

Do women requesting only contraception find attendance at an integrated sexual health clinic more stigmatizing than attendance at a family planning–only clinic?

Ulrike Sauer¹
Arti Singh²
Punam Rubenstein¹
Rudiger Pittrof³

¹Department of Reproductive and Sexual Health Services, Enfield Community Services, London, UK; ²University Health Services, KNUST Hospital, Kumasi, Ghana, ³Guy's and St Thomas' NHS Trust, London, UK

Purpose: Both sexually transmitted infections and the genitourinary medicine clinics that patients attend for management of sexually transmitted infections are stigmatized by patients' perceptions. The aim of this study was to assess whether women requesting contraception only find attendance at an integrated sexual health clinic (ISHC) more stigmatizing than attendance at a family planning (FP)–only clinic.

Patients and methods: Women requesting contraception only were asked to complete a stigma assessment questionnaire in the waiting room of the clinic they attended. Ease of understanding was assessed for each item of the questionnaire prior to commencement of the survey. The questionnaire was given to women attending either an ISHC or a FP-only clinic.

Results: One hundred questionnaires that fulfilled the inclusion criteria were returned. The users of FP-only services were generally older than the users of ISHCs and were more likely than the users of ISHCs to classify themselves as UK white. Stigma perception was significantly higher for the ISHC than the FP-only clinic.

Conclusion: The results of this research indicate that among women who request contraception only, perceived stigma is higher when they attend an ISHC than when they attend a FP-only clinic. As this survey only enrolled clinic users, the authors were unable to assess whether integration generates sufficient stigma to deter some women from accessing contraception from integrated services. Of all stigma-related issues, disclosure concerns are likely to be the most important to the service user. Stigma is not an issue of overriding concern for most service users.

Keywords: stigma, one-stop shop, sexually transmitted diseases, contraception

Introduction

Sexual and reproductive health is a public health priority in the United Kingdom (UK).¹ In a recent review of service delivery, the UK Department of Health envisaged that “comprehensive sexual health services” will provide “testing and treatment for sexually transmitted infections, contraception outside of the General Practitioner (GP; primary care physician) contract, termination of pregnancy ... and sexual health promotion and prevention.”²

Currently, these services are provided free of charge by the UK's National Health Service. Service users who are registered with a GP can access sexual and reproductive health care from their GP or from family planning (FP) clinics, genitourinary medicine (GUM) clinics, or integrated sexual health clinics (ISHCs) providing FP and GUM services. Historically, GUM and FP clinics were provided as separate

Correspondence: Ulrike Sauer
Department of Reproductive and Sexual Health Services,
Enfield Community Services,
Flat 2 Rowan Court, St Michael's
Site, 2 Gater Drive, Enfield,
Middlesex, EN2 0JB, UK
Tel +44 20 8375 2809
Fax +44 20 8375 2957
Email ulrike.sauer@enfield.nhs.uk

clinical services. Current UK health policy (as set out in the National Sexual Health and HIV Strategy in 2001³) continues to endorse the concept of integrated sexual health services where patients can access the complete range of sexual health care from one center and in one visit. This is the “one-stop shop” (OSS) model.⁴

The Department of Reproductive and Sexual Health (RASH) in Enfield has been at the forefront of this integration movement. Specialist sexual and reproductive health services provided by Enfield RASH developed as a merger of stand-alone GUM and FP services. By July 2010, integration had advanced to a level that all Enfield services operated within the OSS model, with the exception of two FP clinics, the community gynecology clinic, and the specialist clinics for termination of pregnancy assessment. Enfield RASH has served as a research site for an evaluation of integrated sexual health care.⁴ While this evaluation could not determine the relative effectiveness of the ISHC as compared with traditional GUM and FP clinics, the results showed that the ISHC was more likely to address additional sexual health needs.⁵

Enfield is an outer London borough with a young and ethnically diverse population of 300,000. It has one of the highest rates of teenage pregnancy and of the human immunodeficiency virus (HIV) being first diagnosed during pregnancy in the country.⁶ Enfield RASH provides services to the whole borough based on four sites. All four sites are in the general community, and they are either in a building that contains GP offices or in a shopping area. Privacy from outside visibility is ensured when clients are in the clinics.

