



The
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Understanding access to Sexual and Reproductive Healthcare (SRH) in General Practice using the Candidacy Framework

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Abstract

Background: Deprived communities are more at risk of poor sexual and reproductive health outcomes, and access to SRH is more challenging in these populations. This is evident from significantly higher rates of unplanned pregnancies, abortions, teenage pregnancies, and a higher prevalence of sexually transmitted infection in deprived communities compared to affluent counterparts. This study aimed to identify and explore practitioner related barriers and facilitators to access of SRH in general practice using the candidacy framework.

Method: A qualitative evidence synthesis (QES) was undertaken with a focus on SRH in general practice within healthcare systems like the NHS. Further exploration was done using semi-structured interviews conducted with 20 frontline healthcare practitioners from general practices serving deprived communities across Yorkshire. Thematic analysis was undertaken to identify factors in general practice which affected access. The candidacy framework guided the design and analysis of both the QES and interviews.

Results: The data revealed the complexities of access to SRH service including the impact of stigma, shame, embarrassment among individuals, communities, and healthcare practitioners. Factors such as female disempowerment and gender-related barriers were identified. The candidacy framework was adapted to explain the complex interaction between the person accessing care and the healthcare practitioner, this developed the understanding of the interplay between appearing or asserting candidacy and the recognition or acceptance of this candidacy by the healthcare practitioner.

Conclusion: To readdress SRH inequalities in deprived communities, there needs to be easily accessible and stigma-free services in general practice. This research highlights the importance of HCPs recognising and accepting the needs of their communities and having the funding to develop tailored and culturally congruent services specifically for their patients.

Dedication

For Dad who gave me passion,
For Mum who gave me belief,
For Adam who gave me love,
For Abigail who gave me a reason,
And for all those patients who gave me inspiration.

Acknowledgements

This thesis would not have been made possible without the guidance and support of my supervisors: Dr Caroline Mitchell and Professor Sarah Salway. Caroline has been a force of nature with continuous support academically and pastorally. She has been a mentor and friend through academic and personal challenges including maternity leave and challenges of COVID-19. Sarah helped me with specific questions and providing valuable feedback, her sociological expertise had helped develop a deeper understanding of the topic.

I would also like to thank other academic colleagues who have given support and guidance. The AUPMC department has been a place of nurture and growth, I have very much enjoyed learning more about medical teaching as well as varied research interests. Thank you to all the people who have been involved in the public involvement work including the members of Darnall Wellbeing community outreach team. Thank you to all the participants in this research who gave their time and energy at a challenging time to work in the NHS.

Last but not means least, thank you to my family for your patience and support. We faced a significant challenge that we could never have anticipated. In the later stages of the MD programme, I experienced complications to my pregnancy, and we had a premature baby girl. Luckily, she has done well and is a force of nature. The COVID-19 pandemic led to school closure and trying to write up the thesis amid home-schooling and working from home. I could not have gotten through this MD without the love and support of my partner, Adam, my mother, Sue, my daughter, Abigail, and the extended family.

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List of abbreviations and acronyms

AUPMC	Academic Unit of Primary Medical Care
BME	Black and ethnic minority groups
BeHEMoTh	Behaviour of Interest, Health context, Exclusions and Models or Theories
CAQDAS	Computer-assisted qualitative data analysis software
CASP	Critical Appraisal Skills Programme
COREQ	Consolidated Criteria for Reporting Qualitative Studies
COVID-19	Coronavirus 19
CRN	Clinical Research Network
GMC	General Medical Council
GP	General practitioner
GRADE-CERQual	Confidence in the Evidence from Reviews of Qualitative research
HCP	Health care professional
HIC	High income country
HIV	Human immunodeficiency virus
LARC	Long-acting reversible contraceptive
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning, plus other sexual orientations, and gender identities
LMIC	Low- and middle-income country
MSM	Men who have sex with Men
NHS	National Health Service
NICE	NICE
PPI	Public and patient involvement
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SAPC	Society for Academic Primary Care
SFB	Scientific foundation board
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted infection
UK	United Kingdom
WHO	World Health Organisation

Preface

This MD was completed part-time as a staff candidate within the AUPMC at The University of Sheffield. The department has a special interest in meeting the primary healthcare needs of underserved populations. I received a Scientific Foundation Board grant from the Royal College of General Practitioners (RCGP) to complete the research and NIHR funding for an In-practice Training Fellowship. Subsequently, I received an Academic Training Fellowship funded by a Health Education England Yorkshire and Humber grant at The University of Sheffield (PI DR C Mitchell).

Daniella

I wanted to share the story of where this research came from as I feel it helps gives context and meaning to the project. It all started in 2015 with a patient of mine when I was working in a high deprivation and new migrant population in Sheffield. Her name was Daniella, and she will forever be etched in my memory. She had a profound impact on my life which led me to academia to try improving services for people like her.

She was in her early 30s and had just arrived in the UK from Slovakia, she was from the Roma People. She had her first baby at 14 and then had 5 children in total. She had no formal education and poor health literacy. Over time we built a relationship, seeing her regularly for minor illnesses in herself and her children. We communicated using interpreters, google translate and even her own children at times.

She shared that she did not want to have any more pregnancies, and over time she trusted me enough to fit her with a contraceptive implant. She was so overjoyed. She gave insight into coercive contraceptive practices in Slovakia and many myths in her community about pregnancy and lack of control with regards to sex and condom use.

Sadly, when I left the practice, she asked me to remove the implant. She was afraid she would need to travel into the central clinic (two buses) and had no trust in other health professionals. I can never forget her tears when the implant was removed. From my perspective, it felt as though our healthcare system continually put barriers and obstacles in her way, and she did not have the assets of ability to negotiate them for better health.

The research question

What are the barriers and facilitators for general practice to address inequalities in access to sexual and reproductive healthcare (SRH)?

To answer this research question, the project aims were:

- To explore practitioner and public perspectives on barriers and facilitators to access to SRH services in general practice in the UK and similar healthcare systems.
- To undertake a qualitative study to explore practitioner and public perspectives on barriers and facilitators to access to SRH services in general practice, focusing on deprived populations.

To address the above aims, the project objectives were:

1. To explore the current evidence around SRH service provision, access, and uptake in primary care settings and in secondary care.
 - a. To identify those who are at risk of inequality in access to SRH.
 - b. Understand the impact of deprivation on access to general practice services.
 - c. To explore models of access and use them to synthesise evidence about SRH in general practice.
 - d. Identify socioeconomically disadvantaged individuals in Yorkshire who are at high risk of negative SRH outcomes.
2. To undertake a qualitative evidence synthesis (QES) that explores access to SRH in general practice.
 - a. Understand contextual factors that influence access for all groups of the population
 - b. Discover gaps in evidence focusing on underserved populations or those who find access most challenging.
3. To ascertain the views of a purposive sample of providers regarding SRH provision in general practice and understand their perspectives on barriers and facilitators.
4. To elicit the barriers and facilitators to the access to SRH from the perspectives of the public who are identified as at risk of inequality in their healthcare experience.

1. BACKGROUND

This chapter introduces factors influencing the research study and is formed into three sections. Firstly, a description of the current UK context in which SRH is delivered and the impact of inequalities on delivery and access. This also explores the implications of Coronavirus 2019 (COVID-19) on SRH services in the UK. The second section will focus on the role of general practice in delivering SRH services and the current issues around the provision and funding of services. The context of general practice providing services in deprived and underserved populations is described in more detail. Finally, the third section describes access to healthcare and looks at frameworks that help further explore SRH in general practice.

1.1. Overview of Sexual and Reproductive Healthcare (SRH)

SRH is an area of health that affects everyone at some point in their lifecycle, whether that be family planning, contraception, safe sex or sexuality and gender. This introduction aims to give an overview of SRH within the UK setting and the impact of funding on access to services. The World Health Organisation's definition of SRH is as follows(1),

Sexual health is an integral part of overall health, well-being, and quality of life.

It is a state of physical, emotional, mental, and social well-being in relation to sexuality, and 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 people must be respected, protected, and fulfilled.

Unsafe sex is described by leading academics as a matter of life and death(2). In low and middle-income countries (LMIC), it is the second most important risk factor leading to disability and death. In high-income countries (HIC) it is the ninth most important risk factor(2). In the UK, there is an imminent crisis caused by a reduction in SRH services in the context of increasing rates of sexually transmitted infections (STI), high unplanned

pregnancies and abortion rates compared to other developed countries(3). The RCGP responded by making SRH a priority area for improvement – ‘SRH Time to Act’(4).

There had been substantial improvements in SRH over the preceding 25 years, but the UK still fell behind other high-income countries. In the late 1990s, Britain had the highest teenage pregnancy rates in Western Europe, with a reported conception rate of 46.6 per 1000 girls aged 15-17 years. Most of these pregnancies were unplanned, and half resulted in abortion(5). In addition, England and Wales ranked highest amongst Western Europe for abortion rates, with nearly 174,000 abortions in 1999(6,7). There have been two crucial strategies that have led to improvements, the Teenage Pregnancy Strategy in 1999 and the National Strategy of Sexual Health and HIV in 2001(5,6). However, the recent reductions in SRH services are predicted to lead to a deterioration in SRH outcomes worse than 25 years ago(8). The Advisory Group on Contraception conducted a study in 2014 that found 2.9 million women in England lived in an area where contraception services are being delivered without adequate assessment of service outcomes or experience(9).

The impact of untreated STIs is vast, increasing mortality and morbidity rates. Around 510,000 new STI diagnoses were made in the UK in 2011, with estimated treatment costs of £620 million.(10) The hidden impact of infections such as HIV or hepatitis is equally devastating on personal and population health(10).

This area of health challenges the personal belief systems of patients and practitioners alike, including societal and community taboos and stigma around sex and sexuality. The understanding of access to services is complex and poorly understood but vital to reducing inequalities, which will be explored later.

1.1.1. Provision of SRH in the UK

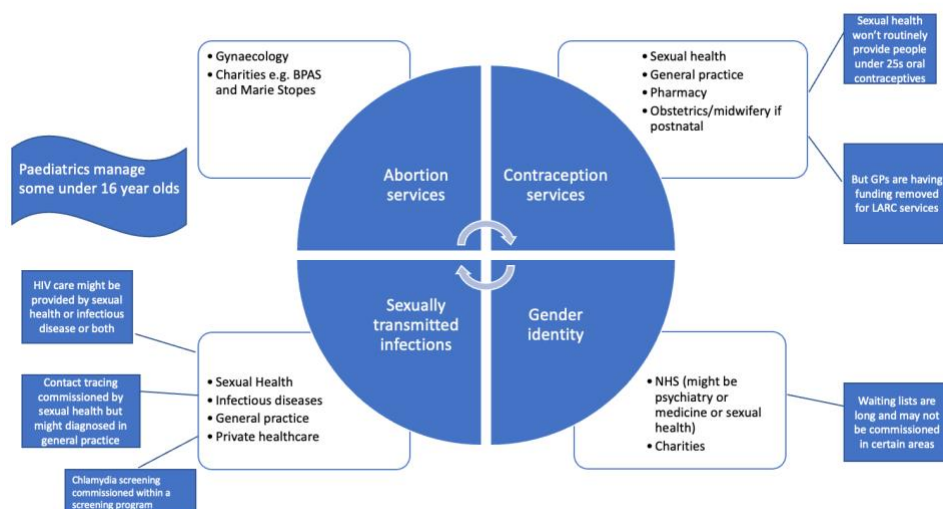
SRH includes a wide range of health conditions and services that receive funding from varied sources. This has led to fractured commissioning and silos of care(8). Sexual health services are under the remit of Public Health which is now commissioned by local authorities rather than the NHS(11). In 2013, the implementation of the Health and Social Care Act meant that local authorities became responsible for commissioning services for sexual health for the first time. This change left services open to budgetary cuts, and in June 2015, the

Chancellor of the Exchequer announced a £200 million reduction in the public health budget(12). Across the UK, local authorities' overall spending on SRH services decreased by 3.5% between 2014-15 and 2015-16. There were geographic disparities between which local authorities reduced spending; more than a quarter reduced spending by 20% between 2013-14 and 2015-16, whereas one in seven increased spending by 20% over the same time frame(3).

A significant challenge with SRH provision is the complexity of commissioning and measuring intervention outcomes. A report by the family planning association, Unprotected Nation, described the economic impact of unplanned pregnancy and untreated sexually transmitted infections(8). In 2015, it was estimated that with levels of provision, the UK health costs would be £24 billion over the next ten years. Every £1 cut to SRH could cost the government £86. With expected costs over £27 billion between 2015 and 2020 to the UK's social welfare, housing benefits and education budgets(10). Unintended pregnancy has potentially negative consequences, including worse child health, compromise to education and relationship instability(13).

Below is a diagram that shows the complexity of funding for SRH and the different specialities involved(11,14). It has been adapted and simplified but highlights the intricacy of services.

Figure 1 Representation of current funding silos in the UK adapted from FSRH and Public Health England reports(11,14)



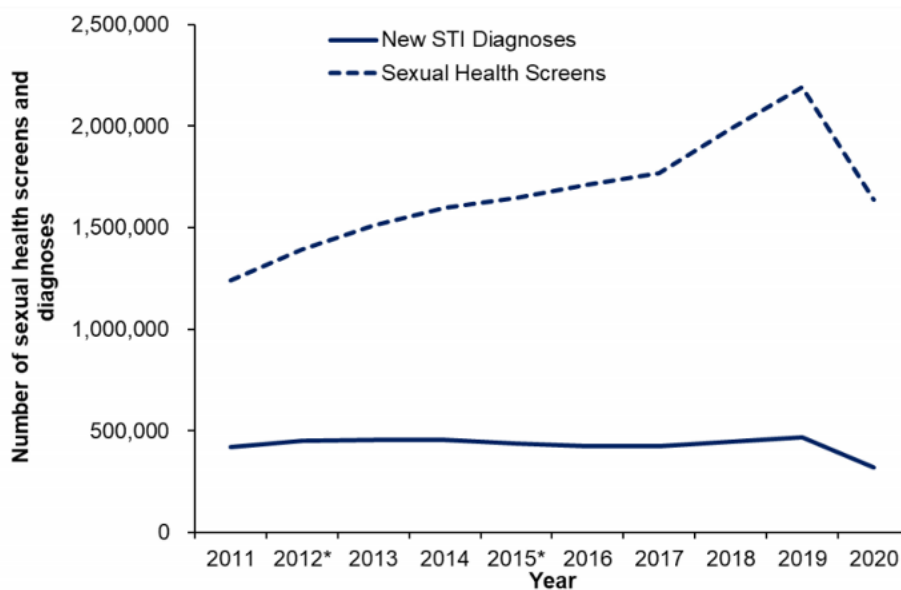
The ever-increasing financial pressures on local authorities has led to reductions in essential services for high need client groups such as vulnerable women, ethnic minorities, looked after children, teenagers and sexual minority groups(15). The reduction in local authority spending on SRH services raises concern for those individuals at the highest risk from discontinuity of provision. Those at most risk of adverse health outcomes such as unintended pregnancy or STIs often struggle most to access services. Teen pregnancies and STIs are more predominant in those who live in deprived communities; these are areas where healthcare provision is often worse affected by service reduction(16).

These inequalities in care will be explored further in the next section along with the role of general practice.

1.1.2. COVID-19 impact on sexual health

The COVID-19 pandemic has led to a reduction in the number of people accessing NHS across all services including SRH(17–19). The ability to provide care has been impacted by staff redeployment, staff sickness, and a need to move to telephone or online consultations(17).

Figure 2 - Number of new sexually transmitted infections (STI) diagnoses and sexual health screens among England residents accessing sexual health services, 2011 to 2020 (Public Health England report, 2020)(20)



This graph highlights the decrease in screening and the diagnosis of STIs associated with the start of the COVID-19 pandemic(21). Services have been depleted, and much of the patient contact is online or via telephone(17). Drop-in services have been stopped due to infection risk, and many outreach clinics were closed to redeploy staff to essential services(22).

The COVID-19 pandemic was reported to have led to a reduction in risk-taking sexual behaviour due to lockdown and reduced social interactions(23). An online survey in Australia reported people delaying presentation for SRH related conditions due to uncertainty and anxiety about what was appropriate and safe(24).

Exploring the data about where people are being tested and diagnosed with chlamydia comparing 2019 (pre-pandemic) and 2020 (mid-pandemic) helps understand the change in provision(21). General practice screen 16.1% in 2019 compared to 14.1% in 2020, where sexual health clinic tested 42.8% in 2019 and went down to 29.8% in 2020(21). It is expected that sexual health clinics have a higher positivity rate compared to general practice due to the higher prevalence of infection in those attending(21).

Figure 3 - Chlamydia tests, diagnoses, and test positivity among 15 to 24 year olds by test setting, 2019 to 2020, England (Public Health England report, 2020)(20).

Test setting	Tests					Diagnoses					Tests positivity (%)	
	2019		2020		% change 2019 to 2020	2019		2020		% change 2019 to 2020	2019	2020
	Number	% of total	Number	% of total		Number	% of total	Number	% of total			
SHSs – specialist STI-related care	580,537	42.8%	284,206	29.8%	-51.0%	74,094	54.7%	38,768	41.4%	-47.7%	12.8%	13.6%
SHSs – non-specialist STI-related care	66,185	4.9%	23,628	2.5%	-64.3%	7,891	5.8%	2,816	3.0%	-64.3%	11.9%	11.9%
GP	218,644	16.1%	134,944	14.1%	-38.3%	13,913	10.3%	7,756	8.3%	-44.3%	6.4%	5.7%
Pharmacy	11,716	0.9%	7,255	0.8%	-38.1%	1,305	1.0%	823	0.9%	-36.9%	11.1%	11.3%
ToP	21,153	1.6%	8,589	0.9%	-59.4%	1,570	1.2%	699	0.7%	-55.5%	7.4%	8.1%
Internet	284,050	21.0%	381,744	40.0%	34.4%	23,426	17.3%	33,294	35.6%	42.1%	8.2%	8.7%
Unknown	19,818	1.5%	13,549	1.4%	-31.6%	1,254	0.9%	992	1.1%	-20.9%	6.3%	7.3%
Other	153,382	11.3%	100,721	10.6%	-34.3%	11,908	8.8%	8,397	9.0%	-29.5%	7.8%	8.3%
Total	1,355,485	100%	954,636	100%	-29.6%	135,361	100%	93,545	100%	-30.9%	10.0%	9.8%

It is unclear what the long-term consequences of COVID-19 will be on SRH. There is an argument that the increase in online and telephone services might increase access for people but also concerns that those most vulnerable to a poor outcome will be detrimentally affected(25,26).

1.2. Inequalities in SRH

The following section explores socioeconomic deprivation, vulnerable communities, recent migration, ethnic and sexual minorities groups in the context of poor SRH outcomes. These factors may not exist in isolation, and disadvantaged individuals often embody multiple characteristics which coalesce to impede further their healthcare access(27). Marmot discussed the social gradient of health and social determinant of health - the poorer the person, the worse their health(16,28). This is clear within the context of SRH.

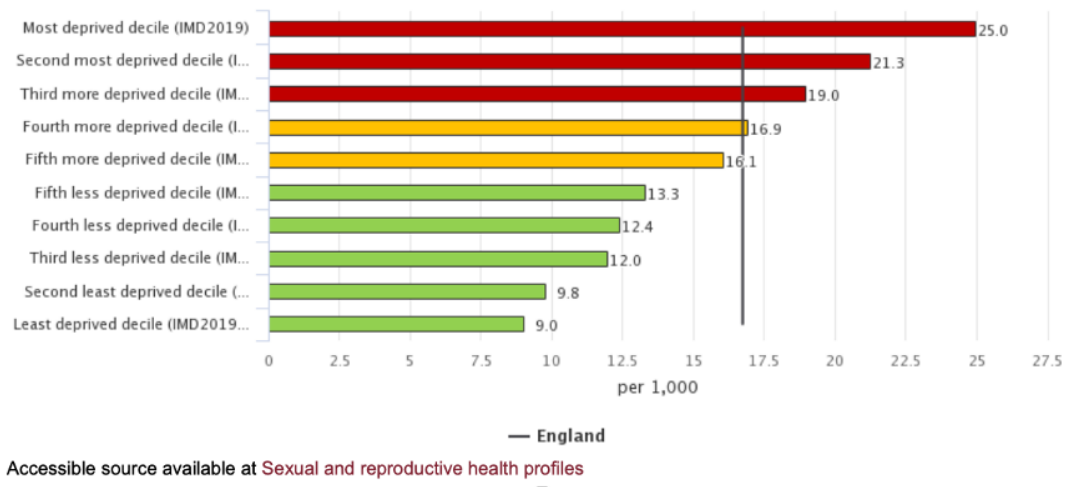
Groups at most risk of poor SRH outcomes include young people, socioeconomically deprived communities, black and ethnic minorities, sexual minorities, including the transgender community(15,29,30). Difficulty accessing SRH services can significantly impact women's health, including future life trajectory in terms of education and economic attainment. Women who find access more difficult are conversely more at risk of late booking antenatally, poor obstetric outcomes, and risk of unplanned pregnancy(31,32). Teenage pregnancies and STIs are more predominant in those who live in lower socioeconomic communities, these are areas where healthcare provision is often worse affected by service reduction(16).

These patients are accessing general practice for healthcare, but there needs to be a better understanding of why their SRH needs are not being addressed. Over 40 years ago, Julian Tudor-Hart described the perverse relationship between health care utilisation and the need of the individual accessing(33). Conversely, many GPs do not feel comfortable treating marginalised groups or discussing sexual health issues which further amplifies access difficulties(34). This can be seen within SRH services, those who are in the most need of healthcare are often those who find it most difficult to access or engage with it.

1.2.1. Low socioeconomic groups

Unintended pregnancy and abortion rates are highest among those women in low socioeconomic groups, which is a worldwide trend(35). The rates of unintended pregnancy and abortion are higher in women with lower levels of education which further disadvantages them in their life trajectory(36). The graph below shows the impact of deprivation on teenage pregnancy rates from 2021 Public Health England data (15).

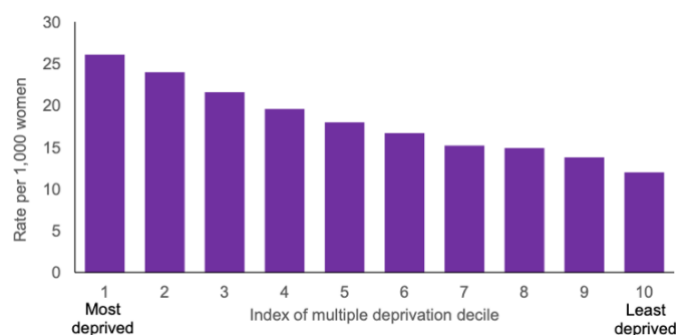
Figure 4 - Under 18s conception rate per 1,000 by deprivation decile (Public Health England report, 2021) (15)



People from low socioeconomic groups are less likely to use contraception; a multi-level analysis of contraception in the UK evidenced the association between disadvantage and decreased likelihood of contraception use(37). Within this, there is an association between social class and unplanned pregnancy. Unskilled manual social class groups were less likely to use contraception than professional and managerial groups(38). An explanation for this was ambivalence about getting pregnant being a predominant factor, the concept of less to lose if there is an unplanned pregnancy(38,39). Low-income groups have been shown to have higher contraceptive failure rates across all methods compared to other income groups(40).

The following graph shows crude abortion rates against deprivation which higher in most deprived communities.

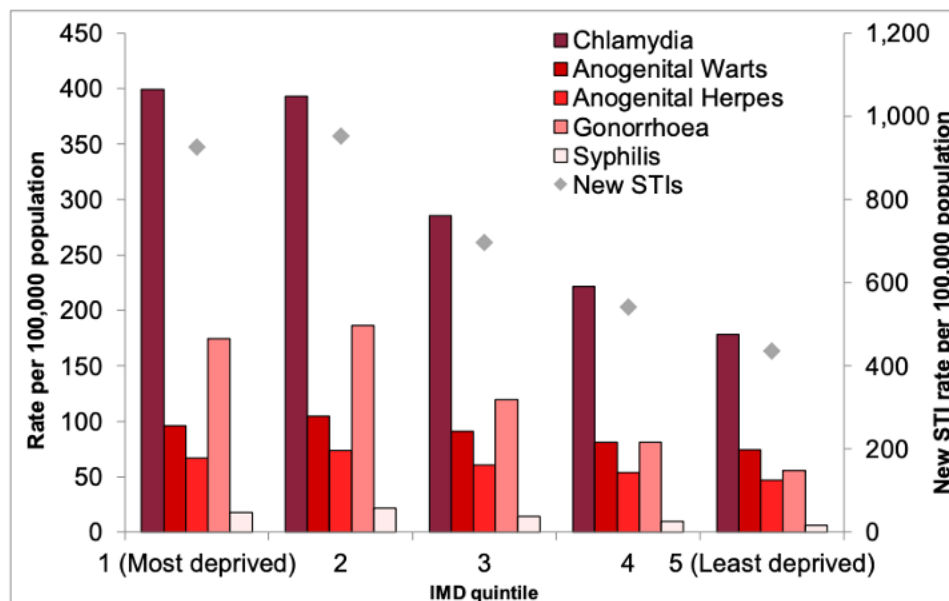
Figure 5 - Crude abortion rate, England, by IMD decile, 2019 ((Public Health England report, 2021) (15)



The Teenage Pregnancy Strategy: Beyond 2010 reported that teenage pregnancy is both a cause and a result of exclusion, poverty and inequality(41). Babies of teenage mothers have a 60% higher risk of dying in their first year of life(32). Unplanned pregnancies can lead to a late antenatal booking, combined with low-socioeconomic factors and deprivation, increase obstetric risk(31). Deprivation and poor psychosocial support increase late antenatal booking and subsequent poor child health, access to care is vital in addressing these issues(32).

The highest predominance of new STI diagnoses is amongst the most disadvantaged population groups(42); this includes HIV and other blood-born viral illnesses, which, if left untreated, can impact mortality and morbidity for these communities. Unfortunately, screening programmes indirectly lead to worsening health inequalities as they tend to attract worried well, affluent population groups rather than reaching those in need(43).

Figure 6 - Rates of STI diagnosis by Index of Multiple Deprivation quintile: England 2019 (Public Health England report, 2021)(15)



In a report to understand teenage sexuality in Ireland, Hyde and Howlett commented on disparities between girls and boys in policing of sexual practices by family members(44). Young working-class women often experience more coercion than those from middle-class areas. They also note that working-class women tend to be less assertive sexually than their middle-class equivalents(44).

1.2.2. Black and Ethnic Minority groups

Black and ethnic minority groups (BME) have been identified as lacking inclusive service provision and poorer access to care(45). The interplay of race, ethnicity and migrant status with socioeconomic status is complex and challenging to define. However, issues like language barriers, education level and discrimination or stigma affect access(46). Within this context of minority groups are further compounding factors such as new migration, which increase access difficulties. The fear of authority and concerns regarding confidentiality also led to a reluctance to access antenatal services(31,47).

BME groups are disproportionately affected by STI and unplanned pregnancy(48). Public Health England estimates that BME groups have rates of gonorrhoea and chlamydia three times higher than the general population(15). There is a need for culturally sensitive services reflecting the community's needs and wants of the individual. Sex is very much a taboo subject in some cultures, so there needs to be a balance of respect for tradition and culture with SRH services (49).

1.2.3. Sexual minority groups

Sexual minority groups have significantly poorer experiences of healthcare and worse outcomes. Data from the English General Practice Patient Survey 2009/2010 was differentiated into those who describe themselves as heterosexual, gay, lesbian or bisexual(50). Sexual minorities were two to three times more likely to report long-term psychological or emotional problems than heterosexual counterparts. They were also more likely to report fair/poor health. This is adjusted for sociodemographic characteristics, ethnicity, and health status. People from sexual minority groups reported significantly more unfavourable experiences of primary care, which is concurrent with other evidence. A large population-based study in the US showed much worse health outcomes for lesbian or bisexual women; this included compounding obesity and mental health factors, particularly in midlife(51). This theme of worsening mental health in sexual minority groups persists through different studies.(52) There has been discussion about the need to know a patient's sexuality within primary care; some feel routinely asking is invasive and unnecessary, whilst others feel it impacts condition investigation. What is clear is that there

is still a great deal of embarrassment and stigma around sexuality which highlights the need for education(53–55).

1.2.4. Sexual health literacy

Health literacy contributes to inequalities in access to healthcare, and this becomes more pronounced when considering sexual health literacy due to the impact of embarrassment, shame, and taboo. Health literacy is defined as the ability to access, understand, appraise, and apply health information to make an informed health decision(56). This is affected by a persons' education, circumstances, access to information and language skills.

Sexual health literacy is the ability to understand preventive sexual health information to make informed choices, increase safe sex practices and reduce STI risk(57). Safe sex practice refers to promoting condom use, reducing the number of sexual partners, avoiding casual unprotected sex, and enhancing sexual communication and negotiation skills concerning sex refusal, condom use, and a partner's STI history. These are challenging areas to understand, especially if a person is young, vulnerable, has limited language skills or is without primary education.

Within the context of sexually transmitted infections, low health literacy has consequences such as poor decision making and delays or difficulty in seeking care(58). This is mirrored when looking at the impact of low literacy on unintended pregnancy(59). Low health literacy may also affect a person's ability to comprehend written information on STIs and can lead to complications or poor treatment outcomes(60).

1.2.5. Vulnerable adults

Some features make individuals more at risk of poor outcomes within the lower socioeconomic community—for example, drug and alcohol addiction or intoxication impact risk-taking and health-seeking behaviour. Alcohol plays a role in unprotected sex, leading to a general ambivalence about using contraception or barrier methods(38). Concurrently, opiate users were shown to be less likely to use contraception or barrier protection, increasing the risk of pregnancy and infections(61,62).

Whether on the streets or any other form of insecure housing, homeless people find uptake and access to contraception and services more challenging. Unintended pregnancy or

blood-borne viral infections in that setting adds further to the personal and economic strain (63,64).

Young people are at high risk of poor SRH outcomes and struggle to access care. Compared to those aged 25-59 years, STI diagnosis rates in 15-24-year-olds are twice as high in men and seven times as high in women(48). Younger people find accessing appropriate services much more complicated, which further compounds the spread of untreated infection (7,65–67). Some young people are more vulnerable to unintended pregnancy and infections, including those with chaotic family environments (68) or those with adverse childhood events(69).

1.2.6. Chronic disease and obesity

Chronic disease and SRH are poorly understood; mental health and physical health issues can make access challenging. (70,71). Within the context of chronic disease, obesity is a risk factor for poor SRH outcomes and a barrier for services. Obese women were shown to be less likely to be offered access contraceptive health services but more likely to have unintended pregnancies(72). The impact of obesity of poor reproductive outcomes was also poorly understood by women (73).

1.3. The role of general practice in SRH provision

This section will explore the current understanding of general practice providing SRH. There are various arguments about where SRH should be provided, and much is impacted by financial constraints and commissioning.

There are opinions about whether SRH should be a public health or primary care issue. Public health focuses on population health, whereas general practice focuses on individual health(74). General practice has dramatically changed since it was initially established. When the NHS was formed in 1948, general practice took on the role of all personal medical care for an individual and acted as the gatekeeper for secondary care referral(75).

The workforce was predominantly male and often in single-handed practices where patients and families were cared for by one individual, usually through their life course. In response, charities emerged such as Marie Stopes and Family Planning Association which offered confidential services separate from the general practice unit to allow women choice. Over

the last 50 years, there has been a steady increase in women in general practice. The General Medical Council (GMC) register shows 54% of the GP workforce was female in 2021(76). The workforce has become more diverse, with practice nurses developing advanced practice and specialising in chronic disease(74). The practices themselves have changed with a move to large multi-handed practices with large population groups; computerised records allow easy transfer of information and maintain confidentiality. This increase in female GPs and upskilling of nurses has led to more people seeking SRH in general practice(74).

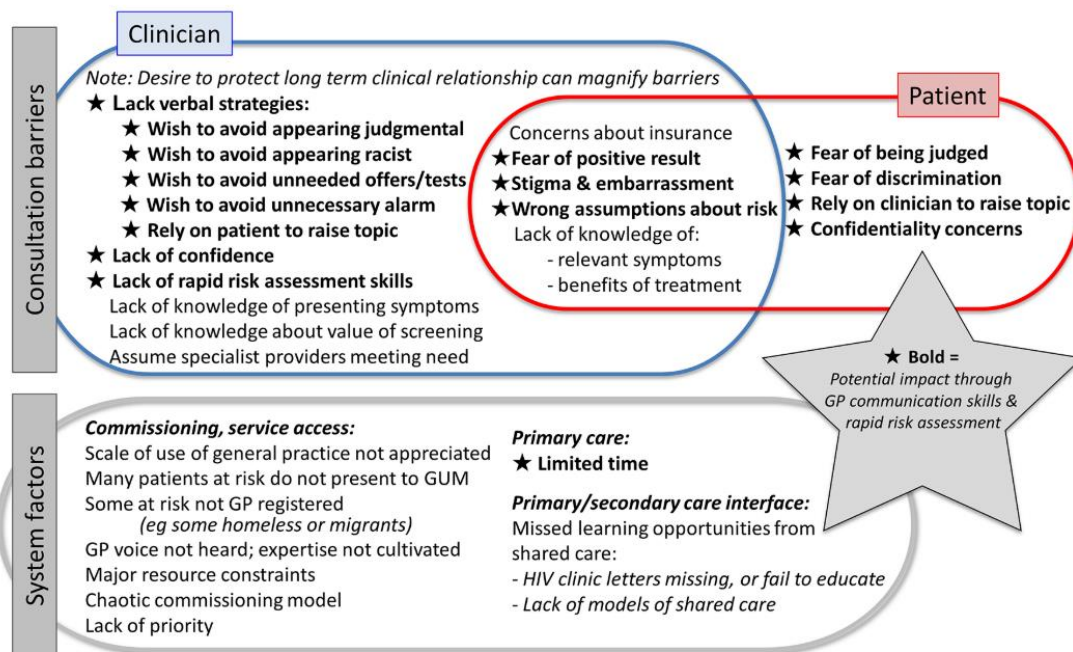
Primary care prescribes approximately 80% of contraception in the UK(77). The contraceptive pill is the most commonly prescribed contraceptive in the UK, even though more effective methods are available(78). Long-acting reversible contraception (LARC) should be the first line offered to all women when seeking contraception because it is best at preventing unintended pregnancy (78). It is estimated that if 7% of women switched from the contraceptive pill to LARC, it could save the NHS £100m by reducing unintended pregnancies(79). If LARC services are funded in general practice in the UK, it will increase uptake by the community. This was evident with the introduction of Quality of Framework (QOF) points regarding long-acting contraceptives(80,81). Rewarding GPs for prescribing LARCs led to more than 100,000 additional prescriptions in the three years after the incentive was introduced through QOF(80). When the financial incentive was removed, there was a drop in LARCs, especially for adolescents aged 15-19(82).

Infections such as HIV and chlamydia are often asymptomatic. People may present to general practice unaware that they are at risk of STI or without understanding they need screening. A large study of sexually active young female students in London looked at health-seeking behaviour and found that 79% had attended their GP within the preceding year, with only 14% having attended Sexual Health Clinics(83). This raises concerns about missed opportunities as of those found to have chlamydia, 69% had been seen by a GP and not screened(83).

HIV screening and care of HIV positive people has been an area in general practice that has been stigmatised(84). A report on HIV stigma in primary care exposed concerning practices such as refusing to take blood or do smears on people with HIV and the practice of double

gloving for procedures or single gloving for simple external examinations(85). In the UK, 13% of people living with HIV are undiagnosed(86). Over the last 20 years, medical school teaching has helped fuel myths around HIV such as negative impact on ability to get a mortgage or insurance. This has led to members of the public either not being offered HIV screening or, in worse cases, being turned away when they ask for testing in primary care(87). Pillay and colleagues developed the following representation of the barriers to access to HIV testing in general practice(88).

Figure 7 - Barriers to access of HIV testing in general practice by Pillay and colleagues(88)



One argument against providing STI screening in general practice concerns consuler or patient embarrassment(89). A patient attending general practice does not expect to be asked about sexual health, especially when they attend with a potential unconnected condition(88). In contrast, a patient attending sexual health clinics expect to consult about sexual health. A challenge in general practice is appropriately raising the issue of SRH (89). GPs feeling less comfortable talking about sexual health was positively associated with constraints around history taking and not offering screening. This was more obvious in older male consulers than younger females (34). This has led to general practice playing a lesser role in managing STIs and a secondary care driven service provision(90,91).

Educational interventions in general practice have been shown to positively impact SRH; for example, a training programme in general practice increased HIV testing within the area(88). The same programme was evaluated and found to significantly impact health provider behaviour(92). The importance of sexual history taking in general practice has been repeatedly highlighted(89,93,94). Over the last 20 years, there has been minimal progression with improvements in SRH in general practice. Matthews and Fletcher called for more asymptomatic screening and LARC provision in 2001 in line with National Strategies to improve SRH in the UK(89). The evidence is clear that general practice has an essential role in contraception provision and STI screening, yet practice, policy and commissioning have been slow to engage(95,96).

1.4. Access to healthcare services

The following section explores access to healthcare and different frameworks, which help to understand further how people seek care. The process of accessing healthcare is dynamic and complex, with individuals and services interacting. In its most basic terms, it is simply the ability of an individual or population to obtain healthcare(97). The purpose of accessing healthcare is to have a health need met quickly and appropriately. This also includes the opportune access to address health needs that may be subclinical or preventative(98).

When thinking about inequalities, there are two compounding factors that can impact access to services. Firstly, some groups are more vulnerable to poor health outcomes, such as migrant populations, their challenges accessing services are a concern for health service providers and policymakers alike(99). Secondly, there are inherent factors within health services and national strategies that cause access barriers(100). Systemic and structural racism within a health system can impact how a person presents and have their need met(101). The European report of the World health organisation, addressing inequalities in health, described equitable healthcare as(102);

“..fair arrangements that allow equal geographic, economic and cultural access to available services for all in equal need of care.”

A vital aspect of this report is that different socioeconomic groups have different health needs, and services must be dynamic to allow opportune access. When discussing the role of health services, the report states(102);

"The end goal of 'equity in health care' would be to closely match services to the level of need, which may very well result in large differences in access and use of services between different socioeconomic groups, favouring the more disadvantaged groups in greatest need."

Healthcare professionals and services have a role in actively reducing inequalities in access to healthcare(102). Understanding the inbuilt and structural barriers to services access helps us create a more transparent and adapted system. The concept of cultural competency can help us understand the complex interplay between an individual with a health need and the healthcare professional and its impact on stigma and inequalities(103).

There has been a change in how people access healthcare with the development of technology and new ways of delivering care. This was conceptualised by Fortney, who explores the weaknesses of traditional concepts around access when looking at access in terms of technology(104). There is also discussion about the growing digital divide in healthcare, which moves towards non-encounter based communication(25,104).

Access to primary care

Primary care access remains a top priority both globally and in the UK for patients, politicians, policymakers and HCPs(105,106). This seems to stem from the research, which shows that national healthcare systems with a strong primary care element are associated with better patient experience and outcomes and low health system costs(107).

Gatekeeping has been associated with lower healthcare costs and expenditures(75).

Conversely, it is linked to delayed cancer diagnosis and poor patient satisfaction(108,109).

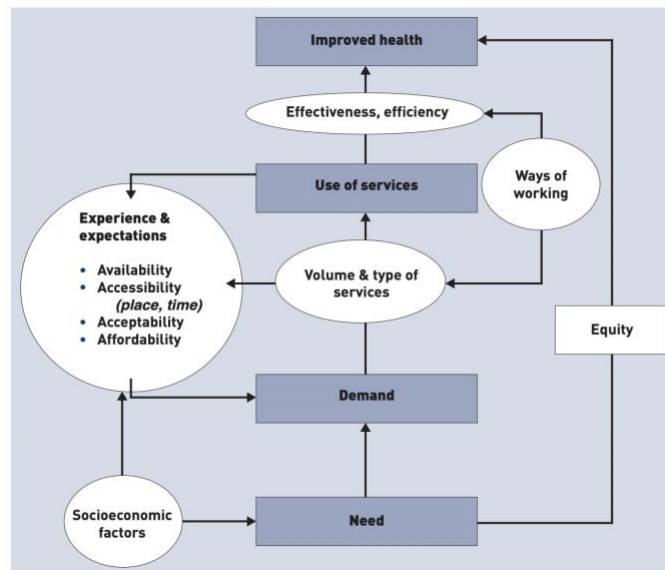
Recent studies have suggested that the gatekeeper role of general practice in the UK, along with constrained resources, contributes to an overburden(26,110).

Pendleton described three factors that need to be considered when exploring access to primary care(111). Firstly, there need to be effective services that support and achieve the ideal of health. Secondly, access needs to be equitable and not biased by socioeconomic

status or ability to pay. Finally, services need to be culturally sensitive and account for users' ideas, concerns and expectations(111).

Salisbury further explored the complex dynamic of primary care to include factors such as supply and demand as well as organisational factors that affect access, this is presented below(112).

Figure 8 – Model of access to primary care by Campbell and Salisbury(112)



The Campbell and Salisbury model builds on previous access models to specifically understand the demands of modern general practice. The overall aim is to improve health but in the context of equity and understanding the impact of socioeconomic factors on access experience and expectation(112).

To manage increased demand in primary care, the implementation of various technologies has been introduced to increase access and provision(105). This technological adoption was propelled by the COVID-19 pandemic. There have been unintended consequences of using online consultations which have led to restricting patient access(113). The widespread use of video consultations has not happened with practice either not adopting them or abandoning them even in the setting of strong policy drives(114). The impact of remote consultations on access has been a concern, especially as more contacts were made in this way during the pandemic. Caution has been raised about the widespread use of remote consultations due to concern about the impact of increasing inequalities(25).

1.3.1 Theoretical models of access to healthcare

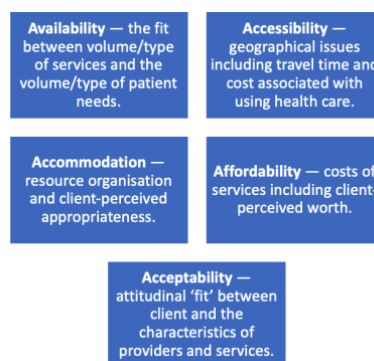
Models of access are used to explain complex health-seeking journeys. They allow researchers to use a framework to understand the complexity of access and give policymakers areas to focus improvements to services. These models can be used as a theoretical framework that forms the foundation from which to build knowledge in the process of research. Eisenhart described a framework as “a structure that guides research by relying on a formal theory...constructed by using an established, coherent explanation of certain phenomena and relationships”(115). It allows a lens through which the research can be regarded and helps develop a blueprint for the research.

One of the research challenges around access is that there are many different concepts of what access means. There are several different models used to conceptualise access to healthcare. This section will explore these further.

Penchasky and Thomas 1981(116)

One of the more well-known access models is shown below and has five domains that reflect access to healthcare(116). The model’s core principles are about the ‘fit’ between the person accessing and the service they try to access. Previous access models described access in terms of utilisation or need, with an assumption that if a service was provided then it would be used(117,118).

Figure 9 - Representation of Penchasky and Thomas domains of access 1981

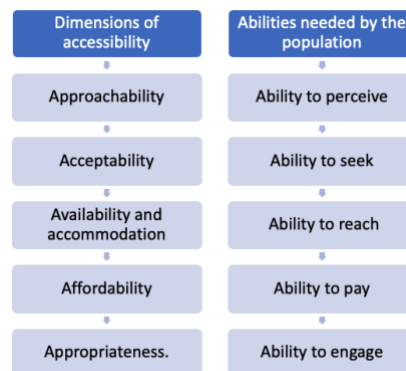


This was modified in 2016 by Saurman to include ‘awareness’ as a vital aspect of access(119). This resonates with this research study as awareness is a crucial aspect of pregnancy prevention and STI screening.

Levesque and colleagues 2013(98)

Levesque developed a holistic conceptual framework based around broader definitions of access to, and accessibility of, health care services. The following model considers the characteristics needed by the individual or community to access a service(98).

Figure 10 - Representation of Levesque's model of access



The model has been popular for researchers looking at access for people who have inequitable provision, for example, primary care for indigenous people in Australia(120). The model offers valuable insight not only to access but also engagement in a service which has implications for ongoing health interventions.

Gulliford's framework of access 2002(97)

The following framework was developed by Gulliford to explore access in the context of the NHS in the UK(97). It has become a popular framework and is used extensively.

Figure 11 - Representation of Gulliford's framework of access



A recent publication by Higginbottom looked at barriers to accessing maternity care by immigrant women using Gulliford's concepts about access (121). This framework on access

aligns with National Institute for Health and Clinical Excellence (NICE) research recommendations on access and models of service provision. It offers a pragmatic and straightforward way to look at access within a complex system like the NHS but may be oversimplified.

The following section explores the candidacy framework of access that has been chosen for use in this research study.

1.3.2. Candidacy framework

Dixon–Wood and colleagues developed the concept of ‘candidacy’ in 2005 from a literature synthesis about inequalities in access and utilisation of health care(122). There is concern that access to services is inequitable, and there are clear patterns of unbalanced uptake of services between different groups, for example, between affluent and deprived communities(123). The concept of candidacy aims to explain the complex physical and behavioural journeys people make, from self-identifying a need to successfully serving that need(124).

Traditional approaches to access have focused on the supply of services meeting the demand of service users; when supply equals demand, then access is no longer an issue(117,118). Others argue that even universal healthcare systems foster health inequalities, and further exploration is needed to understand why(123,125). Candidacy offers a unique framework to conceptualise help-seeking, healthcare structure and access. The concept of candidacy is described as:

The ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services.... [It] is a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals, including how 'cases' are constructed. Accomplishing access to healthcare requires considerable work on the part of users, and the amount, difficulty, and complexity of that work may operate as barriers to receipt of care. The social patterning of perceptions of health and health services and a lack of alignment between the priorities and competencies of disadvantaged people and the organisation of health services conspire to create vulnerabilities(124).

The candidacy framework is formed of seven interlinking and overlapping stages which are presented in the following table. This has been adapted from Dixon-Woods seminal work and SRH has been added to bring context to the stages.

Table 1 - Candidacy framework described in the context of SRH, adapted from Dixon-Woods (122,124)

Candidacy Framework	Dixon-woods (2005/2006)	Examples of SRH access
Identification of candidacy	A persons recognition and response to a symptom. Influenced by own knowledge, health literacy, community behaviour.	<i>Identifying need for an STI screen due to unprotected sex.</i>
Navigation of services	A persons awareness of what services are available and ability to mobilise practical resources or assets needed to attend service	<i>Taking time off work to travel on 2 buses to get to central sexual health clinic for an STI screen.</i>
Permeability of services	More porous services require less qualifications of candidacy and less mobilisation of resources to attend. Less permeable services require a higher degree of cultural alignment for example booking systems, needing to read appointment letters.	<i>Needing to call the clinic at 8.30am each morning, navigate a telephone automated system and speak to a receptionist to book an STI screen.</i>
Appearing and asserting candidacy	A person making a claim to candidacy for medical attention or intervention. They need to provide a coherent history and articulate the issue, have formulated a health need which requires a level of understanding.	<i>A person asking for condoms in a GP appointment.</i>
Adjudication	Healthcare professionals judging worthiness of the candidacy claim and Interlinks with perceived social deservingness.	<i>GP not suggesting an implant as contraception method as they have been unreliable attending appointments in the past.</i>
Offers of/resistance to services	An intervention or treatment course has been offered but declined by the person in need.	<i>Declining offer of cervical screening when in for a practice nurse health check.</i>
Operating conditions and local production of candidacy	Interactions between health care professional and patient which can be affected over time. Includes the perceived or actual availability and suitability of resources in a particular setting	<i>GP turning a patient away when they ask for an HIV test as perceived as not funded in primary care.</i>

Several previous papers have demonstrated the utility of the candidacy framework for understanding the processes involved in access to care including cancer screening, heart disease, domestic violence, ethnic minority elders and south Asian children with asthma(126–130). Normansell and colleagues have explored access and attitudes to STI screening using the candidacy framework, which added a better understanding of interpretation and evaluation of symptoms(131).

An article by Llanwane suggests that the candidacy framework is a helpful tool to understand access within general practice(132). The article examined the ideas around negotiating the consultation, focusing on 'wasting doctors' time', describing the battle to legitimise the decision to present to the doctor. It refers to the stages 'appearing at services" and 'adjudication', which can lead to 'asserting entitlement' as described by Dixon-

Woods(124). Although this paper mainly discusses minor illnesses, similar conclusions could be drawn regarding SRH where patients are well or asymptomatic.

Mackenzie described domestic violence disclosure to general practitioners as the idea of seeking candidacy(130). The research highlights the impact of adjudication and response to disclosing, which can fundamentally affect how women experience support. The personal belief system of the healthcare professional can be crucial in supporting these women. They have the right to support whether they can leave their abuser or not; unfortunately, the paper shows the level of negative judgement and behaviour of HCPs. The impact of a negative experience when disclosing domestic violence will have potential implications for disclosure in the future.

Disclosure of symptoms may also be affected by previous unfavourable GP adjudication. Tookey used the candidacy framework to understand doctor-patient interactions and perceived eligibility to disclose cancer alarm symptoms(126). The interplay between 'symptoms not being taken seriously' and 'patient responsibility' are the main themes around professional adjudication. Trust and communication were also described as impacting access. This highlights the complexity of the interaction between patient and doctor, which can impede or allow access(126).

Bikker examined the interplay between lay epidemiology, perceived cancer candidacy and participation in bowel cancer screening(129). Many parallels can be drawn between this paper and screening for STIs. For identification of candidacy, the patient must have some rhetoric for personal responsibility for their own health and a basic understanding of risk. People were more likely to self-identify for screening if they have experience in their wider community of those with cancer. In SRH, people do not tend to talk about adverse outcomes due to the taboo. This may impact self-identification.

