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Understanding access to sexual and reproductive health in general practice using an adapted Candidacy Framework; a systematic review and qualitative evidence synthesis

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Abstract

Background

General practice has a key role in reducing inequity in access to sexual and reproductive health (SRH). Unplanned pregnancy, abortion and STIs are increasing and disproportionately affects deprived communities and ethnic minority groups. The candidacy framework offers a practical, theoretical framework for understanding the complex interactional processes of access to SRH in general practice.

Aim

To use the candidacy framework to explore access of SRH in general practice. The seven interaction stages include, identification of need, navigation of services, permeability of services, appearing and asserting need, adjudication by healthcare professional, offers or resistance of offer and the local operating conditions or local production of candidacy.

Design and setting

This study involved a systematic review with qualitative evidence synthesis using a framework approach.

Methods

A systematic search of MEDLINE, EMBASE, PUBMED, and the Web of Science was conducted to identify primary qualitative research studies exploring access to SRH in general practice from practitioner, public, and patient perspectives in countries with universal healthcare. The candidacy framework was used to synthesise the findings.

Results

Analysis of 42 studies revealed the impact of stigma, shame, and embarrassment among individuals, communities, and healthcare practitioners. Findings showed limited inclusion of demographics such as ethnicity and socio-economic status. Barriers to access were more evident for those from lower socio-economic communities, ethnic minorities and LGBTQ+. There are multiple barriers, which include the behaviours of

Accepted Manuscript–BJGP–BJGP.2024.0522

healthcare professionals who have a crucial role in recognising an individual's SRH need.

Conclusions

General practice offers a cradle-to-grave healthcare service, which should have SRH as a priority area of provision. Further understanding is needed of the impact of historic harms by medicine and healthcare on racialised individuals and gender minorities.

Accepted Manuscript–BJGP–BJGP.2024.0522

How this fits in

- Health practitioners can be an obstacle to access. Helping healthcare professionals understand personal belief systems that affect access is key to improving recognition and acceptance of candidacy. Further understanding of the complexity of decision making and choice need to be understood when planning policy.
- Stigma, shame, misinformation and fear are still persistent issues in society and the medical profession in terms of SRH. The historic legacy of harm within SRH services and provision must be better understood in order to repair the structural barriers to healthcare.
- Access to SRH in primary care is complex, and it takes root in education, empowerment, and communication. Primary care is the mainstay of contraceptive care in the NHS, but other groups, such as those from the LGBTQ+ community or people living with HIV, are often made to feel silenced or excluded.
- Published primary research studies must include the ethnicity or socio-economic status of participants. Underserved and under-represented communities are being failed by this lack of visibility and inclusion in medical research.

Accepted Manuscript–BJGP–BJGP.2024.0522

Background

Sexual and reproductive health (SRH) affects everyone at some point in their life, whether that be family planning, contraception, safe sex or relationships. The UK has seen a reduction in funding of SRH services within the context of increasing rates of sexually transmitted infections (STI) and high unplanned pregnancies and abortion rates (1,2). Within the broader context of Europe, SRH is provided by various providers, with responsibility falling within different specialities(3). This is predominantly in general practice in the UK and Netherlands, with Sweden and Portugal providing community health centres. Gynaecologists working at a primary care level offer services for women in Germany and Poland, primary care providers for men. In the UK, 59.1% of contraception and 17.2% of chlamydia screening is provided in general practice, yet services are variable and inconsistent between surgeries(4,5).

The COVID-19 pandemic has led to further challenges in access to SRH, as seen in other areas of healthcare(6,7). NHS Digital Data has shown a fall in long-acting reversible contraception (LARC) prescriptions (Intrauterine devices, implants and injections) in GP surgeries since COVID-19(8). In 2021, there were 214,256 abortions for women in England and Wales, the highest since the Abortion Act was established in 1967(5). Abortion rates in the UK are higher compared to other high-income countries; a recent report by the British Pregnancy Advisory Service (BPAS) found key factors such as the cost-of-living crisis, accessibility of abortion, and contraception acceptability(9). The highest burden of poor access and adverse outcomes fall on patient groups marginalised by sexual orientation, gender and transgender status, minoritised ethnicity, socioeconomic deprivation and especially young age (adolescence)(10–13). Similar patterns are seen across Europe and North America, with worse outcomes for underserved populations such as migrant women, black and ethnic minority groups and LGBTQ+ communities(14–16).