The integrated clinics in Enfield – the Town Clinic and, in Edmonton, the Green Clinic – operate within the OSS model of care. Patients can access all components of comprehensive sexual and reproductive health care at a single visit. The Bowes Road Clinic and the Moorfield Road Clinic both offer purely FP services to women of all ages. The providers who staff these two clinics are able to deliver all aspects of OSS-type care (contraception, sexually transmitted infection [STI] and HIV testing, and STI care) but not the full range of GUM services. This is because there are no facilities in these clinics for microscopy or incubation or refrigeration of specimens. These clinics are advertised to service users as “family planning clinics.”

Service users can access either of the integrated clinics on a walk-in basis or by appointment. An all-day service is run from one or other of the integrated clinics every day, Monday to Friday, from 9 am to 8 pm. Both of the FP-only clinics are walk-in clinics, and these two clinics provide only three half-day sessions per week between them. Only a few men

attend the FP clinics, to obtain condoms, but these service users do not need to see the clinical staff.

STIs and HIV are often highly stigmatizing conditions and can be a barrier to accessing care⁷ and to effective communication between patients/service users and clinicians.⁸ As the stigma of these conditions can also be transferred to a service,⁹ attendance at a sexual health clinic could be perceived as a stigmatizing activity. Recommendations have been made to reduce the stigma of sexual health services.¹⁰

Qualitative work undertaken as a part of research has found that the ISHC model may reduce stigma for patients requiring GUM care but that it may also increase the stigma for others.¹¹ There is a lack of studies that test this statement. As a reduction in stigma does not create a disadvantage to the patient or the service, the present authors focused on the group of patients most likely to be affected by the increased stigma that might be associated with an ISHC – that is, women attending a clinic to request contraception only.¹¹ The aim of this study was therefore to test if women requesting contraception only find attendance at an ISHC more stigmatizing than attendance at a FP-only clinic.

Methods

Development of the stigma assessment questionnaire

The authors developed a stigma assessment questionnaire in collaboration with Dr Ellen Mulholland, using the key themes identified in the literature on stigma for conditions such as HIV or epilepsy.^{12–15} The authors based this questionnaire on a widely applied scale developed to measure internalized, perceived, and enacted stigma of a condition.¹⁵ This scale consists of 40 items, divided into four subscales: (1) personalized (enacted) stigma, (2) disclosure concerns, (3) negative self-image, and (4) concern with public attitudes.

The stigma assessment questionnaire (Figure S1) consisted of a brief demographic, a reason for attendance section, and 15 individual statements describing the presence or absence of stigma in the service. Participants were asked to indicate on a five-point Likert scale how much they agreed or disagreed with the statements. The statements addressed the positive aspects of the service (Statements 2, 7, 8, and 14), disclosure concerns (Statements 1, 3–6, and 10), public attitudes (Statements 5, 12, 13, and 15) and negative self-image (Statements 9 and 11).

The ease with which each item of the stigma assessment questionnaire was understood and assessed prior to the survey, in a further education (ie, continuing education) college, a community gynecology clinic, an ISHC, and a

conventional FP clinic. Participation was voluntary but it was restricted to people over the age of 15 who were literate. The 55 participants were required to complete the stigma assessment questionnaire unaided and to answer five questions regarding the ease of using the stigma assessment questionnaire. The participants were allowed to give verbatim information on any aspects of the stigma tool that was relevant to them. The information obtained was recorded by one member of the research team in the form of responses of “yes,” “no,” “maybe,” and “don’t know” to enable consistency in the responses.

Application of the stigma assessment questionnaire

A survey of women attending sexual health services was performed at three of the four different medical sites of Enfield RASH: the integrated clinics in Enfield Town and Edmonton Green and the Bowes Road Clinic, which offers a purely FP service to women of all ages.

A formal sample size calculation was not possible, as the authors knew nothing about the distribution of answers prior to the study. Also, there are no published quantitative studies assessing stigma in sexual health services. The authors looked at studies of stigma of diseases and found that some studies had used a similar sample size. For example, Emler¹⁶ had a sample size of 88, Wright et al¹² had a sample size of 48, and Franke et al¹⁴ had a sample size of 130 when investigating the stigma of HIV in adults.

In a 2011 published systematic review, “The psychometric assessment of internalized stigma instruments,” these studies were “rated as indeterminate, because the sample size for the factor analysis was borderline insufficient” (ie, smaller than seven times the number of items).¹⁷ As there were 15 items on the present authors’ questionnaire, the authors chose to have at least 95 for the sample size.