The area of interest in this review is adjudication by HCPs, primarily GPs or practice nurses. This intertwines with the idea of gatekeeping, a term used to describe the role of GPs and primary care health professionals in allowing or validating access to investigations, laboratory tests and onwards specialist referral(109). It has a significant impact on how a patient can access care and has implications concerning SRH. In the UK, the only way to

access speciality services in the NHS is to refer from general practice. The only areas where this does not apply is accident and emergency, obstetrics, and sexual health clinics. As sexual health services become more restricted and financially constrained, services must be provided within general practice. Unfortunately, the gatekeeper analogy suggests that the 'gate is opened' based on need, but each 'gate' has a personal belief system, knowledge and attitude of both patient and practitioner(109). This is more pronounced when tackling a taboo subject such as SRH, with concerns about rationing of services.

Despite a growing number of primary studies, to date, there is no evidence synthesis of the barriers and facilitators to accessing SRH in general practice and thereby suggesting a way of improving access. Access to SRH in general practice is complex, and there is a gap in understanding of this area.

1.3.4. Concepts that complement the candidacy framework

The section explores concepts that have helped complement the candidacy framework in exploring access to SRH services in primary care.

Cultural health capital - Shim(133)

Cultural health capital was defined in 2010 by Shim, who built on the work by Bourdieu on cultural capital(133,134). According to Bourdieu, cultural capital consists of the social assets of a person (education, intellect, style of speech and dress, etc.) that promote social mobility in a stratified society(134). Cultural capital comes in three forms—embodied, objectified, and institutionalised; Bourdieu argued that cultural capital maintains the distribution of power within society and allows the persistence of inequalities(134). Shim developed an understanding of what characteristics an individual might have, which helped them negotiate the health care system and allow access.

The following diagram presents Shim's perceived characteristics rewarded within the healthcare system(133). Shim's work was in the US context but likely parallels UK healthcare.

Figure 12 - Adaptation of Shim's cultural health capital(133)

- Knowledge of medical topics and vocabulary, which in turn depends upon an understanding of scientific rationality and health literacy
- Knowledge of what information is relevant to health care personnel
- The skills to communicate health-related information to providers in a medically intelligible and efficient manner
- An enterprising disposition and a proactive stance toward health, both of which presuppose a sense of mastery and self-efficacy
- The ability to take an instrumental attitude toward one's body
- Belief in the value of, and the resources to practice, self-discipline
- An orientation toward the future and its control through calculation and action
- A sensitivity to interpersonal dynamics and the ability to adapt one's interactional styles
- The ability to communicate social privilege and resources that can act as cues of favourable social and economic status and consumer savvy

This concept helps develop an understanding of access to SRH services in general practice. New migrant populations, young people, black and ethnic minority groups, and teen parents are disadvantaged by their cultural health capital, worsening health inequalities(135). This model fits well with the study focus on the positive and negative aspects of the interaction between HCP and patient regarding SRH.

The 'doctor-as-person' – Balint(136)

Balint explored the complex interaction between patient and doctor; emotions can be provoked in the doctor by certain presentations in the patient(136).

“the doctor and patient are influencing each other all the time and cannot be considered separately”.

This may be relevant when considering SRH issues such as sexuality, abortion, and sexual risk-taking behaviours. Understanding the concept of 'two-person medicine' may help explore further the interactions happening in the consult(136).

Patient-centredness - Mead and Bower(137)

Mead and Bower described the different factors which can influence the doctor-patient relationship. At a more distant level, they represent 'shapers' such as cultural norms and clinical experience, impacting specific determinants such as gender or attitude(137). This notion of being shaped by environment and social background may help understand some of the healthcare provider's stigma and taboo around certain aspects of SRH.

These models are helpful to look at the system with different levels, including system, provider, and patient. It includes the broader impact of policy and setting to describe the complex barriers.

1.5. Summary

Access to SRH is complex and challenging to understand. Numerous factors affect how an individual accesses care; this involves factors unique to the person, the community, and the social context in which the services are being provided. To reduce inequalities, a better understanding is needed of the specific barriers to access these communities to access services. General practice has a vital role in reducing health inequalities and improving access, but there seems to be obstacles preventing this.

Using the candidacy framework helps to differentiate some of the complex factors which challenge or facilitate access at the various stages of the journey. Focusing on the complex interaction between someone seeking access and someone who can give access gives us a new understanding of the process.

2. QUALITATIVE EVIDENCE SYNTHESIS (QES)

Using the candidacy framework to understand access to sexual and reproductive healthcare (SRH) in general practice

This chapter contains the qualitative evidence synthesis (QES), focusing on factors that affect access to SRH within a general practice population. This synthesis of literature uses the candidacy framework, which has been discussed in the previous chapter, to provide a comprehensive understanding of the different stages of a person's journey to healthcare.

Research question

What are the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare (SRH) access?

Aim

To undertake a QES exploring barriers and facilitators to accessing SRH in a general practice setting, using the candidacy framework to explore practitioner and public perspectives.

Objectives

To determine what evidence has been previously published regarding access to SRH in general practice.

To extract relevant qualitative data from the included papers that will address the aim of this review.

To conduct qualitative evidence analysis via thematic synthesis to identify critical considerations for access to SRH in general practice.

To synthesise these themes using candidacy as the theoretical framework.

2.1. What is a Qualitative Evidence Synthesis?

Flemming and Noyes describe a QES as '*a type of systematic review that brings together the findings from primary qualitative research in a systematic way*' (138). The technique helps to gain a greater understanding of topics, especially when issues might be subtle or sensitive, which primary qualitative research might not frequently address. They also

describe how QES can provide a greater understanding of experiences, views and beliefs or health priorities for certain groups or individuals. This resonates with the topic of this synthesis which aims to address access to SRH in general practice.

QES has become an increasingly popular method for exploring a range of subjects and complexity, helping to address gaps in knowledge. This may include exploring health-related behaviours, barriers, and facilitators to care or implementation of interventions. As a research method, QES has become increasingly popular, as described by Thorne(139). This important role of qualitative evidence synthesis has been recognised by The World Health Organisation(140) and in the British Medical Journal(141). Cochrane reviews are a systematic synthesis of primary research in healthcare and policy; they are an internationally recognised resource that is used for decision-making and guideline development(142). In recognition of the importance of QES, The Cochrane Qualitative and Implementation Methods Group was initiated. The aim of the group is to lead development methodology to benefit the wide QES research community, and they provide a series of papers from which this review draws (143).

The rapidly increased use of qualitative synthesis has raised concern among those who fear researcher bias and confusion between messages and meaning, which can be inferred from studies(139). This concern was confounded by the confusion over terminology and methodology used for QES; Booth describes the extensive terminology used for conducting synthesis(144). In response to this, Cochrane classified QES into three main types of synthesis (thematic synthesis, framework synthesis, meta-ethnography)(145). This QES is a framework synthesis using the candidacy framework. Using a framework helps to accommodate the complexity of access to SRH; justification for the use of the candidacy framework was discussed in the background chapter. As this is pragmatic healthcare research, the model may be adapted if themes develop which do not fit within the chosen framework.

2.2. Method

Booth and colleagues suggest a systematic approach to conducting a QES. This included four stages; search, appraisal, synthesis and analysis(146). This structure will be used in the following section to highlight methodological rigour. This is an approach to the systematic review and synthesis of findings from multiple studies to add a deeper understanding of the topic.

2.2.1. Search

A preliminary scoping review was used to identify the range of qualitative studies focused on SRH and general practice. This found that a synthesis does not yet exist with a specific focus on our review question. This was also used to help improve the search strategy by understanding key domains, which might give a more refined search result. A structured methodological approach to the search was undertaken as defined by Booth(147).

The following electronic databases were searched initially in 2018 at the start of the project and then updated in January 2022 to update the results: MEDLINE, EMBASE, PUBMED and Web of Science. The search strategy included only terms relating to or describing the review question and was developed with advice from the University of Sheffield research librarian. It was challenging to find a search strategy that identified relevant studies. Key domains included [general practice] [contraception] [practice nurse] [sexually transmitted infection], but the full electronic search strategy including MESH terms is included in Appendix 1 – Search terms. The search terms were adapted for each of the electronic databases. There was also a process of snowballing where the reference pages of relevant studies were examined and publication histories of prominent academics in the field, and this led to further articles being included.

The searches were limited to the English language, full-text papers. The date of publication was limited to the last 20 years. The rationale for this was that we wanted studies to be relevant to current society in the context of sexual and reproductive practices; much has changed in terms of acceptability and normalisation of subjects such as contraception, LGBTQ+ and sexual practices.

Quantitative studies, case reports, reviews and conference abstracts were excluded as our research question focuses on primary qualitative research. Papers were included if they met the following criteria:

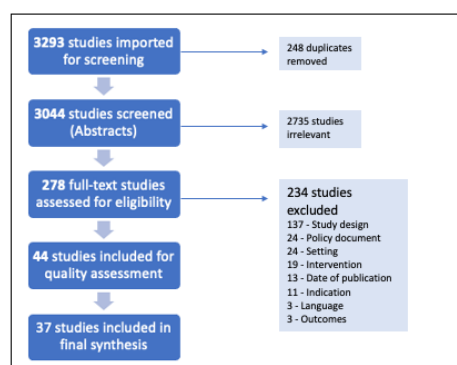
Table 2 -Inclusion and Exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • General practice setting • Published within the last 20 years • Primary qualitative data, including mixed methods. • High-income settings with universal access to general practice • English language. • Health topics including contraception, sexually transmitted infection, sexuality, and gender identity. 	<ul style="list-style-type: none"> • Antenatal, pregnancy or postnatal, sexual dysfunction, erectile dysfunction, female genital mutilation, abortion. • Community clinics not related to general practice (i.e. outreach clinics from secondary care) • Sexual violence. • Systematic or narrative reviews.

(High-income settings as defined by OECD 2008, The Accra Agenda for Action (148))

Results were compiled using the reference manager, Mendeley® and imported into systematic review management software, Covidence® (approved by Cochrane)(149). This allowed an efficient and methodical way of screening large numbers of papers. To reduce bias, three members of the research team were involved in the screening of studies. This included the lead researcher (RM), a colleague (VH) and project supervisor (CM). RM and VH independently screened abstracts and conducted full-text reviews according to the inclusion and exclusion criteria. Conflicts were resolved through discussion (RM, VH, CM). Cochrane guidance was used for quality evidence synthesis and followed the Preferred Reporting Items for Systematic Review and Metanalysis (PRISMA) checklist (145,150).

Figure 13 - PRISMA diagram



Reflecting on the search results, there were large numbers of studies included in the screening process, which took a considerable amount of researcher time. This was made

possible by using the Covidence software. Booth presents the challenges of the search for qualitative studies(147); this included inadequacy of indexing terminology for qualitative methodology, absence of clear descriptions of study samples in the published abstract and use of descriptive non-explicit titles. Often papers did not include key terms in the title or abstract, such as 'general practice' or 'contraception. Several papers needed full-text review as abstracts were not present. This is supported by Dixon-Woods, who reported 23 % of records screened for a qualitative review of support for breastfeeding did not include an abstract (151). The following section explores the appraisal and quality assessment of the studies screened.

2.2.2. Appraisal

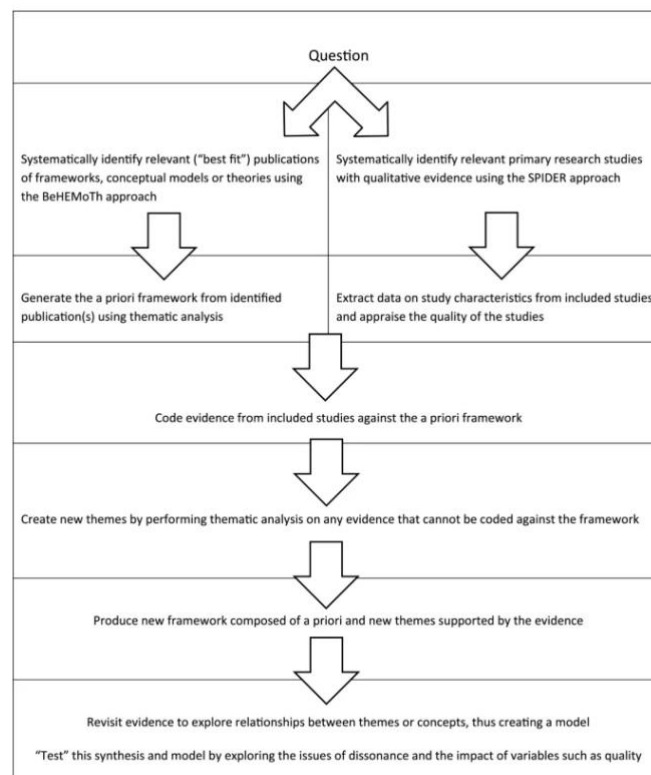
Qualitative research can vary hugely in quality, and we wanted to include high-quality studies to improve the validity of the synthesis. Quality assessment of 54 full-text papers was done using the Critical Appraisal Skills Programme (CASP) Tool for qualitative studies (152). This can be seen in Appendix 2 - Summary quality assessment of qualitative studies (CASP Tool for Qualitative Studies). This tool consists of ten questions that relate to the quality of the research aims; qualitative methodology; research design; recruitment strategy; data collection; whether the relationship between the researcher and participants have been considered; ethical approvals; data analysis; reporting of the findings; and the importance of the research. To avoid bias, the full-text papers were reviewed within our academic department by three people independently (RM, VH, CM). Any discrepancies were discussed, and papers were removed if felt not to be of most relevance and reasonable quality. The studies removed were of poor quality and unlikely to add value to the synthesis. Seven studies were removed; these were not excluded through quality assessment but more methodological rigour of each contributing study. This process contributes to confidence assessments of each review finding and the overall strength of the synthesis.

One of the challenges of quality assessment is the balance of including important themes which might be relevant but from low-quality studies. For example, ethnic minority groups may not be included widely across research studies but feature in smaller targeted studies. This is discussed in further detail in the discussion section.

2.2.3. Synthesis

Framework synthesis was primarily used to review the included studies. Carroll described the concept of 'best fit' framework synthesis, which requires the identification of a relevant framework, theory or conceptual model(153). For this synthesis candidacy framework, as discussed in the background chapter, forms a priori framework. New themes can be developed based on the reviewer’s interpretation of evidence and recursivity. Qualitative evidence synthesis using “Best-fit” framework synthesis from Carroll and Booth 2013 is shown below in Figure 14(153).

Figure 14 - Qualitative evidence synthesis using 'best-fit' framework by Carroll and Booth



Qualitative evidence synthesis using “Best-fit” framework synthesis.

Carroll and Booth describe a technique for systematically reviewing framework, theory or concepts (BeHEMOTH)(154). It was not feasible to complete a full BeHEMOTH synthesis to identify and select a model of access. The candidacy framework was chosen as a framework for the synthesis based as described in the background chapter. The other stages of the 'best fit' framework synthesis are described in this section(153).

The data was extracted from the full-text articles using Nvivo®, which is a computer-assisted qualitative analysis software package(CAQDAS)(155). To synthesise the studies, where possible, the original quotes and primary material were extracted for thematic analysis. On occasion, the findings of the author were extracted as this gave an additional richer and deeper level of understanding to the text. Framework analysis was used to explore the data(156). This consists of five stages: familiarisation, identifying a thematic framework (in this case, candidacy), indexing, charting, mapping, and interpreting(157). Initially, themes were coded against the existing stages of the candidacy framework. Subsequently, new themes based on the reviewer's interpretation were developed and an adapted model was developed.

Within this synthesis, the viewpoints of healthcare professions and members of the public have been treated with the same weight to draw similarities and differences. All data was approached in the same way, whether it was from a patient, member of the public or healthcare professional. There is an argument for giving more weight to the perspectives of the patients or members of the public as this gives an objective explanation of access. A key aim was to understand more about the journey to access in terms of the consult and healthcare provider barriers and facilitators. For this reason, their views are included with the understanding that they are subjective and perceived. The synthesis of the papers drew methodology and guidance as if primary qualitative research were being undertaken(158,159).

The demographic and diversity analysis of participant characteristics was analysed using an Excel® database. The developed codebook from Nvivo® is included in Appendix 3 – Nvivo codebook QES.

2.2.4. Analysis

The final stage of Booth's systematic approach to QES is analysis(153). This forms the discussion section of this chapter, so it is not described in detail here. The analysis will consider the line of argument in terms of overarching themes which aim to reconcile the different studies. It will also include any discrepancies or gaps in the literature.

2.3. Findings

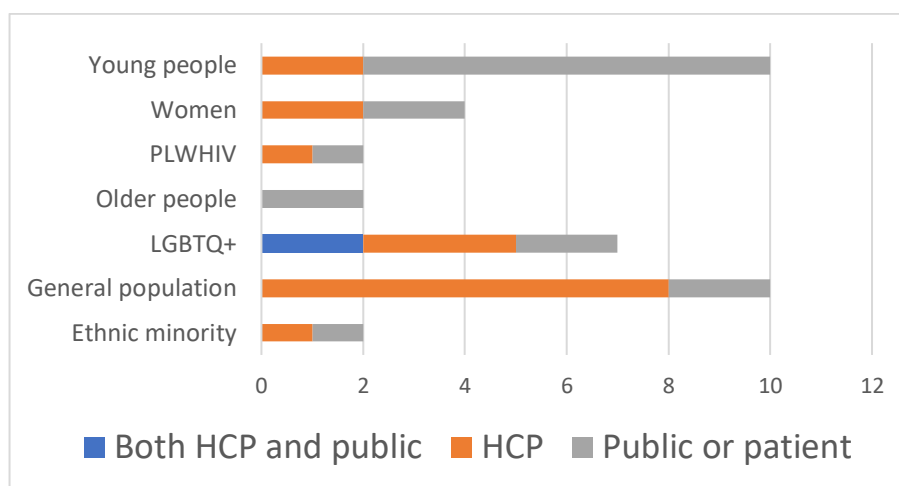
The following section presents the findings, firstly the study characteristics and secondly the themes explored within the candidacy framework.

2.3.1. Study Characteristics

The QES included thirty-seven studies comprising of primary qualitative research from general practice. The studies were in Australia (n=9), Canada (n=1), England (n=19), Ireland (n= 2), Norway (n=1), Netherlands (n=1), New Zealand (n=1), Scotland (n=2) and UK (n=1).

The studies included healthcare workers, members of the public or services users. Some included views from both groups. The population groups of interest in the studies have been grouped for clarity and displayed below.

Figure 15 - Graph representing participants and topics in QES



(PLWHIV – People living with HIV)

17 of the studies included HCPs only, this included GPs, practice nurses, experts in the SRH field and general practice staff members.

2.3.2. Study participant demographics

Twenty of the studies included participants who were members of the public or patients; this included 632 participants, 58% female and 42% male, as identified by the study. Age ranges for the studies varied considerably, between age 15 and 92.

In terms of diversity, 9 of the 20 studies had no mention of participant ethnicity; it may have been collected but not presented in the publications. Of the 11 studies which did include the ethnicity of the participants, the challenge of interpreting and synthesising this data was that there was such a variety of ethnic grouping and terminology, which is represented below. This is also presented in the study characteristic table which follows this section. For each study involving members of the public or services users, there is a comment about ethnicity; none, brief (mentioned it but minimal description) and extensive (includes ethnic breakdown). The category ‘brief’ might include ‘from ethnic minority’ but give no further information.

Figure 16 Variation in terms for different ethnic minority groups

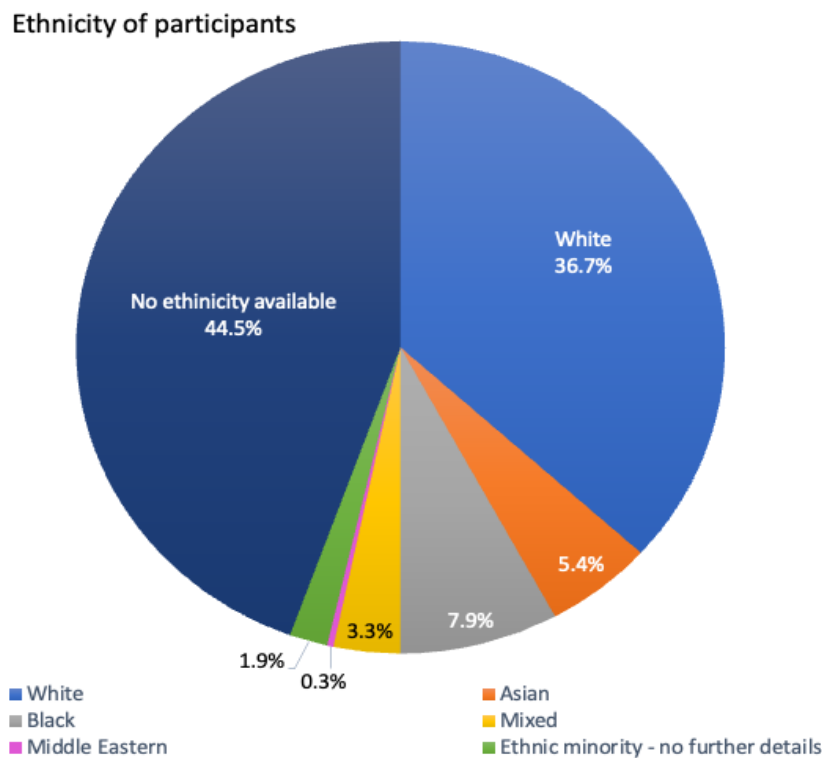
White UK	African Caribbean
White or European	Indian
White other	Irish
South Asian UK	Turkish Cypriot
Asian	White Brazilian
Black African, Caribbean, or British	White USA
Black African	Middle eastern
Black Caribbean	Arab
Black	Ethnic minority
Mixed race	Other

This variation may be due to the studies being done in different countries where there may be different definitions of ethnic minority groups. Interestingly, the studies in Australia tended to not include ethnicity data or have Caucasian participants. This is interesting as white or European ethnicity accounts for approximately only 76% of Australia’s population(160).

Some of the categories of ethnic groups have been merged to form a more straightforward presentation of the data. This is roughly based on ONS groupings of ethnic groups(161). An editorial in JAMA discussed the challenges of using reporting of race and ethnicity in medical and science journals(162). It highlights the impact of terminology, usage and word choice can have on those being described as well as causing bias within the research.

One of the 20 studies included a focus group in Punjabi (163) which was conducted by a bilingual researcher. Four of the 20 studies specifically said they excluded participants who were not proficient in English (131,164–166) with Keogh reflecting on how the may skew results away from people who are not literate in English.

Figure 17 - Represents the percentage of participants (member of public or patients = 632) from different ethnic groups included in the research



In terms of deprivation, there was minimal mention of deprivation in the 20 studies which included participants or members of the public. Nine of the studies used purposive sampling to increase diversity from ethnicity or deprivation, or both. Two of the studies purposively sampled general practice areas to include some from deprived communities to allow for a representative sample. Education level or occupation seemed to be used as a proxy representation of social status. Four studies included occupation, employment status or income of the participant (165,167–169) and three studies included educational background (163,168,170).

In summary, the studies which include members of the public or patients represent more female participants than male. It is challenging to make comments on how diverse the population groups were due to the missing data; those who did include ethnicity or some comment on social status were studies where this was part of the research question. Unless the study was specifically looking at LGBTQ+ related research, then the demographic about sexuality and gender identity was not presented in the studies.

Below is a summary table of the studies used within the QES.

Table 3 - Summary of studies included in QES

Author. Year.	Location of research	Focus of study	Journal	Data collection method	Participants	Title	Health issue of focus	Ethnicity data included
Balfe 2009(171)	Ireland	Young people	BMC Public Health	Interview	Service users	What prompts young adults in Ireland to attend health services for STI testing?	STI testing	No
Balfe 2010(172)	Ireland	Young women	BMC Public Health	Interview	Service users	Young women’s decisions to accept chlamydia screening: influences of stigma and doctor- patient interactions	STI testing	No
Beagan 2015(173)	Canada	LGBTQ	Canadian medical education journal	Interview	GP	Family physician perceptions of working with LGBTQ patients: physician training needs.	LGBTQ	N/A
Bjorkman 2007(174)	Norway	Same-sex-attracted women	Scandinavian Journal of Primary Health Care	Interview	Public	Being lesbian – does the doctor need to know?	LGBTQ	No
Burns 2007(175)	England	HIV	AIDS Care - Psychological and Socio-Medical	Interview	Experts	Why the(y) wait? Key informant understandings of factors contributing to late presentation and poor utilisation of HIV health and social care services by African migrants in Britain	HIV	N/A

			Aspects of AIDS/HIV					
Cant 2002(176)	England	MSM	Primary Health Care Research and Development	Interview	Public	An exploration of the views of gay and bisexual men in one London borough of both their primary care needs and the practice of primary care practitioners	LGBT	Brief
Cant 2006(177)	England	MSM	Health and Social Care in the Community	Interview	Public and managers	Exploring the implications for health professionals of men coming out as gay in healthcare settings	LGBT	Extensive
Collyer 2018(178)	Australia	Young men	Australian Journal of General Practice	Interview	GP	General practitioners' perspectives on promoting sexual health to young men	STI testing	N/A
Dixon-Woods 2001(167)	England	Women	Sexually transmitted infections	Interview	Sexual health service users	Choosing and using services for sexual health: a qualitative study of women's views.	STI testing	Brief
Ejegi-Memeh 2021(170)	England	Women with diabetes	Journal of advanced nursing	Interpretative phenomenological	Member of the public	Sexual health discussions between healthcare professionals and midlife-older women living with Type 2 diabetes: An interpretative phenomenological study	Sexual health	Brief
Ewert 2016(165)	Australia	Young men	Sexual Health	Interview	Students	'Most young men think you have to be naked in front of the GP': A qualitative study of male university students' views on barriers to sexual health	STI testing	No

Fairhurst 2005(179)	Scotland	Emergency contraception	Family Practice	Interview	Mixed healthcare professionals	"Not that sort of practice": the views and behaviour of primary care practitioners in a study of advance provision of emergency contraception	Contraception	N/A
Freeman 2009(180)	England	Chlamydia	BMC Public Health	Focus group	Staff in general practice	Promoting chlamydia screening with posters and leaflets in general practice - a qualitative study	STI testing	N/A
Gott 2004(90)	England	Sexual health	Family Practice	Interview	GP and practice nurse	"Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care	Sexual health	N/A
Gott 2003(181)	England	Older adults	Family Practice	Interview	GP patients	Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people	Sexual health	No
Heritage 2008(182)	England	Young people	Reproductive Health	Focus group	School students and GP patients	A study of young peoples' attitudes to opportunistic Chlamydia testing in UK general practice	STI testing	Brief
Hinchliff 2004(183)	England	Gender-barriers	European Journal of General practice	Interview	GP	GPs' perceptions of the gender-related barriers to discussing sexual health in consultations A qualitative study	Sexual health	N/A
Hinchliff 2005(54)	England	LGBTQ	Health and Social Care in the Community	Interview	GP	'I daresay I might find it embarrassing': General practitioners' perspectives on discussing sexual health issues with lesbian and gay patients	Sexual health	N/A

Hocking 2008(184)	Australia	Chlamydia	BMC Public Health	Interview and questionnaire	GP	What needs to change to increase chlamydia screening in general practice in Australia? The views of general practitioners.	STI testing	N/A
Hogan 2010(185)	England	Young people	BMC Public Health	Interview	GP patients	'...they should be offering it': a qualitative study to investigate young peoples' attitudes towards chlamydia screening in GP surgeries	STI testing	No
Joore 2017(186)	Netherlands	HIV	International Journal of STD & AIDS	Interview and focus group	GP	General practitioners' barriers and facilitators towards new provider-initiated HIV testing strategies: a qualitative study	HIV	N/A
Keogh 2016(164)	England	HIV	Primary Health Care Research and Development	Focus group	Sexual health service users and public	Learning from the experiences of people with HIV using general practitioner services in London: A qualitative study	HIV	Extensive
Latreille 2014(187)	Australia	Young men	Australian family physician	Interview	Students	Finding a segue into sex: young men's views on discussing sexual health with a GP.	STI testing	No
Llewellyn 2012(168)	England	STI testing	Sexually transmitted infections	Focus group	Service users	Understanding patient choices for attending sexually transmitted infection testing services: a qualitative study.	STI testing	Extensive
Lorch 2015(188)	Australia	Chlamydia	BMC Family Practice	Interview	Practice nurses	Practice nurse chlamydia testing in Australian general practice: a qualitative study of benefits, barriers and facilitators	STI testing	N/A
Lunniss 2016(189)	Scotland	Contraception	Journal of Family Planning and	Interview	GP	Views of general practitioners on providing contraceptive advice and long-acting reversible	Contraception	N/A

			Reproductive Health Care			contraception at the 6-week postnatal visit: A qualitative study		
Ma 2005(190)	England	Chlamydia	Journal of Family Planning and Reproductive Health Care	Interview	Mixed healthcare professionals	Chlamydia screening in general practice: views of professionals on the key elements of a successful programme	STI testing	N/A
Malta 2020(166)	Australia	Older adults	Australian journal of ageing	Interview	Members of public	'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care	Sexual health	No
Mikulak 2021 (191)	UK	Young trans people	British Journal of General Practice	Interviews	Health professionals	Health professionals' identified barriers to trans healthcare: a qualitative interview study	LGBT	N/A
McNair 2015(169)	Australia	Same-sex-attracted women	Australian family physician	Interview	GPs and public	Disclosure for same-sex attracted women enhancing the quality of the patient-doctor relationship in general practice.	LGBT	Brief
McNulty 2004(192)	England	Chlamydia	British Journal of General Practice	Focus group	Staff in general practice	Barriers to opportunistic chlamydia testing in primary care	STI testing	N/A
Newman 2013(193)	Australia	HIV	Sexual Health	Interview	GPs and experts	Engaging non-HIV specialist general practitioners with new priorities in HIV prevention and treatment: qualitative insights from those working in the field	HIV	N/A

Normansell 2016(131)	England	Sexual health	Health Expectations	Interview	Students	Exploring access and attitudes to regular sexually transmitted infection screening: The views of young, multi-ethnic, inner-city, female students	STI testing	Extensive
Pavlin 2008(194)	Australia	Chlamydia	BMC Infectious Diseases	Interview	GP patients	Take the sex out of STI screening! Views of young women on implementing chlamydia screening in General Practice	STI testing	No
Sutcliffe 2011(195)	England	Sexual health	Sexually transmitted infections	Interview	Service users	Comparing expectations and experiences of care for sexually transmitted infections in general practice: a qualitative study.	STI testing	Extensive
Tuomainen 2013(163)	England	Preconception health	BMJ Open	Interview and focus group	Public	Opportunities and challenges for enhancing preconception health in primary care: qualitative study with women from ethnically diverse communities	Contraception	Extensive
Woodbridge 2015(196)	New Zealand	HIV	Journal of primary health care	Interview	GP	'He said he had been out doing the traffic': general practitioner perceptions of sexually transmitted infection and HIV testing strategies for men.	STI testing	N/A

2.4. Results

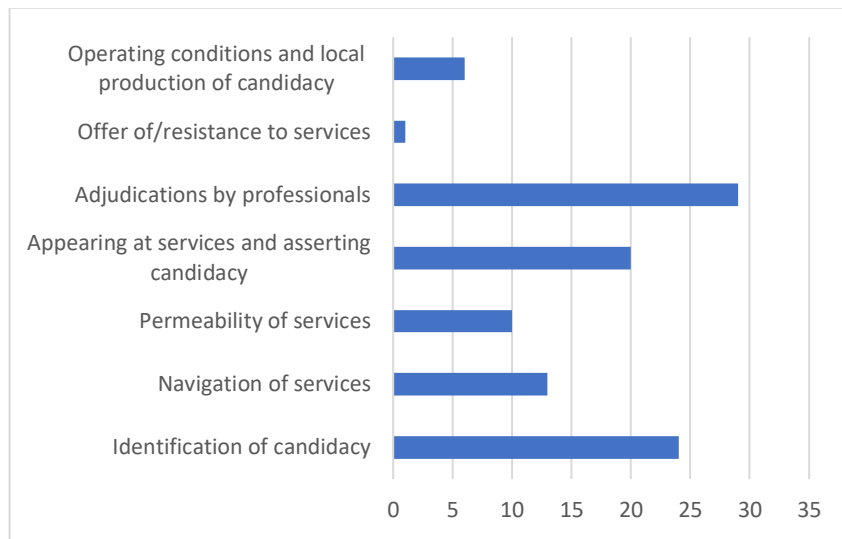
The following synthesis of evidence uses the candidacy framework to understand the different stages of a person's journey to access SRH services, and it incorporates various psychosocial factors which may influence decision-making and behaviour(124,125). The framework outlines seven 'over-lapping stages' involved in the process of access care and can be applied to understand how a person comes to seek healthcare and navigate services. The synthesis is presented in a stepwise format, but the stages are interlinked, and challenges at one stage will impede others. The following table is a reminder of the stages of the framework.

Table 1 - Candidacy framework described in the context of SRH, adapted from Dixon-Woods (122,124)

Candidacy Framework	Dixon-woods (2005/2006)	Examples of SRH access
Identification of candidacy	A persons recognition and response to a symptom. Influenced by own knowledge, health literacy, community behaviour.	<i>Identifying need for an STI screen due to unprotected sex.</i>
Navigation of services	A persons awareness of what services are available and ability to mobilise practical resources or assets needed to attend service	<i>Taking time off work to travel on 2 buses to get to central sexual health clinic for an STI screen.</i>
Permeability of services	More porous services require less qualifications of candidacy and less mobilisation of resources to attend. Less permeable services require a higher degree of cultural alignment for example booking systems, needing to read appointment letters.	<i>Needing to call the clinic at 8.30am each morning, navigate a telephone automated system and speak to a receptionist to book an STI screen.</i>
Appearing and asserting candidacy	A person making a claim to candidacy for medical attention or intervention. They need to provide a coherent history and articulate the issue, have formulated a health need which requires a level of understanding.	<i>A person asking for condoms in a GP appointment.</i>
Adjudication	Healthcare professionals judging worthiness of the candidacy claim and Interlinks with perceived social deservingness.	<i>GP not suggesting an implant as contraception method as they have been unreliable attending appointments in the past.</i>
Offers of/resistance to services	An intervention or treatment course has been offered but declined by the person in need.	<i>Declining offer of cervical screening when in for a practice nurse health check.</i>
Operating conditions and local production of candidacy	Interactions between health care professional and patient which can be affected over time. Includes the perceived or actual availability and suitability of resources in a particular setting	<i>GP turning a patient away when they ask for an HIV test as perceived as not funded in primary care.</i>

To give an understanding of the density of themes that were coded in the articles, this graph below shows the number of studies that are coded to include the different stages of the candidacy process.

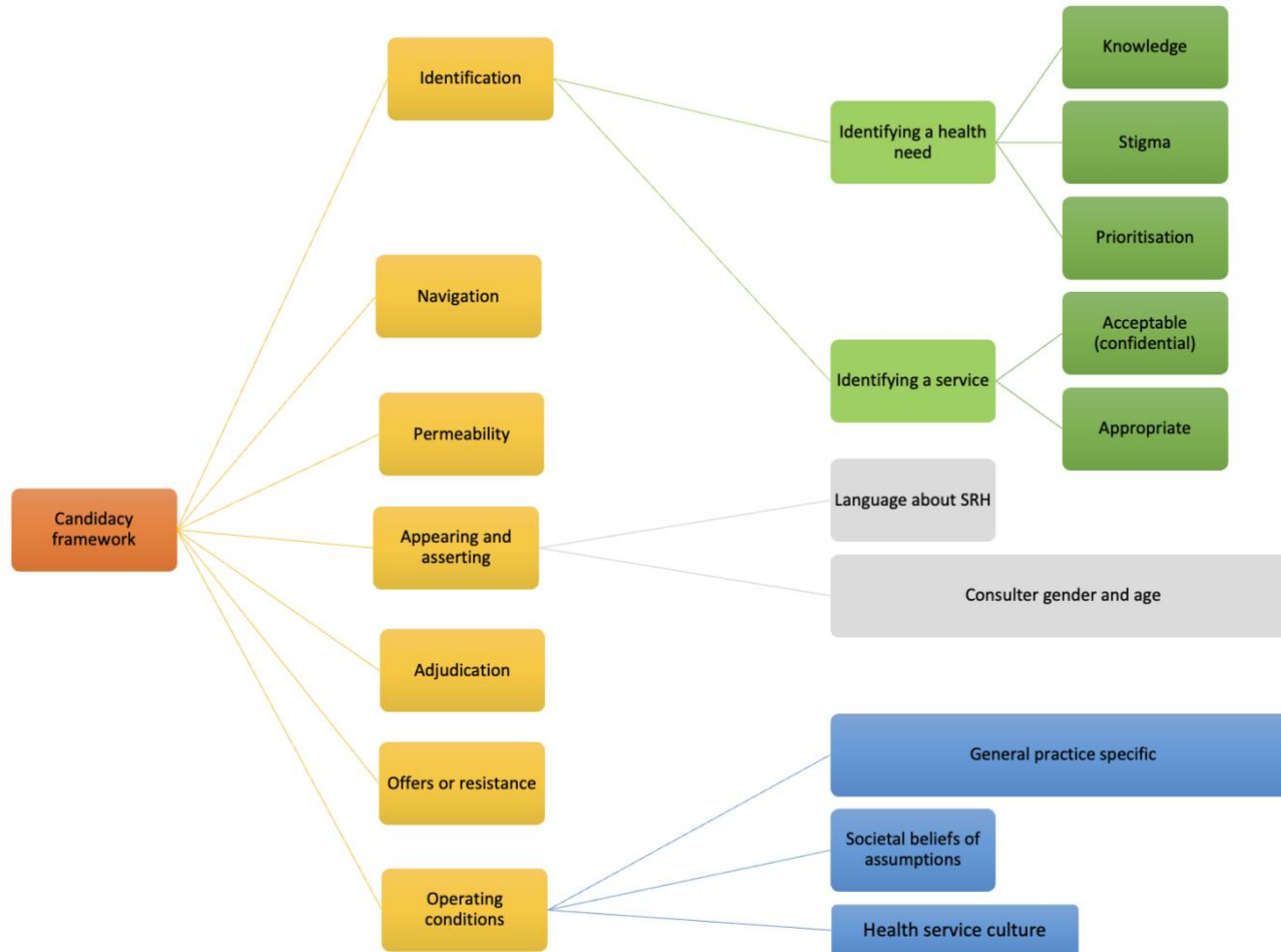
Figure 18 - Number of studies containing codes for the stages of candidacy



The study by Normansell and colleagues used the candidacy framework to explore access to regular STI screening for young, multi-ethnic, inner-city students(131). None of the other studies used this framework for analysis.

The QES uses quotes from the studies to demonstrate themes, the participant identifiers have been adapted for conformity. Not all the studies included the same amount of detail about participants.

Figure 19 – Summary of the candidacy themes which were developed in the QES



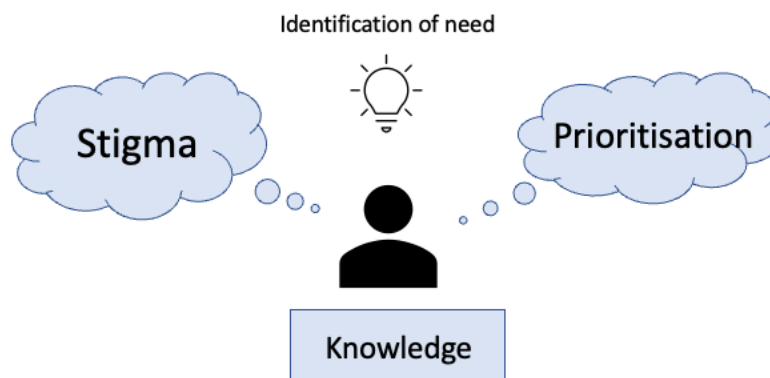
2.4.1. Identification of candidacy

The first stage of the journey towards healthcare access as set out in the candidacy framework is self-identification, or recognition, of a need to access a service(124). Within this, there are two themes present in the synthesis; identifying a need and then identifying acceptable and effective healthcare on offer which relates to that need.

Identifying a health need

A common theme highlighted in all the articles was around the identification of a health need. Within this, there were broad overarching themes, knowledge, stigma, and prioritisation. These are explored further in the following sections.

Figure 20 - Representation of Identification of need



Knowledge

24 of the 35 studies included in the synthesis presented evidence that knowledge is a crucial factor that shapes the identification of candidacy. An example of this was poor knowledge of asymptomatic sexually transmitted infections, and people are more likely to identify a need if they have symptoms.

Most people I know just say, if it looks all right, it's fine. (Male, 16 years old) (187)

Conversely, knowledge sometimes improved identification, especially around concerns of future implications of STIs.

It's not very clear that all you have to do is pee in a pot. (Male, 20 years old) (185)

Oh obviously they check your whole genitalia. You have to take....pretty much....think they stick a camera up there, but I know someone, I can't remember

what it's called though. But probably they just – they'd check it out and they do blood tests or something. I don't know. I can't really remember. (Male, 16 years old) (187)

A subsection of knowledge that was prominent, especially with relation to younger adults, was about risk identification and transitional moment which led to seeking medical care. Latreille describes how young men have a poor understanding of STIs and can catastrophise STIs (187). Personal traits such as invulnerability and macho image were described in three of the studies(165,171,187), which focused on young people and particularly men, the authors suggesting this would make them less likely to self-identify a need such as sexual health screening or contraception.

'It's not something you want to have with you, because once you have it, you can't really get rid of it.' (Male, 20 years old) (187)

Young men seem to be poor at identifying themselves as needing access to sexual health services. Healthcare practitioners working with young men suggest delayed identification of candidacy as described by the following GP.

Young men tend not to come to the doctor, as a cohort. Men, in general, tend to ruminate and self-diagnose or ignore, and often only come in as a last resort. (Male GP, 58 years old) (178)

For those with knowledge around asymptomatic STIs, a reason for identifying candidacy was fear of future complications.

I just wanted to make sure I didn't have anything. I got a full testing like. Just for peace of mind. I could end up not being able to have children or like, I don't know, getting someone else not able to have to children. (Female, late teens) (171)

My main concern is to cause infertility, I'm so scared about this, because I have this in my mind that...I'm infertile... (Female, 20 years old, other white background) (131)

Balfe describes a 'transitional moment' which leads to the identification of candidacy(171); this describes a changing focus from different parts of life or work that require different

mindsets. There are various examples of this described. For a person exiting a phase of life that was riskier such as an increased number of sexual partners or from a high-risk relationship, STI screening was a way of bracketing that time.

I was maybe 24 and I was just moving in with a guy and we'd bought a house and we were going to be having unprotected sex and going on the pill so I said, right, I'm getting everything checked out. (Female, late 20 s)(171)

Balfe discusses the ritualistic aspect of this cleansing process or cleaning and ending a phase understood by the individual to be riskier(171). Access may also be linked to a one-off episode of unprotected sex with an unknown partner. STI screening seems to provide emotional reassurance and re-establish a more respectable version of self.

Stigma

A predominant theme that became apparent during the analysis was the impact of stigma on the identification of an SRH need. The term stigma has been used to encompass a range of different aspects, including shame, fear of judgement, fear of consequences and embarrassment. This section explores these ideas within this theme. Stigma as a barrier was mentioned in 15 of the studies.

... They find it a bit ashamed telling what they've done to the doctor, so a bit of embarrassment. (Male, 18 years old, International, sexual preference not disclosed)(165)

Shame about the topic of sex was a theme that was prominent in 7 of the studies(168,171,172,174,181,182,185). Sexual health issues seem to be perceived as lifestyle-related issues, and people described feeling embarrassed about accessing care.

I think sex is a thing that is very much pushed under the carpet, and we don't talk about it, we are ashamed to talk about it, it isn't something you go to your doctors for. (Female, Single, divorced, 66 years old) (181)

Patients make a risk assessment of their sexual partners based on geographic origin or their appearance. Using a term such as 'dirty' when making judgements about partner's risk status.

If they had AIDS or herpes, I presume I would have noticed something. But this one was so random and drunken and stupid. And I don't know the guy, he was from Africa. I know that's an awful preconception but if he didn't want to use a condom with me, I presume he didn't use one with anyone else. (Female, early 20s) (171)

I had a lying, cheating bastard of a boyfriend... I found him in bed [with another woman] and an automatic reaction was, right, I'm going to get myself checked. (Female, 26 years old) (167)

There was also a theme around blame which prevents people from seeking diagnosis and care, whether it be fear of being blamed themselves for their behaviour or that they may need to look to others who may have caused their condition.

... a lot of my friends struggled the first time just 'cos it's, yeah, an uncomfortable situation. You've got so many questions before it happens, [...] but yeah after the first time it's fine. (Male, 19 years old, Australian, same-sex attracted) (165)

Because ladies just didn't talk about [sex]... We were brought up not to talk about that sort of thing. Like "down there" you just didn't. (Female, 73 years old) (170)

As well as the fear of being blamed, there was also a fear of consequences which makes people not wish to seek diagnosis due to fear of the implications on themselves and others. The language used by the participants shows the negative connotations of SRH diagnosis.

I'd feel embarrassed cos then it won't be a secret. If my parents were exposed to it as well, I would be more ashamed, then I wouldn't be able to look at their face and talk to them face to face as I used, cos I would know, that they know what I have now... especially if my mum was with me. (Asian female – wearing a Hijab) (182)*

As well as embarrassment, there was a fear of being judged by the healthcare professional.

...afraid that the doctors and nurses are gonna judge them, that, that's what I think (Female, 24 years old) (185)

Accessing screening or treatment for sexually transmitted infection can impact on perceived 'good or bad' identity. Those portrayed as needing STI testing were perceived as being more promiscuous and 'bad'. This is described by Balfe when talking to young people about chlamydia testing.

Interviewer: So if you knew that you were being offered screening because the doctor thought that you were being more risky [than other young women] you'd be a bit more offended? Respondent: I would feel offended if I was singled out for testing. That seems ridiculous but I think I would honestly. It would be important to say that everyone's being tested. It would make it more normal, to say everyone's doing it. It's a bit more acceptable. (Female, late teens, student health GP) (172)

Knowledge was seen as a critical factor in accessing and identifying SRH services, and this also links into the next section on prioritising oneself for care.

Prioritisation

SRH not being a priority was a theme present in 14 of the studies, either the individual not prioritising their own health or prioritising SRH within the context of their life. Even when services are provided in general practice, there may be challenges attending for some people. One health care provider raised deprivation as a barrier to access.

Our trouble is not all women come for their 6-week check. We're in a deprived area and many forget all about coming. [Female GP, 44 years old] (189)

Priorities change through a persons' lifecycle. Things that might influence access when older might not be the same when they are younger.

The problem is some of the risks because they're long-term.. .for instance infertility, teenagers don't necessarily think of it. So you do need those sort of almost more shock tactic ones.. . These are the effects of gonorrhoea where it's absolutely disgusting. I think those would work more because I remember at fifteen I didn't want kids; the fact that I could become infertile it didn't make a blind bit of difference to me because I didn't want kids. At 20 I'm thinking, 'ooh in a couple of years I could start a family. (Female, 20 years old, other mixed ethnic background) (131)

There was a theme around people being unsure how to prioritise their SRH, especially when they felt well.

We go to doctors when we're ill, but actually what advice we are getting from the doctors about how we potentially prevent other illnesses or other things that maybe happening to us? (...) I think a bit of planning through your general practitioner may actually help you long term kind of thing. (Female, aged 36–45, Caribbean ethnicity) (163)

This idea of accessing a GP only when you are unwell was a predominant theme throughout the literature. Burns concluded their discussion that '*Health is only a priority when one is unwell; otherwise issues around immigration, housing, employment, and childcare take precedence*' (175). This highlights the challenges people have prioritising health, especially when they are well and have other demands.

Identifying that there is an acceptable and effective healthcare offer

The previous section focused on an individual identifying themselves as having a need, but there was also a theme identified within some of the studies about the identification of a health service. Whilst this may overlap with knowledge about services that are available, there were distinct themes involving identifying acceptable and available healthcare. This section explores barriers within this theme which include the availability of services in a particular location as well as the acceptability of services.

One study which focused on LGBTQ+ access barriers explored how lack of availability to poor geographic access can impede someone identifying to a service. This was in reference to gender identity clinics in the UK.

There [are] so few Gender Identity Clinics around in this country... They simply cannot cope with the demand of the trans patients. (Trans female GP) (191)

For the individual to self-identify to a service, it must be acceptable to them. Confidentiality or perceived confidentiality is a vital aspect of this.

Even though obviously doctors are you know confidentiality is important I probably predict some people will be scared in case they said to their mum. (Female, 18 years old) (185)

Coming from a small town where everybody knows each other, you'd probably be terrified that it would get out [that had accepted screening offer] (Female, mid 20s, urban middle-class GP) (172)

Following this theme about confidentiality was also the concern that the GP knows the family members; a young person reflects this in the following quote.

He knows your family and you kind of think when you are sitting there, he knows my mum, he knows my brothers and stuff like that and knowing that you're at things like that. (Female, 15 years old) (167)

Eight of the studies raised this issue of our health system being heteronormative, which means that people from the LGBTQ+ community may feel unwelcome or silenced.

Or prejudices or that it will be difficult for the doctor so that I don't get good treatment, because he is so preoccupied with me being a lesbian, and that he then erects a barrier against me or something. (Female, aged 28-59 years old, who self-identified as lesbian)

Some people may not want to disclose their sexuality due to feeling it will interfere with their care, or they may be negatively affected.