There are a range of conceptualisations of healthcare access, and some focus on the supply of services meeting the demand of service users; when supply equals demand, access is no longer an issue(17,18). Levesque developed a holistic conceptual framework based on broader definitions of access to and accessibility of healthcare services(19). Unfortunately, using narrow interpretations of access can lead to lack of clarity about various services and the groups seeking to access them. Choice can easily be simplified into the concept of an individual decision. Policies driven at improving

Accepted Manuscript–BJGP–BJGP.2024.0522

range of choice, for example contraception, may not improve uptake because there are far wider influences at play than availability(20).

Dixon–Woods and colleagues developed the concept of 'candidacy' in 2005 from a literature synthesis focused on studies exploring inequalities in healthcare access and utilisation (21). The dynamic and inter-relational stages help to show granularity of access to primary care which has become a contentious political subject(22). Candidacy offers a framework to conceptualise help-seeking, healthcare structure and access, as described in box 1 (23,24).

Box 1. Candidacy as defined by Dixon-Woods (24)

Candidacy *describes the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services. Candidacy is a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals, and managed in the context of operating conditions, including the biography of the relationship between patients and staff, the typification's staff use in categorising people and diseases, availability of resources, local pressures, and policy imperatives.*

The candidacy model has been used previously to explore a range of topics including, colorectal cancer(25), asthma management in South Asian community(26), domestic violence(27) and medical homelessness for women in prison(28). It has not been used to examine SRH in primary care. A limitation of the candidacy model is that it neglects the influence of wide contexts in which healthcare is accessed, the historic shaping of medicine which impacts trust and willingness to seek care. For racialised groups and gender minorities, these intersectional factors lead to worsening disparities and inequity of access(29).

Access to SRH in general practice is vital to ensuring equitable and accessible provision of SRH to all. There has been extensive publication of barriers and facilitators to the provision of SRH with barriers including communication challenges, stigma, personal belief systems, and lack of time/knowledge/equipment(30–32). Studies focus on specific topics such as abortion, sexuality or communication. There is a lack of research

Accepted Manuscript–BJGP–BJGP.2024.0522

on access to SRH services in primary care with an umbrella lens of all areas of SRH within this context. Using a framework approach with the highly salient candidacy model allows us to clarify overlapping pathologies and often challenging contexts.

Methods

A systematic evidence synthesis using a 'best fit' framework, as described by Carrol and Booth, was selected for this research(33). Framework synthesis was chosen over other forms of synthesis because of the complexity and heterogeneity of the data, which required a structural analysis(34). A scoping review was performed to find models or theories of access to healthcare. The candidacy framework was identified as the *a priori* framework for the synthesis. Cochrane guidance was used for quality evidence synthesis (QES) and followed the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) checklist(35,36).

An example of these stages are summarised in table 1.

Table 1 - Candidacy framework described in the context of SRH, adapted from Dixon-Woods (21,23)

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.	*Identifying need for an STI screen due to unprotected sex.*
Navigation of services	A persons awareness of what services are available and ability to mobilise practical resources or assets needed to attend service	*Taking time off work to travel on 2 buses to get to central sexual health clinic for an STI screen.*
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.	*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.*
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.	*A person asking for condoms in a GP appointment.*
Adjudication	Healthcare professionals judging worthiness of the candidacy claim and Interlinks with perceived social deservingness.	*GP not suggesting an implant as contraception method as they have been unreliable attending appointments in the past.*
Offers of/resistance to services	An intervention or treatment course has been offered but declined by the person in need.	*Declining offer of cervical screening when in for a practice nurse health check.*
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	*GP turning a patient away when they ask for an HIV test as perceived as not funded in primary care.*

Accepted Manuscript–BJGP–BJGP.2024.0522

Selection criteria

The review sought to identify primary qualitative research completed in high-income countries as defined by the Organisation for Economic Cooperation and Development(37). The searches were limited to the English language and full-text papers. Case reports, reviews and conference abstracts were excluded. The publication date was limited to the last 25 years, the rationale being that the National Institute for Health and Care Excellence guidance for LARC was published in 2005, leading to the widespread use of more modern methods(38). Inclusion and exclusion criteria are shown in Table S1.