The stigma survey with the finalized questionnaire was undertaken in June and July 2010 (by AS and US). All patients attending the ISHCs and the FP-only clinic were asked to participate in the study to assess how patients felt about coming to each service. Those patients who gave verbal consent to participate received the stigma assessment questionnaire in the waiting room of the clinic they were attending and were asked to complete it while waiting to be seen. Patients were asked to place their completed form into a “ballot box” when leaving the clinic. A total of 250 participants visiting the FP-only clinic and the ISHCs were eligible to participate in the study; of these, 41 were male, 203 were female, and 6 did not reveal their gender. From the 203 women who

visited the Enfield RASH services, 50 attended the FP-only clinic and 153 attended the ISHCs; of these 153 women who attended the ISHCs, 56 women came for contraception only. Of the 50 women who attended the FP-only clinic and the 153 women who attended the ISHCs, 44 and 56 women, respectively, were included in this study.

This article is part of a larger study to assess stigma in sexual health services within Enfield RASH. Ethical approval for this study was sought from the Islington and Camden Research Ethics Committee (REC) and the REC of City and Queen Mary University, London, but these committees decided that ethical approval from a REC was not required.

Analysis

The questionnaires were coded and analyzed using statistical software (SPSS, v 20; IBM Corporation, Armonk, NY, USA). The data were double-checked for accuracy and 10% of the data set was re-entered to check for errors during data entry. No errors were detected.

Of those who were asked to assess the questionnaire prior to the survey, 51 of the 55 respondents (92.7%) found the layout and appearance acceptable and the questions easy to answer. Furthermore, 48 respondents (87.3%) found the questions easy to understand, and 47 respondents (85.5%) thought that the questions made sense to them. Finally, 42 respondents (76.4%) thought the questionnaire described the way people felt about attending the sexual and reproductive health services.

The test–retest reliability of the stigma assessment questionnaire was assessed using the data obtained from completed stigma assessment questionnaires. This was done by comparing all stigma-positive responses of the first half of the participants with those of the second half in all clinics.

Comparing the first half of the participants in all clinics with the second half, the Pearson’s correlation coefficient was 0.81 ($P = 0.00$), indicating good temporal stability in the questionnaire.

Data for patients attending the ISHC were pooled and the numbers of stigma-positive answers for each question in the ISHC and the FP clinic were assessed and compared.

Preliminary associations among the type of clinic attended, the association with stigma, and demographic characteristics was carried out using Pearson’s Chi-squared test. Significant associations were verified using a multiple regression controlling for any confounding factors (age, ethnicity, and social deprivation).

Results

An answer was classified as stigma positive if a patient either agreed or strongly agreed with a statement describing the presence of stigma (Statements 1, 3–6, 9–13, and 15) or if a patient either disagreed or strongly disagreed with a statement describing the absence of stigma (Statements 2, 7, 8, and 14). In the entire Enfield RASH study, nearly 90% of the patients who were approached returned their questionnaires. However, it was not possible to determine the response rate for the “contraception only” group, because the authors did not collect the reason for attendance in patients who declined to participate in the study.

In the next part of this study, the authors tested the hypothesis that women requesting contraception only find attendance at an ISHC more stigmatizing than attendance at a FP-only clinic. For this the authors used the answers given by 100 women attending for contraception only. Of these 100 women, 56 were from the ISHCs and 44 were from the FP-only clinic.

The demographic characteristics of the study participants are given in Table 1. These data show that the mean average age was younger in the women attending the ISHCs than in those attending the FP-only clinic.

The numbers of stigma-positive responses for each statement were assessed and compared for the ISHCs and the FP-only clinic (Table 2). The authors used Pearson's Chi-squared test to generate two-sided *P*-values when comparing stigma-positive and stigma-negative responses toward the ISHCs and the FP-only clinic. The authors used demographic indicators to highlight possible confounders.