I don't trust the doctors to understand enough about what I'm saying; there isn't time and I'd be worried about any kind of prejudice; the last thing you want if you've been beaten up is for someone to sit in judgement on you. (Male, gay or bisexual)(176)

The analysis identified patients 'shopping around' for GP's or practices that they felt more culturally aligned to; this was more prominent in the HIV care and MSM groups. Many described putting substantial effort into finding a suitable GP.

I researched my GP. I asked some people locally and went to four different surgeries and stayed with one, but I never get to see my named GP. I found out that one of them used to work in [named London HIV clinic]. I went to seek him and seek him out each time and he's absolutely fantastic. (Male, MSM, Co-Morbidity Group)(164)

In summary, identification of candidacy is a crucial aspect of negotiating SRH care and involves issues around identifying self and identifying a service. The most commonly described barrier was around knowledge and the impact of this on stigma and shame.

2.4.2. Navigation

Following the identification of candidacy is the navigation of services which refers to the work involved in decision-making and help-seeking. Navigation requires an understanding of what services are available as well as the ability to mobilise practical resources which are needed to appear at the service. This evidence synthesis provided substantial evidence to support navigation being an essential aspect of access, with 13 studies describing it as a barrier. SRH can be accessed via general practice, or people can access sexual health clinics directly. This led to two different themes emerging, people who found access preferable via their own general practice compared to people who wanted access straight to secondary care. Three of the studies describe confusion over who offered which service,

... can my GP even test this for me,[...] or would he like have to send me to a specialist first? (Male, 21 years old, Australian, heterosexual)(165)

In the study by Sutcliffe, there was a theme about the GPs not providing consistent care comparing practices, on respondent voicing frustration that her own GP was saying go to sexual health clinic but a friend being able to get the service from her GP.

I thought they'd give me more advice, I don't know I went there and they just, she was so well you need to go to the GUM clinic we can't do it here, which I thought was liked because my friend had been to the same doctor's as me and she had it done there. (Female, 23 years old, GUM clinic)(195)

There is, however, more confusion over what services are offered in which practice due to geographic and individual differences in provision.

... Some people they don't know where to go, like me [...] do I go to a hospital and just say at the front desk or is there like a specialised person who deals with these issues? (Male, 18 years old, Australian, sexual preference not disclosed)(165)

One patient describes an assumption of a more thorough service from the sexual health clinic.

My personal preference would be to have them at GP surgeries. [but] the problem with GPs surgeries at the moment they can do, I think it's level one STI testing, they can't do the full range like the [local GUM clinic] can and so you can't get a full screening. Whereas if they could do a full screening you could attend your GP's surgery. (Male, younger MSM)(168)

Those who preferred to access through their general practice liked the fact that it was a place where any healthcare could be accessed and a place where they felt comfortable. Two studies reported a preference for convenience and participants being happy with the services offered by their GP.

I'd prefer it (screening) at the doctors.... I've been coming here basically since I was born.... So, I like coming here. (Male 19 years old) (185)

if you're in a general waiting room, nobody knows exactly what you're there for, so if you're seen it would be better than being in a specific building. you feel a little bit awkward when you're with the GP talking, but at least that's only one awkward situation rather than a whole build-up as well. (Male, older Heterosexual) (168)

Others reported a preference for anonymity over convenience and would feel uncomfortable seeking care via GP. Others felt that they wanted a service that is away from the local area as fear of small communities knowing why they are there and what they are being screened for.

I think it has a few drawbacks because in fact specific times aren't convenient for everybody. You come into the doctors and everybody knows at this point, it's when they {are} screening for chlamydia, you don't want anyone to see you going in about this time and that can be a bit embarrassing for some people. (Male, 24 years old) (185)

Within this, some GPs are perceived as having less knowledge than their hospital colleagues, so patients will prefer access via secondary care. This may be mediated by previous

knowledge and experience, especially if they have immigrated from a country with a different model of general practice.

My GP is supposed to know something about sexual health but to be honest I'm not sure they do. I just wouldn't have the faith. That's why they send people off to consultants - because they're the ones who know about these things. (Person with HIV) (168)

For younger people navigating sexual health services can be challenging. Often younger people rely on parents or family members to help them access care and do not have the practical resources. They may rely on these people for practical measures such as transport but also knowledge of services.

... If I was alone then yeah, but like, as for all my visits my parents have been in there as well, so I think that could be a bit awkward. (Male, 18 years, heterosexual) (165)

A woman describes a reason for the delay in accessing treatment as being due to the challenge of missing work to get an appointment with a sexual health clinic.

The reason why I hadn't got checked out earlier is just trying to get an appointment in an STI clinic is very, very hard, especially when you're working full time. And even though they sometimes have a drop in time to go there, but sometimes it's not actually convenient times when you're working. (Female, 27 years old, GP practice) (195)

Interestingly, the only articles mentioning the cost of care were the ones in Ireland where the cost of services deterred immediate navigation. It highlights the impact of cost on navigation.

I mean you could go to your GP and maybe get something done quicker but I went to the clinic where it was free because I couldn't afford to pay whatever to your GP like 50 or 60 euro to see him on top of whatever it costs to get those tests done. (Female, late 20s) (171)

None of the articles mentioned issues such as travel cost or other practical resources needed to access healthcare, and this may reflect the focus on general practice within the review, which should be local and require minimal resources to access.

2.4.3. Permeability of services

In the candidacy framework, permeability is understood as the ease with which people can use services. Services might be more or less permeable depending on the qualification of candidacy needed to access them, for example, a referral, and to the degree to which resources need to be organised(124).

The notion of permeability had clear resonance in the studies reviewed, with over half mentioned barriers around getting an appointment. There was an essential theme within permeability about 'drop-in' clinics which are services either in general practice or sexual health where people do not need an appointment.

I feel it's more suitable like youth based and I feel like they've got more time kind of thing if I need it. Because I know that GP clinics are busy and trying to get an appointment. you know it can be hard work. (Female, 18 years old, GP) (195)

This compares to the challenge of trying to get an appointment through telephone booking systems.

Because it's difficult, it's like a rat race here [GUM clinic] at 9 o'clock in the morning and when I've just arrived at work, you know, spending all the time on the phone it just really didn't go down too well. (Female, 26 years old) (195)

With regards to people accessing general practice but needing sexual health-specific services, those who were given a referral letter or for whom the GP made a GUM clinic appointment described attending the GUM clinic more quickly than those who had only been told to attend or were given a phone number to call the GUM clinic themselves.

She just give me the number for ... (GUM clinic) and said you have to go to a special clinic....she was no help at all. You know being a doctor you should be more caring. These things happen she should be more caring; she could have booked the appointment or given me a letter or something...(Female, 23 years old) (195)

This reflects the way a healthcare professional can help facilitate the permeability of services by simply offering a referral letter or booking the appointment on behalf of the patient. Unfortunately, this is time consuming process.

One area where issues around the permeability of services seem to be most apparent is in HIV care, a condition that needs chronic disease management. There was evidence that general practices were helping permeability of services for HIV patients by identifying them and 'fitting them in' for an appointment.

Before, my GP was very good. If I have an issue and call for an appointment, if they have nothing for today, they will fit me in the next day. With this one, they tell me to call back next day and each time I call, they tell me they are fully booked and to call back the next day. (Female, African Group) (164)

Most patients will have a GP and a specialist who manages their HIV. Patients describe a 'ping-pong' between services.

So now, my consultant gives me a letter saying 'you need to prescribe this' and I take it to my GP and that's the only contact I have with my GP! I don't even trust that the letter will be delivered so I take it there myself. For me it's a hassle and a waste of my time and their time. (Male, MSM Group) (164)

Permeability of services varies between general practices and between sexual health clinics; an important facilitator was that testing was offered opportunistically or drop-in services were available. Barriers include complicated telephone booking systems and limited appointments per day.

2.4.4. Appearances and asserting at health services

This stage of the candidacy framework refers to the ability to self-present, communicate and articulate the 'need' or issue to a healthcare professional(124). Twenty studies referred to appearing or asserting oneself. The overarching theme through these studies was about discordance or disparity between patient and consulter. Different age of the consulter compared to the patient was highlighted as a barrier in several studies. The gender of the healthcare professional was a common barrier for asserting candidacy. This varied

depending on the gender of the person accessing, but predominantly women wanted female consulters.

I just think it's a lot easier to talk to a woman when there's something wrong. Especially about women's stuff. They'd understand more. (Female, late teens, rural GP) (172)

As well as gender, age discordance between individual and provider seemed to have an impact on asserting candidacy.

I mean, if there is a similar age, it would be easy and open but if you see this GP being 60 years old, you would automatically think, OK, they are people who are conservative; I shouldn't ask about sex. We should get younger GPs to help with the young people. (Male, 19 years old) (187)

Twelve studies mentioned language as being a barrier within the consult predominantly; this was language around sex and how to express symptoms or sexual behaviour. There were two themes around language; first, about how language and terminology might cause confusion and misunderstanding. Second, language can cause offence or make people feel excluded.

The language around sex can cause confusion. Three of the studies described the use of slang terms, and this led to misinterpretations. This quote describes the challenge this patient is having to express himself and be understood

A classic quote one of the guys made was, he said he had 'been out doing the traffic' ['cruising' in public places for a sexual partner or casual sex]. He did not have to give an explanation of what he had been up to. (Male GP - High frequency tester, small suburban practice) (196)

The following quote exposes the use of language can cause offence or exclusion.

I saw a GP ... and she asked me if I had a steady boyfriend. And I said, "Well, not like my friends, because they are straight. Guy and girl". She goes, "okay well I'll put you down as single". (Female, bisexual, 25 years old) (169)

Discordance in the language is reflected by terminology about sexuality and gender identity, which leads to challenges for patients asserting candidacy as they may have a same-sex partner, but heteronormative society leads to misgendering.

I think that terminology and language is poor. I think GPs grapple and struggle just to really understand conversations around [gender] identity... [including the] use of pronouns. (Cisgender female GP) (191)

Interestingly, there was minimal evidence of language in terms of people who were non-English speakers struggling to assert themselves. The ten studies that did include ethnic minority groups excluded people who did not have adequate levels of English. This may explain why there was a lack of evidence for how ethnicity and socio-cultural background might act as a barrier. Interpreters or translators were not used in any of the studies. In the study by Normansell, 8 out of the 17 participants did not have English as their first language, but they were all UK students, so they could speak adequately(131).

2.4.5. Adjudication

Once a patient has asserted their candidacy by presenting to a healthcare professional, the judgements made by the professional about that candidacy can have an influence on subsequent management and intervention(124). The studies involved in this synthesis had a wide range of informants and topics, with a bias towards young people and topics of LGBTQ+. The themes in this section are predominantly related to sexuality and judgement related to heteronormative views of HCPs. The themes represent those that are presented first-hand by HCPs as well as the impact of these adjudications on future presentations by the patient.

Twenty-nine of the studies contained themes related to adjudication or the process by which an HCP will validate or invalidate someone's candidacy. It is important to remember that the studies chose these quotes to represent specific themes and are likely to be outliers in views or behaviours of HCPs. An example of adjudication was the topic of prescribing a homosexual man treatment for erectile dysfunction, especially in the context of not being in a 'stable relationship'.

I have relatively few [barriers] over heterosexual relationships; homosexual relationships I find a bit more difficult, prescribing Viagra for homosexual men I think is a bit dubious ... I think it's a slightly inappropriate use of resources really, but it's probably my prejudices, I'm prepared to admit that ... particularly if they are not in a stable relationship, I don't see it's appropriate. (Male GP, 50 years old) (54)

In some cases, the HCP described that they felt they could not maintain an objective opinion of someone who had different sexual practices to them.

I think exposure to different practices which one wouldn't subscribe to – no, let's personalise this one – which I wouldn't subscribe to, and some of which I find personally repugnant in some ways, is rather difficult to maintain an objective and detached view yet at the same time encourage the patient to talk about these issues by appearing to be quite facilitatory. (Male GP, 42 years old) (54)

This theme about avoiding facilitating discussion also encompassed ways that HCP would avoid raising the topics of SRH. There is a concern from the HCPs that asking about sex may be too time-consuming, opening a whole new area for discussion.

There is another issue that you haven't raised yet and this is a can of worms issue in if you're running to a schedule and you broach areas which are potentially incredibly complicated and insoluble and maybe you're outside the ability to do anything about it anyway and then what good does it do you or them? (Male GP, aged 40–49) (90)

In some respects, making judgements is part of the decision making for HCPs. This involves risk stratification, for example, when screening for HIV in pregnant women.

We still don't get a hundred percent screening for HIV in pregnant women, you know, which completely amazes me because GPs are still making decisions around who might have it and who might not. (Non-prescribing GP) (193)

This issue arises when the decision-making process is biased or based on assumption. Within this, there are assumptions that HCPs make about who wants to disclose information.

I assume everyone's heterosexual unless they tell me. (Female doctor, 47 years old) (169)

There were many examples of HCPs having homophobic or transphobic views, with a sense that doctors and nurses felt more comfortable managing heterosexual intimate issues.

I am not very comfortable with any decisions made to change one's body using hormones and surgical treatments. I try not to let my prejudices get in the way. ... I don't see that half-hearted mutilation is of any benefit. I don't want to share these feelings as I am not in the field and don't appreciate the benefits attained by these patients. ... I will be non-judgmental treating them. But at the same time wondering why. (Male GP) (173)

There was a paradox of HCPs feeling uncomfortable and disagreeing with being gay or transgender but then qualifying it with a statement that they still provide the same care.

I'm against it [homosexuality] as a person but that doesn't mean that it will influence my practice towards a person ... I just treat them like a normal person, treating them physically. That's their own beliefs, own moral issues, I don't have to deal with that. (Male GP, 55 years old) (169)

This lack of culturally congruent consultation relates to a theme about lack confidence on how to deal with the subject, especially if they are not regularly dealing with SRH issues or people who express themselves openly as LGBTQ+.

Boiling it down, a lot of people would like to have a handbook on how to deal with queer people, or how to speak to Chinese people. But it's not that easy. (Female GP) (173)

This relates to the presumption HCP make about what patients want in terms of consulter. An example of this was an older female GP who felt young men might not be comfortable with someone of their age.

With a female GP my age, for some of the younger guys, it might be like talking to their mum, and that would make it a bit uncomfortable. (Female GP, 50 years old) (178)

Male GPs, in contrast, were happy to discuss sexual health with young men.

Because I think they get less put off with it if another man asks them. From that aspect it's less awkward. (Male GP, 36 years old) (178)

Patients describe how the perceived views of HCPs may affect their care, and this shows the level of homophobia or lack of knowledge regarding sexuality.

His attitude was that being gay was something that the Bible spoke against and perhaps I should reconsider my position. (Male, gay or bisexual) (176)

It raises the issue of biological norms and imperatives for HCP to understand their own personal belief systems to minimise barriers to access.

2.4.6. Offers and resistance

This stage of candidacy focuses on the reasons why people might decline a referral or a medication. This interplays with previously mentioned themes such as stigma and fear of judgement. This includes fear of a positive result, in this case, STI screening.

Some people don't like to know their results.. .they'd rather die.. .so it's something like that, just scared of knowing what you've got. (Female, 17 years old, black Caribbean) (131)

The two studies by Balfe focused on access to screening services by young people, and it identifies a theme about how STI screening challenges how a person feels about themselves. This brings fear of positive results and that they will be judged as good or bad, dirty, or clean. Balfe states: *'How screening offers were framed was also thought to be significant. Offers that were framed in such a way that they employed moral surveillance styles of interaction and attacked and undermined respondents 'good girl' identities were likely to be rejected; offers that supported these identities, or at least did not threaten them, were more likely to be accepted'*(172).

Some may feel that they are having a judgement made about the way they live their lives.

Testing for HIV is indirectly linked to somebody's lifestyle. Offering an HIV test is not a good idea when there is no connection with your patient. (Focus group: the routine offer of testing) (186)

Interviewer: Why do you think people would be offended if someone brought it [Chlamydia testing] up with them? Respondent: It's just that you're insinuating something about this person. You're almost criticising them, saying that they're a certain type of person (Female, late 20s, rural GP) (172)

A facilitator to access is the idea of normalisation helps people accept an offer of screening. They do not want to feel they are being picked out or discriminated against because of a particular behaviour or personality trait.

If we had a 'blanket' screening policy, might make it easier if GPs were not required to discuss full sexual history. [Female practice nurse] (190)

Anyone that is sexually active that comes into our clinic we recommend a chlamydia screen, an STI overall screen. And we just get them to do a urine sample and nearly everyone is willing to do it. We have a pretty good success rate in doing the screening. (Female practice nurse) (188)

To reduce the chance that someone will resist or decline an offer of a service, they need to be offered in a non-judgemental and non-stigmatised. This interlinks with issues about knowledge, stigma and shame, which was discussed in the section about the identification of self.

2.4.7. Operating conditions and local production of candidacy

Operating conditions or local production of candidacy is identified as the local influences on the production of candidacy and are hugely important in terms of access to SRH services. It encompasses the locally specific influences that impact the interaction between patients and HCP. There were four themes that emerged from the studies. These are divided into general practice specific, community or person-specific and NHS culture.

General practice specific

By far, the most predominant barrier for access was time restriction of general practice, whether perceived or actual, which occurred in 14 out of the 37 studies. Most GP respondents commented that with an average general practice consult time of 10 minutes, for non-patient driven, non-sexual-health consults, the topic of sexual health would be unlikely to be raised.

I think in general practice there is such a wide breadth of things that you try to address, that it is hard within 15 min to address all of that. (Male GP, high frequency tester, large suburban practice) (196)

Often, there is a lack of time in consultations due to competing demands to cover all health topics. In the tight time constraints of general practice, HCPs may steer away from SRH subjects.

Hypertensives for instance, gosh a lot of them cause impotence... I haven't got anything to back this up with, but my feeling is that the sexual side effects would be mostly neglected, cause it's a sort of Pandora's box isn't it?...you don't sort of want to open up all sorts of thing? (Female GP, aged 50-59) (90)

Each HCP has their own priority system and time constraints; they may not want to accept the SRH need presented. They may have a subconscious bias that sexual associated conditions shouldn't be spoken about and are not part of general practice. There are conscious and subconscious interactions between the two parties. A study looking at older women with diabetes explored this, women felt happy to discuss diabetes but awkward raising sexual topics.

I don't think he would have wanted to [discussing sexual health and wellbeing], you know what I mean? I don't want him to feel uncomfortable (Female, black British, heterosexual, 66 years old) (170)

General practice offers the opportunity for a longitudinal relationship to form between patients and HCP. This impacts how comfortable people feel disclosing personal topics.

The doctor that I have now, she knows that I am a lesbian, and she remembers. And I am there around once or three times a year. And then I become glad inside, when she speaks of "she" or "do you have the same lover and is she ..." and so on. I think it is very nice. Not to have to come out, that the doctor remembers me, and how I live and who I am and so on. (Female, aged 28-59 years, who self-identified as lesbian)(174)

A positive relationship between HCP and patients can help adjudication. This is also apparent with good continuity of care and longitudinal relationship.

I think it's a nice thing to see a GP over time and develop a relationship where you can be quite open about different parts and also feeling like you can throw anything in that they may not have known about before and that would be accepted as being part of you and not just a new bit of information that is there to shock. (Female, gay, 23 years of age) (169)

As well as time constraints being a barrier, continuity in UK general practice challenges the ability to form these cohesive relationships with patients.

My GP is fantastic. When I first came to the country I went to see him and when I was diagnosed, I switched to another doctor who was in the same area and nearer to the HIV clinic. And with them I never saw the same doctor twice. I wanted to build up a relationship with my GP. So, I thought well, I'll go back to Dr. S. who wasn't in my catchment area so I had to use a different address. But I am happy now. (Female, African Group) (164)

With regards to patients with HIV in Keogh study, this cohesive longitudinal relationship helped them trust their GP and improved access.

Societal beliefs or assumptions

Within society, there are beliefs or assumptions made about people from specific backgrounds or demographics with relation to sexual activity.

I think that's something we should do a lot more of because again in our society it's [sexual health] one of those things that is just buried and hidden, and yet you know if you thought. (Male GP, 40 years old) (54)

Gott describes a common perception that sex was less openly discussed by people from specific ethnic backgrounds, potentially related to having different religious beliefs.

I think maybe a lot of the Asian and similar folk probably have been brought up not to discuss these types of things because they were brought up in a less liberal society. (Male GP, aged 30–39) (90)

There are societal beliefs around older adults being sexually active, which means it is less likely to be discussed.

People get told things – that once you reach a certain age things stop happening and you shouldn't expect to feel sexy or to have some sexual activity in your life, but I don't agree with that... Who assumes and when is it decided that we become not interested in sex anymore? What's the cut-off point? (Female, aged 60-69) (166)

The impact of these assumptions is that it excludes people from access by designing services that are not appropriate for them.

Health service culture

In all the studies included in the review, sexual health services are provided in part by general practice and in part by secondary care, either hospital or clinic-based. Sexual health is still seen as a taboo, and services are separate from other NHS services. This is likely propagating the stigma within the community.

It is not helpful to propagate the idea of 'special infections' that need to be treated in a 'special place'... we need to demystify STIs among GPs, secondary care colleagues and the public.(Consultant doctor) (190)

Ma raised the question of moving sexual health screening into general practice and if this will help destigmatise testing.

The NHS is, overall, a heteronormative sphere where heterosexuality is the default. This makes it challenging for sexual minority groups who must negotiate discrimination.

(talking about LGBTQ) They are a stigmatised and discriminated-against group. They just are... There has to be an acceptance of where they are in society. And so, connecting them with peers; connecting them with groups; speaking to them about those gives them a resource and a place where they can have a sense of belonging and support. That's important. (Female GP) (173)

These assumptions about sexuality mean that patients might be silenced or deterred from access, especially when it regards an SRH need.

My sexuality has never been questioned. There's been an assumption made that I'm heterosexual. I have this constant battle ... and you just let it go on I suppose. (Female, gay, 61 years old) (169)

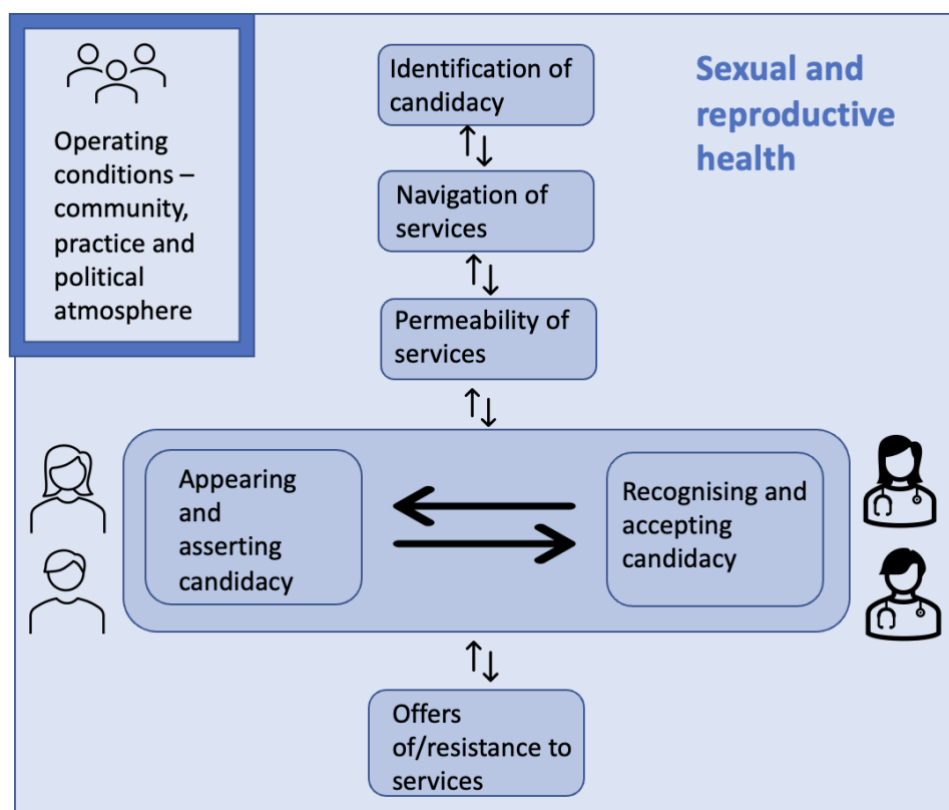
A theme that was generated in the literature was around practitioners and practices behaving in differing ways with SRH. These were presented in three ways. Firstly, proactive behaviour, actively seeking people to screen and offer services. Secondly, passive behaviour, not offering any services and not actively seeking people to screen. Thirdly, reactive behaviour, where the practice or practitioner were happy to help if the patient raised an issue. These different behaviours were evident across many studies (179,182,183,190,192,193).

The three overarching themes discussed in this section have an influence on the negotiation of candidacy. The relationship between the local production of candidacy and the health-seeking behaviour of the person accessing care is complex and multifaceted.

2.4.8. Adaptation of candidacy framework through additional themes

This QES uses 'best fit' framework synthesis to explore access to SRH in general practice, in this case, the candidacy framework. Carroll describes how new themes can be developed based on the reviewers' interpretation of evidence that was not originally captured in this a priori framework(153). An additional theme that was captured during this QES involved the person-to-person micro-interaction that happens in the consultation room. Adjudication is defined as the professional judgements made about the candidacy which the patient has asserted when presenting to the health service. Dixon-Woods describes how this is strongly affected by the local operating conditions, which affect the way in which the practitioner functions(124). This adaptation of the candidacy framework for general practice helps to explore the complex interplay between the person appearing or asserting candidacy and the healthcare professional recognising and accepting candidacy. The figure below shows an adaptation of the framework, aiming to address the interchange between the patient and the healthcare professional regarding SRH.

Figure 21 - Adapted version of candidacy framework

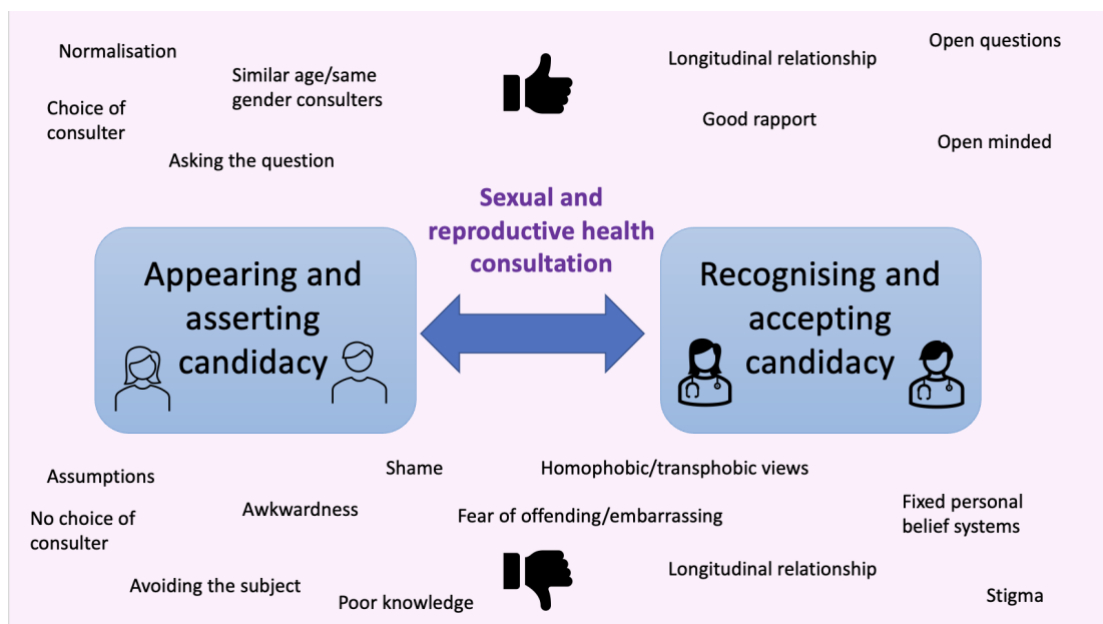


The new theme generates an additional stage of the candidacy level, 'Recognising and accepting candidacy', which considers the influence of adjudication, operating conditions and intricate interaction which takes place in the consultation room. In some ways, this interaction feels like a dance, with both partners pushing and pulling away and together. One is wondering if they should raise the subject of SRH, and the other is wondering if they should discuss it. The following quote looks at older adults raising sexual topics with their GP.

You hesitatingly bring it up in an apologetic manner and they suddenly sit back. They don't say anything. They stiffen up and get a look on their face. Well, you're going to pull back. You're not going to raise it. That's what happens... almost without a word, you are put back in your box... (Female, aged 60-69) (166)

The HCP will be affected by the local operating conditions and by their own personal belief systems, which lead to judgements about worthiness, the adaptation of the adjudication and local operating conditions helps to expand on the importance of the interactional exchange happening in the consult. The following diagram draws together themes that may have a positive or negative impact on this interaction.

Figure 22 - Barriers and facilitators to access of SRH in general practice



This new adaption also helps to explore the use of opportunistic testing and offers of services such as contraception. An interesting theme was the evidence of improving access by opportunistic testing, eighteen of the studies described it as reducing barriers to access. An example of this was offering sexual health screening at the time of smear.

I think that women coming in for smears creates an opportunity to do routine screening that does not tend to exist for men. I am not in the habit of just raising it [sexual health] ... I am a woman, obviously, so that may influence that sort of thing. (Female GP, high-frequency tester, large city practice) (196)

Societal shame and stigma around SRH can impact this dynamic between the patient and professional. Fear of being judged, fear of offending, fear of embarrassment, fear of sexualising a consult. This is less of a barrier if there is a good relationship between the two parties in the exchange. Positive factors include trust, familiarity, professional's recognition of the patient's self (sexuality or gender identity). Negative factors include bigoted or strong personal beliefs on either side, which affect SRH needs to be assessed.

Hopefully, this additional theme focuses on the patient-provider interaction helps to further understand the complexity of how people access SRH services. It adds a way to maintain focus on the person-to-person collaboration, which at its best will help to improve the health of the patient and, at its worse, causes silencing and derogation.

2.5. Discussion

This section draws together overarching themes from the QES and evaluates the candidacy framework as a vehicle for understanding access for SRH in general practice. The final chapter of this thesis is an overall discussion about outcomes and key messages from this QES in combination with the findings of the qualitative interview analysis.

2.5.1. Summary

This QES draws together 37 studies that help to explore the diverse range of issues affecting access to SRH. The candidacy framework was chosen as the 'best fit' model for synthesis and has proven a helpful way of understanding access(124,153). The candidacy framework offers a valuable and highly salient model for understanding access to SRH in general practice. It provides a practical, theoretical framework to understand the complex interactional factors of access to SRH. In particular, the review explored the impact of knowledge, shame, and stigma on access to services. Candidacy offers a mechanism for better capturing the complexity of access by isolating key factors which might influence the journey through health-seeking.

Several components associated with accessing care were mapped to the seven stages of the candidacy framework, including identification, navigation of services, the permeability of services, appearance at the service, adjudication of a healthcare professional, offers of or resistance to services and the operating conditions and local production of candidacy(124). The candidacy framework provides detailed specifications of these factors in the context of general practice. It highlights the continual negotiation between patients, health professionals and the services they are trying to access.

An additional theme has led to developing an adapted version of the candidacy framework. This draws together adjudication and local operating condition to form a level 'recognising and accepting candidacy', which is directly linked to 'appearing and asserting' candidacy.

Key findings from QES

The QES revealed overarching themes about stigma, knowledge, and prioritisation of SRH. This was seen at an individual, community, practitioner, and societal level. From an individual level, the stigma and shame led to self-rationing and fear of health-seeking for

conditions related to SRH, which interplayed with poor knowledge. Knowledge can be gained from communities and social units, which can also perpetuate myths and information. There was evidence of practitioners having perceived or actual poor knowledge about SRH, with a lack of medical education prioritisation. This links with societal shame and embarrassment about any topics related to sex.

There was a theme in the QES pertaining to general practice and how SRH is delivered. Barriers included time constraints of short appointments, poor appointment availability, especially when needed urgently and perceived time pressures to the consultation, which impeded the patient-HCP relationship. These barriers seem especially pertinent when related to SRH as it is seen as a sensitive topic that needs more understanding and empathy. Even with these barriers to access, general practice is preferred for SRH services.

The research highlights how SRH has been formed into silos of care and research. The studies often had a tight research focus, making it challenging to see the broader context of general practice provision of SRH. There was a variable focus in the studies on social determinants of health unless defined explicitly in the research question. The studies with a primary emphasis on LGBTQ+ did not often mention ethnicity or deprivations. Studies looking at ethnic minority groups, HCP and younger people did not include sexuality or gender identity. The studies about LGBTQ+ access used inclusive language for a participant, for example, 'cis-gender female'.

The most concerning finding from the QES was the concept of the HCP as the barrier to access. This defined the impact of personal belief systems or pre-existing bias, which leads to stereotypes, assumptions and judgement about a person seeking health. In some cases, this was innocuous, not offering everyone a sexual health screen or contraception based on the HCP's perception of their risk. In other cases, it was more harmful, people having their sexuality/gender identity denied or silenced, or people trying to access services but being made to feel embarrassed for asking or told to go elsewhere. This has future implications for health-seeking as those having a negative experience were less likely to come back when needed.

2.5.2. Strengths and limitations

This section is explicitly related to the QES as the broader strengths and limitations of the research project are considered in more detail in the discussion chapter.

Strengths

To our knowledge, this is the first QES to use the candidacy framework to improve understanding of access to SRH in general practice. It helps explore a subject in a qualitative methodology that has previously been examined primarily through quantitative methods. The review used triangulation to explore viewpoints of HCPs and members of the public, including different methodologies such as interviews, focus groups and the Interpretative phenomenological approach. The QES included international studies from similar healthcare systems, which aids the transferability of the findings. A rigorous methodology was used, including two independent reviewers, to avoid bias and increase the dependability of the results.

Methodological limitations

It was challenging to identify specific search terms to narrow down results for the review due to the range of subjects in SRH. This meant many studies were screened, which hopefully prevented relevant studies from being excluded, but this was a labour-intensive process. Booth describes the challenges of searching for qualitative studies, especially as keywords were not mentioned in titles or abstracts(147).

The review focused on purely qualitative methodology, meaning that questionnaire-based studies were excluded even though they may have added further to the synthesis. Several studies from Australia were initially included, but on full review were postal questionnaires with no in-depth interview. There was a discussion within the team about whether to include these studies as they had interesting emergent themes although were lacking in rich insights associated with the open questions and qualitative interviews. Still, a decision was made to exclude them as there was too much potential bias from the questionnaire design which incorporated mostly closed questions with limited free-text responses.

On reflection, there may have been studies that discussed access to general practice but not explicitly, and these may not have been identified by my searches. A paper by Mastrocola about street-based prostitutes had mentioned access challenges to SRH in general practice but was not included in the review as it did not fit inclusion criteria(197). There may have been valuable themes in excluded papers, but pragmatically, it would be too complex and time-consuming to review all these articles.

Gaps in the research

There were apparent gaps in terms of participants and their demographics. Within the synthesis, it became evident how little work had been done on the barriers for those living in deprivation to access SRH care through general practice. There was also a lack of literature looking at ethnic minority groups and more vulnerable groups such as looked after children, drug and alcohol users, commercial sex workers and sexual minority groups. This quote by Pavlin summarises an apparent issue across many of the studies(194).

The structure of our study was biased against including the voices of socially disadvantaged women as the women were required to be contactable and to organise appointments in advance, which was difficult for those with a more chaotic lifestyle. (194)

Appearing and asserting oneself can be a significant barrier for people; this is exaggerated when those accessing are young or may not have English as a first language. In the review, there was one study with one focus group in Punjabi, and the remainder of the studies were in the researcher's language. All participants had a high level of spoken English. There was little mention of interpreters or the health literacy of the participants. These socio-cultural differences influence access to and experience of care, the absence in the literature may affect the conclusions drawn from the QES.

There was a bias towards LGBTQ+ communities and younger people who were college students. This over-representation of LGBTQ+ participants is likely to reflect the battle their communities have had to access equitable primary care due to stigma and bigotry by some HCPs(198). One study said they could not ask the participant what their sexuality was due to ethics committee restrictions (54).

Regarding the health care practitioner participants, few of the studies gave demographic details such as ethnicity, place of birth, sexuality. This means little can be derived from the HCP's own backgrounds and how it might impact the services they provide.

GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research)

The GRADE-CERQual approach will be used to assess how much confidence can be placed in the results of the QES(199). This was developed in response to limited guidance about evaluating and using QES in policy development and practice(140). It forms a stepwise approach to describe how much confidence decision-makers and other users can have in the findings of a QES. On reflection, this approach could have added weight to the QES findings and would have been a valuable addition to the analysis. In future QES, this approach could be factored into the synthesis.

2.5.3. Findings in the context of current literature

This section aims to place the results of the QES in the current research context and compare them to other studies already published using candidacy as a framework for understanding access. The QES suggested that people are happy to access SRH services through general practice; it was the preferred location for some. This is confirmed by the Public Health England report that asked women their preferred location for accessing contraception. General practice was favoured over online, pharmacy, and sexual health clinics for women of all ages(200).

Tookey and colleagues used the candidacy framework to understand how doctor-patient interactions can influence help-seeking behaviour for cancer alarm symptoms(126). They found perceived (im)permeability of services and how the availability of appointments, time-limited communication and challenges asserting candidacy all impeded access. MacKenzie and colleagues explored the dynamic of disclosure by victims of domestic violence to their GP(130). They highlight the importance of GP's *imagining candidacy*, using the ideas of structural competency(103) to recognise and respond to clinicians 'biases, inequalities and blind spots'. This resonated within this QES. Mackenzie also described the idea of women making tentative attempts at disclosure and needing a legitimising response from GPs to help enable and accept candidacy.

The concept of the HCP as a barrier to access has been described previously. Berndt examined how the HCP-patient interaction was a barrier to access to contraception(201). The study reported how women's knowledge differed from the HCP's; failure to recognise this created hierarchy acted as a barrier. This was echoed in this QES with unequal partnerships coming from differing knowledge levels and belief systems.

The findings regarding the navigation of services seemed to differ from other studies which looked at different topics such as cancer and heart disease(125) or cancer alarm symptoms(126). In these studies, general practice is regarded as the 'gatekeeper' for access to services, meaning patients know to attend their GP if they have a problem(108). Patients can present directly to secondary care for sexual health services or attend their general practice; the QES suggested this leads to confusion over who provides what service. This was incredibly challenging as different general practices engage in varying levels of SRH care depending on the geography and the healthcare provider. This adds an extra level of challenge for people trying to navigate a system.

Screening for infection forms an integral aspect of SRH provision and offers challenges, and a patient must conceptualise their personal risk and then eligibility for testing. Bikker explored the challenges of screening for bowel cancer in terms of candidacy(129); self-identification relies on your own personal knowledge of risk. If you are not aware of the risk or need for screening, you cannot self-identify hence the need for screening programs or recognition of candidacy by the HCP. These components are evident in STI screening, and even in contraceptive care, there must be a pre-existing level of knowledge or risk awareness to allow self-identification. Stigma and shame were prominent themes in the QES; Cunning describes its impact on people identifying themselves for STI screening in the USA(202). The study shows a significant reduction in STI screening in those with associated stigma or shame related to the topic.

Aspects of social health capital resonate deeply with aspects of this review. The OECD defines **Social Capital** as "networks together with shared norms, values and understandings that facilitate cooperation within or among groups" (203). This idea of shared norms or values around SRH impacts how we behave as a community, whether as a group of HCPs or

as people with similar sexual practices. A better understanding of how social capital affects how people access SRH services might help adapt services to make more equitable provisions.

2.5.4. Implications for policy, practice, and research

In terms of policy and practice, this QES highlights the importance of opportunistic testing, drop-in services, and the normalisation of SRH in the general practice setting. This removes the stigma and improves access to care. As a policymaker and as providers, there needs to be a conscious effort to reduce taboo and provide equitable access to SRH services in all general practices regardless of the commissioners' or practitioners' personal belief systems.

Regarding research, it was clear that investigated topics follow funding streams and can cause bias in coverage. There was a disproportionate amount of focus on chlamydia screening which is likely due to a funding drive in the UK for the Chlamydia Screening Programme. Research funders need to look at ways to develop SRH studies by offering more generic funding streams, which help reduce silos of investigation and promote holistic patient-centred design.

Research involving SRH needs diverse participants, including ethnic minorities and varied socioeconomic populations. To include ethnic minority groups in research, especially those without English as a first language, methodologies need to be developed to help assist in getting good quality evidence when the researcher and participants may not speak the same language. The topic of SRH is still subject to recruitment and topic taboos within the research world; therefore, many studies are done using closed question survey instruments to facilitate ethical approval and increase the sample size. There needs to be a conscious effort by research ethics committees to reflect on stigma and taboo around SRH and make it easier for people to do high-quality research around a sensitive subject.

2.5.5. Conclusions/ future research

The candidacy framework offered a valuable tool for drawing together a wide range of SRH barriers to access. It allows us to understand better the complexity of accessing SRH services from the individual personal perspective, the healthcare professional, and services.

Allowing awareness of the societal context in which these interactions are happening. Hopefully, by understanding the barriers, we can develop services and interventions which target different aspects of the patient journey. The adaptation of the framework with the concept of patients appearing and asserting candidacy interacting with the health professional recognising and accepting candidacy helps explain the complexity of interaction.

The main message of this review was that researchers must improve reporting and inclusion of minority ethnic groups and those from deprived communities. If not included, they are invisible, and their issues are not understood. Future research could focus on population sub-groups, potentially those with worse SRH outcomes, such as people living in deprivation, to explore how this influences health-seeking behaviours and interactions with HCPs.

The following chapters present the research done as part of this study which looks explicitly at views of GPs and practice nurses who provide services in deprived communities.

3. RESEARCH METHODS AND DESCRIPTIVE RESULTS

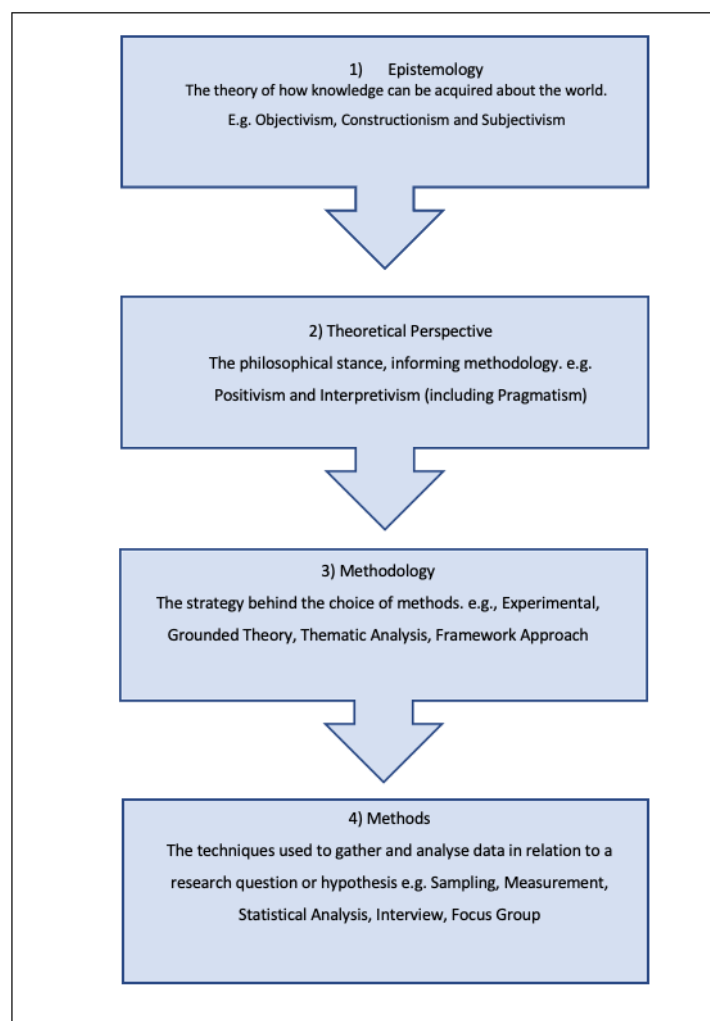
This chapter examines the research process and theory behind the choices made for this specific study. The initial part of the chapter explores the methodological underpinning of the research and the epistemological considerations which justify the choice of qualitative method. The following section explores how the design and development of the study was tailored by peer review, public involvement, and ethical consideration pertinent to this field of research. The sampling strategy and recruitment process are described, and the recruitment challenges for this subject matter. The research process is divided into phase 1 (interviews with HCPs) and phase 2 (focus groups). The impact of COVID-19 is discussed in relation to ongoing fieldwork. There follows a description of the data collection process, including the locations and data analysis. Finally, the summary of the chapter brings together the challenges of research in SRH.

3.1. Design and methodology of this research project

The following section presents an overview of theory, a foundation for the methodology chosen to undertake this project. The discussion about qualitative research can be challenging due to the variety and inconsistency related to methodology and terminology(204). At times, describing the meaning of these terms is complex due to conflicting interpretations found in the literature. The following section will briefly describe these concepts and how they relate to the study method. To help clarify the process of doing high-quality qualitative research, Crotty presents a four-stage approach to research methodology in his book 'The Foundations of Social Research'(204).

The four stages are shown in Figure 23.

Figure 23 - Four-Stage Approach to Research Methodology (Adapted from Crotty 1998)

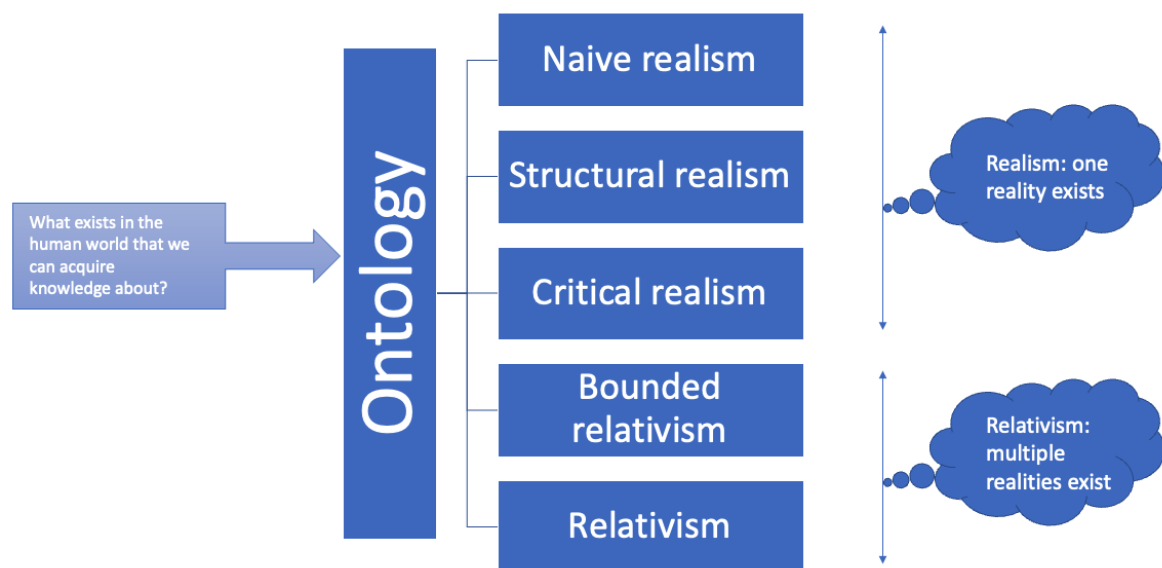


3.1.1. Ontology and epistemology

Epistemology, in its most basic sense, is the theory of knowledge. Ontology is concerned with the nature of reality and beliefs about what the world consists of, which we form knowledge about. Regarding the epistemology of research, the focus is on how the researcher understands and explains what they *know*. This provides a philosophical grounding to help researchers understand what kinds of knowledge exist and that the knowledge they acquire is adequate and legitimate(205).

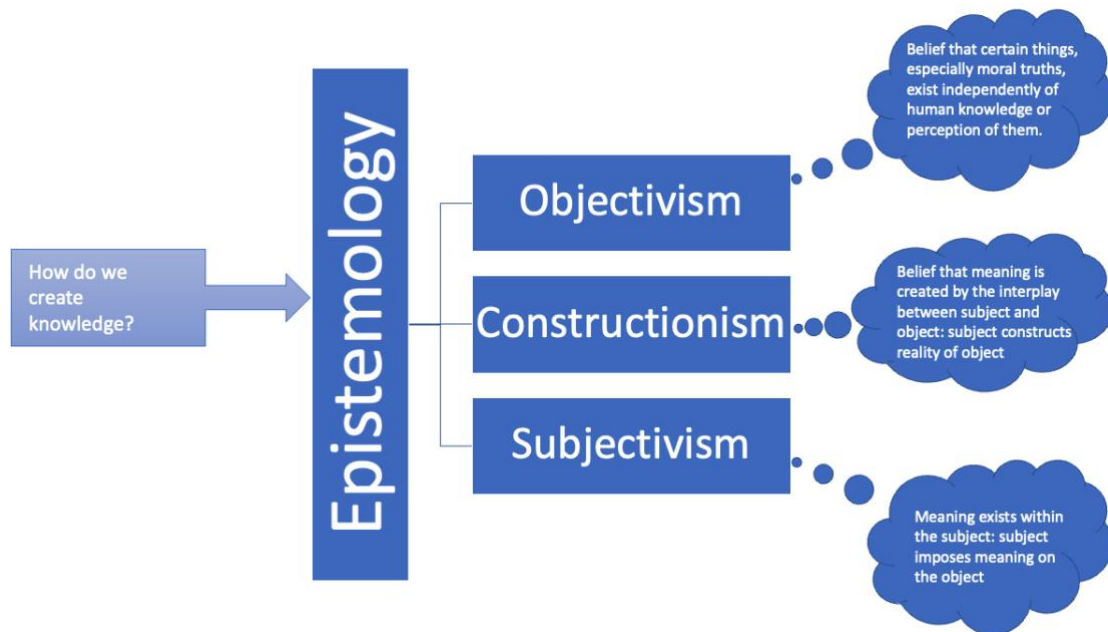
From an ontological perspective, we consider what exists in the human world that we can acquire knowledge about. This perspective can encompass a wide range of concepts from realism, which takes the view of one true reality, through to relativism, which suggests multiple realities exist. This is represented below(206);

Figure 24 - Representation of Ontology from Moon and Blackman(206)



Ontology and epistemology do not exist independently. Crotty(204) notes that having a specific ontological stance implies a particular epistemology and vice versa. Below is a representation by Moon and Blackman of the stances that impact epistemology(206).