Search strategy

The following electronic databases were searched initially in 2018 and then updated in July 2024: MEDLINE, EMBASE, PUBMED and Web of Science, date range 2000-2024. Results were compiled using the reference manager, Mendeley® and imported into systematic review management software, Covidence® (approved by Cochrane)(39). Key domains included ([general practice] OR[practice nurse]), AND ([contraception], OR [sexually transmitted infection]), but the full electronic search strategy, including MESH terms, is included in S2. RM and VH independently screened abstracts and conducted full-text reviews according to the inclusion and exclusion criteria. After discussion within the team, certain potential subjects were excluded, not because they are unimportant but because of the number of publications within the topic. This included abortion and sexual dysfunction. We made a pragmatic decision to exclude to make the data manageable.

Conflicts were resolved through discussion (RM, VH, CM). Figure 1 shows the Prisma diagram of the included studies.

Figure 1. Prisma diagram.

Quality summary

Quality assessment of 59 full-text papers was done using the Critical Appraisal Skills Programme (CASP) Tool for qualitative studies(40). Three people (RM, VH, CM) reviewed the full-text papers independently. All included studies were judged to have taken steps to reduce bias; some did not have sufficient details to meet all CASP criteria.

Accepted Manuscript–BJGP–BJGP.2024.0522

However, in the discussion as a research team, they were included as they brought rich themes for analysis (35).

Charting the data: summary and synthesis

Two approaches were used to chart the data; summary and synthesis. Firstly, the data was extracted from the full-text articles using Nvivo®, a qualitative analysis software package (CAQDAS)(41). The background and methodological information was identified using criteria adapted from Cochrane guidance (42). Framework analysis was used to explore the data with themes discussed by all authors(43). This consists of five stages: familiarisation, identifying a thematic framework (in this case, candidacy), indexing, charting, mapping, and interpreting(43). Initially, themes were coded against the existing stages of the candidacy framework. Within this synthesis, the viewpoints of healthcare professionals and members of the public were both included to draw similarities and differences. The demographic and diversity analysis of participant characteristics was analysed using an Excel® database.

Results

Forty-two qualitative studies were identified, this included results from Australia (n=9), Canada (n=1), England (n=20), Ireland (n= 2), Germany (n=2) Norway (n=1), Netherlands (n=1), New Zealand (n=2), Scotland (n=2), Great Britain (n=1) and UK (n=1). Participants included healthcare practitioners (HCPs), members of the public or services users. Some included views from more than one group. Table S2 summarises the included studies.

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, 11 of the 20 non-HCP studies described participant ethnicity.

Accepted Manuscript–BJGP–BJGP.2024.0522

1 One of the 20 studies included a focus group in Punjabi (44) which was conducted by a
2 bilingual researcher. Three of the 20 studies specifically excluded participants who
3 were not proficient in English(45–47). Nine studies mentioned they used purposive
4 sampling to increase diversity of ethnicity and/or deprivation(47–55). Education level
5 or occupation was sometimes used as a proxy representation of social status. Four
6 studies included occupation, employment status or income of the participant(45,55–57),
7 and three studies included educational background(44,55,58).
8 Study characteristics are presented in Table S3.

Accepted Manuscript–BJGP–BJGP.2024.0522

The results are presented using the seven stages of the candidacy framework. These are not distinct stages and have overlapping and interacting relationships. A visual representation of the analysis can be seen in Figure 2.

Identification of candidacy

The first stage of the candidacy framework is identification of a health need(21).

Self-recognition of SRH need

Self-recognition of an SRH need was reliant on several factors. Knowledge of SRH was the predominant barrier to seeking care and is crucial to the identification of candidacy. Individuals need a certain level of health knowledge to understand the risk of STIs, pregnancy prevention and safe sex. Stigma and shame form dominant themes, leading to a lack of discussion about SRH health, which is a taboo subject among many communities (49,50,55,60,61,63,74). This highlights the unique impact of socio-cultural contexts on access.

> *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) (Heritage 2008)*

Blame prevented people from seeking diagnosis and care, both to avoid being blamed themselves for their 'risky' behaviour or blame others who may have caused their condition. There was also a fear of negative consequences, which made people not wish to seek a diagnosis due to anticipated implications for themselves and others(50).