Younger people were significantly less likely to attend the FP-only clinic ($\chi^2[1, N = 100] = 4.89, P = 0.00$). Ethnicity and

Table 1 Demographic characteristics of study participants

Characteristic	ISHC (n = 56)	FP-only clinic (n = 44)
Mean age (years) ^a	22.98 ± 6.618	29.43 ± 4.353
CI for mean age	±1.73	±1.29
Median age (years)	21	31
Ethnicity (n (%))		
UK white	20 (35.7)	13 (29.5)
UK black	13 (23.2)	3 (6.81)
Other white	5 (8.9)	3 (6.82)
Other black	6 (10.7)	9 (20.5)
Mean deprivation score ^{a,b}	29.8 ± 8.2	29.4 ± 9.6

Notes: ^aData presented as mean plus or minus standard deviation; ^bdeprivation scores were calculated on the basis of postcodes, using statistics on relative levels of deprivation in England obtained from the UK government (<https://www.gov.uk/government/publications/english-indices-of-deprivation-2010>).

Abbreviations: ISHC, integrated sexual health clinic; FP, family planning; CI, confidence interval; UK, United Kingdom.

Table 2 Odds ratios (ORs) and age-adjusted ORs for perceived stigma at integrated sexual health clinics compared with perceived stigma at family planning-only clinics

Questionnaire item	df	OR	Adjusted OR	P-value
Statement 1	1	0.565	0.563	0.017
Statement 10	1	0.413	0.295	0.000
Statement 15	1	0.475	0.440	0.004
Age of respondent	1	1.194	–	0.000

Abbreviation: df, degrees of freedom.

levels of social deprivation were also examined but the authors found no significant differences between clinics (ethnicity: $\chi^2[1, N = 83] = 1.56, P = 0.645$; social deprivation: $\chi^2[1, N = 83] = 2.05, P = 0.364$). When comparing the FP-only clinic and the ISHCs, significant differences in the perception of the presence of stigma were found for Statement 1 (“I won't tell anyone that I came to this clinic because I am concerned about their reaction”) ($\chi^2[1, N = 86] = 7.01, P = 0.010$), Statement 10 (“I am concerned I might bump into somebody I know when at this clinic”) ($\chi^2[1, N = 83] = 13.55, P = 0.000$), and Statement 15 (“I am concerned about coming to this clinic because I worry about what kind of people are there”) ($\chi^2[1, N = 93] = 8.83, P = 0.002$).

As age may prove a confounder within the analysis, significant differences in responses between the clinics were investigated with a multiple regression to control for the influence of age. A binary logistic regression was carried out to identify differences in stigma response, with ISHCs coded as “0” and the FP-only clinic coded as “1.” All items were adjusted for age, as preliminary analysis had identified it as a significant confounder between groups.

All analyses showed that respondents in the FP-only clinic were significantly less likely than those attending the ISHCs to report concerns about the service, independent of age. The strongest disparity in concerns between the clinics was disclosure concerns (Statement 10), with respondents who attended the FP-only clinic being around 70% less likely than those who attended the ISHCs to report fearing that they would run into someone they knew at the clinic. Similarly, respondents who attended the ISHCs were around 50% more likely than those who attended the FP-only clinic to have concerns surrounding negative reactions if they told someone about their visit (Statement 1), as well as concerns about the other types of people who attended the clinic (Statement 15).

Discussion

It has been demonstrated that STIs are stigmatizing conditions.^{17,19} It is also generally accepted (although not

empirically proven) that GUM clinics are stigmatized through their association with STIs.²⁰ Qualitative data suggest that the stigma of GUM services also affect ISHCs, particularly in the perceptions of women attending for contraception only.⁴ However, it is unknown how frequently the STI-related stigma is transferred to ISHCs and whether the magnitude of this effect is serious enough to warrant further action. Both points are significant, as stigma could deter those in real need from attending²¹ and it could induce higher anxiety levels among those who do attend.²² The integration of sexual health into what were previously exclusively contraceptive services could possibly reduce access to care for some women.⁷

To avoid measuring the stigma of a perceived STI risk, the authors focused the analysis on women who attended the ISHCs or the FP-only clinic for contraceptive needs only. This analysis demonstrated that attendance at an ISHC was perceived as more stigmatizing than attendance at a FP-only clinic. It was reassuring that, overall, the majority of ISHC users did not perceive the service as stigmatized. However, there was a stigma-indicative response for Statements 1, 10, and 15. There were no significant differences in “positive aspects of the service” or “negative self-image.” Significant differences in the perception of stigma were expressed toward one of four statements relating to the “public attitude towards the service” and two of five statements relating to “disclosure concerns.” Therefore, the authors believe that any stigma related to attendance at a sexual and reproductive health service is related to the public image of that service.

