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Who goes to a sexual health clinic? Gender differences in service utilisation

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Abstract

Aim Our aim was to review utilisation of the Hamilton Sexual Health Clinic (Hamilton, Waikato, New Zealand) with regard to gender differences.

Methods Notes of those attending during 9 months (1 February 2008–31 October 2008) were reviewed—and their demographic details, source of referral, reasons for attending, and diagnostic coding data were compared. In addition, Waikato Hospital laboratory provided *Chlamydia trachomatis* test results for the study period. Data was analysed for gender differences.

Results Overall, more women attended than men. By age bands, more 15–19 year old women than men attended (23.3% vs 12.5%, $p<0.001$) but, for all age-bands 20 years and older, men were at least as likely to attend as women. Further, for those aged 25–29 years (20.3% vs 17%, $p<0.5$) and 45 years and older (11.9% vs 7.4%, $p<0.001$), more men than women of the same-age band were seen. Men who attended were more likely to self-refer (58.5% vs 43%, $p<0.001$) and less likely to be asymptomatic (30.3% vs 38.4%, $p<0.001$).

Conclusions Our data suggest men aged 20 years and older are at least, if not more, likely than women to attend a sexual health clinic for sexual health concerns. However, there appears to be under-utilisation by younger men. To improve sexual health for men and women, help-seeking must be timely and effective. We need to better understand and address sexual healthcare barriers for young men.

Recent youth-health initiatives in the Waikato district have focused on improving access to primary sexual health care. This includes free sexual and reproductive health visits for registered under-25 year olds at general practices with more rural or lower socioeconomic populations. However, Waikato primary health-collated data suggests most fee-claims from these practices relate to young women.

Where do young New Zealand men go for sexual health concerns, if indeed anywhere? Our aim was to review current utilisation of the Hamilton Sexual Health Clinic, with regard to any gender differences.

Methods

Hamilton Sexual Health clinic provides urban-based publicly-funded services for a district population of approximately 340,000. All attendees are offered testing for sexually transmitted infections (STIs) if they have not previously been tested or had a new sexual partner since their last test.

Electronic notes of those attending during 9 months (1 February 2008–31 October 2008) were reviewed and their demographic details, source of referral, reasons for attending, and diagnostic codes were compared.

Diagnostic coding follows STI surveillance case definitions that, for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, include both 'confirmed' (laboratory detection) and 'probable' cases (all of the following: symptomatic and a contact of a confirmed case and non-laboratory confirmed).¹

In addition, Waikato Hospital Laboratory provided de-duplicated *Chlamydia trachomatis* test results (PCR, Amplicor CT, Roche Diagnostics) for the 9-month period. Data was analysed using SPSS for Windows (v16.0). Differences were tested using t-tests.

Results

In 9 months (1 February 2008–31 October 2008), there were 6838 consultations by 3416 individuals. Average age was 28.1 years, with 47.4% aged 15–24 years (Table 1). Overall, more women attended than men.

By age bands, more 15–19 year old women than men attended (23.3% vs 12.5%, $p < 0.001$) but, for all age-bands 20 years and older, men were at least as likely to attend as women. For those aged 25–29 years (20.3% vs 17%, $p < 0.5$) and 45 years and older (11.9% vs 7.4%, $p < 0.001$), more men attended than women of the same age-band.

Clinic utilisation during this period was higher amongst Māori (26.7%) and lower amongst Pacific peoples (2%) than Census 2006 ethnicity rates for Waikato district population of approximately 20% Māori and 3.1% Pacific peoples. By ethnicity and gender, more Māori women than men (29% vs 23%, $p < 0.001$) and more European men than women (65% vs 60%, $p < 0.01$) were seen.

Men who attended were more likely to self-refer (58.5% vs 43%, $p < 0.001$), with women more likely to be referred by another healthcare provider (28% vs 19.2%, $p < 0.001$) or to have attended in response to a request by our clinic staff (6.7% vs 3.9%, $p < 0.001$). Also, men were less likely to have noted this information in their registration details (19.4% vs 22.3%, $p < 0.05$) (Table 1).