Service recognition

Identifying accessible, acceptable, and effective healthcare relating to the SRH need is essential. For the individual to self-identify to a service, it must be acceptable to their personal demographic and personal needs. Confidentiality or perceived confidentiality is a vital aspect of this(55,56). The review 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

Accepted Manuscript–BJGP–BJGP.2024.0522

suitable GP(51). This highlights the need for inclusive and open services which people can identify with.

> *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)(Keogh 2016)*

Whilst some participants preferred to access services via the relative anonymity and accessibility of general practice where you can attend with any health problem compared to sexual health clinics, others feared the lack of confidentiality especially if from smaller communities in rural areas(74).

Navigation of candidacy

The second stage of the candidacy framework is navigation of services which refers to the process of seeking to assert candidacy(21,23). Navigation requires an understanding of what services are available and the ability to mobilise practical resources to access the service. For younger people, navigating sexual health services can be challenging. Young people may lack SRH service knowledge and practical resources such as transport. They may therefore rely on parents, family members or peers to help them access care. Primary care seemed to have less barriers to access in terms of practical resources needed such as transport, ability to leave school or work, need for childcare.

> *I was told to be at the clinic 90 minutes before they started testing at 1 pm but I was there an hour early. They'd given out all the tickets at 11.30 am so I was too late. I then asked about the the other hospital clinic and was told about the six week wait. (Male/MSM/late 20 s/-) (Balfe 2009).*

Barriers such as missing work, travelling to sexual health clinics and travel costs were evident (60,64,83). SRH was a lower priority in individuals' lives, especially in the context of deprivation. Other priorities such as childcare, work, benefits, substance misuse and probation are more imminent. The idea of only accessing a GP when unwell was a predominant theme throughout the literature. Burns concluded their discussion

Accepted Manuscript–BJGP–BJGP.2024.0522

that *'Health is only a priority when one is unwell; otherwise, issues around immigration, housing, employment, and childcare take precedence'*(64). This highlights the challenges people have prioritising health, especially when they are well and have other demands or priorities.

Permeability of services

Permeability is understood as the ease with which people can use services (21). The notion of permeability had clear resonance in the studies reviewed, with over half mentioning barriers around getting an appointment in general practice(83). Drop-in services are a way of improving permeability.

> *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) (Sutcliffe 2011)*

One area where issues around the permeability of services were very apparent is in HIV care, a condition that needs chronic disease management.

> *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) (Keogh 2016)*

There was evidence that some general practices were helping permeability of services for HIV patients by identifying them and 'fitting them in' for an appointment. Most people living with HIV will have a GP and a specialist, one paper described individuals feeling a 'ping-pong' between services(51,64).

Appearances and asserting at health services

This refers to the ability to self-present, communicate and articulate the 'need' or issue to a healthcare professional(21). Twenty studies referred to appearing or asserting oneself. The overarching theme through these studies was about discordance or disparity between patient and consulter. Gender and age of the HCP compared to the patient were highlighted as barriers to asserting candidacy in several studies.

Accepted Manuscript–BJGP–BJGP.2024.0522

I think there are always difficulties (. . .) that the patient is willing up to open and address issues, fears, worries, needs, and also an erectile dysfunction or loss of libido (. . .)(GP) (85)

The term stigma has been used to encompass a range of different barriers, including shame, fear of judgement, fear of consequences and embarrassment (49,50,55,60,61,63,74).

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) (Latreille 2014)

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) (Woodbridge 2015)

Language was a barrier to discussion. Two sub-themes emerged. Firstly, how language and terminology might cause confusion and misunderstanding(76). Secondly, that language can cause offence or make people feel excluded, the use of slang terms leading to misinterpretations(84).

it's knowing how to deal with that [misgendering someone] 'cause some things that you are not so used to doing, you know and that's where I think we need more support, so we know how to do these things, you know, otherwise it doesn't come across too good. (Practice nurse)(66)

Patients will make a judgement about whether they can trust the HCP they consult with.

"Trust..so I do say to them that it's confidential, whatever you say won't be shared with anybody else, but I think there's still that bit of concern if it is an Asian Nurse or Muslim nurse. They will be like 'shall I tell her, shall I not tell her… we don't..am not sexually active,' but they are sexually active because they are coming for a pill, the morning after pill, they are coming for some other things as well, so.. (Practice Nurse)(41)

Accepted Manuscript–BJGP–BJGP.2024.0522

Adjudication by HCP

This theme explores adjudication or judgements of worthiness by HCPs which have an influence on subsequent management and intervention(20). Twenty-nine of the studies contained themes related to adjudication, predominantly around LGBTQ+ issues and stereotypes of age and ethnicity.