According to Darzi,²³ a high quality of care that is safe and effective leads to a good patient experience. It is likely that perceived stigma of the service would negatively affect the patient’s experience of the service. Therefore, it is possible that integration could reduce the quality of care for women who only require contraceptive services. However, the authors believe that this will be counteracted by the fact that many women who request contraceptive services only will benefit from the extended menu of sexual health care options available within the ISHC environment. It is also clear that further efforts need to be made to reduce the stigma of ISHCs.²⁴

To the best of the authors’ knowledge, this is the first quantitative study assessing the effect of integration of sexual and reproductive health services in an OSS model. The results confirm the finding of qualitative research that ISHCs can be perceived as more stigmatizing than FP-only clinics. The authors’ findings show that this applies to women who attend for contraception only. Two domains are particularly affected by stigma: (1) the negative public image of the

service and (2) disclosure concerns. This corroborates the authors’ earlier research that showed that patients attending the ISHCs in Enfield valued confidentiality more than any other attribute of the service.²⁵

This study also has some significant limitations, as outlined in the following points.

- While a formal sample size calculation was not undertaken, the authors hoped to enroll about twice as many women in the study than the figure finally achieved. Enrolling higher numbers proved to be difficult, as the majority of women attending Enfield RASH services came with a request for integrated or GUM care.
- The stigma assessment questionnaire is likely to be biased towards the detection of stigma, as it contains more statements describing the presence of stigma than statements describing the absence of stigma. The authors consider this is justified, as a questionnaire sensitive toward the detection of stigma was needed.
- One of the main shortcomings of this study is the inability to control for other confounding factors. With the exceptions of age, ethnicity, postcode, and gender, the authors did not collect demographic information from the participants. It is possible that demographic or relationship characteristics, the fact that waiting areas are shared with men also attending the ISHCs, or attendance for emergency contraception among participants could explain the observed differences in perceived stigma of the service. Some of the questionnaire statements may have assessed not only stigma of the service but also the embarrassment that would occur when being identified as a service user. Both are closely related and highly relevant to female service users.²⁶ Further research should collect more information and control for potential confounders such as age, ethnicity, cultural and religious beliefs, level of education, sexual education, and previous attendance at the sexual and reproductive health service. Women’s own views on sexual health and contraception, experience of an STI, and relationship status could all influence health-seeking behavior and perception of stigma.
- The study sample was drawn from service users and thus allows no conclusion about people who did not attend the service. Therefore, it is possible that patients who are sensitive to perceived stigmas are more likely to be deterred from using the ISHC than the FP-only clinic. This could systematically underestimate the perceived stigma of the ISHC. (However, the increase in stigma may not be detrimental when balanced against the likely decrease in stigma among STI service users. In addition,

there are many outlets such as GPs and, increasingly, pharmacies [drugstores] available for women to access contraception.) The authors were thus unable to answer an important question relating to stigma: “Does the stigma of the service deter you from attending it in the first place?”

- Also, only women attending with contraceptive needs alone were studied. It is likely that other groups – including men who have sex with men, commercial sex workers, people originating from sub-Saharan Africa, and teenagers – will have differing levels of perception of stigma of sexual and reproductive health services. Therefore, it is important not to overgeneralize the findings of this study.

Notwithstanding these limitations, the authors firmly believe that this study supports the following statements.

1. Of all stigma-related issues, disclosure concerns are likely to be the most important to the service user.
2. Stigma is not an issue of overriding concern for most service users.

Conclusion

The results of this study indicate that not only conditions but also services can be stigmatized. The study showed that women attending for “contraception only” found ISHCs more stigmatizing than a FP-only clinic. These findings are supported by qualitative research from this and other units.

The authors were reassured that the majority of women who attended the ISHCs for contraception expressed no or only minimal stigma concerns. However, even a limited effect could reduce access for those who are highly sensitive toward stigma. Until it is certain that ISHCs are not perceived as more stigmatized than FP-only clinics, the authors believe that sexual health services should continue to provide a limited number of nonintegrated clinics, to cater for the contraception needs of the stigma-sensitive part of the population.