Figure 25 - Representation of Epistemology from Moon and Blackman(206)



Constructionism is a philosophical stance where truth or meaning is not discovered but constructed in the mind and through experiences. It rejects the idea of one absolute truth and suggests that meaning is constructed rather than discovered. This stance seems to represent the research carried out in this study and fits with qualitative information gathering. The researcher will gain understanding and meaning about the subject matter by constructing and interpreting the world around them. With its roots in sociology, constructionism focuses on how meaning is constructed socially or collectively by a group or community. This is different from constructivism, a term used in psychology to describe sense-making by an individual's mind. Berger and Luckman argue that 'reality' and 'knowledge' is constructed by social interaction with others and not created by an individual(207).

Understanding these different stances help us to understand the realities of qualitative research and find meaning in how individuals and societies make sense of the world around them. Constructionism fits with the aims of the research to explore views about the access of SRH services in general practice.

3.1.2. Theoretical perspective

The theoretical perspective helps us understand the researcher's philosophical orientation that guides their action or research. It allows us to understand if the knowledge acquisition is deductive, 'value-free' and generalisable, or if it is inductive, 'value-laden' and contextually unique(208). The theoretical perspective helps to explain how the research is carried out. Examples of theoretical perspectives include positivism and post-positivism, structuralism, interpretivism and critical enquiry(208).

Many different theories around epistemology dominate social science research(207). The first of these relates to how we acquire knowledge about our world. Inductive logic involves a 'bottom-up' approach where knowledge is developed from observation and interaction with the world around us. Deductive knowledge involves a 'top-down' approach where theory leads to hypothesis development which can be applied to the world. The hypothesis is then confirmed or rejected, thereby validating or refuting the theory(208).

Two main theoretical perspectives, positivism and interpretivism, are often discussed in conjunction(209). Positivism is the philosophy underlying research in natural sciences where there is a truth that can be deduced or an ability to predict an outcome with certainty. Positivists believe in a 'truth' and that theories or hypotheses can be generated and tested using rigorous methods such as statistical observation and analysis(210). Interpretivism comes from the understanding that reality is interpreted and culturally or historically derived. Interpretive research does not predefine variables but explores human sense-making in real-life settings(210).

Concerning the researcher, in positivism and post-positivism, they should be removed and distant to reduce the influence of outcome(211). This suggests that the researcher is objective and has little or no impact on acquiring knowledge(210). This contrasts with a critical theory where the research and theory should be used to change the situation, an example being feminism, where the patriarchy is challenged through research(209).

Interpretivists believe that our knowledge of the world is socially constructed and therefore is not objective but is transmitted to us through ideas, dialogues, and experiences.

Therefore, naturalistic data collection methods such as interviews or observations are often

used(211). The interpretive approach seeks to comprehend human action, which is the core component of qualitative research(210).

After exploring various theoretical perspectives, interpretivism seems most appropriate for this research project. The theories of positivism could have been us to look at numbers of people accessing sexual health services in general practice. However, behind the data, we need to understand why people access services. This type of social science research can be complex and multifaceted. The interpretation by the researcher is an integral part of the analysis and it is crucial to understand researcher positionality.

Personal and functional reflexivity is discussed later in this chapter, in sections 3.4.2.

3.1.3. Methodology: Qualitative, Qualitative, and Mixed methods

The previous section has defended the use of interpretive theoretical perspective for this research, and the following section describes how the data was collected and analysed. These approaches are sometimes defined as a methodology(212) or strategies of enquiry (213,214); they are interlinked to an epistemological theory.

Methodologies are classified as either quantitative, qualitative, or mixed. Qualitative and quantitative research contrasts in many ways, but the two research paradigms originate fundamentally from different ontological and epistemological roots. To understand the different approaches, it is helpful to understand the philosophical debates that underpin the evolution of social research.

Qualitative research is often depicted as a purely inductive process which can be misleading. Blaikie argues that this is an oversimplification to imply that when a qualitative or inductive researcher generates and interprets data, they do it with no preconceived ideas or influences(215). Similarly, with quantitative or deductive researchers, it is unlikely they have no previous exposure or work within the subject matter and are building on previously derived concepts or hypotheses.

Qualitative research is a broad church and includes a wide range of approaches and methods. Denzin and Lincoln describe it as; *'difficult to define clearly. It has no theory or*

paradigm that is distinctly its own... Nor does qualitative research have a distinct set of methods or practices that are entirely its own'pg6 (216)

The method needs to be adapted and justified depending on the research question. Qualitative research helps answer questions about 'why' and 'how' things happen and explore what is behind the data or statistical trend(212). Over the last 25 years, there has been increasing interest and acknowledgement of the significance of qualitative research to help focus on processes and make sense of phenomena in terms of how they affect people(217). In contrast, quantitative research (positivism) is deductive and seeks to enumerate or quantify(218). Quantitative research is concerned with natural sciences and involves hypothesis testing. It expects the object or subject being examined to be independent and unaffected by the researcher(217).

Mixed methods research aims to bring together the two divergent paradigms of quantitative and qualitative methods(219). Researchers will use methods specific to the two different research areas to help answer the same research question, offering a more pragmatic understanding of a topic(219).

This research project aims to understand the views and beliefs of HCPs and members of the public with relation to access to services. Answering the research question will require the construction of meaning through interaction between participant and researcher. For that reason, qualitative methodology was considered the most appropriate. During the development of the research methodology, several methods were considered and are explored in more detail. These approaches are discussed below and include the disciplinary origins (157).

Constructionism (sociology) – exposing 'constructed realities' of people in a particular setting, exploring meaning and explanation. This school of thought stresses the importance of interpretation as well as observation. Constructionism emphasises that knowledge is actively built within the human mind rather than passively received; this forms an integral part of qualitative research (204,215).

Ethnography (sociology, anthropology) – Understanding people and society through emersion in their communities to produce detailed descriptions of their culture and beliefs.

This approach is mainly descriptive and details the life of particular individuals, groups or organisations (220,221). Ethnographic research has been used in the healthcare context to explore how social and cultural contexts in different clinical settings affect patient-doctor communications and relationships(222). This approach might help understand how SRH is managed within the general practice but pragmatically was not an option for this research due to time restraints and human resources.

Interpretive phenomenological analysis (psychology) – Exploring meaning and significance of an experience to a person – what it is like for them – to gain insights into psychosocial processes. This is a psychological approach to analysis that aims to offer insight into how a person, in a specific environment, makes sense of the world or phenomenon within their life(223). It is used broadly in health psychology and concerns how people make sense of the world around them and their experiences. It was considered for the analysis as it might have offered insight into the interaction between the HCP and patient when talking about sex. However, as the focus was more on the societal aspect of the interaction, it was not chosen. It would be interesting to understand how people make sense of SRH issues and how they develop an understanding of access.

Grounded theory (sociology) –This involved the generation of categories and dimensions and the relationship between them via a ground-up approach(224). It is all about what the data reveals rather than testing previous ideas. Grounded theory is a method that generates new theories rather than exploring current theories. The idea for this research was informed by literature review and the lead researcher’s experience working within general practice. So, in conducting the research, existing models of access are explored rather than developing new theories. Grounded theory is not appropriate for this research project.

Qualitative research design

Previous sections have explored strategies of inquiry linked to different epistemological positions, a broad qualitative approach with the foundations in constructionism has been chosen.

An important aspect of qualitative research design is the choice of method for data collection, as this impacts the richness and depth of results. The choice of method depends on the research question and is influenced by the context, structure, and timing of the research. There is a range of potential data collection methods, including interviews, focus groups, observations, and different types of data such as electronic, textual, visual, and virtual data(157). Four areas were identified by Lewis and Nicholls, which help develop a rationale for what data is needed and how best to collect it (157);

- **The importance of context**—generated data allows participants to describe their personal experience or organisational context. Sometimes the context in which is the phenomenon is happening is paramount to understanding the data. Having experience as a GP working in deprived communities helps to understand the data and allows a richer understanding to answer the research question than someone naïve to the setting.
- **This helps to ensure the researched phenomenon is sufficiently detailed, accurate or complete.** An example of this is if a patient does not have a conscious understanding of the impact of stigma or taboo around their access to contraception services or if a doctor does not have insight into how their behaviour might affect access. Using two different viewpoints of the healthcare professional and the member of the public helps to give a complete account of issues around access.
- **Whose interpretation is paramount.** In this research, generated data will need to be interpreted to allow understanding, but hopefully, the participant’s interpretation will be critically important. In an ideal setting, the data would be interpreted by the researcher and then re-discussed with the participants to check understanding and expression of issues. However, pragmatically for this research project, this is not appropriate.
- **Accessibility and feasibility.** Health service research can be challenging, especially when discussing SRH. The method must be acceptable to the participants and allow accessibility concerning deprived or underserved populations. It is essential to account for language, knowledge, cultural beliefs, and attitudes; not causing upset or harm to people is essential.

This research project aimed to obtain data through two different methods, interviews and focus groups. This section will explore these two methods and why they have been chosen to get the richest information about access. Research in SRH is notoriously challenging(225,226). Firstly, engaging HCPs providing frontline patient care can be difficult, so the method must allow maximum information gathering in the shortest amount of time within a flexible setting such as at their workplace or home. For this reason, semi-structured interviews were chosen as the preferred method. Secondly, researching the subject of SRH is challenging, especially with communities where the subject matter might be stigmatised or taboo(225). A method that was non-confrontational and abstract from the SRH topic helps encourage discussion. For this reason, focus groups with case vignette discussions as chosen. These techniques are described in the following section.

Designing and Selecting Samples

This section examines the theory behind sampling strategies and the rationale for the research project. There is a distinction between probability and non-probability samples in social science research(227). Probability sampling is a more rigorous approach to sampling, which is needed for statistical research but is inappropriate for qualitative methods. In a probability sample, populations are chosen at random and have a known quota which makes the sample representative(228). This can be then used to extrapolate to more extensive data. Qualitative research in contrast uses non-probability sampling methods, and 'units' are deliberately selected to reflect a particular feature or experience to enable richness of data(229).

The sampling technique used for quantitative sampling is very different to that used in qualitative research, where samples are usually much smaller. In qualitative research, non-probability sampling identifies units that reflect particular features or groups which are of interest in answering the research question(228). This contrasts with quantitative research, where often a hypothesis is being tested, and a certain number of units are needed to prove statistical significance(230). Quantitative samples tend to be much larger and will have a feature of a particular population (generalisability) group, for example, all women under 25, or have matched controls for comparison(230). Qualitative samples may be criticised for not having robust sample sizes, which could be argued that makes them less

generalisable(230). It is essential not to use criteria used in the quantitative research paradigm to critique a qualitative enquiry(229).

Different sampling strategies are discussed below.

1. **Purposive sampling** is an approach where selecting participants, experiences, or settings is criterion-based(231). This enables exploration and understanding of a particular subject. The researcher has control over who is sampled. The purposive sampling approach selects units based on features or criteria, which help the researcher understand the central themes or characteristics within the research question(230). For example, purposive sampling could select all general practices working in deprived communities or high-risk individuals.
2. **Convenience sampling** is an approach used in qualitative research which refers to a selection made purely based on who is available(232). This is common in health service research as more pragmatic but sometimes leads to limited conclusions that can be made from data(232). For example, the researcher could sample the GPs and nurses within the region who are available during clinical time, therefore missing views of other HCPs working in different environments.
3. **Theoretical sampling** approach selects units, incidents or individuals due to their potential to help the development and testing of theoretical constructs; this is a time consuming and iterative process(224). For example, selecting a GP or practice nurse and using the interview data collection to develop themes and determine where to sample further based on emerging theory.
4. **Snowballing** is a technique that allows for recruitment by using participants to recommend others who fit the research criteria(231). This helps to access people whom the research might have challenges recruiting.

Sometimes a researcher may need to draw on all these sampling techniques to get a rich sample. The challenges of recruitment are discussed in the research process section.

Samples sizes for qualitative research are small, but the time spent with the researcher and subject can be long. In general, sampling should continue until the researcher feels they have reached saturation, which Straus and Corbin define as “no new properties, dimensions or relationships emerge during analysis”(233). Pragmatically, there is a time limitation for

the research project, so sampling must be more purposive. Data saturation is discussed in the following section.

3.1.4. Designing Fieldwork

The following sections examine approaches to data collection and techniques for undertaking qualitative research. It explores the methodology of interviews and focus groups. The section also includes the concept of data saturation and what it means to achieve this in the context of qualitative methods.

Interviews

Interviewing remains a core and effective method for doing qualitative research. Dexter defines an interview as a 'conversation with a purpose'; the researcher asks questions to obtain information and answers given by the interviewee(234). Bryman suggested various types of interviews, but three main forms are most recognised in healthcare research(230). These include structured interviews, semi-structured interviews and in-depth or unstructured interviews(230). The choice of the interview is very much related to the epistemological stance and more pragmatic research restriction with healthcare research. Unstructured interviews do not have pre-requisites from topics that need to be covered. They are inductive and based on the grounded theory approach, allowing for the development of ideas and paths that might not have been predicted before the data collection. Structured interviews are more on the spectrum towards quantitative data gathering, where fixed ideas and responses are gathered. This may give more transparent and defined data but loses the ability to refine ideas and think more exponentially. Semi-structured interviews lie somewhere between a structured and unstructured interview, and there are topic guides that help act as a frame of reference for questioning(230).

The decision was made to use face to face semi-structured interviews to collect data. This was a pragmatic decision based on wanting to collect rich data and within the timescale and time constraints of interview availability with HCPs. The research is aimed at understanding perceptions and views in primary care settings. A semi-structured interview offers a good way of obtaining this and is more suitable than questionnaires, document analysis or open-ended surveys(157). The advantage of semi-structured interviews is that it allows some flexibility in data collection and gives similar themes to help achieve a higher level of

understanding. Semi-structured interviews will provide an in-depth understanding of the views and perspectives of HCPs within the primary care setting (235).

Focus groups using case vignettes

Focus groups or group discussions are a technique that encourages data collection through engagement between participants. This technique offers an interactive effect that might help to encourage people to talk about subjects such as SRH. They might not have thought about the topic before or not know how to express their views. The researcher has a role in facilitating the focus group but not controlling discussion by allowing everyone to have a voice. There are five stages of a focus group as discussed below(157);

1. Scene-setting and ground rules
2. Individual introductions
3. The opening topic
4. Discussion
5. Ending the discussion

In this study, the focus groups aimed to recruit people from communities who find access to services difficult and are at risk of poor outcomes. This includes people from deprived communities and black or ethnic minority groups. There were challenges of language, health literacy, taboo, and stigma. For this reason, the focus group used case vignettes developed through the PPI work and work with community groups to choose topics that give rich data but not cause cultural offence. Some focus groups needed to be translated, which adds another layer of complexity to facilitating as the researcher. The choice of case vignette were to be adapted for specific situations and conditions, and this allows flexibility for different populations(157). Using case studies or vignettes allows the researcher to develop hypothetical but realistic scenarios that the participant can empathise with or understand(236).

3.1.5. Analysis: Principles and processes

There are many ways to analyse qualitative data, and it is essential to understand which approach will suit the type of data and how it was acquired. The way data is collected is influenced by the method analysis and vice versa. Harper and Thompson describe a wide

range of approaches(237). A brief description of techniques that were considered for this research study is included below.

Grounded theory(224,233) – this analysis method involves the generation of categories, themes and the relationship between them. The process continues until categories and relationships are 'saturated', and no new data can be defined.

Interpretive phenomenological(223) – this analysis aims to give individuals in a particular context a voice and make sense of their experience. It uses psychological concepts to interpret these viewpoints.

Thematic(237,238) – this analysis involves discovering, interpreting and reporting patterns of meaning in the data. Thematic analysis applies to a systematic approach to discovering, interpreting and reporting meaning from the data(239). The researcher works through the text to identify topics and coding the text (239). Some would argue that it is not an analytic tradition in itself as it is used in other forms such as grounded theory and content analysis but is more of a generic method(240). With thematic analysis, there is the flexibility to choose an inductive or more deductive approach.

There are five key stages in data management for thematic analysis(159);

- **Familiarisation** – what are people saying which is relevant to the research question?
- **Constructing an initial thematic framework** – Refining and sorting a set of themes which form a list of possible topics.
- **Indexing and sorting** – Which parts of the data are similar and belong together?
- **Reviewing data extracts** –What ways can the data be grouped in a way that might be more coherent or relevant?
- **Data summary and display** – What is each individual saying about a particular theme?

With regards to this research process, thematic analysis of the data offers a practical way to interpret the interviews. Below are the advantages and disadvantages of using thematic analysis and an exploration of using a framework to manage complex data.

Advantages of thematic analysis

Unlike other qualitative methods, thematic analysis is relatively simple to learn and apply. This makes it more accessible to new researchers and those without in-depth backgrounds in social sciences research. It offers a way for researchers to summarise data and highlight key findings of a wide range of data sets. It also can analyse data with an inductive, data-driven approach or a deductive, theory-driven approach depending on the research question(156,239).

Disadvantages of thematic analysis

The flexibility of the analysis method can also be seen as a drawback to this analysis method as it can contribute to a perception of not being rigorous(239). One of the disadvantages of thematic analysis is that it can be conducted poorly, and there can be inconsistencies in how terminology is used. A review of articles that claimed to use thematic analysis was found to have a multitude of different terminology and inconsistent approaches(238). This can lead to challenges in the trustworthiness and reliability of findings.

Framework approach

Whilst undertaking the QES, it became apparent that a framework was needed to manage the complexity of data around the access of SRH services. An initial purely inductive approach led to unmanageable themes and codes. The framework approach forms a subset of thematic analysis and is a tool rather than an approach per se; it was developed by Ritchie and Spencer 1994(156). It allows the formation of a matrix with summaries of cases and subheadings, which help to identify patterns within subgroups and themes(241). The candidacy framework had been identified as a valuable framework to develop the themes. The data was analysed and grouped into the stages of the candidacy framework; different themes were identified and refined. Some themes were recoded back under different

stages of the candidacy framework. It was an iterative process that was refined with further interviews.

Computer-assisted qualitative analysis (CAQDAS)

This form of assisted technology is widely used within universities and social research agencies, and there is debate about the benefits and potential pitfalls of using this tool(155). CAQDAS can assist with three elements of research, data management, interpretive processes, and project management(156). There is concern that the ease and speed of using the CAQDAS might lead to shortcuts and a lack of emersion in the data. The CAQDAS is merely a tool and does not reduce the crucial impact of the researcher within the analytic process(156).

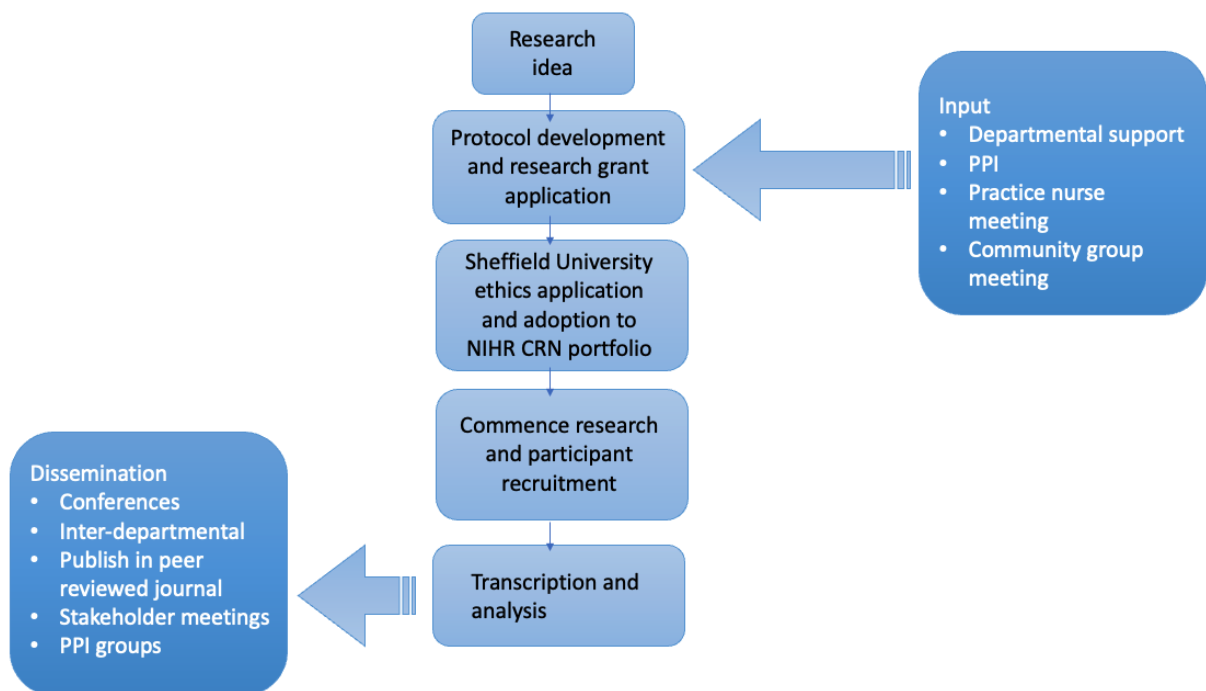
Achieving saturation

The concept of data saturation often comes from proving methodological rigour, but it is a contested concept in qualitative research(242). There will be a number needed to give statistically significant outcomes in quantitative methodologies, and this can be calculated before data collection. Some researchers refer to saturations as the number of interviews needed to collect enough data, while others refer to the saturation of themes when data is analysed. Saunders highlighted the complexities, inconsistencies, and contradictions within qualitative literature, which leads to great confusion(243). Bryman argues that it is challenging for a researcher to know at the start of the research how many interviews or focus groups are enough to gain enough data to make a rigorous claim(230). Some researchers deem saturation as being a point when further interviews cease to provide new themes or insight(242). Regarding how many interviews are enough to gain saturation, other aspects need consideration, such as logistics, pragmatism around clinician time and researcher limits from a time perspective.

3.2. The Research Process

The following section outlines the research process and aims to show the journey from conception of the research idea to the dissemination of results. The steps taken to engage with members of the public, research funding and ethics review process will be discussed. The project originally started in 2017 and interviews began in 2018.

Figure 26 - Diagrammatic representation of the research process



3.2.1. Patient and public involvement (PPI)

There has been extensive involvement from members of the public right from the conception of the research idea. This is described in more detail in Appendix 4 – Patient and public involvement (PPI). The involvement of patients or carers and members of the public in research is essential, and it gives insight and meaning from the development of a research question to the dissemination of results(244). The initial research question was developed by the lead researcher who was working in a deprived area of Sheffield and volunteering with a community wellbeing group. Ideas about access to SRH services were discussed during a teaching session for the community leaders at the wellbeing centre. These leaders were from the local community, primarily new migrant populations from eastern Europe, Pakistan, and Bangladesh. As part of the session, there was a discussion about research ideas, sampling, and recruitment from their community. There was also a discussion about the use of case vignettes to help discuss taboo or stigmatised questions. This began the process of developing the initial stages of research and documentation.

The lead researcher undertook a large teaching session for 150 practices nurses in Sheffield. As part of this, the nurses were asked to give opinions on the research project and on SRH issues affecting them. This information helped shape the research protocol and interview

schedule, giving a better understanding of the context of practice nurses. It also gave insight into the difficulties practices nurses have in being involved in research and how to look at recruitment and reimbursing them for their time.

As the research protocol began to take shape, the lead researcher attended two patient involvement groups at the Royal Hallamshire Hospital in Sheffield. One group was run by the sexual health team and composed of people living with HIV. The second group was a maternity PPI group which has people who have had experiences of maternity care. Both groups helped develop the participant information leaflet and helped to think about recruiting members of the public.

These early review stages helped define the research question and refine the research design. The activities also helped adapt the participant information to be more inclusive and understand the potential challenges of recruitment. The hope is to use these different groups to disseminate the results, but this has so far been challenging with COVID-19 restrictions.

3.2.2. Funding

The research project costs were funded by a grant from the Royal College of General Practitioners Scientific Foundation Board awarded to the lead researcher in 2018 for £10,670 and salary support from a personal NIHR In-practice Training Fellowship for early phase work. A local Academic Training Fellowship award from Health Education England Yorkshire and Humber Academic Support grant allowed funding to complete the doctoral thesis. A proposed financial breakdown is shown in Appendix 5 - SFB application financial support.

University of Sheffield ethics and NIHR adoption

Following feedback from peer reviews, the protocol for this project was submitted to the University of Sheffield ethics committee and approved as per Appendix 6 – Ethics approval. The project was adopted to the NIHR CRN portfolio. Application to HRA was also approved and can be seen in Appendix 7 – HRA approval. Governance sponsorship for the project was granted by the research services at the University of Sheffield seen in Appendix 8 – Sponsorship letter. After an initial discussion with the NHS ethics team, it was decided that

there was no need for NHS ethics as members of the public were not being recruited through any NHS services.

3.2.3. Ethical considerations related to this research

Ethical consideration in research is essential to prevent possible damage to participants and researchers; they may include a formal set of rules or guidelines. Some research topics may be considered more sensitive than others, and this might include topics that are taboo or arouse emotions such as sexual behaviour or personal relationships(225,245). The level of sensitivity can change depending on the characteristics of the participants and may vary between participants depending on personal background. Different characteristics include age (adolescents versus elderly), gender identity, sexuality, and mental capacity. Noland expresses this clearly in the following quote(245);

Perceptions of sensitivity are socially influenced, culturally determined, and can be highly subjective to each individual at any given point in time(245).

It is important to remember that participants might have topics, especially about sexual health, which might be more sensitive for them, for example, people with a history of sexual trauma or a history of pregnancy loss(246).

There are differing views about conducting research when examining sensitive topics. Some researchers feel that sexual topics are not more sensitive than others and should be approached in the same way as any other context(245). Others feel that the subject is highly sensitive and should be approached differently(247). Whilst there is a good argument for researchers not further stigmatising sexual research by changing the way they address data collection, there still needs to be sensitivity to the subject as it is imperative not to cause distress to participants.

Crawford raised this issue of 'sexual double standards' in research, which comes from the social norms around gender and sexuality(247). The team undertook a review of double standards in sexual research, looking at the impact of methodology on double standards between men and women. This comes from the expectation or judgement about sexuality and sexualisation being different between men and women. For example, it is a cultural norm for men to have more sexual partners, whereas women are seen as being

promiscuous for having more than their husband as a sexual partner. Crawford found that qualitative studies were less likely to show bias or double standards than quantitative methodologies(247). The hypothesis was that the language used on surveys and questionnaires often led to shame and concealment of sexuality or sexualisation, for example, terms like 'sexual permissiveness', 'pre-marital sex' and 'steady relationship'(247).

The focus groups aimed to discuss access to SRH services rather than individuals own sexuality or behaviours. Thummapol reflects on working with vulnerable women in Thailand and the challenges of dealing with sensitive discussions(248). For this reason, case vignettes have been chosen, so people do not have to express their behaviours but must comment on others. Hopefully, this means less fear of judgement or concealment of views. The Economic and Social Research Council have published a useful guide to working with potentially vulnerable people(249). This helps researchers to consider negative consequences or lack of personal benefit when being involved in the research as well as how to obtain freely-give consent.

An important consideration is the impact of socio-cultural and religious sensitivities concerning SRH(250). A researcher discussed the challenges of sexuality research in Iran(251).

The common language of sex in Iran is the language of silence because sex and related issues are considered taboo, and talking about them freely in most settings is forbidden(251).

This is relevant in the UK setting as the focus of this research is among deprived communities and those who find access more challenging. Deprived communities often have a high proportion of people who were born abroad. This research needs to be approached in a sensitive way that will not cause distress or discomfort to the participants. In particular, the subject of sexuality and gender identity faces varying degrees of religious, legal (in some countries), and moral norms and constraints(30). Some of the participants in this study may have come from countries where homosexuality is illegal or sex out of marriage is morally unaccepted(30). They may mistrust the researcher and conceal views or behaviours for fear of repercussions(252).

An interesting ethical area is with HCPs who may come from backgrounds with strong socio-cultural or religious views, especially around sexuality. Sexuality and abortion of pregnancy are two areas that still cause debate in the medical world. For example, HCPs from orthodox Muslim or Catholic communities may disagree with homosexuality or abortion(253,254) The researcher needs to approach this with sensitivity and non-judgementally, but also these issues are important for the ways people access services, so need exploring.

An area that also needs to be considered is research and ethnicity. Although this project is not explicitly focusing on a specific race or ethnicity, it explores how people from different socio-cultural groups experience access. Gunaratman explored the issue of how a researcher uses and understand terms such as 'ethnicity' and 'race' as these terms can be seen as reductionist, biological and lead to bias(255). It is crucial to understand the historical and social meaning of the terms, and that they may have political or oppressive meanings(162). Working with community leaders and groups should help give a better understanding of the researcher and the appropriate use of terminology.

This project consists of two discrete recruitment samples, the HCPs and the members of the public. The focus of the study is about access for people in deprived communities or within groups that find access more challenging. The subject of SRH is also a social taboo, and there is a stigma associated with discussing the topic; this might add to the challenges of recruitment.

3.2.4. Confidentiality, Data Management and Safety Precautions

This section considers the operational aspect of the research, including issues such as confidentiality, data management and the safety of the researcher. The principles of Good Clinical practice were followed through the research process(256), certification of the course is in Appendix 9 - Good Clinical Practice.

Data Confidentiality Measures

Anonymised audio recordings and demographic information were cross-referenced to a password-protected computer database at the AUPMC accessible only by RM, CM (supervisor) and the research transcriber. Transcriptions were anonymised to prevent

traceability to participants. Recordings were erased after transcription and analysis. Physical records will be locked in a filing cabinet accessible only by the lead researcher (RM) and the research secretary. CB, the AUPMC Director, will act as custodian for the data. All quotes will be anonymous in publications.

Data Storage

The University of Sheffield is the sponsor for the study. Personal data (age, gender, sexuality, and nationality/ethnicity) will be collected and anonymously linked with the transcription to inform the analysis. This is separate from the personal details, which will be kept in case of future consequences or complaints. This will be encrypted and kept for up to 24 months after the study is finished. Audio recordings will be destroyed as soon as they have been transcribed. Anonymised transcriptions will be stored on a password-protected computer at the Academic Unit of Primary Medical Care for up to 24 months after the study is finished. This ensures adequate time for the study to be written up and submitted to a peer-reviewed journal. A University of Sheffield password-protected computer will be used to store all data, and an encrypted folder with limited access will be used.

Personal safety

As a GP, RM has been trained in personal safety measures and carries a personal alarm when visiting people in the community and will take precautions to maintain safety. A 'buddy' system will be used so that a staff member within the department is made aware of where and what time the interview is being done; a call or text will be completed once the interview is terminated. If the 'buddy' does not hear, they will call the researcher, and if no contact is made, authorities will be informed. The interviews with HCPs will ideally take place in the GP practice but, on occasion, might take place at the home of the GP or practice nurse. The interviews with the members of the public will take place at the place of recruitment. For example, SAYit youth charity and Darnall Wellbeing have offered to allow the use of their facilities which include a private room that allows privacy and safety. The lead researcher is aware of managing challenging consultations and removing oneself from danger.

3.2.5. Phase 1 – Interviews with HCP

The following sections explain how the interviews were conducted. This includes the development of research documentation, sampling and recruitment, and how the interviews were conducted.

Research documentation

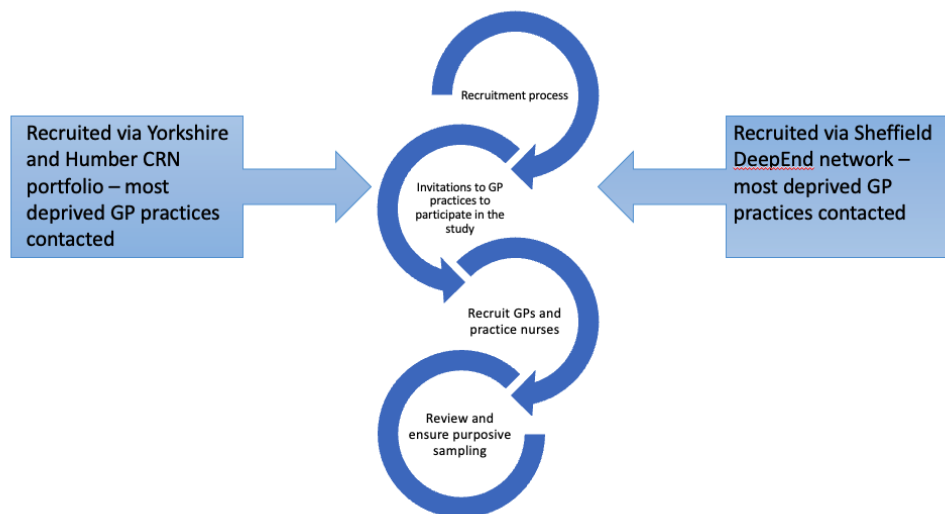
The topic guide for the semi-structured interviews was developed after reviewing the literature and through discussion with the groups previously mentioned. The interview schedule was also checked and discussed among the academic department and by the supervisory team. The questions were submitted to the university ethics panel and the Health Research Authority. The topic guides acted as an aide-mémoire for the interviews are included in Appendix 10 - Interview schedule. The HCP participation consent forms and information sheets were developed and reviewed within the department and are presented in Appendix 11 – Consent forms HCP and Appendix 12 - Information sheets. Even though these were for HCPs, there was a focus on language being accessible and easy to understand.

Recruitment strategy

In terms of the HCPs, the recruitment strategy focused on those working in general practices which serve deprived communities. The main group of HCPs sampled are general practitioners and practice nurses. Many others work in the team providing care; these are the primary staff members who provide frontline SRH services. Below is a diagrammatic representation of how participants were recruited to the study and details of the purposive sampling techniques that were used for both healthcare workers and members of the public.

The HCPs were offered payment for their time, GPs £80 per hour and nurses £40 per hour. This was based on NIHR recommendations at the time of the studies which has now been replaced(257). On reflection, both HCPs should have been paid the same as were doing the same interviews.

Figure 27 - Healthcare worker recruitment



The sampling processes are considered in more detail in the following section.

Purposive sampling of general practitioners and practice nurses

To get a diverse range of general practices within deprived communities, purposive sampling was used to invite participants. In Sheffield, there is a group of general practices in high deprivation areas called the DeepEnd group(258,259). This forms a research cluster that is part of the NIHR Yorkshire and Humber Primary Care Clinical Research Network and was a primary way of recruiting practices. Invitations were also sent to the 100 most deprived general practices on the Yorkshire and Humber NIHR CRN portfolio. Invitations were also sent out to practices in South Yorkshire who form part of the DeepEnd practice group; this is a network of practices that provide services in deprived communities. Purposive sampling techniques were used to reflect a range of healthcare provider demographics, including men and women of various ages, cultural backgrounds and ethnicity. This reflects the diverse range of health professionals working in general practice and understanding their views on the subject area. The National General Practice Profiles (2018) was used to stratify participating practices by size, population, and area profiles, including the deprivation deciles and ethnicity estimates of the GP practices(260).

The practices or individual HCPs emailed lead investigator (RM) to be included in the research project. An excel spreadsheet was updated after each successive interview, with

the demographic details of each participant, including place of work and associated IMD profile of the area, gender, age, number of years qualified, special interests, practice size and training status. The initial responses from GPs and nurses came from females usually aged 30-50, who often have a particular interest in providing SRH. In order to gain a richer data collection and prevent bias, purposive sampling techniques and snowballing were used to recruit more men and more people from ethnic minority groups. There were no male practice nurses recruited; this is likely explained by the predominance of females in the profession.

Twenty participants were recruited from a range of practices. For pragmatic reasons, some participants worked in the same practice to ease recruitment and snowball sampling. The demographic findings are presented toward the end of this chapter.

The research interviews

RM attended formal qualitative research and analysis training that incorporated interview skills and data collection and analysis. RM is a female, qualified GP and academic training fellow. See Appendix 13 – Research training log. The interview process has similarities with the general practice consult. Many of the skills are transferable, such as active listening, responding to cues, and reading the hidden meaning behind the words.

The interviews with the HCPs took place in different locations depending on the availability of the participants. Some were done in their own home and some at work between clinics. Each interview was started with a brief introduction and reminder about the project, consent was obtained, and they were reminded that they could stop the interview at any point. Permission was gained to digitally record the interviews before signing the consent form. The interviews lasted 45-60 minutes and were conducted by the lead researcher between January 2018 and September 2019 (one interview was conducted by another member of the research team, BC, due to logistical reasons).

Face-to-face semi-structured interviews with open-ended questions were chosen as the most appropriate method of data collection. This type of interview was most appropriate because it allows exploration of various topics without being too restrictive. By allowing participants to speak freely, the data collected will help to understand what is most

important to them whilst navigating the conversation to probe further and explore essential points that may be raised. The interviews were digitally recorded and transcribed verbatim.

3.2.6. Phase 2 – Focus groups with vignettes

The following section explores the research process that occurred in developing and preparing the focus groups. Unfortunately, the focus groups did not happen due to the COVID-19 pandemic, which is explained in more detail to follow. A significant amount of work went into the development of the case discussions, participant consents and information leaflets so have been included in the thesis. Several charities and organisations were also recruited; these are included for information.

COVID-19 impact on recruitment of members of the public

The following section describes the impact of COVID-19 on participant recruitment. UK Research and Innovation team have described the impact of COVID-19 on research in the UK(261). Their survey, which was done between February and March 2021, showed that 61% of researchers reported lockdown or shielding to have had a negative impact on their research(261). 58% said that COVID-19 had made it impossible to do the research which had been planned. 88% of respondents with child-caring responsibilities reported this as having a negative impact on their research(261).

Personal COVID-19 journey

Participant recruitment for the focus groups started in February 2020, just before the COVID-19 pandemic. Unfortunately, I was 20 weeks pregnant and therefore recommended to shield. I also had shared responsibility for my stepdaughters' home-schooling when lockdown occurred.

I was diagnosed with Vasa Praevia, which complicated my pregnancy, so I had to be on bed rest for most of April/May, which added to the challenges. My baby was delivered prematurely at 34 weeks and is now doing well. Because of these factors, I did not continue with the public participation phase of research. When I returned from maternity leave 12 months later, there were still major concerns about COVID-19 and a decision was made to discontinue further public involvement.

The potential of organising focus groups via an online platform such as Zoom or Google Meet was considered. However, the logistics of this and the issues around language barriers made it unfeasible. There are significant challenges of doing case discussions about a sensitive topic online, especially with different languages.

A decision was made in May 2020 to stop the research data collection and postpone planned focus group work. A significant amount of time was spent designing and developing this aspect of the research, so it has been included in this methods section. Hopefully, this research aspect will be concluded in the future once more feasible.

Research documentation

The PPI and lay review helped develop jargon-free consent forms and information leaflets, and these are included in Appendix 14 – Consent forms members of public and Appendix 15 - Information sheets member of the public. One important key aspect of developing documents for the members of the public was that it had to be as visual as possible and try to minimise the academic or medical language. Much time was spent trying to make the documents accessible to those with low levels of health literacy. Funding was awarded for translating the documents into various languages.

The case vignettes were developed using the experiences of the lead researcher who works as a GP with a special interest in SRH. Feedback was given by the community workers about the appropriateness of language and topics covered. It became apparent that the case vignettes might be suitable for one group but might not be suitable for other groups. For example, it would be insensitive to discuss anal sex with women from traditional Muslim communities where it is prohibited. Contrastingly, discussing anal sex with men who have sex with men is appropriate and would lead to meaningful data collection. A range of case studies were developed with the involvement of the community workers and the PPI groups. These have been included Appendix 16 – Case vignettes. Different case studies could be used with different groups chosen to be sensitive to cultural and faith-related issues.

The PPI groups who also gave feedback on the documents gave positive comments about the accessibility of the information especially compared to other research material from

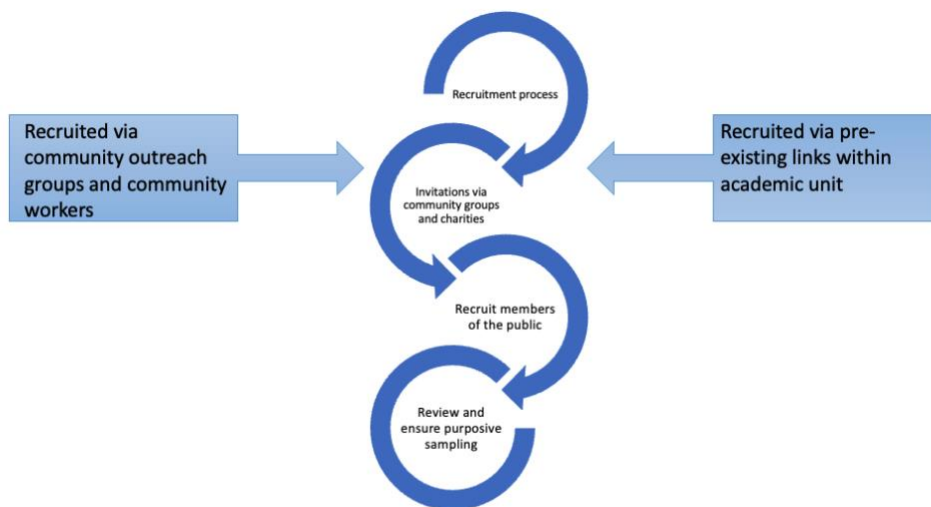
different studies they had reviewed. The questions were submitted to the university ethics panel and the Health Research Authority.

Recruitment strategy

In terms of members of the public, the recruitment posed challenges as the groups of interest included deprived communities, ethnic minority groups and sexual minority groups. Recruitment from deprived communities and ethnic minority groups is often more complex, and this is compounded when discussing a sensitive subject(162,255,262). Often using a pre-existing group such as a playgroup or community charity can be a good way of recruiting people.

Below is a diagrammatic representation of how participants were recruited to the study and details of the purposive sampling techniques that were used for both healthcare workers and members of the public.

Figure 28 - Members of public recruitment



These processes are considered in more detail in the following section.

Purposive sampling of Members of the public

For the community-based work, purposive sampling helped identify areas where people might be recruited. Using pre-existing community groups and charities helped to increase the recruitment sample and gives a diverse range of participants. The aim was to recruit

approximately 20 members of the public for small focus groups of approximately 3-5 people being sensitive to personal belief systems, faith, and demographics.

The research grant included a budget for a translator and interpreter to improve engagement for people who did not have English as a first language. This was an essential aspect for this research as often people are excluded from research studies if they cannot speak English. Using an interpreter can be challenging, and advice was taken from a member of the academic unit who has done focus groups using translators(263).

Inclusion Criteria

- Young people
- Older adults
- Black and ethnic minority groups
- Sexual minorities and the transgender community
- Alcohol and drug users
- New migrants

Must be;

- Over 16
- Have mental capacity for interview
- Voluntary and no coercion
- They do not have to be SRH users and are not expected to share any personal experiences.

The sampling strategy aimed to use established contacts with community groups using forums such as 'Surestart' centres; health visitors, transgender, and gay and lesbian support groups; substance misuse and mental health services, GP, and public health connections with community workers. The initial approach was via community or charity workers who already engage with the individuals and have trusted relationships. Due to the nature of the groups being approached, there needed to be a flexible variety of ways to engage. Some members of the public did not speak English, and the community support workers were able to approach them in their language. To contact individuals, the lead researcher planned to attend open days and community sessions to answer questions and offer information.

Groups engaged as potential partners for the research.

- **PlusMe**
<https://www.plusme.org/>
 A registered charity and user-led organisation supporting South Yorkshire people living with or affected by HIV.
- **Darnall Wellbeing**
<https://darnallwellbeing.org.uk/>
 A local, not-for-profit, community health organisation working to help the people of Darnall, Tinsley and neighbouring areas stay healthy. Predominantly Pakistani, Roma Slovak, Bangladeshi community.
- **SayIt**
<https://sayit.org.uk/>
 A charity that works with young people and professionals to make real lives better e provide practical support around LGBT+ life, sexual health, HIV and mental wellbeing, while our training helps organisations improve knowledge and address discrimination.
- **SWWOP**
<https://www.swwop.org/>
 The Sheffield Working Women’s Opportunities Project (SWWOP) provides intensive support to vulnerable women involved in street prostitution.
- **Roma community group**
www.romasupportgroup.org.uk
 A community group run in Rotherham to offer services and support for Roam people living in the area.
- **Age Better Sheffield (now Age-Friendly)**
<https://agefriendlysheffield.org.uk/>
 Age Better in Sheffield was set up in 2015 with funding from National Lottery Community Fund with the remit to reduce loneliness and social isolation amongst people over 50 in Sheffield.

3.3. Analysis

This section explores data analysis of the interviews with HCPs. For this primary data analysis, transcripts were analysed thematically using a coding index reflecting the candidacy framework(124,238). It was decided to use CAQDAS as a tool for analysis, and this was in the form of NVivo® version 1.6.1. NVivo® allows the researcher to conduct all stages of the data management process with functions to help index and sort the data.

The five stages of thematic analysis were undertaken as described by Ritchie and Lewis(159). RM listened to the recordings, read and re-read the transcriptions to aid familiarisation and identify relevant sections. Candidacy was used as the framework for thematic analysis, but additional themes were indexed and sorted within the matrix. Themes and sub-themes were discussed in research meetings and supervisor sessions. The results are presented in the following chapter, and the coding matrix is included in Appendix 17 – Nvivo codebook interviews.

3.4. Quality and rigour

Reliability and validity are central concepts when discussing generalisability, although their origin is in quantitative methodologies. Due to this, qualitative researchers developed other terms to better evaluate findings(211,224) Trustworthiness or rigour in qualitative research is often questioned due to the perceived limitations of using an interpretivist approach compared to a positivist approach where one truth can be proven(218). Lincoln and Guba developed a foundation to help understand rigour and quality in qualitative research by transferring some of the ideals of quantitative research(211).

- *Credibility* (internal validity)
- *Transferability* (generalisability)
- *Dependability* (reliability)
- *Confirmability* (objectivity)
- *Authenticity* – added later and has no positivist equivalent.

Pope and Mays gave further assistance when trying to assess the quality and validity of qualitative research which included the following characteristics(264).

Figure 29 - Quality and validity by Pope and Mays (264)

- **Triangulation-** comparing results from two or more different methods of data collection
- **Respondent validation-** A technique where the researcher's account is checked with those of the research subject to establish the degree of similarity between the accounts
- **A clear account of how the data was collected and analysed**
- **Reflexivity-** An awareness and account of how the researcher and research process shaped data collection
- **Attention to negative cases-** Searching for deviant cases to facilitate a refined analysis
- **Fair dealing-** Incorporating a wide range of different perspectives

By considering all these various characteristics, a researcher can improve the rigour or trustworthiness of their research(265). Some of these aspects which are particularly pertinent to this research are discussed further. The discussions section will use these concepts to examine the trustworthiness and quality of the findings. COREQ is a 32-item checklist that was developed to promote comprehensive reporting of qualitative data and presented in Appendix 18 – COREQ checklist.

Triangulation

Triangulation improves the credibility of the research by using different methods, using different sources, a wide range of informants and investigators, and exploring different theories(211,265). The original research design was to use two 'viewpoints' from HCPs and members of the public to help offer different lenses of view about access. As mentioned previously, due to COVID-19, this has not happened. The QES offers a deeper understanding of access issues, and many of the studies included are from patients or members of the public. The interviews with nurses and doctors combined with the QES hopefully triangulates the data to offer a credible outcome.

3.4.1. Objectivity and bias

Qualitative research is not objective because the researcher brings their assumptions and biases into the choice and conduct of the research. Personal belief systems and biases may

influence several aspects of the research process. They may play a role in the selection of the research problem, data collection, analysis and the way the data is interpreted (216).

A key aspect of objectivity is to step back from personal views about the importance of SRH and try to see issues from a place without bias or judgement of others providing services. Hopefully, by reflecting on these issues and having ongoing reflexivity throughout the research process, it will maintain a high level of trustworthiness and credibility. This will be further examined in the discussion chapter.

3.4.2. Reflexivity

Reflexivity can be described as a "thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched"(266). This skill needs to be developed and can be used positively to improve enquiry and gain richer data. Reflexivity can be divided into personal, functional, and disciplinary(267). A fieldwork diary was kept showing reflexivity 'in action'. The following section considers personal and functional reflexivity. The narrative presented in this section describes the researcher's background, motivations, and factors that are instrumental in developing the research process and findings.

Personal reflexivity

To understand its impact on the research, personal reflexivity involves the researcher revealing their individuality, including their motivations, interests, and attitudes. The process involves reflecting on personal views and life experiences that might impact how the research is completed.

I am a Caucasian, heterosexual cis female brought up in the UK in a middle-class professional family. I grew up in Sheffield and went to medical school in Leeds. This research involves ethnic minorities or LGBTQ+ communities; it also focuses on areas of deprivation. I am a feminist and have been brought up in an environment of strong women, including a mother who is a leading professor in health technology who has inspired me to question any patriarchy. I need to be cautious interpreting my findings as this work is not viewed in a feminist context.

My personal background as a white middle-class female means that I must be aware of the responsibility to understand and explore racialised positionality and the role of cultural

misrepresentation which has occurred in the past. I appreciate that I have white privilege and that my journey through life has not been impeded by racism or discrimination. I feel a level of discomfort being a white researcher exploring the complexities of race and ethnicity.