[…] because she (the woman) is usually a bit more sensible, I hope she says: 'Hey, you, remember, do you have the condoms with you?' (GP female, 52 years)

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(61).

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) (84)

His attitude was that being gay was something that the Bible spoke against and perhaps I should reconsider my position. (Male, gay or bisexual) (Cant 2006)

There were many examples of HCPs having homophobic or transphobic views, with doctors and nurses feeling more comfortable managing intimate issues for heterosexual patients(44,61,73). 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(47). This lack of culturally congruent consultation and lack of confidence about how to deal with SRH in LGBTQ+ patients created a barrier to providing effective care(61,74).

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

Accepted Manuscript–BJGP–BJGP.2024.0522

relationship, I don't see it's appropriate. (Male GP, 50 years old) (Hincliffe 2005)

Offers and resistance to offer

This stage of candidacy focuses on the reasons why people might decline a service or an offer of treatment. This theme overlaps with previously mentioned themes such as stigma and fear of judgement. This includes fear of a positive result, for example, 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) (Normansell 2016)*

> *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) (Balfe 2010)*

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

Operating conditions and local production of candidacy

Local influences on the production of candidacy are important in relation to access of SRH services.

General practice specific

By far the most predominant barrier for access was time restriction of general practice, whether perceived or actual(50,56,59,62–64,67–70,76,77,81). There was a perceived lack of time in consultations due to competing demands to cover all health topics. In the tight time constraints of general practice, HCPs may avoid these taboo sensitive SRH subjects(50,56,85).

> *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*

Accepted Manuscript-BJGP-BJGP.2024.0522

it?...you don't sort of want to open up all sorts of thing? (Female GP, aged 50-59) (Gott 2004)

Both patient and HCP showed reluctance in discussing SRH as deemed not part of general practice or indeed whether it counted as a valid medical condition. A study looking at older women with diabetes explored this, women felt happy to discuss diabetes but awkward raising sexual topics(52). General practice offers the opportunity for a longitudinal relationship to form between patients and HCP. This impacts how comfortable people feel disclosing personal topics(56).

As well as time constraints being a barrier, loss of continuity in UK general practice challenges the ability to form cohesive longitudinal relationships with patients(65). With regards to patients with HIV in Keogh study, this cohesive longitudinal relationship helped them trust their GP and improved access(65).

Health service culture

Sexual health is still seen as a taboo and stigmatised area of healthcare, and secondary care services often having responsibility for its provision over primary care(56,61).

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) (Ma 2005)

The NHS is, overall, a heteronormative sphere where heterosexuality is the default(47,48). This makes it challenging for sexual minority groups who must negotiate discrimination(45,56,61). These assumptions about sexuality mean that patients might be silenced or deterred from access, especially when it regards an SRH need(45,47,48,74).

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) (McNair 2015)

The is a variation in how different practices provide SRH services. As health providers we often act reactively, for example with pre-conceptual health interventions, we often only become engaged when patient are already pregnant.

Accepted Manuscript–BJGP–BJGP.2024.0522

the reality is that I guess we're more reactive only and 'oh you're pregnant' and we rely on somebody else, some other unknown persons, to advise that woman on pre-pregnancy care. (practice nurse)(86)

There were examples of proactive practice behaviour (actively seeking people to screen and offer services), passive practice behaviour (not offering any services and not actively seeking people to screen) and reactive behaviours (where the practice or practitioner was happy to help if the patient raised an SRH issue)(54,59,60,70,75,76). This fragmented and variable delivery of care leads to inequality of provision.

Discussion

Summary

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. The review assimilated 42 studies with diverse topics. Participants included HCPs, service users, and members of the public. These diverse viewpoints help provide comprehensive perspectives of care journeys. The studies were from worldwide locations in high-income settings with various age groups.

The review 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 in the context of improved universal access to SRH via general practice by tackling issues such as confidence, language, stigma, taboo, knowledge, and literacy. It creates a better understanding of how individuals and healthcare providers are impacted by societal, religious and cultural belief systems when dealing with SRH. The impact of intersectionality was clear, disparities were layered dependent on individual and group identities(89). Those at most risk of poor SRH outcomes were those with combinations of discrimination and oppression.