Acknowledgments

The authors thank Ms Ellen Mulholland, senior lecturer in psychology, School of Social Sciences and Law, Teesside University, Middlesbrough, UK, for her invaluable help with the development of the first draft of the stigma assessment questionnaire. The authors also thank Ian Rubenstein, Alexandra Bogaardt, and Andrew Bone for their review, all members of the staff at Enfield RASH, and all patients who participated in this research.

Disclosure

The authors report no conflicts of interest in this work.

References

1. Department of Health. *Our Health and Wellbeing Today*. London: Department of Health; 2010. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122088. Accessed November 18, 2011.
2. Department of Health. *Healthy Lives, Healthy People: Update and Way Forward*. London: The Stationery Office; 2011. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf. Accessed November 18, 2011.
3. Department of Health. *Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV*. London: Department of Health; 2001. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133. Accessed November 18, 2011.
4. French RS, Gerressu M, Griffiths C, et al. *Evaluation of One-Stop Shop Models of Sexual Health Provision*. London: Department of Health; 2008. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083201.pdf. Accessed November 18, 2011.
5. French RS, Mercer CH, Robinson AJ, Gerressu M, Rogstad KE; One-Stop Shop Evaluation Team. Addressing sexual health needs: a comparison of a one-stop shop with separate genitourinary medicine and family planning services. *J Fam Plann Reprod Health Care*. 2010;36(4):202–209.
6. Demography Team, Greater London Authority. *GLA Intelligence Update: 2010 Mid-Year Population Estimates*. London: Greater London Authority; 2011. Available from: <http://www.london.gov.uk/sites/default/files/Update%2011-2011%20Mid-2010%20population%20estimates.pdf>. Accessed November 18, 2011.
7. Malta M, Bastos FI, Strathdee SA, Cunningham SD, Pilotto JH, Kerrigan D. Knowledge, perceived stigma, and care-seeking experiences for sexually transmitted infections: a qualitative study from the perspective of public clinic attendees in Rio de Janeiro, Brazil. *BMC Public Health*. 2007;7:18.
8. Cunningham SD, Tschann J, Gurvey JE, Fortenberry JD, Ellen JM. Attitudes about sexual disclosure and perceptions of stigma and shame. *Sex Transm Infect*. 2002;78(5):334–338.
9. Scoular A, Duncan B, Hart G. “That sort of place ... where filthy men go ...”: a qualitative study of women’s perceptions of genitourinary medicine services. *Sex Transm Infect*. 2001;77(5):340–343.
10. Sonnex C. Destigmatizing genitourinary medicine and sexually transmitted infections in the UK. *Int J STD AIDS*. 2009;20(11):748–751.
11. Scoular A, Duncan B, Hart G. “That sort of place ... where filthy men go ...”: a qualitative study of women’s perceptions of genitourinary medicine services. *Sex Transm Infect*. 2001;77(5):340–343.
12. Wright K, Naar-King S, Lam P, Templin T, Frey M. Stigma scale revised: reliability and validity of a brief measure of stigma for HIV+ youth. *J Adolesc Health*. 2007;40(1):96–98.
13. Zelaya CE, Sivaram S, Johnson SC, Srikrishnan AK, Solomon S, Celentano DD. HIV/AIDS stigma: reliability and validity of a new measurement instrument in Chennai, India. *AIDS Behav*. 2008;12(5):781–788.
14. Franke MF, Muñoz M, Finnegan K, et al. Validation and abbreviation of an HIV stigma scale in an adult Spanish-speaking population in urban Peru. *AIDS Behav*. 2010;14(1):189–199.
15. Berger BE, Ferrans CE, Lashley FR. Measuring stigma in people with HIV: psychometric assessment of the HIV Stigma Scale. *Res Nurs Health*. 2001;24(6):518–529.
16. Emler C. Measuring stigma in older and younger adults with HIV/AIDS: an analysis of an HIV stigma scale and initial exploration of subscales. *Res Soc Work Pract*. 2005;15(4):291–300.