As a woman of childbearing age, I have had interactions with contraception services and sexual health, impacting the way I perceive the findings. I recently had a baby and had a negative experience with the NHS, mainly due to COVID-19 restrictions. I am aware I have unresolved anger towards HCPs and the lack of support I was given at the time. This may affect my interpretation of the findings.

As a doctor, I have done training in obstetrics and gynaecology and sexual health. I work as a GP and sexual health doctor now. I have been involved in setting up a contraception clinic in a high deprivation area of Sheffield to improve access to IUCD and implants.

Unfortunately, I left the practice due to an episode of burn-out, and the service was disbanded. I have always felt a level of guilt for this and sadness that those women must go to a central health clinic to access services. I know the people in that community and got an insight into their day-to-day challenges; this inspired the research.

I have a passion for improving access and feel frustrated when people are denied or struggle to access the care they need. I have worked in high deprivation general practice and closely seen the impact of poor services. I have had male colleagues in the practices who I feel have neglected SRH and ignored patient needs; this may impact my assumptions of the gender of the consulter as a barrier to care.

I am involved in the development of services in Sheffield and have worked with the Sheffield city council to improve services in the community. I feel passionately that SRH services need to be close to the person requiring them rather than in hospitals. This could bias my analysis, and I need to be aware of this in the interpretation.

Functional reflexivity

Functional reflexivity explores the relationship of the role of the researcher on the findings and any potential power imbalance during the data collection. This involves examining the role of the researcher pertaining to the process of conducting research. It helps to understand the rationale behind decision making and how one's values might impact how you approach research.

I am involved in training and teaching, which may cause bias with the HCP participants. They may recognise me as an 'expert' in the area and feel like they need to conceal or refine answers on my behalf. Scene setting and introductions can help build rapport and allow them to see me as a researcher rather than a trainer. I need to be aware of a 'power' imbalance between researcher and participant. I need to engage and empower them within the research process, mindful of what other competing priorities may be going on in their lives.

I am a doctor and need to be cautious of keeping the interviews as information gathering rather than letting them become therapeutic. This is more of an issue with members of the public, but if I speak to HCPs who are struggling, then my instinct is to help them. The interviews are about a deeper understanding of a subject, so my own views mustn't affect the discussions' direction. I am aware of this regarding personal beliefs or opinions of HCPs which I might find offensive or biased. I mustn't correct them in this setting; usually, I would challenge views that might be homophobic, for example.

During the recruitment of HCPs, I reflected on a sense that male GPs did not wish to participate in the study. There was a sense that female GPs provide the bulk of SRH, but my study needs to explore this and understand why that might be. I wondered about adapting the methodology to include a focus group of male GPs, so they feel less awkward about identifying a lack of engagement in SRH. This might be something for further research.

I have reflected on how the loss of the public voice will impact my credibility in answering the research question and feel that HCPs can give voice to the communities they work in. The QES helped reflect the views of patients and members of the public. Although this is a proxy representation for communities' struggles, it still carries weight and validity.

Debriefing sessions and peer scrutiny

Regular debriefing sessions were held between the lead researcher (RM) and her project supervisors. These were a variety of face-to-face meetings and online sessions, which helped develop the research questions, the process and analysis. In the later stages, the sessions have been used to discuss themes from the research.

The research project underwent peer scrutiny at various points through presentations to colleagues and academic conferences. The initial project was presented as part of the

doctoral development stream at the Society of Academic Primary Care conference; this gave helpful feedback and introduced the work by Dixon-Woods about candidacy. The project has been presented to the AUPMC in Sheffield at several stages as part of the seminar programme. The latter stage of the project was presented to the joint AUPMC meeting between Sheffield and Manchester. This feedback and academic scrutiny has ensured that the research project is relevant and peer-reviewed.

Field notes and reflective journals

In-depth field notes and a reflective journal was completed during the research process. This was completed after each interview and after a session with supervisors. This was an opportunity to reflect on each interview, digesting different things that had happened and might be relevant. Some of the concepts were developed from the field notes and diagrams.

3.5. Descriptive findings

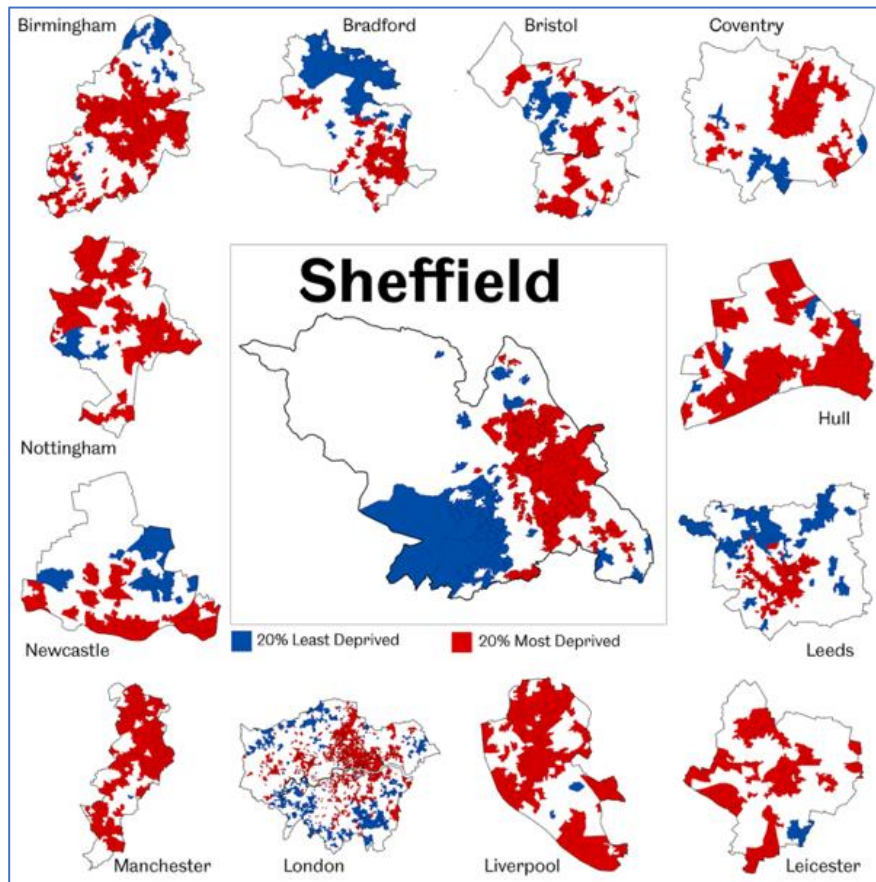
This section describes the contextual and demographic results, characteristics of the health professionals, their practices, and a summary of descriptive data. To acknowledge the research focus on deprived communities, the deprivation index and ethnicity of the practice population are included in the following section. The descriptive findings are presented here in stepwise sections. Practice demographics and deprivation indices are presented with the details of interviewees.

3.5.1. *Sampling location*

Having decided on using a qualitative methodology drawing on an interpretivist epistemology and semi-structured interview and focus groups as a method, the next consideration related to the sampling of participants for this research. South Yorkshire was chosen for the study location. For logistical reasons, Sheffield and towns in the South of Yorkshire were chosen as a broad geographical location. Sheffield and other towns around South Yorkshire contain areas of high deprivation and have some of the most significant inequalities in health in the UK. Yorkshire and the Humber is one of nine official regions of England with a population of 5.391 million(268).

Sheffield is a metropolitan city in the south of Yorkshire; it has two universities and has an ethnically diverse population with approximately 20% of its population from black or minority ethnic backgrounds, including Pakistani, Caribbean, Indian, Bangladeshi, Somali, Yemeni and Chinese communities(268). There is a gradient of social deprivation from the west to the east of the city. F shows the socioeconomic status of Sheffield in relation to other English cities. Sheffield is comparable to other major cities in England; therefore, the results of this research can be transferrable nationally(269).

Figure 30 - Inequality through the Indices of multiple deprivation in 13 English cities presented by Rae in 2011(269)



With regards to how comparable South Yorkshire and Sheffield is to the rest of the UK, the following table shows the current key indicators for SRH as reported by Public Health England(270).

The table below shows that Yorkshire and Humber have above UK average teenage pregnancy rates(21). This is important because teenage mothers are less likely to complete education, more likely to need social care input and have worse health outcomes(271). The focus on deprived communities in Yorkshire and Humber will help understand the barriers to access for those in most need.

Table 4 - Key indicators for SRH as reported by Public Health England fingertip profiles 2021 (270)

Indicator	Period	England	North of England PHE region	North East PHE centre	North West PHE centre	Yorkshire and the Humber PHE cent.
Syphilis diagnostic rate / 100,000	2020	12.2	7.6*	8.5	9.6	4.5
Gonorrhoea diagnostic rate / 100,000	2020	101	63*	59	66	61
Chlamydia detection rate / 100,000 aged 15 to 24	2020	1408	-	1515	1249	1498
		<1900	1900 to <2300	≥2300		
Chlamydia proportion aged 15 to 24 screened	2020	14.3	13.2*	13.5	11.7	15.0
New STI diagnoses (exc chlamydia aged <25) / 100,000	2020	619	-	449	490	419
		New data				
HIV testing coverage, total (%)	2020	46.0	39.8*	39.4	36.9	46.2
HIV late diagnosis (all CD4 less than 350) (%)	2018 - 20	42.4	-	39.8	42.5	47.7
		<25%	25% to 50%	≥50%		
New HIV diagnosis rate per 100,000 aged 15 years and over	2020	5.7	-	3.0	5.0	4.1
HIV diagnosed prevalence rate per 1,000 aged 15 to 59	2020	2.31	1.67*	1.10	1.99	1.51
		<2	2 to 5	≥5		
Under 25s repeat abortions (%)	2020	29.2	29.2*	27.3	30.7	27.6
Abortions under 10 weeks (%)	2020	88.1	88.3*	85.1	89.8	87.3
Total prescribed LARC excluding injections rate / 1,000	2020	34.6	32.8*	28.9*	29.4*	39.1*
Under 18s conception rate / 1,000	2019	15.7	19.8*	21.8	19.4	19.3
Under 18s conceptions leading to abortion (%)	2019	54.7	52.0*	47.2	57.0	47.8
Violent crime - sexual offences per 1,000 population	2020/21	2.3*	-	2.7*	2.4*	2.7*

Sexually transmitted infections (STIs) represent a significant public health problem in Yorkshire and Humber. Out of all the Public Health England areas, it has the third-highest rate of new STIs in England. More than 37,400 new STIs were diagnosed in Yorkshire and Humber residents in 2017, representing a rate of 690 diagnoses per 100,000 population(272). The number of new STIs diagnosed in Yorkshire and Humber residents rose by 2% between 2016 and 2017(272). This increase was seen in common STIs, including

syphilis increased by 12%, gonorrhoea by 16% and chlamydia by 5%. In Sheffield, 14% of new STI diagnoses are in people who are born abroad(273).

3.5.2. Participant description

Twenty participants were recruited via our Sheffield DeepEnd network, NIHR CRN portfolio and snowball sampling techniques. The sample contained more women (n=13) than men (n=7), likely reflecting the high proportion of female practice nurses and the higher number of female GPs with a special interest in SRH. Table 5 shows the GMC data for the gender of GPs. This data is from 2016 and may have changed with the recent issues with GP pensions and tax payments but is expected to be like current proportions.

Table 5 - The percentage of licensed GPs by age and gender, 2013 to 2016 (GMC)(274)

Gender and age	2013		2013–16 % change	2016	
	GPs	%		GPs	%
Men (less than 50 years old)	12,660	24%	0%	12,617	23%
Men (more than 50 years old)	14,411	27%	-10%	12,961	24%
Women (less than 50 years old)	17,953	34%	9%	19,614	36%
Women (more than 50 years old)	8,074	15%	9%	8,832	16%
Total	53,098		2%	54,024	

There were 7 practice nurses and 13 GPs recruited to the sample, and this is probably slightly disproportionate due to the purposive sampling of male practitioners to balance the gender disparity. No male practice nurses were recruited, representing the low number working within the region. NHS Digital data shows the gender disparity between male and female practice nurses; in September 2020, there were 10,885 full time equivalent female practice nurses and 175 full-time equivalent male practice nurses in the NHS(275).

The following table shows the demographics of the HCPs involved. The practice demographics and participant demographics have not been linked as some features would make the participants more identifiable to those working in the area.

Table 6 - Demographic information of healthcare professional participants

Gender	Age	Profession	Place of training	Ethnicity
Male	50	Doctor	Abroad	Asian
Male	50	Doctor	UK	Caucasian
Male	50	Doctor	UK	Caucasian
Male	21-30	Doctor	UK	Caucasian
Female	31-40	Doctor	UK	Caucasian
Female	31-40	Doctor	UK	Caucasian
Female	41-50	Doctor	UK	Caucasian
Female	41-50	Doctor	UK	Caucasian
Female	41-50	Doctor	UK	Caucasian
Female	41-50	Doctor	Abroad	Chinese
Male	41-50	Doctor	UK	Caucasian
Male	41-50	Doctor	UK	Chinese
Male	41-50	Doctor	UK	Caucasian
Female	50	Nurse	UK	Caucasian
Female	21-30	Nurse	UK	Caucasian
Female	31-40	Nurse	UK	Caucasian
Female	31-40	Nurse	UK	Caucasian
Female	41-50	Nurse	UK	Caucasian
Female	41-50	Nurse	UK	Caucasian
Female	41-50	Nurse	UK	Caucasian

All the practice nurses recruited were Caucasian and trained in the UK. It would have been helpful to speak to nurses trained abroad or from ethnic minority groups. Government figures show that the NHS workforce ethnicity consists of 77.9% white and 22.1% from all other ethnic minority groups(276). This is comparable with the Workforce Race Equality Standard report data, which contained data from CCGs in England that had 14.3% BME staff(277). There is no data available that shows the ethnicity of practice nurses in the UK, but the NHS workforce data shows the following ethnicities(276).

- Asian people made up 10.7% of NHS staff, compared with 7.2% of working-age people,
- Black people made up 6.5% of NHS staff, compared with 3.4% working-age people.
- People from the other ethnic group made up 2.6% of NHS staff, compared with 1.1% of working-age people.

Table 7 - The percentage of licensed GPs by selected primary medical qualification (PMQ) and ethnic group, 2013 to 2016 (GMC)(274)

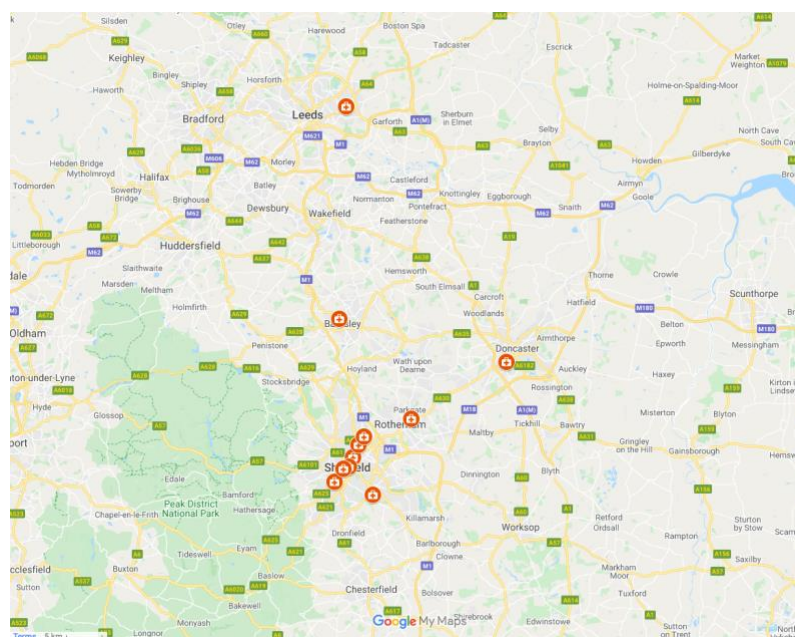
PMQ and ethnicity	2013		2013–16 % change	2016	
	GPs	%		GPs	%
EEA BME	293	1%	15%	338	1%
IMG BME	6,532	12%	-1%	6,489	12%
UK BME	4,998	9%	32%	6,583	12%
EEA white	1,708	3%	-1%	1,698	3%
IMG white	714	1%	-3%	694	1%
UK white	26,723	50%	-1%	26,524	49%
EEA not recorded	662	1%	-6%	619	1%
IMG not recorded	1,962	4%	6%	2,083	4%
UK not recorded	9,506	18%	-5%	8,996	17%
Total	53,098		2%	54,024	

It would have been helpful to have known the ethnicity of practice nurses working across the South Yorkshire area, but this data is unavailable. Interestingly, the CCGs in the UK have only this year started reporting staff ethnicity to the Workforce Race Equality Standard report(277).

3.5.3. Practice description

There were 20 participants from 11 practices spread around South Yorkshire and West Yorkshire. The below map shows the locations of the medical centre, and the deprivation data for the area from Consumer Data Research Centre (CDRC)(278).

Figure 31 - Location of participant practices presented on Google maps and deprivation data from CDRC 2021 (278)



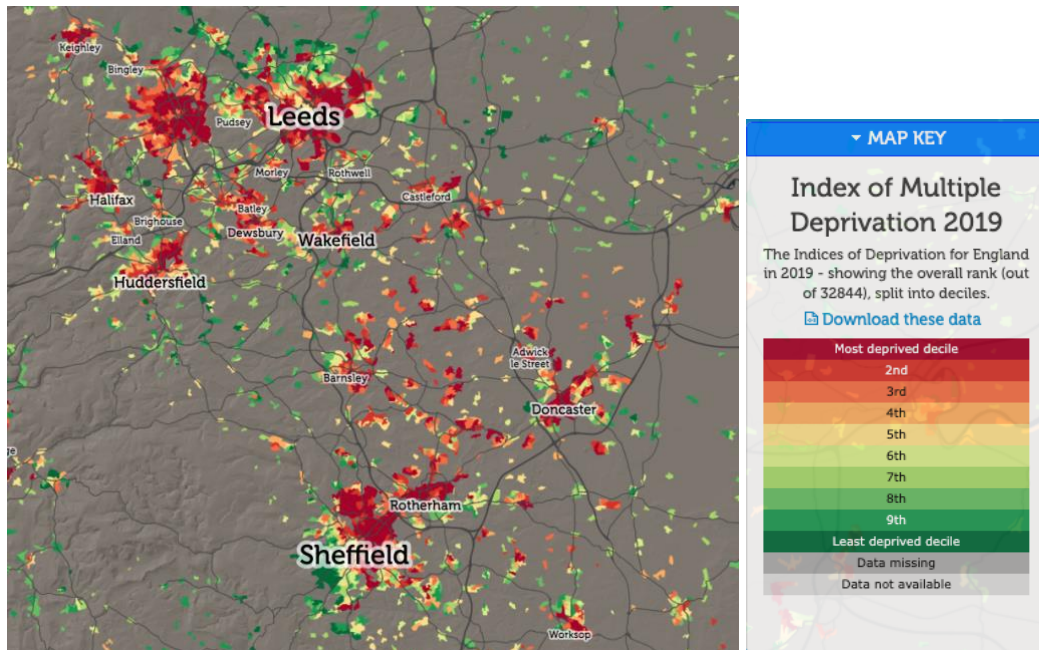


Figure 31 shows that most recruited participants were from practices in deprived areas of Yorkshire.

Table 8 shows practice demographics including the location and deprivation decile, with one being most deprived and ten being least deprived. The male and female life expectancy for the practice was also included as highlights the health inequalities between deprived communities and more affluent and the difference between men and women.

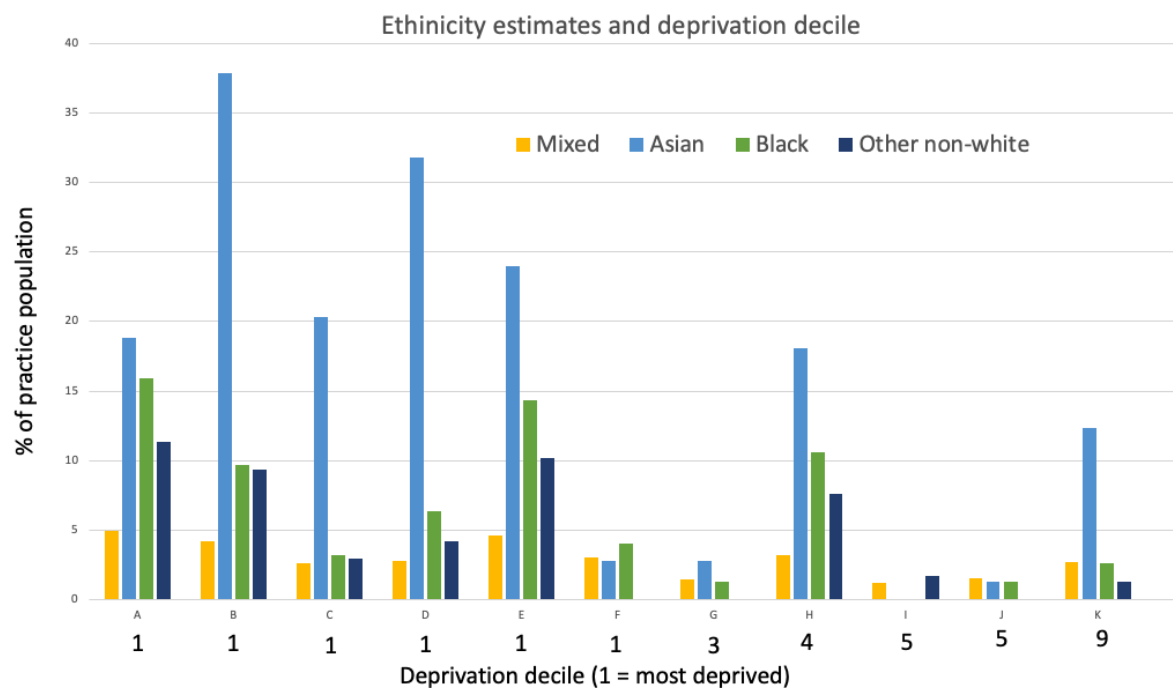
Table 8 - Practice demographics including deprivation decile

Practice	Location	No of participants	Deprivation decile	Life exp male	Life exp female	Size
A	Sheffield	4	1	75.7	78.9	6877
B	Sheffield	2	1	75.3	78.3	7933
C	Rotherham	1	1	75.2	79.7	5612
D	Sheffield	1	1	77.3	80.4	17363
E	Sheffield	3	1	75.2	78.5	14773
F	Leeds	1	1	75.3	81.3	6893
G	Doncaster	1	3	77.6	82.3	14763
H	Sheffield	1	4	76.9	79.1	7222
I	Doncaster	1	5	79.1	83.1	13681
J	Sheffield	3	5	79.7	84.1	3788
K	Sheffield	1	9	81.5	85.4	9849

One of the interview participants was a GP working in a local CCG who had a background in public health and sexual health. He was not included in practice descriptive findings as he had no practice allocated.

Figure 32 shows the community ethnicity taken from fingertip public health data with each practice represented as a letter with the deprivation decile below.

Figure 32 - Practice ethnicity estimates and deprivation deciles



The graph shows the higher proportion of people from black and ethnic minority groups, although the term Asian is non-specific and could include people from Southeast Asia or China.

One practice (K) was from a less deprived community, but it has a high Asian Chinese population of students, and the participant recruited was a GP who trained in China. She offered a helpful insight into that community's health needs and access challenges. The Chinese student population have been identified as having poor SRH outcomes in terms of higher abortion rates and unplanned pregnancies; they are a valuable group to understand access barriers(279).

3.6 Summary

This chapter has described the key methodological concepts and philosophical assumptions that guide the research questions and design. To answer the research question about the barriers and facilitators for general practice are to address inequalities in SRH access, a qualitative methodology using the candidacy framework as a framework for analysis has been selected.

Unfortunately, due to the COVID-19 pandemic, the focus groups planned with members of the public could not happen, as explained earlier in this chapter. Research participants were interviewed using semi-structured interviews, and the data was analysed using thematic analysis (238) until data saturation was achieved.

The participant and practice demographics have been described in this chapter, and the next chapter will present the findings of the research based on the use of approaches and methods already described.

4. RESULTS

This chapter presents the findings of the qualitative interviews done with GPs and practice nurses working in practices in areas of high deprivation. These HCP have worked with underserved populations over many years and have expertise in communicating with these communities. The candidacy framework was used as a theoretical model to explore the journey through healthcare. The HCP offers a narrative of their own and a perspective of patient experience over time.

The candidacy framework was discussed in the background chapter concerning access to healthcare by vulnerable populations (Dixon-Woods) and further developed in the QES. Within this chapter is an initial overview of the various steps of the candidacy framework, followed by more in-depth findings from the qualitative interviews.

Whilst many of the themes are interconnecting and influential on different levels of the candidacy framework, the chapter structures them as stand-alone domains.

In the QES chapter, an adaptation of the candidacy framework was proposed, which removed the domain of adjudication and explored the idea of recognising and accepting candidacy. This chapter explores these concepts further using the data from the qualitative interviews. It examines the more complex interactions and the interplay between the individual seeking care and the HCP through the lens of the GPs and practice nurses.

Summary of participant identifiers

F – female

M – Male

GP – General practitioner

PN – Practice nurse

Age – e.g. 41-50 years of age

C – Caucasian British

Ch – Asian Chinese

Pk – Asian Pakistani

4.1 Overview of categories and themes

The following section revisits the stages of the candidacy framework previously explored in the background and QES. These are highlighted in the following table.

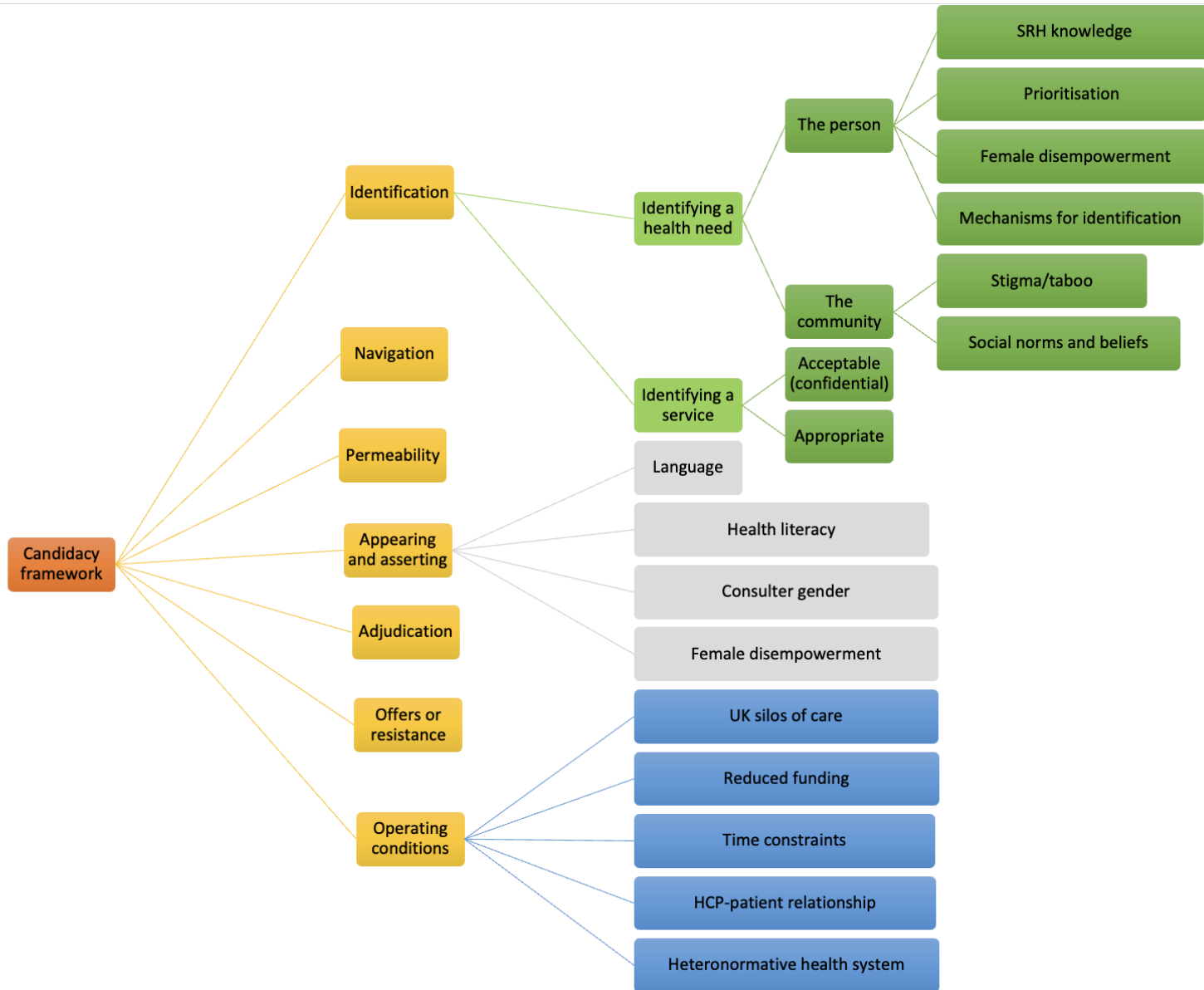
Table 1 - Candidacy framework described in the context of SRH, adapted from Dixon-Woods (122,124)

Candidacy Framework	Dixon-woods (2005/2006)	Examples of SRH access
Identification of candidacy	A persons recognition and response to a symptom. Influenced by own knowledge, health literacy, community behaviour.	<i>Identifying need for an STI screen due to unprotected sex.</i>
Navigation of services	A persons awareness of what services are available and ability to mobilise practical resources or assets needed to attend service	<i>Taking time off work to travel on 2 buses to get to central sexual health clinic for an STI screen.</i>
Permeability of services	More porous services require less qualifications of candidacy and less mobilisation of resources to attend. Less permeable services require a higher degree of cultural alignment for example booking systems, needing to read appointment letters.	<i>Needing to call the clinic at 8.30am each morning, navigate a telephone automated system and speak to a receptionist to book an STI screen.</i>
Appearing and asserting candidacy	A person making a claim to candidacy for medical attention or intervention. They need to provide a coherent history and articulate the issue, have formulated a health need which requires a level of understanding.	<i>A person asking for condoms in a GP appointment.</i>
Adjudication	Healthcare professionals judging worthiness of the candidacy claim and Interlinks with perceived social deservingness.	<i>GP not suggesting an implant as contraception method as they have been unreliable attending appointments in the past.</i>
Offers of/resistance to services	An intervention or treatment course has been offered but declined by the person in need.	<i>Declining offer of cervical screening when in for a practice nurse health check.</i>
Operating conditions and local production of candidacy	Interactions between health care professional and patient which can be affected over time. Includes the perceived or actual availability and suitability of resources in a particular setting	<i>GP turning a patient away when they ask for an HIV test as perceived as not funded in primary care.</i>

The process takes an individual from recognising a need to having that need realised.

Although it looks like a stepwise process, it is much more complicated, with stages interacting and impacting one another. Individuals may not flow through the process in one smooth process and may get stuck at different levels, needing repeat attempts to have their candidacy realised. The results are presented as discrete themes but, in reality, are more integrated and complex.

Figure 33 - Summary of the key topics identified in the thematic analysis



4.1.1. Identification of candidacy

This theme refers to individuals gaining awareness and seeking access to a service for their identified needs(124). It is a crucial aspect of the candidacy journey, and this section explores two distinct themes; identifying a health need and identifying a service to meet that need. To have a health need met, the individual must self-recognise a problem or an issue. Self-recognition is how a person identifies they need to access a service. There are complex and interacting influences that might impact this self-recognition. These are explored further in the following sections.

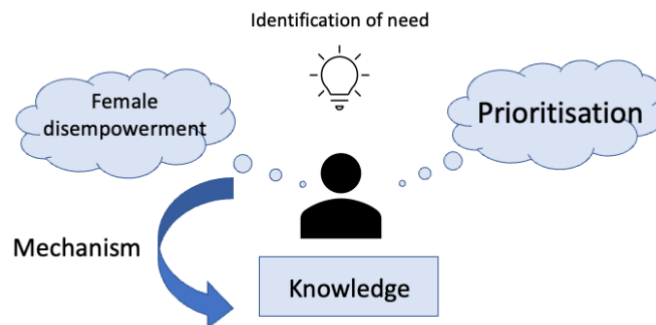
Identifying a health need

A common theme in the narratives was around the HCPs perception of how a patient identifies a health need. Identification of a need was a persistent barrier expressed during the interviews. Within deprived or vulnerable communities, two themes became apparent, those related to the individual and those related to the community. The themes developed in this section reflect the importance of knowledge, taboo and stigma, social norms, and prioritisation of health on access. This topic is discussed in more detail in the following sections.

The person

At this personal or individual level, there were different factors that the HCPs expressed as being barriers or enablers to access. Firstly, and probably most described, was knowledge which included subjects such as risk identification and how we seek information. Secondly was the ability to prioritise health within the context of the complex and challenging lives that the HCP perceived. Thirdly, the role of female disempowerment in her ability to access SRH services. Finally, there was a mechanism of becoming aware of a health need and factors that might impact this.

Figure 34 - Representation of identification of need



Knowledge about SRH

The interviews with the HCP revealed how knowledge specifically about SRH can be poor in deprived communities, for example, understanding the risk of infection and the need for screening. Access is challenging without knowledge or understanding of a health need or condition.

A lot of teenage pregnancies, especially with the Slovakian Gypsies. Lots of underage sexual activity going on. So, we have the teenage pregnancies, and then patients who have contracted sexually transmitted infections, and they lack a lot of knowledge in that. So, they'll come and speak to the doctor in triage, you know, because of having X, Y, Z symptoms, and then they actually have no sort of...they don't realise that the activity they've been doing is related to these sort of infections. So, a lot of it is about education and advising them about condoms and safe sex and things like that.(P11 – F/PN/41-50/C)

One of the interviewees, who was born and did her medical training in China, describes the poor knowledge about reproduction in Chinese students who have come to study in the UK. She explains how this lack of contraceptive knowledge leads to unplanned pregnancy and abortion.

Yeah so many of the young people they come in for contraception you know the people here and especially the students there's a few like cases when Chinese students there are not so many Chinese students coming in and there's a few cases they come in for abortion.....And so yeah and the girls come in like several times for abortion and I just feel like yeah, and obviously quite upset that you can

avoid all of these and they are very they don't know what contraception's are and you know they're very sexual knowledge is quite poor. (P18 – F/GP/41-50/Ch)

Not only do individuals need knowledge about what can happen if they have unprotected sex, but they also need to know what is available to them to prevent pregnancy. In this example, knowledge about what different contraception options are available might prevent people from accessing the right one for them.

I think there's still a definite sort of barrier to access, and you certainly see that in the younger women that come through, I think. I don't know how you still see people that really think the Pill is the only thing that they can have, so the message isn't getting out. (P13 – F/GP/41-50/C)

These quotes illuminate the issue of how challenging it is for people who have limited knowledge about SRH; they are not aware that a particular behaviour might put them at risk of pregnancy or infection.

Knowledge can be gained in different ways. The HCP perceived different ways people acquired knowledge from various social network members; this includes friends and family who seemed to be prioritised over medical advice.

..... So people might come in and they want to talk about contraception or we might bring it up and say 'have you thought about something to stop you having any more children', the word contraception is something that people don't understand what contraception actually can mean and even if you say that or it's translated into their language, they may not still understand what we actually mean by that. So, yeah, there's certainly a lot of misconceptions about what's on offer, what the different types are, how they work, but there's also a lot of, you know, 'my sister, she had one of those things in the arm and I want that too', or 'she says you put weight on if you have a depo, I don't want a depo'. So there's lots of sort of hearsay about certain types of contraception. I think it seems almost that there are fashions for things too so, you know, you might see a lot of, you go on a run of people having implant or having a coil, that sort of thing. (P5 – F/PN/50+/C)

Unfortunately, this can lead to barriers to access caused by myth and misinformation, which propagates through communities. It was unclear why there was a preference for lay-person advice, but it could be an essential way of influencing health literacy in deprived communities.

An interesting theme that became apparent in the interviews was a perception of change in knowledge and behaviour as people become more 'westernised' over time. The HCP observed a progression and confidence which developed over time, especially related to women in Asian communities. A GP working in a practice with a high population of Muslim Pakistani people described a change in knowledge over time.

If a third-generation chap is married, who is educated, he will let his children go to mixed classes. Second generation won't, no. Their head will be covered, perhaps hijab. No, certainly big no. But as I said, if the third generation who are becoming more, girls are becoming more emancipated, and the parents are educated, then I see less of a problem. They will come and discuss even contraception or their gynae or obstetric problems.....a Pakistani woman of thirty-something. She asked for the contraceptive pill. Yeah. Aged thirty-six. So she asked for contraception. So there's a smattering of patients. It's not a regular occurrence. A patient would not come and ask me for contraception, except some of the third generation. Third generation are getting better. They're coming forward. With the third generation, me being a male is less of an impediment rather than with the second-generation females. Third generation are more forthcoming, and they understand, because they're taught sex education and the Pill and everything. (P7 – M/GP/50+/Pk)

First and second-generation families were described as having very traditional views and relatively poor knowledge about SRH. This was contrasted with the more westernised younger people who were perceived as having more sexualised behaviour. Problems arise with this changed behaviour but not having the knowledge or parental support to deal with the implications. The GP describes the patient as having had a risk that led him to identify a health need.

And we all learn from there. And if – the tragedy is the second generation who are not educated, cannot educate their children. They have to rely on extraneous

sources or resources, for example school sex lessons, and then experimenting if they want to be adventurous. (P7 – M/GP/50+/Pk)

Another male GP discussed the perceived increased risk-taking behaviour of younger people, with practices such as anal sex becoming more common and normalised in heterosexual relations.

...the youth, thinking they're the next generation, I want them to start well, got a high risk of pregnancy, got a high risk of STI, and also I want them to be proud of their bodies – I'm worried about women's perception of themselves, I'm worried about this idea that anal sex comes before vaginal sex now in people's repertoire, I'm worried about it being more about male-dominated sexual pleasure. (P15 – F/GP/41-50/C)

It is unclear whether this change in sexual behaviour has led to changes in health-seeking behaviour and could not be inferred from the interviews. Knowledge interplays with many different aspects of the candidacy framework, and although discussed in isolation, it is a theme that runs through all aspects of access.

Priority

The prioritisation of self has a significant impact on accessing SRH services and is more relevant for deprived communities. Many of the narratives around vulnerable women explored the competing priorities in their lives. One of the GPs who worked in an asylum-seekers clinic expressed this clearly.

I don't think in that setting thinking of those women that people were putting a pressure on them, they just didn't want to – it was just down the list of their priorities. And some of them, especially the traffic women with babies, quite often were living in an all female environment or all female and babies environment where it just wasn't what they were, you know, they were maybe living in a sort of supported accommodation and that wasn't what they were thinking about at their first postnatal check, it was just down the list of priorities. (P4 – F/GP/41-50/C)

A GP who worked with homeless women and sex workers discussed the challenges of looking after your health, especially reproductive health, in the setting of addiction and probation.

There is plenty available, it's just not a priority. So if your priority – and it's difficult, 'cause when you're on the, if you're on a probation service, probation comes first, health comes second, so you have to be there to sign on. If you're tagged, you have to be where you are at night, so these things go further and further down the list. So probation is first, then maintenance therapy is second.

So third, fourth, fifth, when it comes to those. (P8 – M/GP/50+/C)

The complexity of these perceived competing priorities makes sexual wellbeing of low importance.

I imagine these women are very vulnerable especially in terms of you know sexual health, sexual wellbeing you know whether there might be sex workers or other groups that you kind of look after but do you but you definitely get the feeling that it's just not a priority when you know when you've got competing priorities in your life. (P19 – M/GP/41-50/C)

The narrative about competing priorities for these women from vulnerable communities helps us understand the gradient of health inequalities. Even when services are available, they may not be accessed as they are not essential in that women's day to day life.

Female disempowerment

The theme of female disempowerment has been a collective narrative through all the candidacy topics; it is defined as where such individuals *are denied the liberty of making fundamental life choices*(280). This is explored in the following section.

A GP who works in the health clinic for people seeking asylum described how women have been trafficked and become pregnant through sexual violence.

Quite often with those women, they had no prior experience of having used contraception and they weren't, as I say, quite often I would say women in that context who were pregnant through, quite often, especially with the traffic women, they were quite often pregnant through sexual violence and they just

weren't at a point where they were, you know, they weren't in any partnership or they weren't regarding themselves as wanting to have sex at the moment or they just didn't want to – it felt like it was difficult to go there and yet you knew that there was a kind of risk that they would quickly find themselves at a different position again. So I felt like the uptake of contraception there was pretty poor and difficult to get people, yeah, difficult to get people to engage. (P4 – F/GP/41-50/C)

Although not as overt as sexual violence, women may be sexually exploited or misinformed about their partners' risk of infection or pregnancy. A practice nurse describes Roma man not wanting to wear condoms and using the unreliable withdrawal method.

And a lot of people tell me they're using, their husband's using condoms – whether they are or not is another story, because that's a whole another ballgame, particularly amongst the Roma, the men won't wear condoms, they do the withdrawal technique that is not always very effective! (P6 – F/PN/31-40/C)

For some women, access is delayed due to fear of repercussions. A GP described how women might be afraid of a SRH diagnosis. Some women do not have the choice about their partners' fidelity but would be blamed if they had an infection.

If I say he's got it from another woman, my God, I'm done. What evidence do I have? I don't. And then Asian men are very cruel, Pakistani men. Because if she says something he will say "I got it from you". (P7 – M/GP/50+/Pk)

The impact of female disempowerment on identifying their candidacy was a fundamental keystone in healthcare access for women in deprived communities.

Mechanism of identification

This final section of identifying a health need revolves around the different mechanisms employed. A theme that became apparent was the idea of someone else either identifying a person's candidacy or someone using a person to identify their candidacy.

A concept originates in work by Balfe, which was mentioned in the QES, about a transitional moment that will instigate someone to identify a need(171,172). This concept of transitional moments describes a life event or transition from one frame of life to another,

which then triggers a behaviour such as screening. A practice nurse described an example of this when someone changes relationship status.

So they sort of say, you know, it's either 'I've been with a new partner' or 'had a one night stand and I'm just a bit conscious that we didn't use protection' or 'I did use protection but I don't know if..', you know, that sort of thing. So we do, it's often that and that's usually how we get to see people is they might book themselves in for swabs. (P3 – F/PN/31-40/C)

A typical prompt for people accessing sexual health screening was having undertaken an at-risk behaviour. During his training, a male GP describes working in an accident and emergency department.

Yeah, so I think the most interesting experience I had was actually in A&E, we had a young chap come in very worried that he'd slept with a prostitute who wasn't sure of her HIV status, so sorting out all the tests and that was a really interesting experience.(P17 – M/GP/21-30/C)

Others described events like marriage or pregnancy being a moment to access a service for screening or contraception. The below quote describes a woman who tested because she had come to the UK for marriage.

I mean, there was one particular lady who was from Zimbabwe and she joined the practice maybe four or five years ago, she married a much older Caucasian man. She was probably about 35 and came over here, they married in Zimbabwe, he was maybe about 65, he married her there, brought her over here, she'd already got a daughter who was about 14, she had a routine bloodborne virus screening done, showed she was HIV positive. (P5 – F/PN/50+/C)

The quote raises the issue of consent and pressure to be tested by an outside influencer. The GP recognised the external pressures for testing and how those interplay with female disempowerment. Conversely, this may also improve access through advocacy from relatives. An example below is from a practice nurse who described a woman brought in by her husband-to-be for screening and immunisations.

One of them doesn't speak English so she had a translator on the phone. It was the partner, he came on the phone and he just said 'I'm marrying her and she needs immunisations and screening', so that came from him and I don't know him. And then the other lady, a Somalian lady again who was a midwife but then I don't think she's worked for quite a long time, she's had several children and then she's marrying again, so she was just basically saying 'I just know that I need to get tested'. (P1 - F/PN/41-50/C)

A practice nurse describes how a patient was diagnosed with a sexually transmitted infection that she had received from her husband who had been unfaithful. He had told his wife to go for screening.

I mean, I can remember feeling a sense of awkwardness at bringing up certain things and I suppose in a way culturally, particularly with some of our Muslim families, to bring up something like that could be really, you know, you're opening up something that could be really significant for a couple, so to suggest, I mean, there has been instances I guess where we've had ladies, Muslim, Pakistani Muslim ladies who may have come in for what we thought might be a UTI, sent off samples and come back as chlamydia positive and so then that lady will have come back and, you know, you have to – and so you tell them that they've got chlamydia, the only way you can get that is through sexual contact and then that woman would then say – I mean, there has been a case, probably two or three years ago where this happened and a lady, she'd only ever had sex with her husband all her life, she'd got children and so it eventually came out that her husband had been unfaithful to her. (P5 – F/PN/50+/C)

It was evident from these different mechanisms that there may be different candidacies at play, the candidacy of the people accessing the service, and those of partners bringing them in for testing.

The community

There were several themes that the HCPs perceived as barriers to the community. This section contains themes about stigma, taboo, cultural norms, and beliefs. These subjects are intertwined and complex but help add richness to an understanding of health-seeking in deprived communities.

Taboo, stigma and shame around SRH cause a barrier to access to services and impede candidacy. One participant shared her problems offering education about contraception to a Somali women's group.

I remember once I was doing a talk to a Somali group on Vitamin D and TB they wanted and I offered to come again and talk about contraception and they just totally flattened me with like 'no way, you're not allowed to come and talk about contraception'. (P2 – F/GP/31-40/C)

Unfortunately, taboo and lack of discussion cause issues with health literacy which affects women being able to access care. The following quote also expresses the sense of helplessness from a healthcare professional regarding changing community stigma.

I remember there was someone called X who was the Somali link woman and she just said it's not something that they are used to talking about and it maybe just in sort of health literacy, they're not brought up talking about sex I would say and it's not something that they maybe feel they have much choice about or, I don't know, I'm really not sure I can answer that. (P2 – F/GP/31-40/C)

Another GP, who was himself from Pakistan, spoke of the impact of religion and sexual health. He also recognised the changing cultural norms as younger people become more 'westernised'. The idea is that as patients become more westernised, they become more confident or better at self-identification for SRH issues.

But having said that, what goes on behind the curtains, we don't know. I'm sure the younger generation is getting more emancipated and therefore they are becoming more adventurous, and therefore maybe they're engaging in sexual activity. It may be a good thing because if you teach them a lot of things – but it's not only a taboo but it's a sin. (P7 – M/GP/50+/Pk)

He also uses terms such as 'sin' and 'hell' when discussing SRH, reflecting the societal demonisation of this area of health. Fear would be an inferred barrier for people living in his community.

It's a sin, and therefore when the parents say it's a sin and what's going to happen to you, you're going to go to hell, the hellfire and the consequences, then

it puts a lot of sort of damper on. But if they were given a free hand as the natives have or the Czechs have or the other European nations have, they will go wild as the local community. (P7 – M/GP/50+/Pk)

This topic can be more exaggerated for sexual minority groups living in ethnic minority areas, as described by this female GP working in a Muslim community.

We have a handful of people with gender identity issues but probably be less than a lot of practices but we do have a handful. Yeah, I do worry, I mean, maybe this is a slight different issue but, there again, I do worry that there's such a stigma about homosexuality within the Muslim community that we just don't see, sometimes I see men maybe like I can think of men I've seen in the Pakistani community and I'm thinking like everything about you is suggesting to me that you're gay but here you are with your wife and your child, I don't know, but I'm just thinking there must be so much that's hidden away and that's not, again, if you had a sort of anonymous survey about people's behaviour behind the scenes, I really wonder what's happening and if you were, yeah, a gay man in the Pakistani community, how do you organise your life, like, how do you and how would you ever ask for, you know, appropriate.... And how do we raise it and all of those things. So that has struck me before that there must be so much of that that's hidden away and that's stigmatised and that is a real taboo, so I'm kind of aware of that but I have no idea how you. (P4 – F/GP/41-50/C)

This barrier is not primarily related to religion or ethnic minority groups. This perceived intolerance to homosexuality was observed by a GP who works in a poor white area, and he described a woman from the local council estate being ostracised when she came out as gay.

Yes, right. Sure, yeah. Yeah you know – so sad case of a woman who's now in her late 40s, she was married, she's had children, she came out as gay during her marriage, which has now fallen apart – she's faced quite nasty persecution really from you know, people in the locality. So that's really difficult for her. (P16 – M/GP/41-50/C)

The impact of community stigma and taboo has been demonstrated, and it is particularly challenging when dealing with SRH topics. A further theme expressed by HCP was about

cultural norms and beliefs, particularly concerning marriage and pregnancy. Pregnancy is seen as a gift within some communities and using contraception to prevent this would seem ungrateful. A practice nurse describes her experience of Muslim women seeing pregnancy as a gift from God.

...but it's more that culturally they don't want it, the Muslim community feel like, you know, to have babies is a gift from Allah so they keep going until Allah stops giving them babies. And the Roma tend to start having babies at sixteen and keep on going until they've got about eight. And culturally, I don't know how many generations on it'll be until they feel like they can stop after a couple and actually invest in their lives as well. (P6 – F/PN/31-40/C)

Another practice nurse from a practice serving a predominantly Roma population described the cultural drive for early marriage and pregnancy. The lack of ambition or hope for social mobility is a perceived barrier to identifying the need for contraception.

We see quite a lot of teenage pregnancies....culturally I expect partly to do with culture, so a lot of our Slovak families in terms of their culture, they get married very young or there isn't a huge aspiration within families to think of a career or studying, it's more about having children seems to be – also some of our Pakistani families, again, they often can get married very young, they can have arranged marriages and, again, start quite young when they first have their children. (P5 – F/PN/50+/C)

There was a narrative about perceived ambivalence to pregnancy for women living in deprived communities. The impact of teen pregnancy for women includes issues completing education and leads to social disadvantage, as described by a practice nurse working in a deprived ethnically diverse practice.