More men than women attended with genitourinary symptoms or with specific STI-related concerns (62.5% vs 53.9%, $p < 0.001$); this included a large number of dermatological consults in the context of sexual risk-taking behaviour. Significantly more asymptomatic women attended for "peace-of-mind" STI testing (38.4% vs 30.3%, $p < 0.001$). There were no differences with regard to other reasons (Table 2).

The number of chlamydia cases managed during the period exceeded the number of clinic positive test results because of "probable" chlamydia cases and confirmed cases tested at other settings but referred to our service for treatment and partner management.

Overall, there was no significant gender difference in chlamydia test positivity rates (14% vs 16%, $p = 0.087$) although, by age and gender, there were more positive tests in women than men aged 25 year and older. There was no gender difference noted for any ethnicity group.

Table 1. Demographics of clinic attendees (February–October 2008)

Demographics of individuals	Totals	Men	Women	Difference
Number of individuals	3416	1475	1941	T=67.037, p<0.001
Number of visits	6838	2830	4008	
Average age in years	28.1	29.7	26.9	
Age bands in years				
0–14	22	8 (0.5%)	14 (0.7%)	T=0.647, p=0.517
15–19	637	184 (12.5%)	453 (23.3%)	T=8.151, p<0.001
20–24	982	425 (28.8%)	557 (28.7%)	T=-0.075, p=0.940
25–29	629	300 (20.3%)	329 (17%)	T=-2.533, p<0.05
30–34	404	181 (12.3%)	223 (11.5%)	T=-0.701, p=0.483
35–39	251	123 (8.3%)	128 (6.6%)	T=-1.936, p=0.1
40–44	173	79 (5.4%)	94 (4.8%)	T=-0.677, p=0.498
45+	318	175 (11.9%)	143 (7.4%)	T=-4.493, p<0.001
Self-reported ethnicity				
European	2130 (62.3%)	960 (65%)	1170 (60%)	T=-2.875, p<0.01
Māori	911 (26.7%)	339 (23%)	572 (29.5%)	T=4.256, p<0.001
Pacific*	69 (2%)	33 (2%)	36 (1.9%)	T=-0.787, p=0.431
Asians/Others	269 (7.9%)	121 (8.2%)	148 (7.6%)	T=-0.622, p=0.534
Not given	36 (1.1%)	21 (1.4%)	15 (0.8%)	T=0-1.846, p=0.1
Behaviour last 12 months				
Opposite sex partners only		1223	1706	
Same sex/bisexual		99	54	
Not clearly recorded		153	181	
Source of referral, if noted				
Self-referral		850 (58.5%)	834 (43%)	T=-8.506, p<0.001
Provider-referral (by doctor, nurse, midwife)		283 (19.2%)	544 (28%)	T=5.977, p<0.001
Clinic request (contact tracing)		57 (3.9%)	130 (6.7%)	T=3.628, p<0.001
Not given		287 (19.4%)	433 (22.3%)	T=2.059, p<0.05

*Mostly of Samoan, Tongan, Niuean, or Cook Islands origin.

Table 2. Clinical data of clinic attendees* (February–October 2008)