Accepted Manuscript–BJGP–BJGP.2024.0522

Strengths and limitations

A strength of this synthesis was the rigorous critical appraisal throughout, with adherence to PRISMA guidelines for the systematic review and the use of the CASP checklist(87,88). The review formed part of a successful doctoral thesis that underwent peer review and critical appraisal throughout. Using 'best-fit' approach allowed for adaptation and development of alternative themes outside the *a priori* framework(31).
A limitation of the findings was the lack of diversity in ethnicity or inclusion socio-economically deprived communities in the published data. This is relevant as those with worse SRH outcomes are predominantly from ethnic minority groups(89). When ethnicity data was reported, a disproportionate number of young white people were included. This likely represents the challenges around recruitment and conducting qualitative research among this cohort(90,91).
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(92). In the USA, studies within the National Institute of Health must publish ethnicity, race and sex of participants to improve equity and representation(92). There is no similar requirement in the UK and Europe.
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.
There was a bias towards the perceptions of healthcare professionals, which might be explained by the challenges of recruiting patients and participants for sexual and reproductive health research(93,94).

Comparison with existing literature

This review highlights the importance of identifying needs in the candidacy journey. Crucial barriers are stigma, knowledge, and the ability to prioritise SRH.
This is evident with STIs, which are often asymptomatic, and therefore, preventative measures and screening is essential(72). For this to happen, the individual must have pre-requisite knowledge of infection to identify a need(42,95). Those at most risk of poor health outcomes will often find prioritising and mobilising the necessary assets

Accepted Manuscript–BJGP–BJGP.2024.0522

needed to access more challenging; this was well described in a paper on medical homelessness for women transitioning from prison(26).

The impact of socio-cultural context and religion was evident throughout the review. A systematic review of LARC views and experiences of ethnic minority women found similar findings, with external factors influencing choice(96). Acceptability or perceived adverse effects of contraception have also been found to impact uptake, with poverty and education playing a crucial role(97).

The local production of candidacy or operating conditions was also relevant when looking at access barriers in general practice. Critical barriers were time constraints, poor appointment availability, and time pressures. There was a sense that SRH topics needed more time and tact to discuss a sensitive subject area, and continuity of care was a key facilitator(98,99). Within the review there were different countries with varied health-care systems. These structural differences may impact provision of SRH. For example, the NHS is free at point of contact where as some insurance based systems may need initial financial outlay.

In the US, patients preferred physicians leading enquiries around SRH(100). Trust is an essential facet of communication, especially in this subject area. This links to the concepts of appearing and asserting candidacy. Paradoxically, healthcare professionals prefer a more passive consult with the patient-initiated discussion about sexual health, which concurs with current evidence(27,100,101). It seems common for providers to wait for patient initiative, while patients wish for providers to initiate conversations concerning SRH(27,29,100).

Implications for research and/or practice

Understanding access or use of healthcare services is complex and can be challenging to understand and research(102). Previous studies had looked at healthcare access in terms of utilisation, with an understanding that if a service is there, it will be used(17). Dixon-Woods offered the candidacy framework as a mechanism to better understand access for vulnerable groups(20).

We have an opportunity to improve inequalities in health in the post-pandemic era; targeting the patchy and fragmented provision of SRH is critical. There needs to be a focus on those for whom access is most challenging, particularly socio-economically deprived communities. This evidence synthesis formed the foundations of subsequent

Accepted Manuscript-BJGP–BJGP.2024.0522

projects which interviewed HCPs in high deprivation practices to better understand access barriers to care, this was presented in a policy document to highlight the need for focus on underserved populations(103). It further led to a participatory action research project exploring contraception access for those in racially minoritised groups(104,105).

Researchers and grant providers have a responsibility to proactively engage with people from communities often excluded from research. Examples include ethnic minority groups, high-deprivation areas, and LGBTQ+ communities. Without their input, research is not transferable, nor can it be used to develop widespread intervention or service change.

Conclusions

The candidacy framework offers a valuable tool for identifying a wide range of SRH barriers to access. It allows us to better understand the complexity of accessing SRH services from the perspectives of individuals, healthcare professionals, and services. We need to provide services that are culturally congruent and take account of the variation in health literacy, knowledge, and acceptability of contraception.