I had a conversation a few months back with a fifteen year old Roma girl who didn't know if she was pregnant or not and had come for sexual health screening and actually she thought she might have chlamydia again, so we were having a chat about that and then kind of having a chat about, you know, was she using any contraception, did she think she might be pregnant, she said 'oh I don't know', I said 'how would you feel if you were', 'I don't really mind', I said 'well, you know, you're fifteen, what about getting your GCSEs?', 'well', you know, and she

had absolutely – even at fifteen – and she had quite good English actually – she had no expectation for the future at all apart from to have babies and it was just like blimey! (P6 – F/PN/31-40/C)

A GP describes there being little initiative for women to seek contraception. This ambivalence is a challenging area to understand, and there are complexities in that a teen pregnancy might not be seen as a negative thing in some cultures.

But we also have a lot of young families and a lot of young pregnancies, and in a way that's a little bit more normal in our practice as well, so I don't if there's as much a drive to make sure you don't get pregnant. (P13 – F/GP/41-50/C)

This subject also ties into the issues around female empowerment, which are discussed later in the results section. This theme of perceived social norms also interplays with health literacy and perpetuating cycles of behaviour within communities.

Identifying that there is an acceptable and effective healthcare offer

A core theme around the identification of candidacy was the need for acceptable and appropriate services; confidentiality featured predominantly within this. This section explores this in more detail.

The HCPs perceived that services also need to be appropriate for those accessing them. An example of this was a discussion comparing traditional sexual health clinics to those services offered in general practice. The sexual health clinics are seen as better for serving people who are gay as they might offer more of a range of screening. Conversely, some members of the heterosexual population are deterred from accessing those services as they might be seen as 'gay clinics'.

Sexual health and you might feel there were a lot, if you were coming from a particular background where you might feel like oh this service isn't for me and, you know, it's obviously very open about, I don't know, all kinds of sexual activity and gay clinics and I just don't know whether that's like a barrier, like 'well this service isn't for me, this is something different'. (P4 – F/GP/41-50/C)

This theme was also discussed regarding younger people and that they might need clinics that are specifically designed for their needs.

So I think I'd go for youth. And I'd make this a youth-friendly place – I don't think it is, I don't think we're getting – I think there are teenagers out there, but I don't think they're coming here. I think this is old, this is – I don't think particularly open to young – we'll see them, I mean they come and come back, and it's fine. But I don't think we're shining and dancing youth services at all.(P15 – F/GP/41-50/C)

To identify themselves to a service, it must be acceptable to them and appropriate to their needs. Participants expressed the importance of confidentiality in people accessing a service. A GP described the lengths a patient went to avoid discussing her reproductive health with the reception team.

Lots of people are a bit funny about – so I had someone again on triage the other day who had kind of told the reception that she'd had a cough for three weeks and when I spoke to her she said 'no, it's nothing to do with that at all, you know, I just didn't want to tell somebody who wasn't a clinician'. So we do get a lot of that. A lot of people fearful that if they tell reception then reception will go and blab to their friends. (P6 – F/PN/31-40/C)

There were also concerns about the impact of a small community such as the Roma people, where the interpreters might be members of their social network.

We had an issue at one time about some of our Roma interpreters who were related to some of the Roma community. So I think there is that kind of fear sometimes of interpreters or staff kind of knowing things about them, even though the staff have had loads of training in confidentiality, you know, they say would never, you know, but it's someone knowing, isn't it? (P6 – F/PN/31-40/C)

The interviewees described a difficult balance between having staff members who are culturally competent and have the language to help access versus causing fear of lost confidentiality.

so there are issues with confidentiality, I mean, as far as I'm aware, it's on our practice website and, you know, it's clearly documented that the service we provide is confidential, but if somebody can't read English then they're not going

to know, but I think even having that, they still worry. People worry greatly about confidentiality. (P5 – F/PN/50+/C)

This is particularly relevant for communities who do not have English as a first language, and it is unlikely they will read the confidentiality information on practice websites.

Confidentiality, whether perceived or actual concern, is particularly relevant to SRH. This topic plays into the stigma and shame of seeking this area of healthcare.

4.1.2. Navigation of services

This theme explores the process of navigating services, and this describes the work involved in decision-making and help-seeking(124). It requires the individual to understand what services are available and mobilise necessary assets to all access.

A barrier described by the HCPs was about navigating a health system that you are unfamiliar with. People who have been born abroad may be unaware of what services are available and where to access them; this overlaps with knowledge. In this example, a practice nurse describes the Slovak families who have moved to the UK.

Our Slovak families, the ones that have come from Slovakia that access to contraception is different in Slovakia compared to in the UK, so I think there's a lack of awareness that contraception is free here and how to access it, that you don't have to pay for it, that people won't be judged on obtaining contraception, that we won't tell anybody, you know, if somebody wants to go on the Pill or have a coil or something, we're not going to tell anyone else, it's all confidential. (P5 – F/PN/50+/C)

If you have come from another country with a different healthcare system that is not free at the point of access, you may be unaware of what is available within the UK.

Those living in poverty have fewer financial and physical assets that help access services further away from their home. Many sexual services tend to be centrally located as this practice nurse describes.

Two buses from here. If they drive – but there's a lot of poverty in this area, so most probably don't drive. If they do drive, you just can't park anywhere near anyway. Or you're spending a fortune parking.

So yeah, there's not – there's not any – I mean when the sexual health clinic was in town, it was really good for the kids, because a lot of them have to get a bus to school, and they change in town. So they would drop off there and pop in. I think it was a lot more convenient. (P10 - F/PN/41-50/C)

This can be as simple as means of travel or more complex, such as travelling without a partner being aware. When asked about location preference for having a LARC fitted, a practice nurse described the challenges of childcare and transport.

Probably because it's nearer, because they say they can't afford the bus fare or they've got to drag all their children with them, whereas they know here if they've got kids, there's usually one of us or, you know, can sit with the child while they're having their coil fitted. P1 - F/PN/41-50/C

One of the female GPs working in a high deprivation area described the struggle for women to access resources like mobile phones and childcare and being able to travel without their husbands.

There's big barriers of any kind of travel or yeah, institution kind of change, anything like that is difficult for our patients because they're just not open with doctors or anything, they really struggle if they haven't got a chance or they haven't necessarily got telephones that are working all the time and they've got lots of babies and yeah and they might also have a controlling husband. (P2 – F/GP/31-40/C)

The same GP also describes a contrast she has seen between ethnic minority women and their white counterparts who can travel to sexual health clinics.

They prefer to come here I think, although depending on the community I think a lot of the Somali ladies and Muslim ladies like to come here. But I think probably our younger, white population definitely use the sexual health clinic. (P2 – F/GP/31-40/C)

Another female GP described the challenge for younger people to navigate services as they either do not have access to assets or cannot ask parents for help.

I think that in that population a lot of it will be accessibility and ease of knowing whether there is a service that they can go into confidentially, that's local. That won't mean that they've got to explain why they need to get the bus to the other side of town to their mum, rather than I'm just popping over to see such and such down this road, and then being able to get sorted. (P9 – F/GP/31-40/C)

Navigation of services is a challenge, especially for those living in deprived communities and local services are beneficial as people do not need as many assets to help them access.

4.1.3. Permeability of services

This theme explores how easily accessible SRH is in terms of getting a booking or a service. Permeability depends on the qualifications of candidacy which an individual needs to use the service(124). It also includes the degree of resources or assets which need to be organised to access. UK general practice requires an individual to call or book an appointment online.

During the interviews, a perceived barrier to access was the receptionists. In general practice, the receptionist is the main point of access to get an appointment. It relies on those working on reception, who are not medically trained, to do a basic triage into an appointment. A GP describes the challenges of someone trying to change a contraceptive implant.

I think sometimes receptionists need to be a little bit more care... I had someone that was booked in for a phone consultation for an implant change and she'd phoned about two weeks ago and things had expired in that time. (P13 – F/GP/41-50/C)

In some cases, the reception will ask the health concern to appropriately direct to a service. One of the practice nurses describes how this can cause issues with access.

We tend to ask what an appointment is for when the patient rings up, so if a patient rang up and said 'I want to book an appointment with the nurse', they wouldn't necessarily volunteer that it was to discuss contraception, because they would be worried that that would be written down on a screen and a member of staff might see it who might know their mother and then that member of staff would tell their mother or something like that. so sometimes we do have things

put up on the screen and it'll say 'doesn't want to say' and when you get through to that patient, they'll say 'well I didn't want to say it because it was so and so and I know she knows my mum', (P5 – F/PN/50+/C)

This quote also exemplifies the stigma and shame associated with any SRH need and interplays with community concerns about confidentiality.

A barrier that was perceived by HCPs with regards to permeability was the challenging booking systems employed in general practice. One of the GPs who provides a LARC service in Sheffield talked about the 'hoops' that women must jump through to get a LARC fitted. They need to have multiple appointments, making it a less permeable service.

So, for example, unfortunately in one of the practices, all of it has to go to a GP before you get referred through for a coil, which is a little counterproductive, particularly as a practice... yeah, and we've got no female GP there at the moment either, due to leave. (P9 – F/GP/31-40/C)

This also highlights an issue around the need for the availability of female consultant, which will be examined more in the following section on asserting candidacy. This GP expressed having a choice of gender of consultant helped with access, although not directly related to permeability, having a good availability of both genders was critical.

Yeah, I think they are offered, if they don't specifically ask for an appointment with a particular doctor, they'll be given on the front desk, you know, an appointment with whoever is on this day – but yeah, I don't particularly think they're sort of channelled unless – you know, I suspect that if a patient has had, has seen a particular doctor before, they probably will ask for her. (P16 – M/GP/41-50/C)

The most permeable or most straightforward way to access service is a drop-in clinic where people do not need an appointment and can simply attend when they have a health need. One of the nurses working in a high Roma Slovak population area described the drop-in clinic they provided before the COVID-19 pandemic.

Yeah, it's one of the ways that we try to do that is to reduce barriers so the people who the drop-in clinics are targeted at are the patients who might not physically

be able to ring up and make a phone call to book an appointment. (P19 – M/GP/41-50/C)

The drop-in clinics which do not need an appointment booking offer staff the chance to do opportunistic testing and screening.

So, the drop-in gives us chance to do all the stuff opportunistically so people will be coming in with their gout or their cellulitis or their leg ulcer or whatever and if they catch on a good day we'll do everything in the consultation and catch all the opportunistic things that, that might be borne virus screening or it might be safe injecting or it might be sexual health. (P19 – M/GP/41-50/C)

This was particularly useful for patients from ethnic minority groups and helped improve permeability to various aspects of SRH.

It's quite a wide range really. I mean the ones that we would like to see more of probably is the Slovaks and the Somalians – and that's – a lot of that is we'd like to see them for their smear tests, as they don't tend to come for their smear test. But they will sometimes – as I say the older Roma Slovak will come for contraception. Somali ladies will come for contraception. But often you might bring up the fact that they're overdue a smear test. And they'll always be some – they'll try and put it off very often. They'll say oh I wasn't prepared for it, I don't want it today. And then never come back. (P11 – F/PN/41-50/C)

This also highlights the ability for the healthcare professional to be reflexive and offer services such as opportunistic cervical screening, rather than asking them to come back on another date to have a booked smear appointment.

There was good evidence in the narratives about how HCPs adapted services to improve permeability based on the longitudinal knowledge of their communities. A GP who is a LARC fitter describes how she has changed referral mechanisms to help improve permeability.

So, the referral systems we've got in place are often bent now because if people were to ask me directly... actually, you need to get them in, and you just look at the notes and work out what's going on, which works because I've got access to all of the records which works across the city, but it's fine. (P9 – F/GP/31-40/C)

The HCP described attempts to change clinics to drop-in services which offer times best suited to the people they are trying to engage with.

Yeah definitely, it's quite a long clinic. So it's half 4 to half-past 6. So we kind of chose those times hoping that sort of 4 o'clock, people could possibly come after they picked their kids up from school, after work. So people could access that.

(P11 – F/PN/41-50/C)

A practice nurse identifies an at-risk group and develops services to improve access.

we're having trouble getting people in for postnatal checks, so we're experimenting at the moment with inviting them to come into the drop-in instead of giving them a set appointment in case that's a bit easier for them to arrange with baby and stuff. (P10 - F/PN/41-50/C)

There was a sense of the communities served by the HCPs preferring drop-in access, especially when they wanted to avoid telling receptionists what the complaint or need was.

it might be a case that we see one person and then they tell their relatives or friends that it's a casual drop-in, and then they come then. So, if patients don't want to come to a booked appointment, they can come to the casual drop-in and be seen then, which is quite helpful. (P12 – F/PN/21-30/C)

There were interesting comments about the drive for better access to service through online booking and self-testing for STIs. Some of the practices described having self-testing kits in the patient toilets, but they are culturally insensitive and need a reasonable level of health literacy to complete.

Yes, so in the toilets we've got these self-kits. But I think they are hopeless. The silver foil – they used to be silver foil, now they're grey. And they say on them penis – I mean it's just so uninformative. (P15 – F/GP/41-50/C)

There is pressure on practices to provide a certain level of online bookable appointments to improve access. Unfortunately, for deprived communities, this has the opposite effect. It also prevents practices from adapting services for the population's needs as they have specific targets to meet.

Yeah, but if we've got 18 so 36 appointments that are drop-in each day their counted within that 75% that aren't online bookable. (P19 – M/GP/41-50/C)

These interviews were done before the COVID-19 pandemic and cannot be used to comment on the impact on the permeability of services. However, considering the move to telephone and booked appointments, people from deprived communities may have more challenges accessing.

4.1.4. Appearing and asserting candidacy

This theme encompasses how a person can formulate and articulate their health issue for the healthcare professional to understand and accept their candidacy(124). All the themes explored in this section relate to the unequal power dynamic created in the consult, making it harder for the person to voice their health needs.

Language

For a person to appear and assert their candidacy, they must communicate their need, which relies on the ability to speak the same language as the HCP. Deprived communities tend to have higher numbers of new migrants who might not speak English as a first language. This section explores the issues around using an interpreter and how they could act as a barrier to appearing and asserting candidacy.

The NHS provides interpreters for practices either via telephone or face-to-face. Usually, the gender of the interpreter can be requested, but they cannot always organise a female interpreter for female patients. The practice nurse will call before the consult to ensure a female interpreter.

...specifically for the family planning drop-in because we can get sometimes...well, friends and relatives who are interpreting for them, but actually having a male friend who they don't know very well to interpret whilst having an intimate procedure is quite, you know, it's not very nice for them and it can make them feel quite uncomfortable. So, the fact that we always have the interpreters there and we always know they're going to be female helps. (P12 – F/PN/21-30/C)

This can be challenging, especially for consults where there need to be intimate examinations or discussions around women's health problems. A practice nurse describes this issue with Roma Slovak patients.

So we've had, we try and have predominantly female interpreters because of that but occasionally I've had male interpreters for smears, you know, and I've said particularly with Roma, like Slovak ones, you know, I've said to the patient 'are you happy to kind of have this with a male interpreter kind of sat in the room' and the interpreter gets a bit 'well I'm trained to interpret for smears', I'm like 'well you might be but the patient's booked in with a female clinician and we've got a male in the room' and generally the Roma have been fine with that actually, whether it's a case of 'oh I'm here now, just get on with it'. But, yeah. (P6 – F/PN/31-40/C)

This was echoed by another practice nurse concerning younger women and older male interpreters.

I think the younger girls get a bit more embarrassed talking about things in front of older male interpreters. Certainly, the Somalian populations, well, very much we prefer just females in the room if they were talking about anything quite personal. So yeah, it definitely does have an impact. (P11 – F/PN/41-50/C)

The interpreter impacts the consult directly or purely by having another person in the room. A practice nurse describes this inhibition.

And we do – our sort of drop-in clinic of an evening, and we don't always have an interpreter, so sometimes there is a little bit struggling without an interpreter, or like you say, having them in a room, it can be a bit of a barrier as well. Yeah. So – it probably – yeah, inhibits them probably a little bit. (P11 – F/PN/41-50/C)

In some cases, when an interpreter is not available, family members or friends will be needed to translate. This can cause issues as described by this practice nurse.

In particular, the language barrier because you're trying to ask questions via an interpreter who has then got to ask, and it's quite an intimate question to somebody they've never met, so that's probably quite a challenge. So, I think it's quite helpful if they come with a family member, who you know is a family

member, they tend to open up a bit more rather than explaining quite embarrassing and private problems to two people they've never met. (P12 – F/PN/21-30/C)

The practices often employ community members as receptionists, and they can act as informal interpreters to help with advice and bookings. Although this does bring in questions around confidentiality and access for people with personal problems, they do not wish their community to know about it.

Oh right yeah – so we have got people that live in the area, but we haven't got – we did have an Asian receptionist who could speak Urdu, but she's gone to another job now in hospital. So we've not got any people that can speak different languages, if you know what I mean, from the sort of minorities of the area. But a lot of the reception staff and me live sort of in this area. (P10 - F/PN/41-50/C)

Unfortunately, there are not always interpreters available or the facilities to organise them. This practice nurse discusses the challenges around interpreters.

No, it's not something that they tend to come in asking for, so much. Whereas probably people that have been born in this country will ask for it more, than those not. [Long pause] It's probably something that I don't feel the push enough here – I don't know whether we've got the facilities to sort of – you know, and often not the interpreters, because you're trying to sort of struggle on with interpreters, using basic English with them. So it's probably something that we could be better at promoting, if I'm honest. (P11 – F/PN/41-50/C)

There was an interesting theme specifically related to the Roma People and the use of interpreters. Interpreters from Slovakia tend to be more westernised and educated than the Roma people, who have often been treated poorly in Slovakia, living in slum communities without healthcare or education(281). The practice nurse is describing consent for chlamydia screening.

....so I think there's a lot of problems with people fully understanding consent for things when they're working through interpreters. We've got a lot of problems with shared decision making because culturally they're used to being told what to do. So whether our patients are fully consenting, again, fully English speaking

patients, no matter where their kind of ethnic background is, I feel they're far more westernised because they've got the language. It's the patients that we're using with interpreters that are far more still in there – you know, because they're recent to the UK or because they've never learned English, they're far more, you know, entrenched in their own communities, I'm not sure how much consent and shared decision making actually happens, partly because they refuse to engage in that process, but partly because when you're using the interpreter you lose (P6 – F/PN/31-40/C)

An imbalance created in the consultation dynamic is caused by a mismatch between the interpreter, healthcare professional, and the patient. This also raised the issue of informed consent in a situation where a patient might not have any scientific knowledge or medical understanding, and full informed consent is unlikely even when using an interpreter.

Health literacy

As well as speaking the same language, there might be a differing level of health literacy, especially among deprived communities. This GP describes how there may not be a word for certain parts of the female anatomy in specific languages, making it challenging for women to assert their candidacy.

If they're a mix of Ghanaian woman, a Punjabi woman, and Urdu speaking, then a person who can speak all the languages. They might not necessarily have a word for, I don't know, say cervix or they might not necessarily have a word. We do have. I do have. For example for the uterus I have a word. For cervix I do have a word – not clinical word in Urdu, Punjabi or native language, but an explanatory word, so that they get a grasp. And I would be prepared there to draw a diagram of uterus, fallopian tubes, and cervix and explain. (P7 – M/GP/50+/Pk)

A GP who was born and trained in China works in a practice where she speaks the same language as many of the patients. She realised that they might speak English but did not have the medical understanding.

Yeah, because I guess I think the interesting thing about language is that we might have a good you know normal language you know being able to buy stuff

in a shop but medical language is very different and I think. (P18 – F/GP/41-50/Ch)

This exemplifies the added burden of complexity for those working in deprived communities. Organising interpreters and then consulting with them can be an extra demand.

Male consulter

An interesting theme was the perceived impact of the gender of the consulter on how a woman can appear and assert her candidacy. A male GP described the challenge of seeing a woman from his local Pakistani community.

All gynae, yeah, anything kind of like breast-related, any breast lumps, occasionally people will, you know, even rectal things, no. Anything that's kind of slightly personal or even like listening to a chest, you know, sometimes they'll say 'I'm not seeing a male if I need to kind of disrobe a little bit'. (P6 – F/PN/31-40/C)

This challenge around the gender of the consulter exacerbates the issues of women in deprived communities accessing services as many are from ethnic minority groups where it is culturally inappropriate to show their body to a male other than their husband.

Another male GP described how he has become less skilled in women's health as he feels women self-select female GPs.

They definitely self-select. So when we had a lot of – so this is kind of complicated 'cause when we had quite a lot of appointments that you could book in advance, they self-selected completely away from me. It's very rare. I mean there are some women who I've looked after since they were children who will always come to me for everything, so they will, but they're young, healthy women, they don't tend to come. (P8 – M/GP/50+/C)

One of the male GPs who works in a Pakistani community described how new migrant women find it more difficult to appear and assert candidacy. He noted a change as they become more westernised, second and third-generation women are now happy to talk to male GP and ask for contraception even from strict Muslim communities.

second to last patient asked for contraception, a Pakistani woman of thirty-something. She asked for the contraceptive pill. Yeah. Aged thirty-six. So she asked for contraception. So there's a smattering of patients. It's not a regular occurrence. A patient would not come and ask me for contraception, except some of the third generation. Third generation are getting better. They're coming forward. (P7 – M/GP/50+/Pk)

In the medical community, there is a feeling that male and female doctors are the same and patients should access them equally. In reality, the lack of a female consultant leaves some women unable to engage.

Female disempowerment.

How a person asserts themselves can vary between cultures, especially for women. The theme of female disempowerment interlinks with many other aspects of the candidacy journey and expresses the extent to which individuals are denied the liberty of making fundamental life choices. This can include marriage and fertility, as described by a practice nurse discussing women coming to the UK from Pakistan.

I think culturally they're less empowered but I don't think they would necessarily feel like they were disempowered. I think culturally the expectation is that they would have babies. A lot of them, or a proportion, I don't know what percentage as a proportion of our female patients, have come here to get married and so they don't have any role in the UK apart from to have babies and they don't speak very good English, so actually their role will be fulfilled and they'll feel fulfilled as a person because - whereas our English speaking Pakistani patients particularly they tend to be far more into the contraception, it's a lot more – it's very much tied in with language I think and if they can't speak English then the chance of them getting a job here and all of that, I think there's a lot around health literacy and language (P6 – F/PN/31-40/C)

One GP talked about how some cultures have a more paternalistic behaviour, and it can be unclear whether the women are making personal choices or being influenced by their male relatives.

Not always, but certainly we definitely see that through the language barrier and also through this sort of slightly paternalistic kind of patterns that they might have sort of grown up with and then their culture might be more so than in other cultures. So they might not know they can get an interpreter, so they might not present unless they're with their husband and so then they're going along with what the husband wants. And we quite often see men sort of expressing wishes to have lots and lots of children and I don't know how well that is reflected in the women's ideas about how many children they want to have. It's very difficult to unpick. (P2 – F/GP/31-40/C)

Language around SRH can be challenging and often make people uncomfortable as they are not used to discussing the topic. One of the practice nurses describes the difficulties when other people attend with a female patient as it can affect what questions you can comfortably ask and trust the response.

And I think being careful of who they come with, so if it's a friend or if it's a boyfriend or a family member. Sometimes they're not quite honest about who it is, so you need to be careful about asking questions, particularly with pregnancies. If you're asking, you know, the pregnancy at the minute, is this the same father to your other children, it might not be, so that can be quite difficult because you never know what you're going to get through your door. I think definitely their level of understanding of being careful and using protection is a lot different to maybe the Arabic community, because they tend to not want contraception pills as much, they just want condoms, which is fine as long as they know the risks of using that. Whereas if you offer condoms to the Slovak community, again, you get a little bit of a giggle and it's as if they've never heard of that before or it's not used in their community. (P12 – F/PN/21-30/C)

These issues are complex and interplay, making it difficult to deduce clear causative reasons for challenging asserting candidacy.

4.1.5. Adjudication by professional

The adjudication stage of candidacy encompasses the attitudes and judgements that a healthcare professional makes about a person's worthiness to have a treatment or onwards referral(124). There was a theme about assumptions and judgements about the person

seeking healthcare made by the HCP might affect care. An example of where this might affect recognising candidacy is an assumption about sexual activity. This GP discussed the challenges of making judgements about behaviour.

Yes, it's interesting, 'cause there is a sort of reverse culture effect here where actually I might see a young Asian woman, you know say nineteen-year-old girl. She might be veiled, or she might look a bit more Western in her dress. She may be in employment. She may have very good English. She may seem quite sort of street wise in one sense, but you know from a culture point of view, she may well be in a situation where they wouldn't, where sex before marriage might be less likely, but it might happen. And so it's actually, it's a more nuanced consultation isn't it, of making – you don't want to make any assumptions, but you also want to say it in a way that's permission giving and non-judgmental. And if a nineteen-year-old Asian woman wants to say "Well actually my boyfriend and I we're having intercourse and we want some contraception" then they can say that. Equally, I don't want to offend people by making an assumption that you're nineteen, you've got a boyfriend, you must be having sex you know. (P20 – M/GP/50+/C)

This was echoed by a female GP talking about assumptions about sexual activity.

I think there's a whole unknown quantity about especially the young, unmarried women. I just don't know if we assume too often that they are not sexually active and we don't do enough to take chances maybe when they're consulting on their own just to check out. Occasionally, you do get requests for contraception for young unmarried women but it's so much rarer than in another practice. (P4 – F/GP/41-50/C)

In general practice, where there is a limited amount of time, quick judgements must be made to formulate a diagnosis. Healthcare professionals may rely on their intuition or assumptions to help this process. This was highlighted by a GP talking about HIV screening and risk assessment.

I mean I think one of the ones is this historical baggage of this, is this is a very special test and it can only be done in certain circumstances. And that attitude, or that was the position for probably more than a decade, possibly even two

decades you know, so actually changing the mentality. We never have an issue around protecting from hepatitis C or something like that and you think well hepatitis C is far worse now isn't it than HIV, but we never have that issue you know, all the other bloodborne virus screens you know, so there is the historical thing with HIV. The second thing is it's this perception of you're making a value judgment, either on the basis of the information you have or your assumption or you're a black African, you're you know, you've had multiple sexual partners, you've got some tattoos, you've used drugs, your boyfriend's an IV drug user, so, all of which are sort of helpful but there's an inference from those isn't there? It's a bit like the GP playing this sort of "I think you're high risk" and actually we need to change your mindset where actually it's the person who has no clues, no pointers at all who could be the person with HIV.(P20 – M/GP/50+/C)

Unfortunately, this can lead to errors and missing recognition of candidacy, which is discussed further in the section about 'recognising and accepting candidacy'. There is discomfort around SRH which one GP perceived.

And I think the discomfort, you feel it's the cycle, it's a social barrier and one thing good about the sexual health clinics is that the sexual health clinic practitioners have gotten over the hump, where they can take a sexual history without going red in the face. (P14 – M/GP/41-50/C)

One GP described people seeking care as being 'silenced' or told that service is not provided here. This reiterates the judgement or stigma about SRH.

Because do you think there is like a definite amount of trust. I do think patients really trust their GP and I think if you're then suddenly shut down and told to go somewhere else or, you know I think we should have the ability to offer both almost. (P17 – M/GP/21-30/C)

There was also a theme of how our personal views can lead to judgement about people, this was described by an older male GP who was trained abroad and works in a predominantly Muslim deprived community

Interviewer - Is there much kind of homosexuality in this community?

Respondent I don't know about the gay community here. But I think it is quite possibly less gay problem here because – I'm sorry if I say that, I may sound flippant, but because the availability of girls, Caucasian youngsters, engage in heterosexual relationship – well not relationship but activity. And therefore gay sex is not really common.

Interviewer - Obviously there's a religious aspect to that as well. Communities where it isn't necessarily part of the religious –

Respondent Well actually, gay sex is forbidden in Islam. It's clearly written in Koran. (P7 – M/GP/50+/Pk)

His personal views about homosexuality have an impact on those seeking candidacy for specific sexual health issues. He is unlikely to suspect his patient to be homosexual and may not discuss factors that may affect that person's health-seeking journey.

4.1.6. Offers of or resistance to offer

This stage of candidacy looks at offers or resistance to an offer of a referral, test or service to meet a person's health need(124). It is especially relevant for SRH as there is stigma and fear around diagnosing or managing SRH needs. A practice nurse describes these challenges when the patient has been recommended to do a swab or urine sample and then not attended the appointment.

...we will be advised to come and do the swab or a urine sample, and then don't turn up. So, we don't often know the outcome. We might send a letter to say we're really worried, we would want you to do these swabs or a sample and then, again, they don't turn up. So, whether it's the fear or they're just worried or nervous or forget, you know, it's quite difficult to tell. (P12 – F/PN/21-30/C)

The practice nurse is inferring that patients might be worried or nervous about attending, but this is difficult to assess without speaking to the person themselves.

As mentioned in previous sections, communities and family members influence health-seeking. Sometimes this can be a barrier to access as there may be misinformation about different treatments or services. A GP describes this issue in her practice.

I think there is a great emphasis on what other people in the family have done. So, for our coils, we quite often have a good coil uptake once people know about it within our Asian population, typically we don't want to get rid of their periods. But again, there are also problems with kind of inaccurate Chinese whispers going around with that. But the other thing, this morning actually... that I did actually think about when I was seeing somebody this morning, I had a young Slovak woman in postnatally for an implant, and she was in with another family member who I'd done and implant on earlier in the year. (P9 – F/GP/31-40/C)

This also expands on improving access as knowledge about services improves, in this case, a girl coming for a contraceptive implant because her family member had one previously.

There may be resistance or refusal of an option by someone else in the individual's life rather than the person whose candidacy is being expressed. A GP, who provides a LARC service in a practice with a high Somalian population, describes a situation where a husband disagreed with his wife having a fitting.

Occasionally I've had someone come in, I was fitting a coil for a Somali woman and the man found out and came in and dragged her off the bench. (P2 – F/GP/31-40/C)

This is an example of how a person's candidacy is affected by those external to them and helps us understand the complexity of someone refusing or declining treatment or referral.

4.1.7. Operating conditions and local production of candidacy

This theme explores the impact of locally specific influences which may impact access to services and treatment. Dixon-Woods describes how local production of candidacy is affected by the perceived or actual availability and suitability of resources required to meet a person's candidacy(124). This was clear in the analysis of the interviews, particularly regarding underfunding of SRH services and general practice.

UK silos of care

This silo of care has been described by a GP who works within a drug and alcohol service. He talks about the frustration of not being able to provide holistic, rounded care for people accessing the drugs and alcohol clinic.

So, they don't do coils because we haven't got the available space to do it, but they do the implant. They offer them the injection and we offer condoms nearly all the time, handing them out. Because we do the Bloodborne virus screening we ask a kind of sexual health in the history, but it's our funding. So, whereas we're funded to give condoms and we're funded to do the Mirena coil, we're not funded to give contraception other than the depo, and that..., there's a remit to actually make it more of a general health clinic, so that we actually become more GPs there. (P8 – M/GP/50+/C)

This quote also highlights how challenging it is for those living with alcohol or drug issues to access care. However, they are the ones who are at most need due to poor reproductive outcomes like unplanned pregnancy and sexually transmitted infections.

Reduced funding for SRH and general practice

SRH in the UK has seen significant funding reduction(282), and commissioning has transferred from the NHS to the local authority under the provision of public health. This reduction in funding has made it challenging for general practice to continue providing services such as LARC. Often providing these services means a financial loss. However, some practices feel this is worth it for provision to vulnerable women as described by this GP regarding Somali woman she cares for.

..the payment for coils being quite low for the GPs to do them, because if GPs are disincentivised to do things like coils and sexual health and just really it's those sorts of opportunities of sort of, they come to see you because they need contraception, they come to see you because they've just had a baby and they know the times when they almost have to present and know the times when these things might kind of come out and they might disclose stuff. (P2 – F/GP/31-40/C)

A GP, who works in a practice in a deprived area with a predominantly white population, reflects on general practice struggling to cope with financial pressures and staffing issues.

So I think realistically, we're struggling to survive. We're not thinking about progression or making things better. We're just trying to retain enough staff to actually keep this place going. We lost a receptionist last week, we're losing

another one this week. It's looking like we're going to struggle. (P15 – F/GP/41-50/C)

This was echoed in an interview with another doctor in a practice with a predominantly Asian deprived population.

I think partly where there is, for example, there's has to be very high locum usage in some of the practices, my suspicion is that probably isn't discussed particularly. Also, unfortunately, there is reluctance in a couple of our nurses to discuss it, despite having been offered extra training actually. (P9 – F/GP/31-40/C)

This reliance on locum doctors affects services such as LARC fitting or STI screening; they might not know how to organise or even that services exist in the practice they are temporarily working in.

Time constraints of general practice

General practice in the UK offers 10-minute appointments. Unfortunately, this is not appropriate to deal with many SRH issues. This GP, who is used work in sexual health, found it frustrating coming into general practice and not having time to offer the service.

Because if they don't, I think it's frustrated and I think it would be good if GP practices could offer it. But if the fact is that they don't offer it at the time that it's asked for then all you have to do is you should gently signpost to GUM and maybe scratch the surface a little bit and take a bit of a history, because as I say you've got those 10 minutes. (P17 – M/GP/21-30/C)

A GP also described the issue of asking about domestic violence in a setting where you are time constrained.

And certainly, one of our worries at the moment is sort of DV cases, and who has got access and coercive behaviour and things like that. So, I think it feels like a bit of a can of worms that's coming with that, and I don't know how much the patients appreciate how much is shared really. (P13 – F/GP/41-50/C)

The following quote highlights the impact of time constraints when thinking about fertility and chlamydia screening.

When somebody comes in at thirty-five, and they are infertile, and they've got chlamydia, and they say "I was never asked about chlamydia, I was never told about .." you know, probably they were and they didn't remember it, but the point is we should be making sure we pick those before – so I think you should be able to put it in. Now the time constraints might stop me but I want to ask. (P8 – M/GP/50+/C)

This was echoed with other interviews, especially with practitioners who have seen the changes over the last 20 years.

Well, my workload's gone up by more than twenty percent. I know they say it's twenty percent but it's definitely more. I mean I was one of, when I first started in general practice, I finished my morning surgery probably around eleven thirty, did a couple of visits and then I did nothing until I came back to work at three o'clock. I really did nothing. I could actually go swimming and I could have a meal, and so I did go to meetings and things at the health authority. But that's vanished. There is no middle of the day any more, so the work has gone up, and that's two or three hours a day, and it's a ten hour day, so it's more than twenty percent. (P8 – M/GP/50+/C)

This time pressure makes it more difficult to adequately address SRH issues and creates a fear of addressing issues that might cause the practitioner to run late.

HCP-patient relationship/rapport

This theme explores how contingent and locally specific influences influence HCP and patient interactions as described by Dixon-Woods. The HCP and patient relationship is hugely important when managing complex conditions that may cause embarrassment or controversy. This GP discusses how meaningful that relationship can be.

But I think because they know me and they know the building, they feel safe here, I think they are more likely to come. Because I think coils are quite a big deal for a woman. (P2 – F/GP/31-40/C)

It also includes the longitudinal aspect of general practice where relationships develop over time, some saw this as beneficial, and some worried that it hindered raising sensitive topics.

And do you think the relationship helps, like, the sort of longitudinal relationship that we have with patients helps or do you think it hinders offering - Respondent I don't know. I can imagine it might do both in equal measure, depending on the person. (P4 – F/GP/41-50/C)

There was also a feeling that raising an SRH issue might cause a change or disruption in the relationship and could be damaging.

I think if you ask that question at the wrong time with someone who wasn't willing to tell you, that can really set you off on the wrong foot. And then, you know, if you saw them again, they'll think there's that nurse that I felt was judging me, and then it breaks down that trust and you'll never be able to build that trust. So, I think I'd probably feel quite uncomfortable asking somebody at this stage, but again it might come with experience. But again, it might be someone who is really experienced, might also feel uncomfortable asking. (P12 – F/PN/21-30/C)

It was clear that the GPs and practice nurses interviewed aimed to provide a holistic service and felt they provided more than medical treatment alone.

People come to us, we're more than just people who are to dole out prescriptions and things we'll deal with other issues that they bring, we have to deal with anything they bring through the door and yes, we can signpost them, but you've got 10 minutes that you can spend reassuring them if they've come to you for something that your service can't provide, that's different from just saying 'I'm not interested'. (P17 – M/GP/21-30/C)

The HCP-patient relationship is an essential aspect of general practice and has a crucial role in helping people assert and express their candidacy.

Competing priorities in primary care

Another interesting theme noted in interviews was competing priorities in general practice and interlinks with time constraints. There is a transition for more to be done in the community setting and practitioners feel torn between how to deal with different conditions. This is evident by a quote from a practice nurse describing the different courses she must do.

I've just got to sort of see – because I haven't done any of my diplomas or anything so I came here from hospital, and I did a lot of the introduction to asthma and I've got asthma anyway so I felt quite comfortable with that. I did diabetes and so it was just before I went, I was going to do an asthma or COPD diploma and then I got pregnant, so I thought well, enough for now. (P3 – F/PN/31-40/C)

And not all practice nurses will have the same level of knowledge so will offer different levels of SRH service, this was expressed by one of the more senior practice nurses.

No, I think – we've got a relatively new practice nurse who's not been with us too long and yeah, obviously she's not trained up for smears yet, but she's starting to pick off the list things that she thinks she can deal with. She's started doing some contraception courses and study days, and seems very interested. She's really keen to do her smear training. (P11 – F/PN/41-50/C)

It is understandable how challenging it must be prioritising SRH in a setting where the patient might not have attended for an SRH need.

Heteronormative health system

A theme became apparent related to the heteronormative NHS and how this impacts sexual minority groups such as gay or transgender people. One of the practice nurses described a situation where she was trying to get a smear for a trans-man (changed from woman to man), but because he was a male on the computer system, there was no way of submitting the sample.

Well, I rang the cytology lab and I just said 'this patient's got a cervix' and she said 'that's fine, anyone with a cervix is entitled to a smear test', but she said the computer won't be able to do it electronically because it won't accept female screening onto a male. P1 - F/PN/41-50/C

Within the medical community, the number of people from the gay community is often underestimated. This was evident when talking to one of the GPs who had trained abroad.

I don't know about the gay community here. But I think it is quite possibly less gay problem here because – I'm sorry if I say that, I may sound flippant, but because the availability of girls, Caucasian youngsters, engage in heterosexual

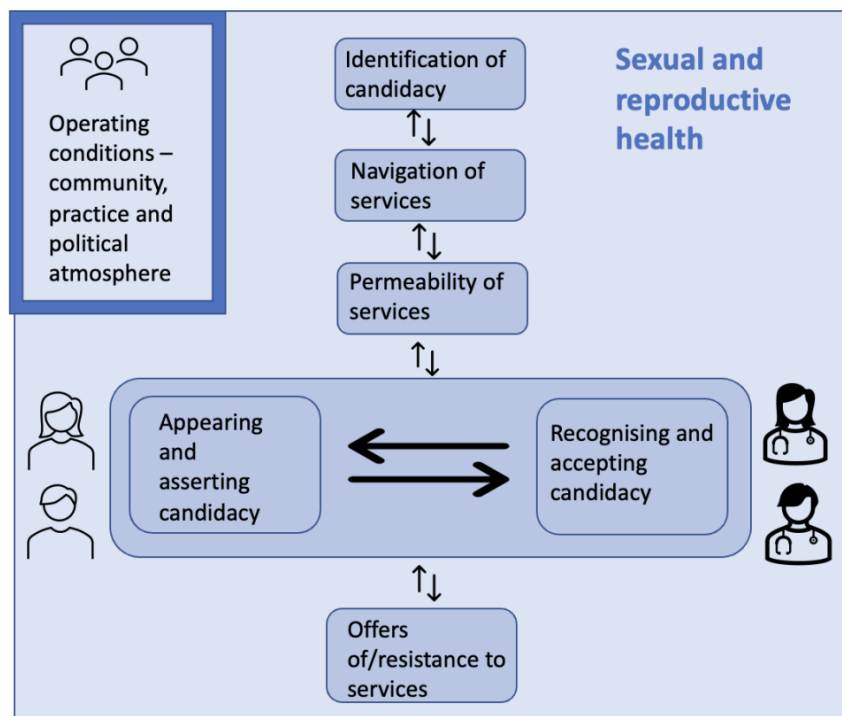
relationship – well not relationship but activity. And therefore gay sex is not really common. (P7 – M/GP/50+/Pk)

If sexual minorities are not thought to exist in a community, their health needs will always be hidden and silenced. It is apparent in this section the importance of providing inclusive healthcare that helps people to access a service which listens to their needs.

4.2. Expansion using an adapted version of the candidacy framework

This section builds on the QES chapter, it draws together themes from the interviews and other theoretical concepts. Data or themes which were ‘un-accommodated’ within the candidacy framework was coded and conceptualised into a new category.

Figure 21 - Adapted version of candidacy framework



4.2.1. Recognising and accepting candidacy

The following section aims to evidence this concept of 'recognising and accepting' candidacy which is exemplified in general practice. It is proposed to encompass adjudication and local production of candidacy to express the complex interaction which happens in the consult. This is relevant within the topic of SRH due to the barriers for people identifying themselves as having a health need, and they may be unaware of the risk. Two examples of this are

unaware of pregnancy risk or being unaware of sexually transmitted infections. As discussed in the background chapter about health inequality, unplanned pregnancy and sexually transmitted infections predominantly happen in deprived communities. These deprived communities may have low levels of SRH knowledge due to education, taboo topics, or health literacy. This concept of HCPs recognising and accepting candidacy helps explore who HCPs working in deprived communities help or hinder access to SRH services in general practice.

This concept was interrogated further in the HCP interviews and the following section helps represent the findings. This section explores this concept and factors which affect how a healthcare professional might impact access. There are examples of where a candidacy might be ignored or avoided and examples of HCPs doing something extra to help recognise a candidacy.

Advocacy

The HCPs interviewed expressed ways to advocate for their communities by developing a rich understanding of the people they are providing services for. It was evident in the interviews that HCPs can have a significant impact on helping people assert their candidacy. This was described in an interaction between a mandarin speaking GP and her mandarin speaking patient. That recognition of language barriers had an impact on communication and asserting candidacy.

Yeah, I there's it's funny you said about the language I just thought that the young lady she came with her partner and because I was being told by my girls you can't be just imagining they are speaking Chinese they say they are stereotype you should speak Chinese. So I would be cautious and saying are you ok to speak English you know I speak English, and they I ask all these young people you know they ok and then she says yeah fine and it's funny to take a long time to ask her like where was the last time you had your period and then she told me so like like three or four weeks and then I thought you can't be pregnant like that if it's only three or four weeks but actually she'd been delayed for three or four weeks and it's only when I asked her to get me a urine sample because I don't it's yeah exactly and then I was talking to his, her partner and she told, he told me like her English is not good and then he said yeah it's ok just speaking

Mandarin because I was speaking to him with Mandarin he said yeah that's a lot better so eventually we are speaking Mandarin which is a lot easier. (P18 – F/GP/41-50/Ch)

Understanding the community and being able to interpret social dynamics is essential. A common theme was the transition of women from being 'traditional' to 'westernised and the challenges that can bring to the consult. It is a skill to interpret body language and non-verbal cues as described by the GP.

Because they don't tend to be the ones who are sort of from the last Pakistani women who have born here are now say maybe in their 20's and they've got a car and a job and they're wearing the veil quite sort of loosely and they tend to the ones who have got a skip in their step and are smiling and feel, to me feel quite liberated and are happy within their kind of culture that's a sort of a mix of cultures for them, partly in quite a traditional Pakistani culture but partly also taking on some good stuff about our culture as well. So those are the ones that I feel will talk to me about sex and be quite open about it and maybe come to me about domestic abuse and stuff. Whereas the ones that come in with their husbands and their body language is all completely wrong and we see it everywhere and those are the ones you feel, like you're saying, never going to really talk to you about what's really going on. (P2 – F/GP/31-40/C)

There was also recognition of situations where the healthcare professional needed to alter the dynamic to allow a woman to assert her candidacy. This comes from an understanding of relationship dynamics and female disempowerment.

That understanding also includes knowing the background of people being seen; for example, with some Roma Slovak people, there is a distrust of authority which may impact asserting candidacy.

I think also perhaps issues with authority and I think in Slovakia, there've been examples of women that have been sterilised without their consent, without their knowledge even. So there's massive issues with people in authority and trust. Yeah, I'm just trying to think what else. I know that I think there's been, sort of, I mean, I've had people tell me that in Slovakia you have to pay so many euros to have a coil fitted or, yeah, so things like that, financial stuff. (P5 – F/PN/50+/C)

A GP was describing issues relevant to her community such as female genital mutilation (FGM) in the Somali population and preferred methods of contraception for Muslim women.

Sometimes as complications of that, of FGM, and we see it – and I fit quite a lot of copper coils because we have a lot of Muslims and they prefer the copper coil for sort of tradition, well for sort of purposes of prayer and Ramadan and things, they prefer the copper coil. (P2 – F/GP/31-40/C)

In deprived communities or those in sexual minority groups, the idea of recognising and accepting someone's candidacy becomes even more critical, especially if the person is struggling to assert or appear to the healthcare professional.

Adaptation

There was a theme developed around how HCPs can adapt the environment or consult to help recognise the patient's candidacy. This nurse asks the parents to leave the room to aid discussion.

Respondent - Even on the situation sometimes where we've seen young Roma girls become pregnant and they're not entirely sure who the dad is or they met the situation around conception wasn't ideal, it might have been at a party with a stranger etc. They still – they're not usually overly unhappy about it. They will usually go ahead with the pregnancy.

Interviewer - And are they quite open about – are those girls quite open about talking about sex with you, or do they – is it difficult?

Respondent - They usually are after – once you've built a rapport with them - they're not always so happy talking about it in front of their parents. But if you ask their parents to step out, and then... (P11 – F/PN/41-50/C)

Other examples have been discussed in previous sections, including the development of drop-in services to help permeability for patients with challenges accessing care.

An interesting insight from the interviews was their insight into unequal relationship dynamics. This was expressed by understanding different levels of education, health literacy

and language. A practice nurse describes how she helps tailor her language to help the patient.

Probably their level of understanding, you know. When you say 'when was your last period?' not everyone calls it a period, so tailoring your language to suit people is probably a challenge because my understanding will be completely different to another practice nurses understanding. (P12 – F/PN/21-30/C)

Recognising that patients have challenges to talk about sensitive subjects and building rapport is vital to help a person assert their candidacy.

So, I think it's probably hard enough for them to tell you at first, you know, their history, so I think postponing that conversation a little bit later on is probably best, but again you can tell that from people's body language. (P12 – F/PN/21-30/C)

This understanding of the challenges raising an SRH need comes from looking at non-verbal cues and body language to adapt the conversation.

Recognising a need

Helping a patient identify a health need is essential in SRH, such as opportunistic testing, which means offering a screen to someone who has come for another reason. A practice nurse described how she asks about changes in sexual partners when the women are coming for a smear test, and they might not have realised they need screening without the prompt for the nurse.

Or sometimes if they've been with someone for a while we'll do a smear and say 'oh, while I'm here, I've had a new partner, I've been with him for about six months but could you just..', you know. (P3 – F/PN/31-40/C)

Another practice nurse offered contraception advice to those women at the time of smear.

I think they know it's available. I think culturally they don't want it so, for me personally, every smear test I do, I talk about contraception, partly as is there a chance you're pregnant but partly, you know, do you want any, what are you using. (P6 – F/PN/31-40/C)

These examples highlight the impact of the healthcare professional on aiding candidacy and therefore access, particularly with people from deprived or vulnerable groups.

Normalising

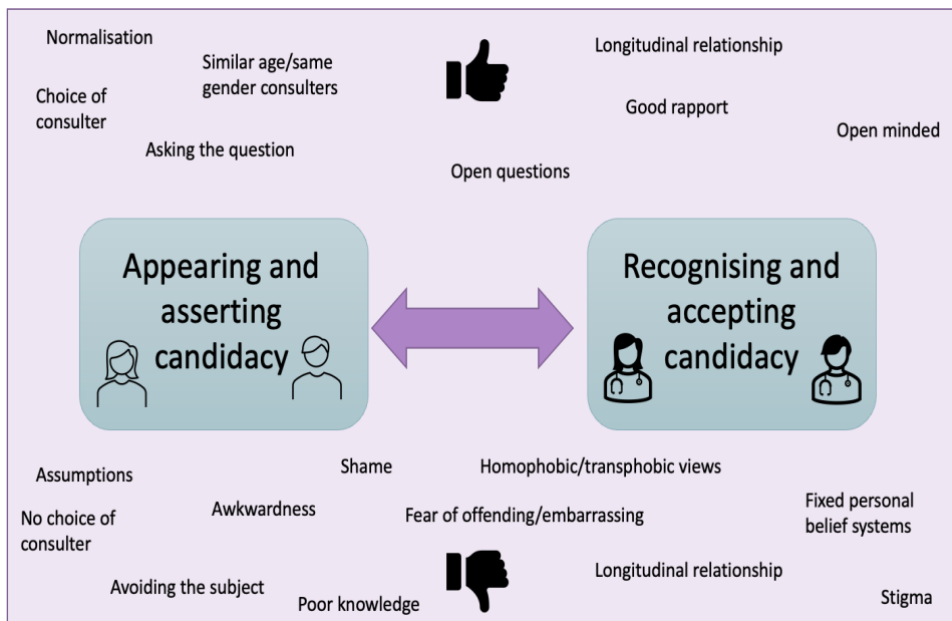
Sexual and reproductive health has much stigma and shame attached. Healthcare professionals can have a role in reducing this and normalising seeking testing and treatment. This was described in the following quote about HIV care.