Main attendance reason	Men	Women	Difference
Genitourinary symptoms or STI-related concerns	1738 (62.5%)	1991 (53.9%)	T=-7.026, p<0.001
Asymptomatic STI testing	843 (30.3%)	1420 (38.4%)	T=6.768, p<0.001
Other concerns (including information, sexuality, sexual dysfunction, etc)	198 (7.1%)	286 (7.7%)	T=0.926, p=0.355
	2779 visits	3697 visits	
Coded cases of:			
Chlamydia	335	436	
Gonorrhoea	81	106	
Syphilis (any stage)	14	7	
Genital herpes (1 st diagnosis)	32	70	
Genital warts (1 st diagnosis)	323	459	
Chronic hepatitis B (1 st diagnosis)	13	5	
Chronic hepatitis C (1 st diagnosis)	10	5	
Positive chlamydia tests (% of tests)			
All positive tests	192 (14%)	314 (16%)	T=1.714, p=0.087
Under-25 year olds	98 (16%)	174 (16.4%)	T=-0.249, p=0.803
Those 25 years or older	94 (11.7%)	140 (15.7%)	T=2.391, p<0.05
By European ethnicity	108 (12%)	158 (14.3%)	T=1.546, p=0.122
By Māori ethnicity	69 (18.7%)	132 (19.2%)	T=-0.198, p=0.845
By Pacific† ethnicity	1 (3.1%)	3 (7.7%)	T=0.823, p=0.414
By Other ethnicity	12 (13.3%)	19 (15.3%)	T=0.406, p=0.685
By unknown ethnicity	2 (12.5%)	2 (20%)	T=0.498, p=0.623

*Excluding gender-specific reasons—e.g. termination of pregnancy, hormonal contraception, etc; †Mostly of Samoan, Tongan, Niuean, or Cook Islands origin.

Discussion

Our data show gender and age differences in sexual healthcare utilisation. For all age-bands 20 years and older, men were at least as likely, if not more likely, to use our service than women.

Men were more likely to self-refer and more likely to be symptomatic, thus suggesting help-seeking behaviour around specific concerns. This is encouraging, given other utilisation data suggests New Zealand men visit general practice less frequently than women.²

Of concern is that young men were less likely to use our service. This is in keeping with previous data showing that young sexually active New Zealand men seem less likely than women to access sexual health care.

Amongst a birth cohort at age 21, significantly more women than men (75.8% vs 50.7%, $p < 0.05$) with five or more partners in the previous year had visited their own GP over that period and more sexually experienced women than men attended any setting appropriate for STI testing (93.6% vs 71.6%, $p < 0.001$).³

New Zealand STI surveillance data also suggests gender differences in sexual health care. In 2007, North Island laboratories reported the rate of all chlamydia cases amongst females as being 2½ to 4 times that in males (Waikato 794 vs 325 per 100,000, Auckland 1002 vs 358 per 100,000 and Bay of Plenty 1552 vs 391 per 100,000 population, respectively).⁴ However, as *Chlamydia trachomatis* is often asymptomatic, opportunistic testing patterns affect detection rates and gender-testing inequities may explain some of the reported gender-rate variation.

In 2000, an Auckland laboratory reported the number of female tests as being approximately 10 times that of males.⁵ Similarly, in 2003 and 2004, 85% of Waikato community laboratory chlamydial tests (excludes hospital and sexual health clinic samples) were from women.⁶

Lower primary care STI testing rates do not necessarily equate to less service utilisation, however. As men tend to be more symptomatic for STIs, syndromic primary care management may mean less testing. Likewise, men may receive STI treatment without testing if their partners are found to have an infection. Nonetheless, it remains a concern that younger New Zealand men are less likely to seek, or be offered, sexual health care.

Help-seeking practices and health service use are complex issues with biological, psychological, and sociological considerations. Although there is a risk of assuming homogeneity in male behaviour, recurrent published themes are the influence of masculine stereotypes and gender norms of risk-taking, resilience, and self-reliance.⁷⁻⁹

Discussion on men's help seeking often infers negative behaviour, of "men behaving badly" with respect to their health. Yet, in keeping with our findings, a recent Australian study reports older men do have a keen interest in their health.¹⁰

Our clinic data may not be representative of other sexual health clinics in New Zealand as many factors, including geographical proximity and clinic hours, may affect service access and hence utilisation. That said, general practice utilisation and laboratory testing data add support that younger men are missing out.

Perhaps it is time to reflect on how much the current health system and health promotion messages seem tailored to women. For example, the emphasis of the HPV vaccine as protecting young women risks further disengagement of young men.

To improve sexual health for men and women, help-seeking must be timely and effective, not least to limit further transmission of infections. It's high time we understood better and addressed sexual healthcare barriers for young men.

Competing interests: None known.

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