17. Nyblade L, MacQuarrie K; POLICY Project. *Can We Measure HIV/AIDS-Related Stigma and Discrimination? Current Knowledge about Quantifying Stigma in Developing Countries*. Washington, DC: United States Agency for International Development; 2006.
18. Stevelink SAM, Wu IC, Voorend CGN, van Brakel WH. The psychometric assessment of internalized stigma instruments: a systematic review. *Stigma Res Act*. 2011;2(2):100–118.
19. Neal TM, Lichtenstein B, Brodsky SL. Clinical implications of stigma in HIV/AIDS and other sexually transmitted infections. *Int J STD AIDS*. 2010;21(3):158–160.
20. Mulholland E, Van Wersch A. Stigma, sexually transmitted infections and attendance at the GUM clinic: an exploratory study with implications for the theory of planned behaviour. *J Health Psychol*. 2007;12(1):17–31.
21. Griffiths C, Gerressu M, French RS; One-Stop Shop Evaluation Team. Are one-stop shops acceptable? Community perspectives on one-stop shop models of sexual health service provision in the UK. *Sex Transm Infect*. 2008;84(5):395–399.
22. Arkell J, Osborn DP, Ivens D, King MB. Factors associated with anxiety in patients attending a sexually transmitted infection clinic: qualitative survey. *Int J STD AIDS*. 2006;17(5):299–303.
23. Darzi A. Quality and the NHS next stage review. *Lancet*. 2008; 371(9624):1563–1564.
24. Sonnex C. Destigmatizing genitourinary medicine and sexually transmitted infections in the UK. *Int J STD AIDS*. 2009;20(11):748–751.
25. Hitchings S, Allotey J, Pittrof R. What do patients want most from sexual health services? *Int J STD AIDS*. 2009;20(10):719–722.
26. Dixon-Woods M, Stokes T, Young B, Phelps K, Windridge K, Shukla R. Choosing and using services for sexual health: a qualitative study of women's views. *Sex Transm Infect*. 2001;77(5):335–339.

Supplementary material

International Journal of Women's Health downloaded from <https://www.dovepress.com/> by 54.191.40.80 on 10-Jun-2017
For personal use only.

Dear Patient

This is a questionnaire designed to assess your attitude towards our clinic. We would be grateful if you could answer its questions. Your responses will be kept anonymous and treated in confidence. It will help to better understand the needs of our patients and to improve the quality of care we deliver.

Please show your level of agreement with each of the following statements by circling or ticking one response per statement only. This is not a test, and there are no right or wrong answers, just your own views are required.

Thank you for filling in this survey. Please fold this form and post it into the ballot box in the waiting area.

If you had any problems answering this questionnaire, or any general comments you want to make or if you would like to help us you could write them on the back of this paper.

What is the reason you came today? Sexual health Family planning
 Both Other

Gender	Male <input type="checkbox"/>	Age (in years)	
	Female <input type="checkbox"/>	Ethnic group	
Postcode (first 4 letters only)	<input type="text"/>	UK white <input type="checkbox"/>	Other white <input type="checkbox"/>
Have you been here before	Yes <input type="checkbox"/>	UK black <input type="checkbox"/>	Other black <input type="checkbox"/>
	No <input type="checkbox"/>	Other <input type="checkbox"/>	

Statement	Response				
1. I won't tell anyone that I came to this clinic because I am concerned about their reaction.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2. I think coming to a clinic like this is no different to going for any other kind of health check.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3. If my friends found out I came here they might stop socialising with me.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4. I could lose friends by telling them that I came to this clinic.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5. I am very careful who I tell that I have been in this clinic.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6. I worry that people who know I have been here will tell others that I come to this clinic.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7. If I like the care I receive I will tell my friends to come here.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8. Coming to this clinic shows I look after myself.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
9. Coming to this clinic makes me feel unclean.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
10. I am concerned I might bump into somebody I know when at this clinic.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
11. Coming to this clinic makes me feel that I'm a bad person to a certain extent.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
12. Most people think that a person who comes to a clinic like this is disgusting.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
13. Most people who go to clinics like this are shunned by others when they find out.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
14. Coming to a clinic like this makes me feel good about myself because I know I am doing what's best for me.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
15. I am concerned coming to this clinic because I worry about what kind of people are there.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Figure S1 Stigma assessment questionnaire.

International Journal of Women's Health

Dovepress

Publish your work in this journal

The International Journal of Women's Health is an international, peer-reviewed open-access journal publishing original research, reports, editorials, reviews and commentaries on all aspects of women's healthcare including gynecology, obstetrics, and breast cancer. The manuscript management system is completely online and includes

a very quick and fair peer-review system, which is all easy to use. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <http://www.dovepress.com/international-journal-of-womens-health-journal>