I think primary care's the prime place for it because you've got the relationship with that person, and it destigmatises it and normalises it, you know, the fact that HIV now can be managed like a chronic illness, the fact that we're doing it in primary care means that we're kind of treating it alongside diabetes and asthma and things and it becomes – I think it just normalises it and people are more likely – I think the more we offer it, the more people see it as a normal blood test to have and the more in their consciousness it becomes, you know, a normal thing so that when their friends turn around and say 'I've got HIV', they're not like '[mock gasps]', you know, how it was in the 80s, you know, it kind of becomes far more normal, so I think it's the best. (P6 – F/PN/31-40/C)

As well as normalising and destigmatising, HCPs can adapt their language and find ways that help a person express their candidacy.

Below is a summary of the factors that affected this complex interaction developed in the QES, from section 2.4.8.

Figure 22 - Barriers and facilitators to access of SRH in general practice



4.3. Summary

This chapter has explored the issues around the provision of SRH using the candidacy framework to further interrogate the qualitative data. There was strong narrative through the interviews of inequalities related to the role of women in deprived and ethnically diverse communities which interlinks into disempowerment, language, and assertion of their need for access. An adapted model of candidacy was developed to build on concepts around the consultation dynamic and the role HCPs have in accepting and recognising candidacy. The overall key findings from this study and their relationship to relevant published literature will be discussed in the next chapter.

5. DISCUSSION AND CONCLUSION

5.1. Chapter summary

This final chapter discusses the findings from the QES and the qualitative themes drawn from the interviews with HCPs. The findings will be explored in the context of the existing literature.

First, this chapter will briefly summarise the work undertaken as part of this MD. Second, it explores how the key findings addressed the primary research question '*What are the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare (SRH) access?*'. This focuses on the use of the candidacy framework in the QES and the interview analysis, also exploring the adaptation of the model to represent further the role of general practice in recognising and accepting the candidacy of patients. Third, the overarching themes which seemed particularly relevant to providing SRH in general practice and stood separate from the candidacy framework. Forth, implications for research and practice are explored. Fifth, it explores the limitations and strengths of this research project and the impact of COVID-19 on the data collection. Sixth, it includes some reflections on the relevance of the overall research findings in the context of the ongoing COVID-19 pandemic. This will be followed by a conclusion to highlight the key findings along with the main empirical and theoretical contributions of the research presented in this thesis.

5.2. Summary of the work undertaken during this MD research programme

This MD research programme aimed to explore practitioner and public perspectives on barriers and facilitators to access to and uptake of SRH services in general practice in the UK and similar healthcare systems. It also aimed to undertake a qualitative study to explore practitioner and public perspectives on barriers and facilitators to access to and uptake of SRH services in general practice, focusing on deprived populations. To achieve these aims, first, a scene-setting review was undertaken to establish the current issues around the provision of SRH services in the UK and the impact of inequalities in access to services. Within this process, pre-existing frameworks of access to healthcare were examined to see whether a helpful structure could inform the subsequent analysis. Second, a QES was conducted to explore current evidence about barriers and facilitators to accessing SRH

services in general practice in the UK and similar healthcare settings. Third, interviews were undertaken with a purposive sample of practice nurses and GPs who work with socioeconomically deprived communities in Yorkshire. Unfortunately, the planned focus groups with members of the public could not go ahead due to the COVID-19 pandemic being at its height during the phase of data collection. This was due to the fixed timescales of the research project.

Throughout this research programme, ideas and suggestions from the public involvement panel and peer support within the academic unit of primary care were integrated into the research and informed the methods and analysis.

Background to research project

This thesis gives a vital insight into the inequalities in SRH and how it interlinks with the provision of services in general practice. One of the starkest inequalities evident in the UK is the impact of deprivation on SRH outcomes(31,32). People living in low socioeconomic communities have higher proportions of unplanned pregnancies, abortions and STIs(35,49). The impact of ethnicity and race is also apparent, people from black and ethnic minority groups also having worse SRH outcomes(270). This may link into issues with health literacy and education especially in the context of a taboo health topic such as SRH(56,60).

Another important group who have challenges accessing SRH include 'looked after children' or young adults in care, people who are homeless or have insecure housing, and people using drugs and alcohol(38,61,63). For these people, unintended pregnancy can have a negative impact on their own life as well as that of a future child(35). The LGBTQ+ community have faced challenges accessing all forms of healthcare but especially face inequalities in SRH due to stigma and the heteronormative health system(50). To combat these inequalities in access, this research explores barriers to access in general practice.

Understanding access or use of healthcare services is complex, and it can be challenging to understand and research(97). Previous studies had looked at healthcare access in terms of utilisation, with an understanding that if a service is there it will be used(104,117,118). Dixon-Woods offered the candidacy framework as a mechanism to understand access better for vulnerable groups(124). Rather than focusing on how people use a service, the

candidacy framework explores the journey from realising a health need to that health need being met. This thesis uses the candidacy framework in the QES and the interview analysis. The candidacy framework is highlighted below; stages are interactive and overlapping.

Table 1 - Candidacy framework described in the context of SRH, adapted from Dixon-Woods (122,124)

Candidacy Framework	Dixon-woods (2005/2006)	Examples of SRH access
Identification of candidacy	A persons recognition and response to a symptom. Influenced by own knowledge, health literacy, community behaviour.	<i>Identifying need for an STI screen due to unprotected sex.</i>
Navigation of services	A persons awareness of what services are available and ability to mobilise practical resources or assets needed to attend service	<i>Taking time off work to travel on 2 buses to get to central sexual health clinic for an STI screen.</i>
Permeability of services	More porous services require less qualifications of candidacy and less mobilisation of resources to attend. Less permeable services require a higher degree of cultural alignment for example booking systems, needing to read appointment letters.	<i>Needing to call the clinic at 8.30am each morning, navigate a telephone automated system and speak to a receptionist to book an STI screen.</i>
Appearing and asserting candidacy	A person making a claim to candidacy for medical attention or intervention. They need to provide a coherent history and articulate the issue, have formulated a health need which requires a level of understanding.	<i>A person asking for condoms in a GP appointment.</i>
Adjudication	Healthcare professionals judging worthiness of the candidacy claim and Interlinks with perceived social deservingness.	<i>GP not suggesting an implant as contraception method as they have been unreliable attending appointments in the past.</i>
Offers of/resistance to services	An intervention or treatment course has been offered but declined by the person in need.	<i>Declining offer of cervical screening when in for a practice nurse health check.</i>
Operating conditions and local production of candidacy	Interactions between health care professional and patient which can be affected over time. Includes the perceived or actual availability and suitability of resources in a particular setting	<i>GP turning a patient away when they ask for an HIV test as perceived as not funded in primary care.</i>

5.3. Summary of key findings from this research programme

A summary of key findings from this research is provided as answers to the research aims below.

- To explore practitioner and public perspectives on barriers and facilitators to access to SRH services in general practice in the UK and similar healthcare systems.
- To undertake a qualitative study to explore practitioner and public perspectives on barriers and facilitators to access of SRH services in general practice, focusing on deprived populations.

The primary research question is discussed in detail later in the chapter as it was addressed by collating and integrating all the findings. This discussion chapter will draw together findings from the QES and the HCP interviews.

5.3.1. Findings from the QES

This section aims to explore the barriers and facilitators to accessing SRH services in general practice in the UK and similar healthcare systems by using evidence from the QES. This is discussed briefly as already presented in the results section 2.5.

The QES assimilated 37 studies with a diverse range of topics but focussed on access to SRH care in general practice. This included contraception, sexual health, gender identity and sexuality. The participants of the studies included HCPs, service users and members of the public. The studies were from worldwide locations in high-income settings with a range of age groups included. A secondary analysis was undertaken using the quotes within the published studies to further identify themes.

In terms of the candidacy journey, the QES highlighted the importance of identifying needs, with crucial barriers being stigma, knowledge, and the ability to prioritise SRH. There were also interlinking factors related to social norms and community behaviours that impacted people's access, either because of fear or because it was seen as the correct way to behave. This was particularly apparent with regards to pregnancy or sex, and the effect of lay perspectives and peer discussion. The local production of candidacy or operating conditions was also relevant when looking at access barriers in general practice. This was related to time constraints, poor appointment availability, and time pressures. There was a sense that the SRH topic needed more time and tact to discuss a sensitive subject area, continuity of care was a key facilitator(252,283). The HCP as a barrier is discussed further in the overarching themes.

An interesting finding of the QES was the lack of data published that included participants' ethnicity or the deprivation indices. In the context of SRH inequalities for people in deprived communities and those from ethnic minority groups, this represents a missing group of interest. This is discussed further in the limitations section of the chapter. There was only one focus group from one of the studies which was translated. This is relevant to this area of research as those with worse SRH outcomes are predominantly from ethnic minority groups. Even in the reported ethnicity data, a disproportionate number of young white people were included. This likely represents the challenges around recruitment and conducting qualitative research among this cohort(284,285).

A further finding was the inconsistent use of ethnic groups, making the comparison between groups challenging. Some studies grouped people into 'ethnic minority', whereas others gave more detailed race demographics(162). The sample sizes for the qualitative research were small so getting a diverse ethnic mix of participants only occurred in studies focusing on ethnicity and access. Deprivation is another factor linked with poor SRH outcomes, and it was interesting how the different researchers tried to present this. There were comments about purposive sampling to get a diverse socioeconomic distribution, especially regarding general practices recruited from an urban and rural area. In terms of the participants, there were apparent challenges representing their 'deprivation level'. Some studies used employment, education, or income to proxy deprivation. This highlights the challenge of defining deprivation and the impact this has on good quality evidence synthesis.

5.3.2. Finding from the interview analysis

This section explores the evidence from interviews with HCPs of barriers and facilitators to access to and uptake of SRH services in general practice. It builds incrementally on the evidence from the QES. The barriers expressed are from the viewpoint of the HCP but add insight into the deprived communities they practice within. This is discussed further in the limitations section as the findings reflect the perspectives of HCPs of the obstacles faced by their patients. The interview analysis adds new knowledge as it examines SRH holistically rather than in silos of SRH topics. Understanding the overarching obstacles helps to shape future interventions.

Twenty face-to-face semi-structured interviews were conducted between January 2018 and September 2019. The sample included GPs and practice nurses purposively sampled from practices in deprived communities around Yorkshire and Humber. There was a range of men and women, also a range of age groups. There were no male practice nurses which reflects the low numbers in the workforce. The practices included in the study had diverse patient groups with above average populations from ethnic minority groups.

The identification of need was a key barrier for access to services, and this was relevant in deprived communities that may have lower levels of health literacy and education(28,56). This is relevant in the UK as specialist sexual health services rely on the patient be aware of a health-need and then knowing which service to access(11). For those with lower levels of

health literacy and education level, this ability to self-identify and then recognise a correct service for an obstacle for access.

The community behaviours and social norms interplays with this as misinformation and myth perpetuates cycles of health-seeking for contraception and STI screening(60). The interviews highlighted the importance of personal and community knowledge and taboo and stigma about SRH.

Following on from knowledge as a barrier was how people from new migrant communities change knowledge and behaviours over time. The concept of new migrants becoming more westernised and having riskier sexual behaviour but not having the family or community knowledge to help support that safely. Many of the interviewees had worked in practices for many years and had a longitudinal understanding of how the community changed. This longitudinal relationship is a specific feature of general practice(74,286).

Navigation of services was discussed concerning deprived communities, especially with reference to the practical resources and physical assets, which might cause a barrier as reported by Dixon-Woods(124). This has been mirrored by reviewing the impact of poverty on end of life care(287). For example, having the ability to take time off work, get childcare, have credit on telephones to call for appointments and have funds to pay for transport. General practice still has barriers for navigation but was perceived as less than those for accessing secondary care as reflected in the QES findings.

The interviews gave insight into vulnerable groups of people who were not included in the QES. This included those who are homeless or in unstable accommodation, using drugs and alcohol, or on parole must prioritise fundamental needs such as food, money and medication(64,288,289). The interviews helped give voice to those who often are excluded from research due to chaotic lifestyles and competing life priorities(248,249). SRH access was seen to be low in the priority levels, but conversely, the impact of unplanned pregnancy or STIs can have such a damaging impact when they are already struggling to meet basic needs(64,289).

Similarly, as in the QES, the operating conditions or local production of candidacy was integral in accessing services. This was perceived as the utilisation of care and demand not

being met by supply with the current financial and time constraints of general practice in the UK. There was a sense from the interviews that SRH had been deprioritised politically and funding was defragmented, leading to holes in care provision(8,11). Understanding more about the complexity of these interactions between HCPs and the person seeking access may help us develop resources and educational interventions(290). These can focus on bypassing the unconscious bias of HCPs which impedes access and was clear in the QES and interviews. It could be helpful for professionals to reflect on their own personal belief systems and how these might impact care(291).

The interview analysis revealed the concept of female disempowerment was seen at all levels of the candidacy framework. This was the perception that women were not being able to make choices about their reproductive rights. It links with themes about knowledge, language, health literacy and community norms of behaviour. The HCPs perceived that woman from ethnic minority groups had more reliance on their husbands and not being able to control their own access to services. This also becomes apparent when examining the ability to appear and assert candidacy, especially in a setting with a male HCP and the challenges of the unequal power dynamic in the interaction. This perception by HCPs of female disempowerment has been challenged by minority women scholars(292,293). Bilge discussed the false assumption that Muslim women wearing a veil equated to a women's oppression by Islamic patriarchy(293). This highlights the need for engagement with members of the community to understand their obstacles to access, this was unfortunately not explored in this study due to COVID-19 limitations.

5.3.3. Adapted version of the candidacy framework

The candidacy framework offers a valuable structure for understanding the complex issues around access. During the QES and interview analysis, data that was 'un-accommodated' within the candidacy framework was interpreted and conceptualised into a new category. The new category, 'recognising and accepting candidacy', refers specifically to SRH in general practice. There is an argument that aspects of this new dimension are already accounted for in the existing candidacy framework, but by drawing them into a separate category it allows focus on the importance of the interaction and behaviour of the HCP in

health-seeking journey. This concept of the HCP as a barrier was a strong narrative in the QES and interview analysis.

This combined factors from the operating condition specific to general practice and the need to explore the interactional relationship between the consulter and patient. The longitudinal relationship of general practice allows relationship building and a better understanding of the community, which helps to facilitate candidacy. By using the candidacy framework, we were able to explore further the local production of candidacy, the micro-interactions between the patient and the individual. This is a dynamic process with the patient appearing and asserting their need with the HCP identifying and accepting that need, imagining their candidacy.

Four broad themes were collated together to form the concept of 'recognising and accepting candidacy' within the setting of deprived communities. This includes advocacy, adaptability, recognising a need and normalisation of SRH.

Advocacy – The HCP interviewed described advocacy for the needs of their patients, there was a sense that they must give a voice to those underrepresented population groups. This comes from longitudinal relationships and an understanding of the needs of the community(259,294).

Adapting – There was evidence of HCPs adapting services to meet the need of communities. This was represented as services such as drop-in clinics, opportunistic screening, and contraception offers at smear consults. This helps to explore the impact of HCPs and services adaptability to help improve access socioeconomically deprived communities(295,296).

Recognising a need – The QES and interviews analysis highlighted the HCPs ability to recognise candidacy for a patient. This links to the deeper understanding of a community and person which develops over time in general practice. This might be opportunistic testing as an example or awareness of competing priorities when a patient presents with a symptom(297,298). This links to the adapted version of Pechansky and Thomas model of access, Saurman added the dimension of 'awareness' which links into how someone identifies a need(119).

Normalisation – The QEs and interviews realise the multiple levels of shame and stigma associated with SRH. The role of the HCP in normalising health-seeking and behaviours is crucial for changing the rhetoric around sensitive or personal issues. Normalisation has been recognised in other literature as facilitating access to SRH(169,299,300).

Conversely, the impact of poor recognition or acceptance of candidacy was apparent in the QES and interviews. It was interesting to understand how an HCPs own personal belief system might cause a barrier to access(291). This might be represented in assumptions, silencing of sexuality, avoidance of SRH topics or failure to ask questions pertinent to the presenting complaint to avoid embarrassment(169). These findings demonstrate the importance of person-centred, reflective consultation in general practice and the influence of underlying personal belief systems of the healthcare professional and not just the patient(137,301).

5.4. Overarching themes in the QES and interview analysis

This section draws together the evidence from QES and interviews, comparing and contrasting with previous literature. Dixon-Woods and colleagues originally synthesised the candidacy framework regarding access to healthcare for vulnerable groups(122). It resonates with the results of the QES and the interviews. Other researchers have adopted the candidacy lens to understand access to healthcare across a range of social groups(27,128,302–304). These articles propose an additional dimension (race, gender, symptom-type) that compounds social disadvantage to impinge the candidacy process. This section draws together research from other disciplines which have used candidacy as a theoretical framework and other concepts which share a commonality.

Unequal dynamics

An unequal dynamic between the consulter and patient was a prominent theme during this research, and it was particularly relevant in deprived communities and with ethnic minority communities. The work by Shim about cultural health capital helps to understand healthcare interactions and dynamics of unequal access. This builds on the work by Bourdieu, who proposed the notion of cultural capital, that our cultural practices and even styles of dress, eating habits, verbal skills, scientific knowledge, educational

credentials, and so on have a form of capital. This creates inequality as a hierarchy is formed, and those with certain forms of cultural capital will be economically more dominant and affluent. This ties in with the ideas of social health capital which Shim describes as the social assets a person has (education, intellect, style of speech and dress, etc.) that promote a balanced dynamic with a healthcare professional(133).

Shim uses this to explore patient-provider interactions that generate disparities in healthcare, based on what repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviours, and interactional styles are brought into the consult(133). This idea of discordance between patient and consulter, also seen as an unequal power dynamic, was evident in this research study. The more significant the gap between patient and professional, the less likely there will be the production of candidacy at that local level or consultation.

An overarching theme in this research was female disempowerment and the impact of gender on seeking healthcare for those living in deprived communities. Pfeffer examined candidacy in relation to breast cancer screening in a deprived and diverse population in Hackey, London(305). Her paper described the impact of faith or religion, which may be more predominant in ethnically diverse communities, the impact of this on preference for same-gender consulter. Bourdieu described this in terms of 'bodily hexis', which he used to describe people's sense of entitlement to show their body in public (Bourdieu, 1984, p. 474). To empower women and to reduce gender disparity in the consult, allowing a choice of gender of consulter is essential, especially in communities with strong faith. However, it is important to be aware of westernised assumptions about symbols such as women wearing a veil(293).

Community behaviour and social norms

This section draws together evidence from current literature about how the 'community' can affect access. Aspects of social health capital resonate deeply with aspects of this research. The OECD defines **Social Capital** as "networks together with shared norms, values and understandings that facilitate cooperation within or among groups"(203). Koehn's work examines the importance of family and social norms on access and how elder ethnic

minority communities negotiate candidacy(128). Klassen examined breast cancer screening in low-income women and explored the impact of societal racism and the impact on those from socioeconomically disadvantaged groups (27). The work by Koehn and Klassen was echoed in the perceived barriers expressed by HCP in this research.

Hudson used candidacy as a framework to explore asthma management in South Asian children, finding a potential lack of alignment between the priorities and competencies of British south Asian families and the organisation of health services(127). This highlighted the importance of extended family perceptions and the need for HCPs to be aware and sensitive to conflicts with traditional understandings. A similar theme was explored in the interview findings about how knowledge is gained and the impact of misinformation within a family or community.

How a community conceptualises illness or health-seeking can impact access. This was seen in the QEs and the interviews regarding contraception and pregnancy risk. Bristow explored this topic in a study about the candidacy of people with mental health problems for 'hard-to-reach' groups, often finding it hard to conceptualise their distress as a biomedical problem(306).

Vulnerable groups

The term vulnerable group is used in this section to describe people who find accessing care more challenging. In the HCP interviews, several groups were highlighted as being at risk of poor SRH outcomes who find access most challenging. This included people with a lack of proficiency in the host country's language or poor health literacy, people who are homeless or in insecure housing, drugs, and alcohol addictions. Prior knowledge and understanding of illness had an impact on the management of asthma in children from South Asian communities(127). Malzer reported older women from ethnic minority groups being less equipped to cope with mainstream society's different cultural and linguistic demands (307).

Abbott explored candidacy for women in prison and drew similar barriers to access as raised in this research(288). This work highlighted the importance of making claims to care (asserting and appearing) and judgement of eligibility by providers (adjudication). It also highlights a 'transitional moment' such as entering prison, where changes in priorities can

allow women to identify health needs. This concept was raised by Balfe and explored in the QES regarding people identifying a health need such as STI screening.

Prioritisation is a crucial barrier for people accessing care. Abbott discussed the concept of prioritisation of health in the imprisoned women who were often overdue medical care due to barriers in the community such as substance misuse and cost (Australian setting)(288). A study by Mastrocola explored candidacy for street-based prostitutes accessing healthcare(197). The study highlighted the challenges of chaotic lifestyles and accessing care. This included difficulty judging the seriousness of the health-seeking problem, often leading to seeking help at a time of crisis.

An overarching theme in the QES and interviews was the impact of socioeconomic factors compounding the increased need for care. This was reported by Kovandzic's study of mental ill-health and healthcare access. It illustrated that symptoms together with socio-demographic factors conflate to punctuate the candidacy process with additional illness-related hurdles(303). The more vulnerable and complex the person is, the more pressure on the restricted time in general practice(197).

The healthcare professional as a barrier

Combining the QEs and interview synthesis can conceptualise the healthcare provider as a potential barrier to access rather than being an inert conveyer of access. HCPs often report difficulties speaking with patients about sexual health due to the multifactorial and multicultural context(290,308).

General practice or, more specifically, GPs have been described as gatekeepers(309). This refers to people having to access most healthcare in the UK via their GP, who determines whether they need referral onwards. The concept expects all gatekeepers to make a similar and sound diagnosis and management plan. The candidacy framework explores this topic using the concept of adjudication or judging the worthiness of care. Making assumptions or judgement about a patient can lead to missed opportunities and silencing of disclosure. A large French study showed that people who were obese were less likely to have their SRH needs addressed by doctors who assumed they were not sexually active(72). It concluded

that obese women are less likely to access contraceptive healthcare services and have more unplanned pregnancies.

In addition, stereotypes and myths about sexual topics persist despite decades of reforms in medical curriculums(310,311). This includes examples such as using 'double gloves' for HIV patients and misunderstandings about nulliparous women being able to use intrauterine contraceptive devices. Efficient clinical decision making which happens in a time-limited general practice setting requires an element of stereotyping and making assumptions(173,308,312). Unfortunately, this leads to blind spots and missed opportunities as reported in the QES and interviews.

Metzl and Hansen used the ideas of structural competency to recognise and respond to HCPs 'biases, inequalities and blind spots'(103). They define structural competency as the trained ability to understand how disease, behaviour and symptoms are affected by a range of different patient-related factors. The research in this thesis aligns with this concept of HCP having personal belief systems that can affect how they deliver care or adjudicate health-seeking. Mastrocola described how street-based prostitutes felt HCP's judged them and provided worse care if they knew their situation(197). These negative experiences had an ongoing impact on health-seeking; women were less likely to access if they had a need. This was recognised by Hunter and explored in terms of 'recursivity', which related how our past experiences of healthcare affect how we access in the future(302).

There are also factors specific to general practice rather than the HCP. This includes perceived (im)permeability of services and how the availability of appointments, time-limited communication and challenges asserting candidacy all impeded access. This was highlighted by Tookey when exploring doctor-patient interactions that can influence help-seeking behaviour for cancer alarm symptoms(126). Methley reiterated this with regards to MS patients who perceived poor continuity of care and poor interpersonal interactions with perceptions of limited person-centredness as affecting access(301).

Recognising candidacy

The concept of recognising and accepting candidacy was developed to better explore issues around the behaviour of the HCPs. Chinn uses candidacy to explore access to mental health

services for those with intellectual disabilities, and a key finding was the staff having a facilitation role in improving inclusivity. Services are developed for a certain level of intellect and are hard for others to access(313). Bristow describes how healthcare workers can adapt services and behaviours to help 'hard-to-reach' groups who have mental health needs. This concurs with the finding in the research where HCPs actively try to assist access. It requires a level of insight and understanding of people's needs and how to enable them.

Recognising a person's candidacy can come in the form of screening for infection or disease. Bikker explored the challenges of screening for bowel cancer in terms of candidacy; self-identification relies on one's own personal knowledge of risk(129), which means that if someone is unaware of their risk, then a healthcare professional needs to recognise this and offer screening.

Mackenzie and colleagues explored candidacy for victims of domestic violence(130). They explore the potential role of GPs in 'imagining candidacies' from a structural perspective which links to this concept of recognising and accepting candidacy. The research describes women making tentative attempts to disclose domestic violence, which can be dismissed or silenced by the GP. Women want to be legitimised and enabled.

Another concept that was raised by Mackenzie and links to this research study is the concept of multiple candidacies and understanding dynamics between people seeking help(298). This was apparent in the interview when discussing husbands bringing their wives to be tested, and the HCPs perceived the other candidacies at play, those of the husband who had been unfaithful and those of the wife being screened. Understanding these different intersecting candidacies is essential to help empower women in choices and access.

5.5. Strengths and limitations

Qualitative research is a valuable method through which to understand complexity within an area better and gain an understanding of why things are happening. To present valuable and generalisable results, there needs to be rigour in the methodology and interpretation. This is discussed further in this section with reference to trustworthiness as set out by Lincoln and Guba (211). The trustworthiness of the research presented in this thesis is

demonstrated by looking at the credibility, transferability, dependability and confirmability of the process and findings. These principles have been an integral part of the research design, process, and data analysis. Aspects of quality and rigour were discussed previously in the methodology section 3.4. This is examined further in the following section, first exploring the strengths of this thesis, and then moving to present limitations. The impact of COVID-19 on the validity of the findings is included at the end of the section.

Strengths

This is the first time research has integrated a QES with HCP qualitative interviews to understand SRH in general practice. It shines a light on an area that is often ignored or stigmatised, especially in research, as it is challenging to explore a more sensitive subject(314). The QES explores the overarching themes associated with providing SRH in general practice, and this is the first systematic synthesis of multiple aspects of this type of health that have been explored. Rather than examining barriers in terms of specific subjects such as chlamydia screening or LGBTQ+ consults, this project took a more holistic approach to try to understand the broader context of SRH in general practice. This allowed themes to emerge which overarch all SRH topics and allow us a way to improve universal access via general practice by tackling issues such as confidence, language, stigma, taboo, knowledge, and literacy. The qualitative interviews with HCPs helped to delve deeper into this understanding around barriers specific to SRH. This helps to build a deeper understanding of what is happening within the consultations, which can improve or deny access.

From the inception of the research idea, the foundation has been about access for people who face the most significant challenges getting the right services. This included deprived communities as well as those from ethnic or sexual minority groups. The research was born from an assumption that if services can be improved to help those with the most challenges accessing, then everyone benefits from improved access. This is a strength of the research as it comes from a commitment to universal health equity and consciously aims to improve care for the underserved. In the original grant application, funding for interpreters was an essential aspect of the research as we wanted to allow all voices, no matter the language they spoke.

Within the area of healthcare research, it is notoriously difficult to get GPs and practice nurses to engage in interviews due to time pressures and working conditions. A strength of this research was that we were able to recruit 20 healthcare participants, this required flexibility and pragmatism. Sometimes interviews were conducted out of hours, in people's homes or in their workplaces. This flexible approach helped to engage HCPs and enriched the results. The diverse group of practitioners provide a rich tapestry of experience; their knowledge of patients and communities over time offers a collective experience that helps them form a transferable understanding of access issues. This helps bring validity to a single perspective of the practitioner.

The following sections are from the trustworthiness framework presented by Lincoln and Guba (1985). The reasoning behind the use of these parameters was discussed in section 3.4.

Credibility – to establish confidence that a result (from the perspective of the participants) is true, credible, and believable. As a GP with a special interest in SRH, the lead researcher has worked in a variety of general practice locations as well as secondary care, with a prolonged and varied engagement with these settings. This allows a deep understanding of the context and the challenges associated with this area of work, helping build confidence in the results being a representation of the perspectives of the participants.

In order to ensure the interview process and techniques were satisfactory, research training was undertaken, which is highlighted in Appendix 13 – Research training log. This helped acquire adequate knowledge and understanding of how to undertake the research and improved the credibility of the results.

Debriefing sessions occurred with academic supervisors as well as independent verification of data required by the method for both the QES and qualitative analysis and support for critical interpretive challenge within regular research supervision meetings. These research supervision meetings allowed feedback and discussion on the topic guidelines, interviews, themes being derived from the data and any necessary modifications. A peer support group was attended with other doctoral students looking at theoretical stances in relation to

access to healthcare. This allowed a deeper understanding of theory and supported the use of the Dixon-Wood candidacy framework, which has become integral to this thesis(124).

The research protocol was presented during the doctoral research stream at the National Society for Academic Primary Care (SAPC) conference in Warwick in 2018 during the initial development of the study, and this allowed me to utilise senior external feedback and incorporate ideas into the final design. The stages of research have also been presented at numerous departmental and regional meetings. This has helped gain insight into other viewpoints and helped to ensure credibility to the findings. See Appendix 19 – Research presentations for a summary of the meetings in which the research has been discussed.

Triangulation is an approach to validating the qualitative research and was achieved by presenting the results to the meetings and using the feedback to help proceed. Respondent validation was considered as well, but logistically it was too time-consuming and impractical for the HCPs who were already taking time to do the interview, particularly during the pandemic. This could have been a helpful way to validate the data further.

Transferability –allows the results to be interpreted within the rich descriptors of context, sociodemographic and practice demographic background of participants and also allows other clinicians and researchers to interpret how the findings may be transferred to other contexts or settings. This research examines whether the findings are relatable to other general practices across the UK. For this reason, it was essential to get a wide range of HCPs from different gender and ethnic backgrounds as well as the country of birth. The only caveat to this was that the sexuality of the healthcare professional was not identified.

As discussed in descriptive findings 3.7, the interview sample was close to representational of UK general practice workforce. Practices were in deprived communities with a diverse socioeconomic and ethnicity. Within the interviews, data saturation was achieved, which enhanced the transferability of the results.

Dependability - to ensure the findings of the qualitative research are repeatable if it were carried out again with the same cohort of people, coders, and context. The research protocol and design offer a detailed description of study methods. There is a clear search

strategy for the QES, which offers the ability to replicate the data. Appendix 1 – Search terms.

The interview schedule offers a way to replicate the data collection. Interviews in this research project were taken until data saturation was reached and no new themes were identified. The perspectives of the HCPs were, on the whole similar and confirmatory.

The dependability for the research was further enhanced by using computer-assisted qualitative analysis with Nvivo for both the QES and the interview analysis. This allowed an audit of the thematic analysis and the ability to share it with others to check the meaning and agreement of coding and mapping. The codebooks for both the QES and the interview analysis are in Appendix 3 – Nvivo codebook QES and Appendix 17 – Nvivo codebook interviews. Research findings were subject to critical interpretive challenge in regular research meetings with senior supervisors experienced in qualitative research

Confirmability – To ensure the confidence with which the findings would be confirmed or corroborated by other researchers. The critical aspect of confirmability was that the research findings were shaped by the participants and not by bias, motivation, researcher special interests, or personal perspectives. From the inception of the project, reflexivity has been an integral part of the research process, either through field notes and journaling or meetings with colleagues and supervisors.

Public and patient involvement was integrated throughout the research process. This included engagement with a team of community wellbeing supporters, a practice nurse forum and two formal PPI groups from the sexual health services and maternal health services. A summary of these can be found in Appendix 4 – Patient and public involvement (PPI). Their accounts and experiences helped shape the research question and the development of consent forms, information leaflets and interview guides. On reflection, the PPI groups could have been involved in the analysis and have added another level of depth, but due to logistics and financial challenges, especially with the community workers, this was not appropriate. It would have been helpful to have developed a project-specific PPI group that could have given consistent input through the research rather than using different groups and individuals. Unfortunately, this stakeholder engagement was

restricted by the pandemic which restricted and influenced the practicalities during the main phase of data collection.

A further strength of this thesis is the use of the PRISMA guidelines for the systematic review and the use of the COREQ checklist in the methods that were employed to qualitatively answer the research question(315,316). See Appendix 18 – COREQ checklist.

Limitations

The main limitation of the interview findings is that it represents the perceptions of obstacles to access rather than the voice of those living in the community. The original research was meant to include focus groups with members of the public; this could not happen due to COVID-19 safety measures. This means that the results of the interviews represent the perspective of the healthcare professionals working in those communities. The QES includes both healthcare professionals and members of the public, helping to bring context to and resonance with overarching themes. As mentioned in the QES chapter, a limitation of the findings was due to the lack of representative sampling of ethnic minority groups or deprivation. This is likely due to convenience sampling by researchers and a failure to engage with people from different cultures, ethnic groups, or low socioeconomic areas.

The HCPs do offer an insight into a subject matter which is infamously challenging to research(314). Using the practitioner lens may help to add understanding to access issues for people from deprived communities especially where they have worked in these settings for many years. Many of the participants had been working in those communities for many years and could offer a credible insight into their patients. SRH is an area of health that is taboo and stigmatised; it can be challenging to get rich data from qualitative research with diverse communities, mainly when language and socio-cultural barriers exist(225). The hope is to complete this aspect of the research once it is appropriate from a COVID-19 perspective, as there are likely to be access barriers that healthcare professionals may not be able to contextualise.

A further limitation is the sample of HCPs involved in the interview study. All the HCPs were purposively selected as working in high deprivation areas with patients who are vulnerable

and in higher need(259). A possible bias is whether these HCPs might have specific characteristics which make them more likely to work in deprived communities. It would have been interesting also to have a sample of HCPs working in affluent areas and see if similar levels of adjudication and adaptability. More affluent areas tend to have more Caucasian populations and less translated consultations(294). There might be characteristics of the HCPs which make them more likely to work in these affluent areas, and it would be interesting to understand how they interpret barriers to access to SRH services.

5.6. Reflexivity revisited

Reflexivity was explored in section 3.4.2. This will now be revisited to reflect on how professional, personal, and academic biases can influence the interpretation of results and conduct of the research. There are also examples from the research journal of issues that affected the lead researcher.

I have found completing this research thesis challenging, mainly due to the impact of COVID-19 and having a new baby on top of other childcare commitments. I have been doing the research part-time and then working clinically in different roles. This has been hard to switch from one role to another. At times I have taken time to just focus on the interpretation and analysis of the findings, which I felt needed immersion in the topic. This was an excellent way to create mental space to focus on the findings. Unfortunately, I could only take so much leave from clinical work.

There were two particular events in the data collection which I thought interesting to share. However, I need to be vague to reduce the possibility that the participant might be identified. Firstly, in one of the interviews, the HCP made a homophobic comment related to religion, saying that there would be no gay people in the practice population as it was not allowed. I struggled with this as I could see its impact on their patients and had to work to prevent myself from challenging this viewpoint. Secondly, in an interview, one of the HCPs became upset when talking about a specific topic they had a close emotional connection with. I was drawn into a more therapeutic conversation to support them. I am aware of the challenges of being a doctor and a researcher, keeping boundaries between academic and clinical behaviours.

Through the research process and write up, I have become aware of the issues around racism in research and unconscious bias, which can occur when white people do research about white people and present it as the whole picture. I can see the impact of health inequalities for those from ethnic minority groups and feel cautious in approaching this in a culturally sensitive way. I am aware of the power dynamic of white privilege and how that can impact research undertaken. I was surprised by the lack of diversity in the SRH research and that studies did not include it as a relevant demographic. The inequalities in health for people of colour seem so apparent that it is a shocking omission from the data. I was surprised that it was customary to exclude people due to lack of English; this silencing of non-English proficient people, whilst making the research easier, excludes essential views.

I have also been contemplating gender and gender identity. Language can be very powerful especially terms about sexuality, gender, and race. During this thesis, the terms such as woman, female, man, male are used. I support and recognise that terms like woman can exclude people. Not everyone with a vagina is a woman. I aim to include all identities, although some of the quotes I included have out of date language and gender-specific terminology. Hopefully, SRH can be inclusive of all gender identities in the future.

5.7. Reflections on the research findings in the context of the COVID-19 pandemic

This research project was started prior to the COVID-19 pandemic; aspects of the research had to be adapted or stopped due to risk to the researcher or participants(261). As the pandemic has resulted in widespread changes to our daily lives and health services, it seems appropriate to include some reflections on the possible implications this could have on the findings of current research and SRH more generally(17).

We are yet to fully understand the implication of the COVID-19 pandemic on poverty, violence against women and widening health inequality. The impact on SRH health is already apparent. Data from Public Health England has shown a drop in STI screening for chlamydia and gonorrhoea, which is not explained by reduction in infection rates(19,20). Between 2019 and 2020, consultations in sexual health decreased by 10%. Face-to-face consults were reduced by 35%, and internet consultations doubled in the same time frame(20). An ongoing study by the team at UCL and UCLH (CAP-Covid) has shown that the number of unplanned pregnancies in the UK almost doubled in the first COVID-19

lockdown(18). The proportion of women reporting issues getting contraception rose from 0.6% pre-lockdown to 6.5% post-lockdown(18).

Dr Balachandren, from the Reproductive Medicine Unit at UCLH, expressed reasons why there may be increased unplanned pregnancy rates: *“this includes a lack of clarity about the legitimacy of trying to access Sexual and Reproductive Health services (SRH) during a pandemic, uncertainty about which SRH services are still available, limited GP appointments, challenges to contraceptive prescribing and closure of usual points of access to free condoms within community settings”*(317). NHS Digital data shows the COVID-19 pandemic has also led to a fall in LARC prescriptions (IUDs, IUSs, implants and injections) in GP surgeries(318). The number of prescriptions is now 17% lower than in 2019(318). Based on this research project, those who were already finding access challenges are going to have even more inequality in health, specifically those in deprived communities.

One of the positive things to have come from the pandemic is a move towards more patient-led online services(20,22). Sexual health screening tests can be done at home and ordered online with treatments posted to patients. Contraceptive checks in general practice are moving to online forms and telephone-based consults. The progestogen-only pill can now be bought over the counter, which may be the start of more pharmacy-based contraceptive measures. Whilst moving forward with technology can improve access for some, there is a need for those who do not have access to online services or need extra help with decision making or health literacy, as discussed in this study(25,319–321).

One of the more distressing aspects of the pandemic has been the way social media has been used to target and spread misinformation about the impact of COVID-19 vaccination on women. There has been misinformation spread about the vaccine causing miscarriage, infertility, and stillbirth, which has a hugely negative impact on women. It appears 'anti-vax' campaigns have specifically chosen subject areas that women fear, using them to manipulate and scare women away from vaccination. More needs to be done to mitigate these false statements, and social media companies are being challenged to reduce misinformation, but the damage has already been done. Unvaccinated pregnant women are at significantly higher risk of mortality and morbidity if they contract COVID-19 and are more likely to have poor pregnancy outcomes(322,323).

There has been a general realisation that we have a post-pandemic opportunity to look at rebalancing inequalities in health, SRH had become fragmented with patchy provision before the pandemic(22). This may be a chance to look at how we can improve care for the wider population, and this research suggests that general practice is the key to offering adaptable, pragmatic and near-user services which are tailored to the needs of the local population.

A spotlight is being shone on gender inequalities, and a recent Westminster Forum which was attended called for better funding for reproductive and women's health research. In her speech to the House of Lords, Baroness Jenkin stated, 'Less than 2.5% of publicly funded research is dedicated solely to reproductive health, despite the fact that one in three women in the UK will suffer from a reproductive or gynaecological health problem. There is five times more research into erectile dysfunction, affecting 19% of men, than into premenstrual syndrome, which affects 90% of women(324). Hopefully, this is the start of a new provision of healthcare and research that put women's health firmly in the centre of the conversation.

5.8. Recommendations and implications for policy and practice

We need to move away from a one-size-fits-all provision of sexual health services that are commissioned at the lowest price by private providers who are often national or international companies. Primary and secondary care should not be battling against each other to get funding to provide LARC services. There needs to be a variety of services for different levels of health literacy and health confidence, avoiding the current fragmentation and silos of care(11,22). We want a service that can look after people holistically and close to their home but also that is culturally sensitive and with clear confidentiality protocols.

Below is a summary of how SRH services could be provided.

Level of service	Services
Nationwide	Country-wide online services which are easily accessible with up-to-date information in a public-friendly manner. Contraception online via pharmacy. No need for appointments/missed work. All forms of STI screening are available. Free emergency contraception and accessible over the counter contraception methods. Remove unnecessary GP/practice nurse visits.
General practice	Primary care adapted community-specific services provided by GP with easy access to LARC. Ideally, drop-in clinics with translators present. One-stop shop for all SRH issues. No silos of care. Community engagement. LGBTQ friendly. Youth-friendly. Funded. Reward innovation.
Complex tertiary services.	Outreach from SRH to schools, drug clinics, homeless shelters. Take the services to the people who have the most challenges accessing. MSM vaccine programs and safe sex for CSW. Contact tracing. Complex STI care. Vulnerable groups.

A key aspect of improving access to SRH services is to allow a general practice to develop community-specific services and to fund these. General practices need to be allowed to create adaptive services which are targeted at their practice population.

Improving access to online contraception and STI screening will improve access for those who understand what is available and will reduce the burden on general practice.

Unfortunately, online access will not benefit those who do not know they have a need and will negatively affect those who do not have access to technology. Most at risk of poor outcomes are those in deprivation, ethnic and sexual minority groups. Services such as IUC and implants should be provided within communities in practices to aid trust and

engagement. General practice offers a holistic service from the cradle to the grave, but it needs to be funded so that practices can undertake essential services.

5.9. Suggestions for future research

This research study has led to further questions which need to be answered to understand access to SRH better. Future research needs to focus on interventions that will aid those at most risk of poor health outcomes rather than focus on creating one-size-fits-all services. It is important that research is inclusive of ethnicity, genders, and sexuality rather than focused on specific demographics. Rather than research studies that target specific groups, there needs to be a broader concept of population. Studies with a focus on a particular population group can further stigmatise communities when obstacles are labelled as 'as a problem for black women' or 'a barrier for gay men'. Research techniques need to be developed for inclusive and diverse study populations, drawing on methods from sociology and ethnography to aid pragmatic healthcare research.

Below are some research questions which have developed during the process of this study.

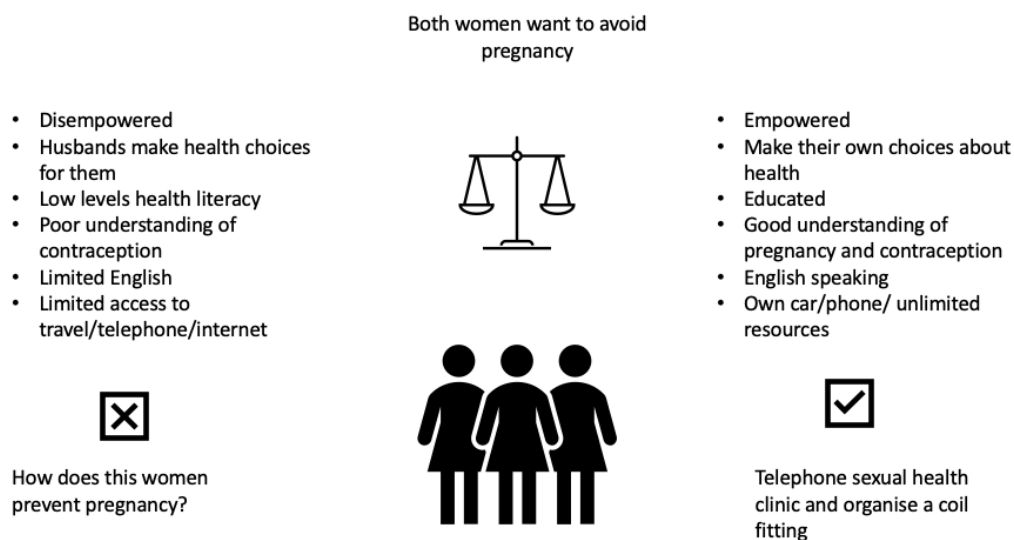
- What do people in ethnic minority groups want their services to look like? Co-designed projects by people from ethnic minorities to develop an intervention to increase access to contraception and testing. Development of an intervention working with communities that helps to adapt services for them. Importance of bespoke services for people rather than one size fits all.
- How can we conduct better research with communities where English is not the primary language? Can we look at ways to do focus groups without the leading researcher having English for example training community members and interpreters as co-community researchers in research interviews.
- Can we work with UK medical schools to develop an understanding of the impact of personal belief systems on how we offer 'stigmatised' health services such as abortion care, contraception and STI screens? Focus on GP training to improve knowledge with generic SRH training modules? Increase SRH in practice nurse training?

- Can we develop resources for non-English speaking communities or those with a low level of literacy? Where do people acquire knowledge? How can we work with a preference for lay-person, local community members? Can we tackle health literacy by understanding this more reliable locally appropriate advice?

5.10. How does this project answer the original research question?

What are the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare (SRH) access?

This research has explored barriers and facilitators to access services, with a focus on deprivation. Below is an overview of the inequality of care between two women wanting the same outcome; although this example is pregnancy prevention, it can be applied to many other aspects of SRH.



Our current services provide services that are accessible for those with empowerment and health literacy. This has created inequitable services which are more easily accessed by some than others. The most significant barrier to access is being unable to identify a need or another option such as contraception, hence the need for recognition and acceptance of a need by an HCP.

5.11. Overall contribution of this research

Findings from this pragmatic research project have generated several novel contributions to the understanding of access to SRH services in deprived communities. This research brings a new understanding of SRH in general practice and incremental knowledge development by building on the work of others.

See Appendix 20 - Plans for disseminating the findings of this research.

5.11.1 Empirical contributions

The key empirical contributions relate to findings from both the QES and the interview analysis. The QES determined barriers and facilitators which shared commonality across general practice and various health needs. The synthesis showed a lack of inclusive research for vulnerable groups or those at most risk of poor SRH outcomes. This included a lack of ethnic minority groups or those without proficient English skills. The interview analysis highlighted the importance of general practices in deprived communities adapting services to try to improve access. The HCPs gave a rich and deep knowledge of their communities and passion for improving health within the areas.

They saw SRH as an essential and poorly provided aspect of healthcare. The impact of poor funding and silos of care was apparent. There was a contrast between secondary care services where there was a perceived lack of continuity and longitudinal relationship and general practice where practitioners adapt to the behaviours of their community. To access secondary care services, the individual needs to have a level of education, health literacy and the assets to mobilise access. This contrasts with general practice, where a patient may seek access with any health condition and be offered SRH care. The power of general practice is to enable access for vulnerable groups, in particular disempowered women. General practice is integral to reach those who struggle to access care.

Furthermore, this research has provided a deeper understanding of how HCPs can act as a barrier to access. This may be a benign lack of knowledge or understanding of risk, or it may be more sinister bigoted views, discrimination of sexual minority groups and avoidance of sensitive subjects such as sex. Improving understanding of the impact of personal belief systems and reflexivity for HCPs is vital in reducing this as a barrier. It was apparent that the

impact of shame, stigma and taboo related to sex both from the patient and provider context. The findings highlighted the importance of the interaction between HCP and provider. In general practice, this was facilitated by the longitudinal relationship building that occurs over time.

5.11.2. Theoretical contributions

The research has emphasised the benefit of using the candidacy framework as an approach to understanding the complexity of access to SRH services in general practice as well as determining possible influences on health-seeking. To explore this further, an addition was made to the candidacy framework called 'recognising and accepting'. This stage integrated 'local production of candidacy' and 'adjudication by HCPs whilst also identifying the importance of the interaction and relationship between HCP and patient on access.

5.11.3. Final conclusion

Overall, the findings suggest the need to focus on equal provision of SRH through every practice but with a focus on those with the most significant challenges accessing. In practical terms, such a shift could be achieved by; ensuring adequate funding of SRH services in general practice, including the provision of LARC; all general practices should include an HCP who has a deeper level of expertise in SRH; policy needs to allow practices to look at services that empower communities and target myths and misinformation.

Women have the most significant burden when it comes to SRH, which has compound disadvantages for women who are disempowered or vulnerable with other competing priorities. Recognition of their candidacy is key to helping reduce inequalities and acknowledgement that gender of the consulter can ask as a barrier.

General practice has a vital role in reducing SRH inequalities and a part to play in rebalancing gender inequalities by providing local, easy to access services for contraception and sexual health.

