ☐ yes

2. What is the reason for your visit today (please check off all the answers that apply)

☐ Birth control ☐ Testing or checking for infection ☐ Pregnancy test
☐ To pick up condoms ☐ Counselling or information ☐ Treatment
☐ Annual exam ☐ Hepatitis or HPV vaccine
☐ Other reason (Please explain) _____

Part C Why did you choose the sexual health clinic to meet your needs today today? **Check all that apply**

I do not have a family doctor or other health care provider (ie nurse practitioner)
I am not able to receive the service I need elsewhere
My was not ale to get an appointment with my doctor or regular health care provider
I am uncomfortable talking about sexuality with my regular provider
I don't want my parents/guardian/partner/other to know about my need for sexual health services
I prefer to see a female health care provider
I was referred here
– if so please write in who suggested you come here (for example a friend, teacher, school nurse etc)
Other reason
- please explain

Part D

. This is a list of things that others have said are important reasons for choosing a place to go for sexual health services

What are the **3 things on this list that are most important to you? Please mark them #1,#2 and #3.**

Confidentiality (not telling anyone about my visit to the clinic or anything that was said here)
Having the clinic in a convenient location
Getting an appointment when I want it
Not having to wait to be seen
Being treated with respect
Having the clinic staff listen to me
Free or low cost medication or treatment
Getting accurate information
Getting the care or treatment I need or want
Other: Please explain

2. Is this a good clinic location? ☐ No – What is bad about this location? _____

_____

☐ Yes – What is good about this location? _____

Part E – Please complete this section AFTER your appointment is complete

. How long did you wait before being seen today ?
☐ Less than 15 minutes ☐ 15-30 minutes ☐ more than 30 minutes

2. Was this wait time a problem for you? ☐ No ☐ Yes

3. Please answer the following questions by placing a check in the appropriate box

	Yes	No	Please explain any problems
Were you able to get an appointment for when you wanted it?			
Did the staff treat you politely and with respect?			
Did the staff listen and pay attention to you?			
Are you satisfied with the confidentiality of your visit?			
Did you receive the treatment, information or care you were looking for?			

3. Did you receive any health teaching today? (information, education or written material)
☐ No
☐ Yes – if so please check off what health teaching your received (Check all that apply)
☐ birth control ☐ HPV, genital warts or HPV vaccine
☐ chlamydia and/or gonorrhea ☐ Hepatitis A, B and/or C
☐ HIV/AIDS ☐ syphilis
☐ any medication or prescription you received
☐ other teaching (please explain – be as specific as possible) _____

_____

4. What did you like best about this sexual health clinic? _____

_____

5. What did you like least about this sexual health clinic? _____

_____

Please fold your completed survey, place it in the envelope, seal the envelope and return it to the person at the front desk. Thank you very much for completing this survey

This information is collected under Section 5 of the Health Protection and Promotion Act. The information collected in this form will be used only for the purposes of program planning and service delivery. Quesitons regarding the collection and use of information should be directed to the Associate Director of Corporate Services, Simcoe Muskoka District Health Unit, 15 Sperling Drive, Barrie ON L4M 6K9 telephone 705-7520 Ext 7231.