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APPENDICES

Appendix 1 – Search terms

1. exp General Practice/
2. general practice.af.
3. General Practitioners/
4. General Practitioners.af.
5. Physicians, Family/
6. GP.af.
7. Primary Health Care/
8. primarycare.af.
9. primary care.af.
10. Family Practice/
11. family practice.af.
12. family medicine.af.
13. Physicians, Family/
14. family Physicians.af.
15. family practitioner.af.
16. primary healthcare.af.
17. primary health care.af.
18. Primary Health Care/ or Primary Care Nursing/ or Nurse Practitioners/
19. Primary Care Nursing.af.
20. Nurse Practitioners.af.
21. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20
22. Reproductive Health/
23. sexual health.af.
24. reproductive health.af.
25. pelvic infection/ or reproductive tract infections/ or exp sexually transmitted diseases/

26. Pregnancy, Unwanted/ or Pregnancy/
27. Contraception Behavior/ or Contraception/ or Contraception, Barrier/ or Contraception, Postcoital/ or contraception.mp.
28. Gender identity.mp. or Gender Identity/
29. exp sexual behavior/ or exp sexuality/ or exp unsafe sex/
30. Abortion, Induced/ or Family Planning Services/
31. transgender.mp. or Transgender Persons/
32. sex workers/ or exp sexual minorities/
33. Contraception, Postcoital/
34. 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33
35. 21 and 34
36. Health Services Accessibility/ or Professional-Patient Relations/
37. "Attitude of Health Personnel"/
38. barrier.ab,ti.
39. facilitator.ab,ti.
40. "barrier*".ab,ti.
41. "facilitator*".ab,ti.
42. "delivery of health care, integrated"/ or health services accessibility/ or health equity/
43. 36 or 37 or

Appendix 2 - Summary quality assessment of qualitative studies (CASP Tool for Qualitative Studies)

Y, Yes; N, No; ?, can't tell; NA, not applicable

		Section A: Are the results valid?		Is it worth continuing?				Section B: What are the results?			
Author	Full text exclusion if appropriate	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Balfe 2009	Y	Y	Y	Y	Y	Y	?	?	Y	Y	Y
Balfe 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Beagan 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bjorkman 2007	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burns 2007	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
Cant 2002	Y	Y	Y	Y	Y	Y	?	?	?	Y	Y
Cant 2005	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Collyer 2018	y	y	y	y	y	y	y	y	y	y	y	y
Dixon-Woods 2001	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Ewert 2016	Y	Y	Y	Y	Y	?	N	?	Y	Y	Y	Y
Ejegi-Memeh 2021	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Fairhurst 2005	Y	Y	Y	Y	Y	Y	N	?	Y	Y	Y	Y
Freeman 2009	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Gott 2003	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Gott 2004	Y	Y	y	Y	Y	Y	?	Y	Y	Y	Y	Y
Heritage 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hinchliff 2004	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hinchliff 2005	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Hocking 2008	Y	y	y	y	y	y	y	y	y	y	y	y
Hogan 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Joore 2016	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Keogh 2016	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	Y
Latreille 2014	Y	Y	Y	Y	Y	Y	?	?	Y	Y	Y	Y

Llewellyn 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lorch 2015	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
Lunniss 2016	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
Ma 2005	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Mikulak 2021	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McNair 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McNulty 2004	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McNulty 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McNulty 2010	Y	Y	Y	Y	Y	Y	Y	Y	?	Y	Y
Newman 2013	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
Normansell 2016	Y	Y	Y	n	Y	Y	Y	Y	Y	Y	Y
Pavlin 2008	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Poljski 2003	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Stott 2013	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Sutcliffe 2011	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y

Tuomainen 2013	Y	Y	Y	Y	y	y	y	y	y	y	y
Woodbridge 2015	Y	y	y	Y	y	y	y	y	y	y	y

Appendix 3 – Nvivo codebook QES

Name	Description	Files	References
Candidacy framework		0	0
1 - Identification of candidacy	Process in which a person comes to appraise their issue as needing medical help which legitimises them as a candidate for particular health services.	24	130
Awareness of future complications		1	3
Invulnerability		1	1
Macho image		1	1
Not a priority		14	18
Patient knowledge		4	7
Protect others		1	1
Symptom free		3	4
2 - Navigation of services	Knowledge of services provided and appraisal of the practicalities involved in making contact with and accessing services. Includes barriers to accessing services such as needing transport, convenience of appointment times and accumulated costs of attending services.	13	21
Cost		1	3
Inverse care law		2	3
3 - Permeability of services	The ease with which a person can use health services. Includes levels of gate-keeping within a service, the complexity of its referral processes, and the 'cultural alignment' of services with the person's needs and values.	10	21

Name	Description	Files	References
4 - Appearing and asserting candidacy	The person's ability to assert their candidacy by presenting at services, articulating their issue and articulating their 'need' for care.	19	51
Assumptions about the healthcare professional		4	6
Embarrassment		10	13
Fear of being judged		9	14
Fear of consequences		8	10
Fear of disclosure by patient		4	6
Good or bad identity		3	16
Language of respondents		2	3
4.5 - Recognising and accepting candidacy	How a HCP allows access or denigns candidacy. Internalised bias, beliefs, own views. Includes demographics and behaviour as a consulter. patient centred behavior. enabling factors.	0	0
Candidacy identification	When the patient is unaware of a health need and access opportunity for example screening and sti testing or discussion about contraception. proactive targeting.	0	0
Lack of opening		1	3
Unexpected offer		12	20
Who makes the offer		8	21
Consultation skills		2	4

Name	Description	Files	References
Dr-pt interaction		9	17
Everyone as an individual		3	10
Fear of offending		1	1
Forced disclosure		2	3
HCP awkwardness		7	13
HCP demographic		9	16
Health materials posters etc		8	10
Knowledge HCP - actual		14	22
Knowledge HCP - perceived		5	12
Labels		1	2
Language		3	8
Medicalisation of sex		2	3
Normalisation		12	16
Pathologising		1	1
Personal views of HCP		11	28
Route in to conversation		1	1

Name	Description	Files	References
Sexual act rather than orientation		1	1
Transphobia or homophobia		3	5
Understand sexuality understand person		5	19
Variation in Knowledge, attitudes and skills of HCP		3	4
5 - Adjudication by healthcare professionals	A person's candidacy is judged by healthcare professionals, subsequently influencing the person's progression through services and access to care. Adjudication may disadvantage certain people by perceiving them as either 'deserving' or 'undeserving'.	28	129
6 - Offers of, resistance to services	A person may refuse offers at multiple stages in their journey to treatment including resisting offers for appointments, referral, and treatment.	1	7
7 - Operating conditions and local production of candidacy	Incorporates factors at societal and macro levels which influence candidacy, such as the availability of local resources for addressing candidacy, and relational aspects which develop between the healthcare provider and patient over multiple visits.	6	10
Confidentiality		8	9
Heteronormative		7	16
Lack of continuity		1	2
Practice mechanisms		0	0

Name	Description	Files	References
Actively ignore		1	1
Passive		3	4
Proactive		6	8
Reactive		2	3
Shame		7	10
Small communities		3	4
Stigma		15	24
Taboo		2	3
Time constraints		14	24
Participant demographics		37	39
Excluded if not proficient in English		4	4
Purposive sampling diversity		9	9

Appendix 4 – Patient and public involvement (PPI)

I have undertaken a range of different PPI events to embed my research with insight and expertise of people affected by sexual and reproductive health conditions or who work in the area. This includes;

- Darnell Wellbeing community support workers 3rd Dec 2016
- Practice nurse teaching event 4th February 2017
- Lay Expert Advisory Panel for South Yorkshire HIV Network (LEAP) 30th January 2018
- Obstetrics and gynaecology (OGN) PPI meeting agenda on Tuesday 6th March 2018

PPI form an essential aspect of this research, from conception of ideas through to the research process and then disseminating the results. There are many issues doing research involving sex or sexual health, there are taboo subjects, stigmatised diseases and unspoken socially or culturally unthinkable subjects. The use of PPI helps me to understand some of these so that I can avoid causing offense or distress but still explore important subjects.

Darnell Wellbeing community support workers 3rd Dec 2016

At the conception of my research question, I had the opportunity to engage with a group of community health workers who work with a charity called Darnell wellbeing. The community workers come from the communities they look after and have insight and expertise working with groups who may be vulnerable, isolated, new migrants or from black and ethnic minority groups.

The aim of the session was to understand better what was seen as the main issues around sexual and reproductive health and to find out what was acceptable to the community. In return I offered some basic teaching on sexual health and contraception. The group was a mix of men and women with a range of ethnicities. The main ethnicity was Pakistani with a few community workers from the Slovak population.

Useful themes,

- Uncomfortable for women to talk openly about SRH in front of men, even when they are colleagues. Also, discomfort for men to talk to myself as a female researcher about sexual health.
- Certain topics are not appropriate to discuss such as anal sex or men who have sex with men, specifically with the more traditional Muslim communities as this is illicit within the religious teachings.

- Knowledge among the community support workers regarding SRH was low and they felt unable to offer their community advice regarding this.
- I would need to do gender specific groups if trying to explore SRH issues with these groups of people otherwise the responses would be limited to what is socially acceptable to discuss.
- Still much taboo and stigma about talking about sex and genital body parts. May need to adapt the case vignettes for the groups that I am talking to.

Practice nurse teaching event 4th February 2017

During the early phase of the research, I was asked by the local commissioning body to do a teaching session for practice nurses in Sheffield. This involved a 3-hour teaching session on SRH, as part of this I asked them to fill in a simple questionnaire to give input and expertise with the initial

146 Practice nurses in Sheffield attend for an education event led by myself supported by the commission group which was an update on Sexual and Reproductive Health.

Questionnaire following teaching regarding where they feel research should focus and acceptability. I received 25 responses from the practice nurses, all were female and aged between 20 and 50+. The following themes were written in free text on the questionnaires;

Q1. What are the difficulties you have providing these services?

- *Confidence especially with different types of pills, GP decisions about contraception, local access to LARC, confused about quick starting and whether I should be advising about it.*
- *lack of knowledge/confidence due to intermittent nature of my input into these services*
- *Time limits*
- *Time can be a limiting factor, having the confidence to ask about sexual behaviour in such a way as not to offend.*
- *"rarely do emergency contraception and would always seek advice from GP.*
- *Time in consultations - to get information from pt and then check which contraception is suitable in 15 mins. best practice for dealing with issues like irregular bleeding, GPs often have different approaches. "*
- *As student health service we tend to gear our service around the students.*
- *Lack of knowledge*
- *Time and follow up can sometimes be a problem, sometimes due to nursing updates our information and advice may differ from GP's which can cause confusion.*
- *resources, restrictions from GP's re cost*

- *KEEPING UP TO DATE.*
- *getting patients on board*
- *none for our population*
- *Keeping up to date with changes*
- *Lack of PIL for patients, keeping ip to date with so many methods.*
- *possibly need more local clinics*
- *need clear and concise guidelines*
- *I am specialised in Respiratory nursing so rarely work in this area apart from occasional contact smears*
- *im not a prescriber*
- *Knowing where to direct patients too if we can't offer services at GP practice*
- *Lack of time*
- *Short of appts and length of appts.*
- *Lack of experience in this area- booked to spend time at Sexual Health Doncaster to share practice which I feel will give me more confidence.*
- *Lack of confidence and knowledge to a degree*

Q2. Where do you think we should be putting our efforts with research in this area?

- *Don't know*
- *Not sure, I think you have more knowledge of this than me! I don't know where the problems lie in Sheffield*
- *Unsure*
- *more training for practice nurses and clear policies so that we have increased confidence in our practice and more able to implement change in practice.*
- *seeing if practices offer dedicated sexual health clinics*
- *Not sure*
- *So far so good.*
- *educating local high-risk communities*
- *PREVENTATIVE STRATEGIES AND AVAILABILITY OF SERVICES /ACCESS*
- *minority groups*
- *consent and sex, education for what is consent*
- *Provide PIL and PN updates*
- *STI 's*
- *providing simple and straightforward pathways and protocols, backed up with short / practical training sessions*

- *Schools and colleges*
- *Possibly creating a precise map of which groups, we should be promoting this research to; to assist in promoting this practice/ empowering the right groups.*
- *Unsure*

Q3. What would make it easier to provide sexual health and contraceptive services?

- *Local access to LARCs. Better knowledge/ understanding about different types of pills and side effects.*
- *Easy access to expert advice and guidance. Access to easy-to-use local resources. Being able to give out condoms in practice.*
- *More access to family planning training for practice nurses*
- *more time! increase in my own confidence to ask questions.*
- *perhaps some shadowing opportunities in sexual health to see GUM consultations and how the process works.*
- *providing dedicated sexual health services in practices thus avoiding patients having to 'ask'*
- *More training for primary care nurses*
- *Maybe making it more a subject that can be specialised with for example maybe easily available level 5/6 courses and online updates.*
- *training more often*
- *SPECIALIST CLINICS IN LOCALITIES*
- *a forum to check up to date information, share ideas etc.*
- *drop ins, late night/weekend opening*
- *More frequent updates-this recent one has been very helpful*
- *Regular updates*
- *nurses who specialise in sexual health to do clinics in GP surgeries,*
- *more clinic time...plus the above*
- *If all surgery staff i.e. GP's as well had been at the meeting it would have had more impact*
- *more staff and appointments.*
- *Continuing to have woman's only clinics, working with GPs*
- *Outreach services and training particularly aimed at Primary Care.*
- *I feel that if secondary care were to take the lead in routine testing of HIV etc. It would be much easier to offer this in primary care.*
- *A simplified stepping process*
- *Regular updates for staff undertaking.*

I used these themes to help generate the interview schedule of what to explore further, some of the topics are outside the scope of what I can achieve in the interviews. I feel I have little ability to impact on policy and funding but more interested in interactions and how people feel about other people providing sexual and reproductive health. Many of the nurses who completed the questionnaire have left email addresses for further contact and were happy to be interviewed in more detail.

Lay Expert Advisory Panel for South Yorkshire HIV Network (LEAP) 30th January 2018

During the development of my research information such as participant leaflet and consent forms I was involved with a PPI group who runs from the sexual health clinic in Sheffield. The group consisted of men who have been under the HIV team at sexual health Sheffield. They have first-hand experience of living with HIV and had great experience to share.

The overall feeling was that the information leaflet was clear and explanatory. They contracted it to a recent 'more science' research proposal which they had looked at in previous meeting and found it difficult to read and a poor lay summary. They found mine much easier to understand.

The PPI group helped me develop the vignettes to make some more appropriate for LGBT+ communities and they suggested changes to the diagram on the information sheets. We talked about ways I might be able to get men to talk to me and how to engage with members of the community.

One of the men in the group shared personal experience of living with HIV and that his GP had bent he first person he had come out to and supported him with issues around HIV diagnosis. He said that sometimes the specialist does not know how to treat things such as rashes or minor ailments, but the GP sorts it straight away. It highlighted for me the need to better understand the interplay between primary and secondary care.

OGN PPI meeting agenda on Tuesday 6th March 2018

Introductions were made around the table for the benefit of Rebecca; she was invited to give a brief explanation of the research study. Rebecca is a GP and is doing a PHD with the University of Sheffield. She is in receipt of a grant from the Royal Collage of GP's to undertake this study.

The study has already been through the University Ethics committee.

The aim of the study is to highlight the barriers to receiving good sexual health services. This includes all areas of sexual health including:

- Family planning
- Pregnancy planning
- Contraception
- Infections
- Gender identity
- Sexuality

More generic discussion of appropriate case studies with general population that will include:

- Vulnerable people
- Young people
- Minority ethnic community including the Romany community
- Deprived people

The reason to targeting these groups is because of their situations they are the people who would benefit from a proactive Sexual Health service. These are also the groups who tend to have the worst outcomes. An improvement on these outcomes would be a benefit to everyone.

The participant recruitment will be through various community based and charity groups. There is a budget for translation. A suggestion was made to spend an amount of monies on having a video made of a person reading out the original Patient Information Sheet (PIS) and the various translated Patient Information Sheets (read by the translators) for those who are illiterate. An example can be found on You Tube from the Endometrial Scratch study. H;

The panel commented on the patient information leaflet:

- The information is written very well, it is clear and easy to understand.
- Clarification of amount of participants.
- Recruitment will be from Youth groups, (16 to 18 – 18+) LGBT and community groups
- Sure Start is another Parent and toddler group that could be approached.
- The youth group “Chillipep”.
- Clarification needed on tailored interviews / discussion groups.
- The picture is very good.

- Explanation on the fact that there has been research in specific areas, the idea of this study is to show that all themes that are causing barriers to receiving a good sexual health service are the same.
- Title – General Practice “your family doctor”.
- Clarify that different case studies will be discussed with different groups.
- Adding the Research Title to the PIS is not necessary
- The results are planned to be disseminated to all different groups at the end in one event.
- The data anonymised by giving an interview number, when transcribing the interviews, the originals will be kept in a secure file. If any identifiable quotes are used in the publication, then permission would be sought.
- Recording will be kept for 5 years.
- Only basic information would be taken:
 - Age, ethnic background
 - There will be a voucher to cover expenses for taking part.
 - Query on if the Smear test screening, could be used as a point when sexual health could be approached with the patient.
 - A stakeholder co-applicant would be advisable
 - A stakeholder group is being considered.

It was noted that it is best to approach PPI prior to Ethics approval, as there may now need to be some amendments. The panel felt that this is a very worthwhile and interesting study they asked that she keeps the PPI group informed of progress.

Appendix 5 - SFB application financial support



SECTION 7F		Research proposal: financial support for project	
Details of support requested			
<i>Including salaries of assistance, superannuation and NI contributions etc. apparatus, printing and other expenses. Include additional breakdown of anticipated claim. If the project is longer than one year, please list each year separately.</i>			
Salaries (e.g. salaries for assistants etc.):			
Item		Amount	
Administrative and secretarial support (point of contact for patients in the department, administration of letters, setup and maintenance of practice and participant database. (2 hours per week)) (Year 1 and 2)		£ 0	
Translator services (SCALIS £27/hour) 25 hours of individual interviews		£675	
Running costs (e.g. travel, stationery, printing etc.):			
Item		Amount	
Travel to participants and practices (personal)		£500	
Travel to participants and practices (participants)		£250	
PPI groups (room hire, refreshments, travel reimbursement) x2		£500	
Vouchers for patient participants to interview (25 x£15)		£375	
Stationery/printing/postage for invitation for interviews		£50	
Backfill for health professional participation interviews studies(15 GPx£80/hour and 10 Other x£40/hour)		£1600	
Stationery/printing/postage for invitation for follow up correspondence		£50	
Advisory group meeting (room hire, refreshments, travel reimbursement) x4		£400	

Equipment costs (e.g. apparatus, computers, software, tape recorders etc.):	
Item	Amount
Recording equipment	£450
Dissemination costs (e.g. posters, publications, conferences etc.):	
Item	Amount
Conference costs	£1850
Open access Publication costs	£2000
Report writing printing and binding	£50
Poster printing for presentation	£120
All other costs (e.g. transcribing etc.):	
Item	Amount
Transcribing for interviews	£1800
What is the total project cost?	
£10670	

Appendix 6 – Ethics approval



Downloaded: 29/01/2019

Approved: 14/07/2017

Rebecca Mawson

Medical School

Dear Rebecca

PROJECT TITLE: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.

APPLICATION: Reference Number 015091

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 14/07/2017 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 015091 (dated 04/07/2017).
- Participant information sheet 1032135 version 2 (04/07/2017).
- Participant information sheet 1032133 version 3 (04/07/2017).
- Participant consent form 1032137 version 2 (04/07/2017).
- Participant consent form 1032136 version 2 (04/07/2017).

The following optional amendments were suggested:

All much clearer, thanks. Bonus points for calling one of your cases Jolene! Jeya case- are you deliberately implying that she might be being coerced? If not would be nice to say that she wants to have sex rather than her boyfriend wants her to have sex.

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

Paula Blackwell

Ethics Administrator

Medical School



Health Research Authority

Dr Rebecca Mawson
Sam Fox House
Northern General Hospital
Sheffield
S5 7AU

Email: hra.approval@nhs.net

06 June 2017

Dear Dr Mawson,

Letter of HRA Approval

Study title: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.

IRAS project ID: 220726

REC reference: 17/YH/0171

Sponsor University of Sheffield

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page 1 of 8

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document “*After HRA Approval – guidance for sponsors and investigators*” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the

feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **220726**. Please quote this on all correspondence.

Yours sincerely

Alex Thorpe

Senior Assessor

Email: hra.approval@nhs.net

*Copy to: Deborah McClean, University of Sheffield, Sponsor's Representative
Michelle Horspool, NHS Sheffield CCG, Lead R&D Contact
NIHR CRN Portfolio Applications Team*

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [insurance]	1	06 June 2017
Interview schedules or topic guides for participants [Case studies for discussion]	Version 1	02 May 2017
Interview schedules or topic guides for participants [Interview schedule - health professionals]	Version 1	02 May 2017
IRAS Application Form [IRAS_Form_02052017]		02 May 2017
IRAS Application Form XML file [IRAS_Form_02052017]		02 May 2017
IRAS Checklist XML [Checklist_02052017]		02 May 2017
Letter from funder [SFB grant acceptance]	Version 1	19 January 2017
Letter from sponsor [NIHR award acceptance]	Version 1	26 July 2016
Other [SoE]	1	06 June 2017
Other [SoA]	1	06 June 2017
Participant consent form [HCP consent]	Version1	31 January 2017
Participant consent form [Participant consent]	Version1	31 January 2017
Participant information sheet (PIS) [SHIP participant info]	Version 2	11 April 2017
Participant information sheet (PIS) [SHIP HCP info]	Version2	31 January 2017
Research protocol or project proposal [Protocol RLM]	Version 2	20 April 2017

Summary CV for Chief Investigator (CI) [CV RLM]	Version 1	20 April 2017
Summary CV for student [CV RLM]	Version 1	24 April 2017
Summary CV for supervisor (student research) [CV CM]	Version 1	24 April 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in

England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.*

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Deborah McClean

0114 22 21449

d.mcclean@sheffield.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with	Comments
---------	-------------------------	----------------	----------

		Standards	
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	The applicant has confirmed that there are no NHS service users participating in this study. They will be participating by nature of their involvement with charity groups and will be approached by volunteers of those organisations.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The applicant has provided a Statement of Activities and Schedule of Events and intends these to be used as the agreement between the sponsor and participating site.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional
Section	HRA Assessment Criteria	Compliant with Standards	Comments
			indemnity provided by their medical defence organisation covers the activities expected of them for this research study

4.3	Financial arrangements assessed	Yes	No funding will be provided.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	This study involves staff participants and people recruited outside of the NHS.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is only one site-type for this study.

Study documents will not be shared with participating NHS organisations in England because the applicant will undertake all research activities. No specific arrangements are expected to be put in place at each organisation to deliver the study.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for

participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research**, because the applicant will undertake all research activities.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than **11/07/2017**):
 - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate
 - You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed..
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed. The document [“Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected”](#) provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expectations, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator would be appropriate for this study and has already been identified.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

NHS patients will not be recruited for this study. HR Good Practice Pack arrangements should not be required to interview staff participants.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 8 – Sponsorship letter



The
University
Of
Sheffield.

Research &
Innovation
Services.

Dr Rebecca Mawson
Postgraduate Room,
Level 3
Sam Fox House
Northern General Hospital
14th July 2017

New Spring House
231 Glossop Road
Sheffield
S10 2GW

Telephone: +44 (0) 114 222 1400
Email: aj.kenny@sheffield.ac.uk

Project title: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.

URMS number: 151471

Dear Dr Mawson,

LETTER TO CONFIRM THAT THE UNIVERSITY OF SHEFFIELD IS THE PROJECT'S RESEARCH GOVERNANCE SPONSOR

The University has reviewed the following documents:

1. A University approved URMS costing record;
2. Confirmation of independent scientific approval;
3. Confirmation of independent ethics approval.

All the above documents are in place. Therefore, the University now **confirms** that it is the project's research governance sponsor and, as research governance sponsor, **authorises** the project to commence any non-NHS research activities. Please note that HRA approval will be required before the commencement of any activities which do involve the NHS.

You are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Good Research & Innovation Practices Policy: www.shef.ac.uk/ris/other/gov-ethics/grippolicy. Ethics Policy: www.sheffield.ac.uk/ris/other/gov-ethics/ethicspolicy and Data Protection Policies: www.shef.ac.uk/dics/records

Your Supervisor, with your support and input, is responsible for providing up to date study documentation to all relevant sites, and for monitoring the project on an ongoing basis. Your Head of Department is responsible for independently monitoring the project as appropriate. The project may be audited during or after its lifetime by the University. The monitoring responsibilities are listed in **Annex 1**.

Yours sincerely

Deborah McClean
Interim Director Research and Innovation Services
Co: Dr CA Mitchell
Head of Department/School: Professor Deborah Murdoch Eaton





Certificate of Completion

Rebecca Mawson

has completed

Introduction to Good Clinical Practice (GCP)

A practical guide to ethical
and scientific quality standards in clinical research

on

Monday, 6th March 2017

Modules completed:

Introduction to Research and the GCP standards
Preparing to deliver your study
Identifying and recruiting participants: eligibility and informed consent
Ongoing study delivery and data collection
Safety Reporting
Study closure

This course is worth 6 CPD credits



Delivering research to make patients, and the NHS, better

Appendix 10 - Interview schedule

- Can you describe your practice – population and patients you look after?
 - What are the type of sexual and reproductive health issues you see in the practice?
 - What screening services does your practice offer and what is the uptake like?
 - What contraception does your practice offer and what is the uptake like?
 - Have you worked at other practices and noticed differences?
-
- Have you seen issues related to the cuts to sexual and reproductive health by secondary care?
 - How does your practice help access from an organisational level?
 - How do you think organisations such as practices or hospitals make access better for vulnerable groups?
 - How can we improve access for vulnerable groups to sexual and reproductive health care?
 - How can we reach those who don't know they are at risk?
-
- How do you think culture or ethnic background affect health seeking behaviour in terms of sexual and reproductive health?
 - Do you think there is an aspect of stigma around seeking sexual and reproductive healthcare?
-
- Thinking more about the consultation – what challenges do you feel when trying to discuss sexual or reproductive health?
 - Do you think this varies between individual patients – what makes you feel more comfortable or less comfortable discussion things to do with sexual and reproductive health? Why do we feel like this?
 - In terms of HIV – does your practice screen for this? How do you feels raising the offer in a consultation? What makes it feel awkward?
 - In terms of sexuality – do you think it is important for us as health care providers to know about sexual orientation? Is it helpful in some settings? Do you ever ask?
 - Do you have many consults around gender identity?
 - Just to finish – is there any other things that frustrate you or that have thought of with regards to sexual and reproductive health?



Study Number: **220726**

HEALTH CARE PROFESSIONAL CONSENT FORM

Title of Project: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.

Name of Researcher: Dr Rebecca Mawson

box

Please initial

1. I confirm that I have read and understand the information sheet dated 04.7.17

(version 3) for the above study. I have had the opportunity to consider the

information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time,

without giving any reason. This will not affect my legal rights in any way.

3. I understand that the data collected during the study may be made available to

responsible individuals from the NHS , the University of Sheffield, regulatory authorities

or the NHS Trust, where it is relevant to my taking part in the research.

4. I understand that the information from this study may be published in research journals

and anonymous quotes may be used.

5. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed, 1 copy for patient; 1 copy for researcher site file; 1 (original) to be kept in medical notes

Participant Information Sheet – Healthcare professional

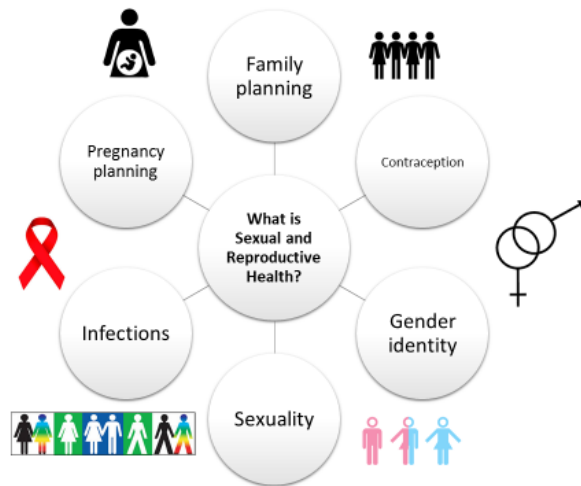
Study title: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective

We want to know what you think

You are invited to take part in a research study about sexual and reproductive health (explained below).

Before you decide if you want to take part - you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully - talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.



1. What is the reason for the study?

Sexual and reproductive health has often been provided in hospital run clinics but due to cuts to these services we are looking at ways to provide it from your own family doctor. Many people already go to their own GP for services but others find it more difficult. We want to understand this better and then make changes which might make it easier to get the services you want.

2. Why have I been invited?

We are looking for GPs and practice nurses who would be happy to be interviewed regarding provision of sexual and reproductive health care provision in primary care. We are focusing on more deprived areas of Sheffield or areas with difficult to reach patients.

3. Do I have to take part?

No. You can stop at any point and you can ask to have your interview deleted.

4. What type of study is this?

This is an interview study where you will be asked a few questions and then we will look at everyone's responses to see if there are important ideas that come up.

5. What happens if I take part?



6. What will I have to do?

We will ask about your background and how you feel about providing sexual and reproductive health in primary care. We have case studies which we can discuss during the interviews to help raise topics. Interviews will be reimbursed at a rate of £80 per hour for GPs and £40 per hour for practice nurses.

Interviews will be audio recorded and transcribed.

7. What are the possible disadvantages and risks of taking part?

Some of the questions in the questionnaire may be about certain topics which you find sensitive or you don't wish to answer. If this happens you can skip these questions.

8. Will my taking part in this study be kept confidential?

- Your name and details will be removed - anonymous
- Information will be stored under lock and key or secure passwords if on computer
- Only authorised people will be able to see your information
- We will only use this information for this study – if we wanted to look at the interviews again we would have to go to a special meeting.

9. What will happen to the results of the research study?

We plan to share the study results with other people who work in the area, this might be through writing in journals or at conferences.

Your name and details will not be put in these but we might use some quotes from you. You will not be able to be identified from these.

We will post a copy of the overall results to yourself and invite you to come to a public event for a presentation and thank you.

10. Who is organising and funding the research?

This research is being funded by the National Institute of Health Research and Royal College of General Practitioners.

11. Who has reviewed the study?

All research in the University of Sheffield is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by University Ethics Committee.

12. What if there is a problem? The small print!!

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the head of department, Professor Christopher Burton. Details below.

Specific information about this research project

Dr Rebecca Mawson (GP and researcher)

C/o Peggy Haughton

Academic Unit of Primary Medical Care

University of Sheffield

Sam Fox House

Northern General Hospital

Herries Road

S5 7AU

Sheffield

268

Tel: 0114 222 2201

Email: r.l.mawson@sheffield.ac.uk

Who you should approach if unhappy with the study

Prof Chris Burton (Head of department)

C/o Peggy Haughton

Academic Unit of Primary Medical Care

University of Sheffield

Sam Fox House

Northern General Hospital

Herries Road

S5 7AU

Sheffield

Tel: 0114 222 2201

Email: chris.burton@sheffield.ac.uk

Appendix 13 – Research training log

Training	Content	Completed on	Renewal date	Credits
Protecting information	This mandatory course will teach you the basic skills needed to use University information safely and introduces the key concepts of information security.	14/03/2022	14/03/2023	
Protecting Research data	Research data is one of our most valuable assets, and a tremendous amount of time and money is invested in the creation, discovery, analysis and processing of it; therefore, we must take all necessary precautions to protect it.	14/03/2022	14/03/2023	
Supporting our students	This course aims to provide information about the various support services that are available for students. After completing this course you should be able to quickly and confidently signpost students to relevant support or information.	14/03/2022	14/03/2024	
Counter fraud and bribery mandatory training	This mandatory course will help you understand what Fraud and Bribery involve, and how we can protect against them.	01/06/2021	01/06/2023	
Cyber safety	This mandatory course will help you protect yourself from cyber attacks and criminals. It is based on recognised security practices and the types of attack we've seen at the University of Sheffield.	01/06/2021	01/06/2022	

Protecting personal data	This mandatory course will teach you the basic skills needed to process personally identifiable data. Processing personal data is an essential part of university work but we must do it safely.	01/06/2021	01/06/2023	
PGA in Health Professionals Education course	Experts in the fields of sexual and reproductive health and medical education deliver this quality-assured course in medical education as part of courses offered by the University of Keele. The unique course is designed to support you to achieve FSRH Registered Trainer status.	01/05/2018		30
MED6950 Research Training – Literature Review	Part of the DDP for MDH at University of Sheffield. This unit allows the student to conduct a comprehensive literature review specifically focused in the area of their research project.	10/04/2018		
MED6960 Research training	Part of the DDP for MDH at University of Sheffield. You will master a number of basic laboratory skills, including those related to safe working in the laboratory. You will be expected to keep details of their laboratory work (laboratory notebooks) and a log of related activities (seminars attended, skills developed, training received, safety courses attended).	10/04/2018		

SRA course - Writing up qualitative research	This is an intermediate course run by the Social Research Association. It is essential that participants are already familiar with the principles and practice of thematic analysis, including data management and categorisation, or have attended the SRA qualitative analysis course.	08/02/2018		
SRA Qualitative Data Analysis course	The overall emphasis of this course is on the interpretive and thematic analysis of qualitative data, as a generic form of analysis. Qualitative research generates a phenomenal amount of data, and it can be overwhelming at times knowing how to deal with it. Similarly, data analysis approaches are diverse, sometimes confusing and overlapping, and are not always clearly defined in terms of the steps required to achieve rigorous and reliable results	11/10/2017		
FCM6100 Research ethics and integrity	This unit is to encourage PGR students to critically analyse/reflect on their own actions and behaviours in conducting research and in their interactions with research participants, supervisors, and co-workers and to heighten PGR students' ethical sensitivity and reasoning, enabling them to plan and prepare for challenges they may face	30/06/2017		

	and to be able manage challenges in an ethical way.			
HAR6531 Qualitative research design and analysis	Part of the Clinical Research Msc at SchARR University of Sheffield. This module aims to provide a comprehensive introduction to key terms and concepts that underpin qualitative research design and analysis, with reference to the discipline of health services research and public health.	01/06/2017		15
HAR6051 Practical aspects of research	Part of the DDP for MDH at University of Sheffield.. Part of the Clinical Research Msc at SchARR University of Sheffield. To equip students with the knowledge and skills required to plan, undertake and complete a research project within clinical or health related settings.	01/06/2017		30
Good Clinical practice	GCP is the international ethical, scientific and practical standard to which all clinical research is conducted. Compliance with GCP provides public assurance that the rights, safety and wellbeing of research participants are protected, and that research data are reliable.	06/03/2017		



Study Number: **220726**

PARTICIPANT CONSENT FORM

Title of Project: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.

Name of Researcher: Dr Rebecca Mawson

Please initial

box

1. I confirm that I have read and understand the information sheet dated 4.7.17.

(version 3) for the above study. I have had the opportunity to consider the

information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time,

without giving any reason. This will not affect my legal rights or clinical care in

any way.

3. I understand that the data collected during the study may be made available to

responsible individuals from the University of Sheffield, regulatory authorities or the NHS Trust, where it is relevant to my taking part in the research.

4. I understand that the information from this study may be published in research journals

and anonymous quotes may be used

5. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed, 1 copy for patient; 1 copy for researcher site file; 1 (original) to be kept in medical notes

Participant Information

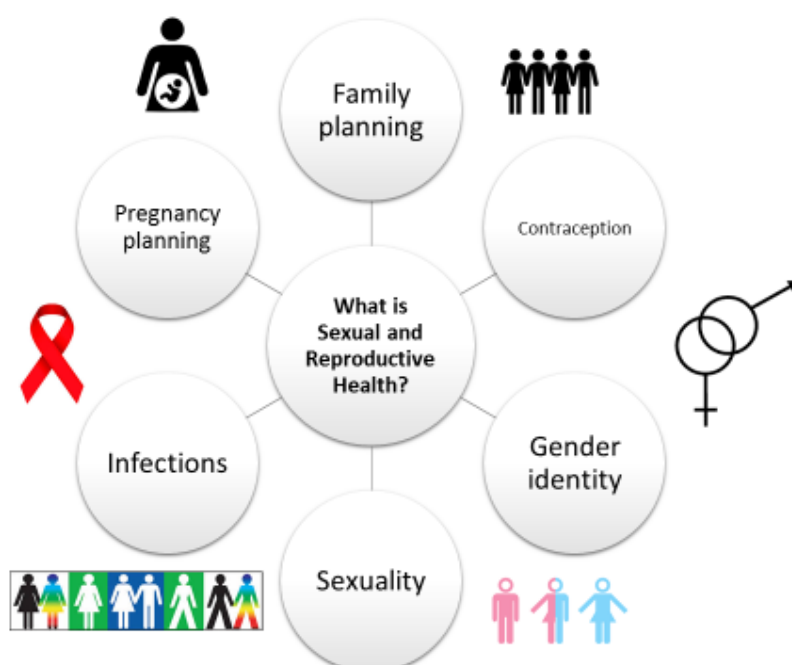
Sheet – members of the public

Study title: What do you think are the good and bad things about your general practice offering sexual health and contraception services?

(Research Title: Determining the barriers and facilitators for general practice to address inequalities in sexual and reproductive healthcare access and uptake from the patient and provider perspective.)

We want to know what you think

You are invited to take part in a research study about sexual and reproductive health (explained below).



Before you decide if you want to take part - you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully - talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

13. What is the reason for the study?

Sexual and reproductive health has often been provided in hospital run clinics but due to cuts to these services we are looking at ways to provide it from your own family doctor. Many people already go to their own GP for services but others find it more difficult. We want to understand this better and then make changes which might make it easier to get the services you want.

14. Why have I been invited?

We are looking for members of the public who might have used services in their GP or hospital sexual health or family planning clinic. We are also looking for people who have never used services but might one day in the future. *Up to 25 people will be invited to participate in the study.*

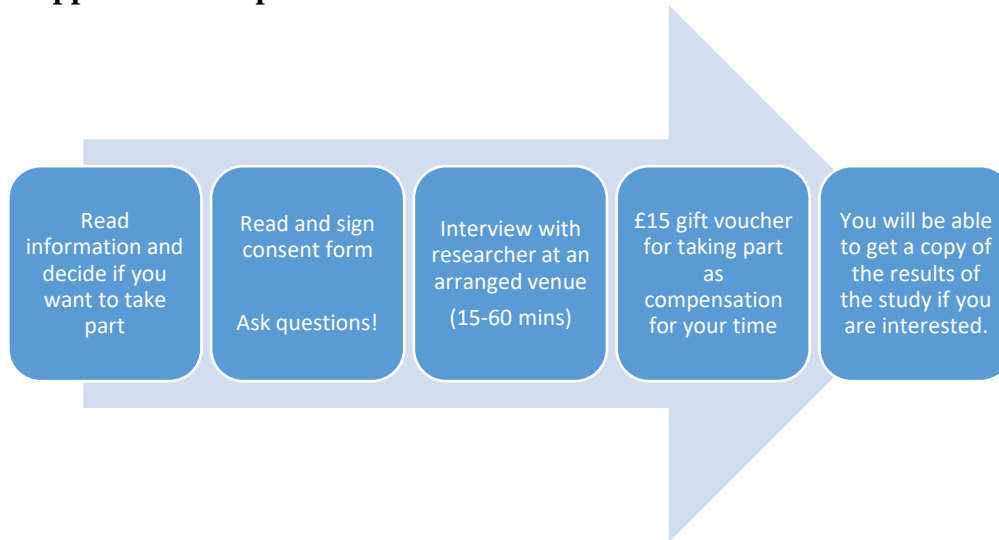
15. Do I have to take part?

No. You can stop at any point and you can ask to have your interview deleted.

16. What type of study is this?

This is an interview study where you will be asked a few questions and then we will look at everyone's responses to see if there are important ideas that come up.

17. What happens if I take part?



18. What will I have to do?

You will be asked a little bit about your background and if you have accessed any of the services we mentioned. We will then talk through some made-up stories of people, thinking about what good and bad things they might feel seeing their GP. We offer a £15 shopping voucher to thank you for taking part and giving up time.

The interview will be recorded on an audiotape and then written up by a typist who will remove personal details.

19. What are the possible disadvantages and risks of taking part?

In the interviews we will discuss a range of made up stories about issues people have had and ask for you to comment on what you think might have been good or bad about the situation. The stories might include contraception, pregnancy problems, sexually transmitted infections, sexuality and gender related issues.

Some of the questions in the questionnaire may be about certain topics which you find sensitive or you don't wish to answer. If this happens you can skip the story.

If something comes up in the discussion that makes the interviewer worry about your safety or the safety of people around you, then it is their responsibility to raise this as a safeguarding issue with appropriate organisations. This is unlikely as we do not expect you to talk about your own personal experiences.

20. Will my taking part in this study be kept confidential?

- Your name and details will be removed - anonymous
- Information will be stored under lock and key or secure passwords if on computer
- Only authorised people will be able to see your information
- We will only use this information for this study – if we wanted to look at the interviews again we would have to go to a special meeting.
- We will not inform your GP of you doing this study

21. What will happen to the results of the research study?

We plan to share the study results with other people who work in the area, this might be through writing in journals or at conferences.

Your name and details will not be put in these but we might use some quotes from you. You will not be able to be identified from these.

We will post a copy of the overall results to yourself and invite you to come to a public event for a presentation and thank you.

22. Who is organising and funding the research?

This research is being funded by the National Institute of Health Research and Royal College of General Practitioners.

23. Who has reviewed the study?

All research in the University of Sheffield is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by University Ethics Committee.

24. What if there is a problem? The small print!!

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the head of department, Professor Christopher Burton. Details below.

Specific information about this research project

Dr Rebecca Mawson (GP and researcher)

C/o Peggy Haughton

Academic Unit of Primary Medical Care

University of Sheffield

Sam Fox House

Northern General Hospital

Herries Road

S5 7AU

Sheffield

Tel: 0114 222 2201

Email: r.l.mawson@sheffield.ac.uk

Who you should approach if unhappy with the study

Prof Chris Burton (Head of department)

C/o Peggy Haughton

Academic Unit of Primary Medical Care

University of Sheffield

Sam Fox House

282

Northern General Hospital

Herries Road

S5 7AU

Sheffield

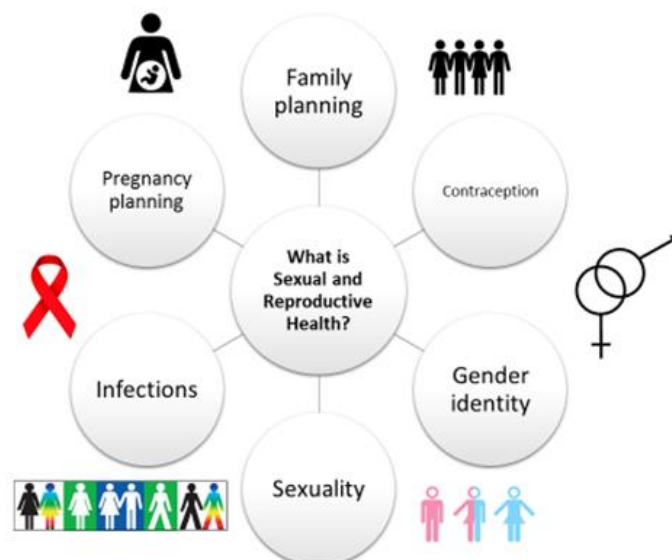
Tel: 0114 222 2201

Email: chris.burton@sheffield.ac.uk

Case studies

The topics being discussed during this research are sensitive and participants might have personal or cultural issues related to different aspects.

These 6 cases have been developed to look at a range of sexual and reproductive health issues. Not all the cases will be suitable for all groups. Initial work has already been undertaken with community groups to better understand cultural issues such as gender, sexuality and religion which might make certain cases uncomfortable or too sensitive. The researcher will have a basic understanding of these issues and select appropriate cases. Ongoing public participant involvement work will aid this.



Jolene – 25-year-old woman

Jolene had a baby 4 weeks ago.

She has two other children who are 4 years old and 7 years old.

She does not want to have any more babies.

Her partner works full time and Jolene does not drive.

- What could Jolene do next?
- Could she see her GP or nurse for contraception?
 - what are the good things about her seeing her GP/practice nurse?
 - what are the bad things about her seeing her GP/practice nurse?

Sara – 20-year-old woman

Sara has a partner and they have been using condoms for contraception.

The condom broke last night and she is worried she might get pregnant.

She might think about using something else other than condoms.

- What could Sara do next?
- Could she see her GP or nurse for help?
 - what are the good things about her seeing her GP/practice nurse?
 - what are the bad things about her seeing her GP/practice nurse?

Jeya – 16-year-old woman

Jeya has been seeing her boyfriend for a few weeks and he wants her to have sex.

She wants to be on something to protect her from pregnancy.

She also worries about getting infections.

- What could Jeya do next?
- Could she see her GP or nurse for help?
 - what are the good things about her seeing her GP/practice nurse?
 - what are the bad things about her seeing her GP/practice nurse?

Zeyd – 45 year old man

Zeyd was born in East Africa and moved to the UK 10 years ago.

He recently found out that an old friend of his has been diagnosed with HIV.

HIV is a virus (infection) which lives in the blood and can be passed from person to person through contacts such as during sex, blood sharing and from mum to baby.

He is worried as he has never been tested.

- What could Zeyd do next?
- Could he see his GP or nurse for help?
 - what are the good things about him seeing his GP/practice nurse?
 - what are the bad things about him seeing his GP/practice nurse?

Joseph - 55 year old man

Joseph is gay and married to his partner Steve.

Joseph noticed some weight loss and that there is blood when he goes to the toilet to pass a motion. He also has tiredness and weakness.

He is worried that it might be something bad but is worried about talking about his sexuality to the GP.

- Does the GP need to know about his sexuality?
- Could he let the GP know – is it relevant?
 - what are the good things about her seeing his GP/practice nurse?
 - what are the bad things about her seeing his GP/practice nurse?

Steven – 35-year-old trans-man

Steven underwent transition surgery 5 years ago.

He has recently received a letter from the cervical screening programme requesting he attend.

He still has a cervix and would like to maintain his health screening.

- What could Steven do next?
- Could he see his GP or nurse?
 - what are the good things about him seeing his GP/practice nurse?
 - what are the bad things about him seeing him GP/practice nurse?

Appendix 17 – Nvivo codebook interviews

Name	Description	Files	References
Candidacy framework		0	0
1 Identification		18	55
Appropriate services		9	16
Confidentiality		5	7
Behaviours change		1	1
Knowledge		9	17
Not a priority		8	10
Risk		4	7
Taboo		13	25
2 Navigation		17	46
3 Permeability		17	47
4 Appearing and asserting candidacy		14	36
Choosing a consulter		2	3
Opener		6	9
5 Recognising and accepting		20	107

Name	Description	Files	References
Normalisation of offer		9	16
Practitioner dependent		5	6
Promotion or prioritising SRH		6	8
Tailoring consult to recognise candidacy		1	1
6 Offers or resistance to services		5	5
7 Operating conditions and local production of candidacy		17	47
GP capacity		4	5
Staffing		1	1
Time pressure		1	1
Other concepts		0	0
Awkwardness		1	1
Assumptions		1	2
BAME		14	50
Language		2	2

Name	Description	Files	References
Competing priorities in general practice		5	8
Female disempowerment		11	29
Ambivalence		7	10
Gap in social capacity		5	5
HIV		11	15
Holist care - whole person care		2	3
Homeless		1	2
How do you improve services		11	11
Interpreters		5	10
Known unknown		1	2
LGBT		14	24
Male Doctor		9	11
deskilled		1	1
Patient - doctor relationship		8	15

Name	Description	Files	References
silos		1	1
Practice demographics		19	28

Appendix 18 – COREQ checklist

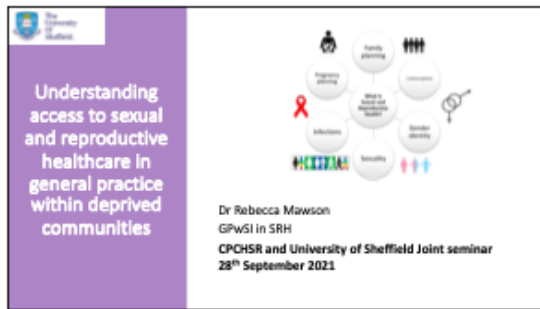
COREQ (Consolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

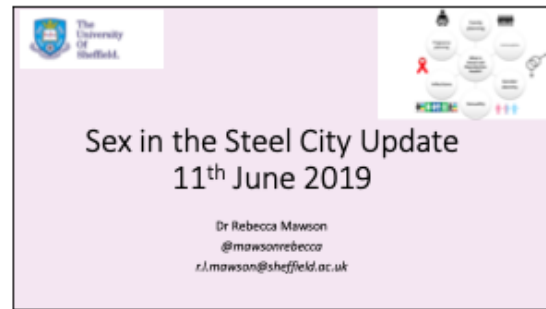
Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	111
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	111
Occupation	3	What was their occupation at the time of the study?	111
Gender	4	Was the researcher male or female?	111
Experience and training	5	What experience or training did the researcher have?	111
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	119
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	119
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	119
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	89
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	110
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	110
Sample size	12	How many participants were in the study?	126
Non-participation	13	How many people refused to participate or dropped out? Reasons?	126
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	111
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	111
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	126
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	109
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	109
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	109
Field notes	20	Were field notes made during and/or after the interview or focus group?	119
Duration	21	What was the duration of the interviews or focus group?	111
Data saturation	22	Was data saturation discussed?	102
Transcripts returned	23	Were transcripts returned to participants for comment and/or	102

Appendix 19 – Research presentations

I have done a range of research presentations over the last 5 years.



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Project update – joint supervision meeting

- 23/01/18
- Medical school
- Recap
- Current ideas around framework
- Progress update

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Appendix 20 - Plans for disseminating the findings of this research

There are five key audiences for this research, these are:

- A. commissioning organisations (such as Clinical Commissioning Groups, Commissioning Support Units and NHS England)
- B. General practice
- C. The public
- D. External statutory organisations (such as Department of Health, Faculty of Sexual and Reproductive Health, Primary care women's forum, The Lowdown)
- E. academia

From research evidence we know that research is most effectively disseminated using multiple vehicles, ideally with face-to-face interaction. Dissemination activities will include:

- Lecture/presentation at University of Sheffield (all)
- Plain English summary report – translated and visual. (C,D)
- Use of electronic media such as websites and social media such as Twitter/Instagram/TikTok (A,B,C,D)
- Webinar and video (Youtube/TED) (C)
- Publications in peer reviewed journals (E)
- Conference presentation (abstract submitted WONCA/RCGP 2022)(A,B,E)

Planned publications in peer-reviewed journal.

1. Using an adapted candidacy framework to understand access to sexual and reproductive healthcare (SRH) in general practice
2. Perceptions of barriers to access of SRH services in general practice: the views of GPs and practice nurses in high deprivation communities