Improved reporting and inclusion of patients from minority ethnic groups and those from deprived communities is essential in future studies in SRH. If not included, they are invisible, and their issues are not understood.

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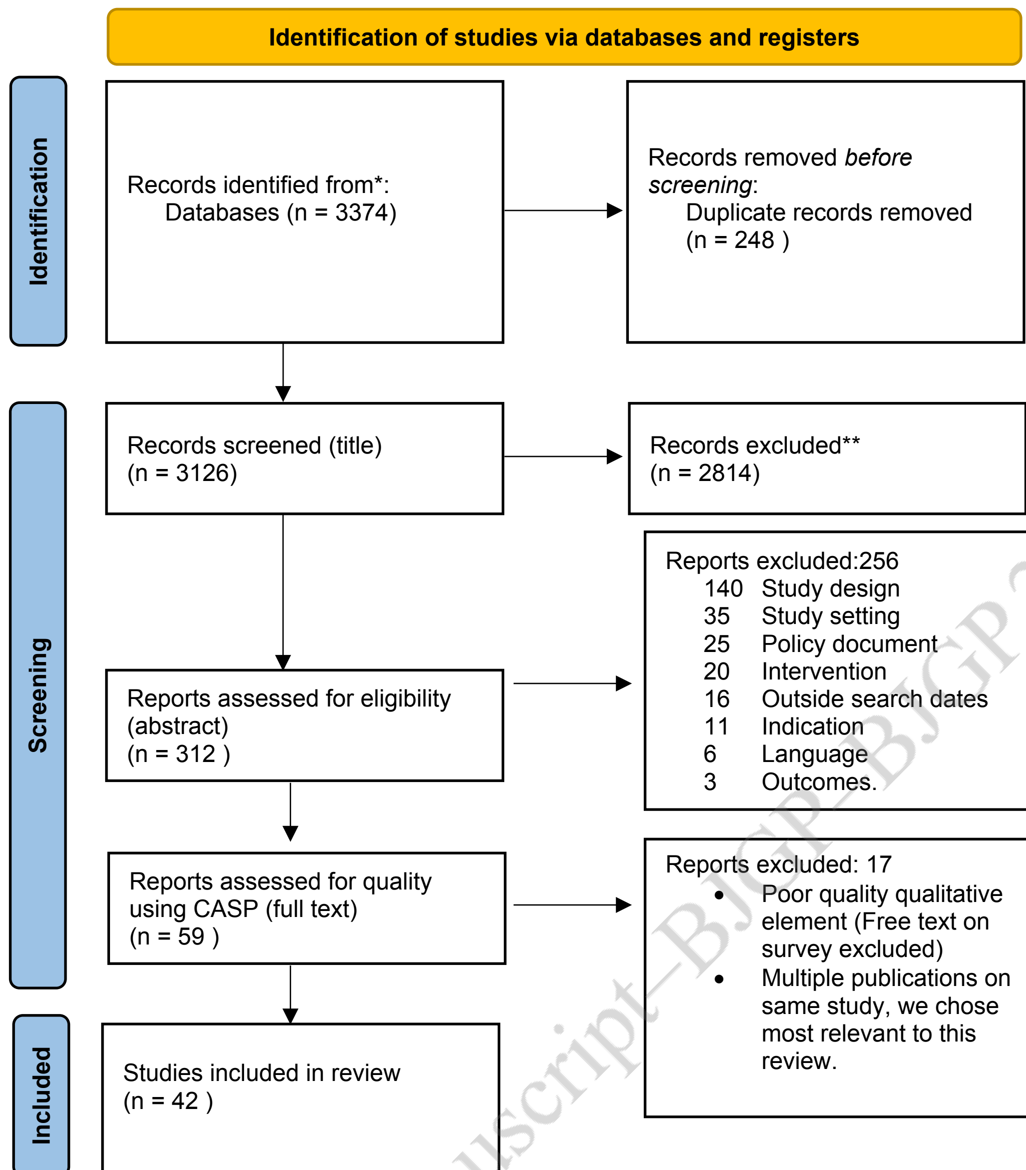
Accepted Manuscript–BJGP–BJGP.2024.0522

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

Accepted Manuscript–BJGP–BJGP.2024.0522

Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

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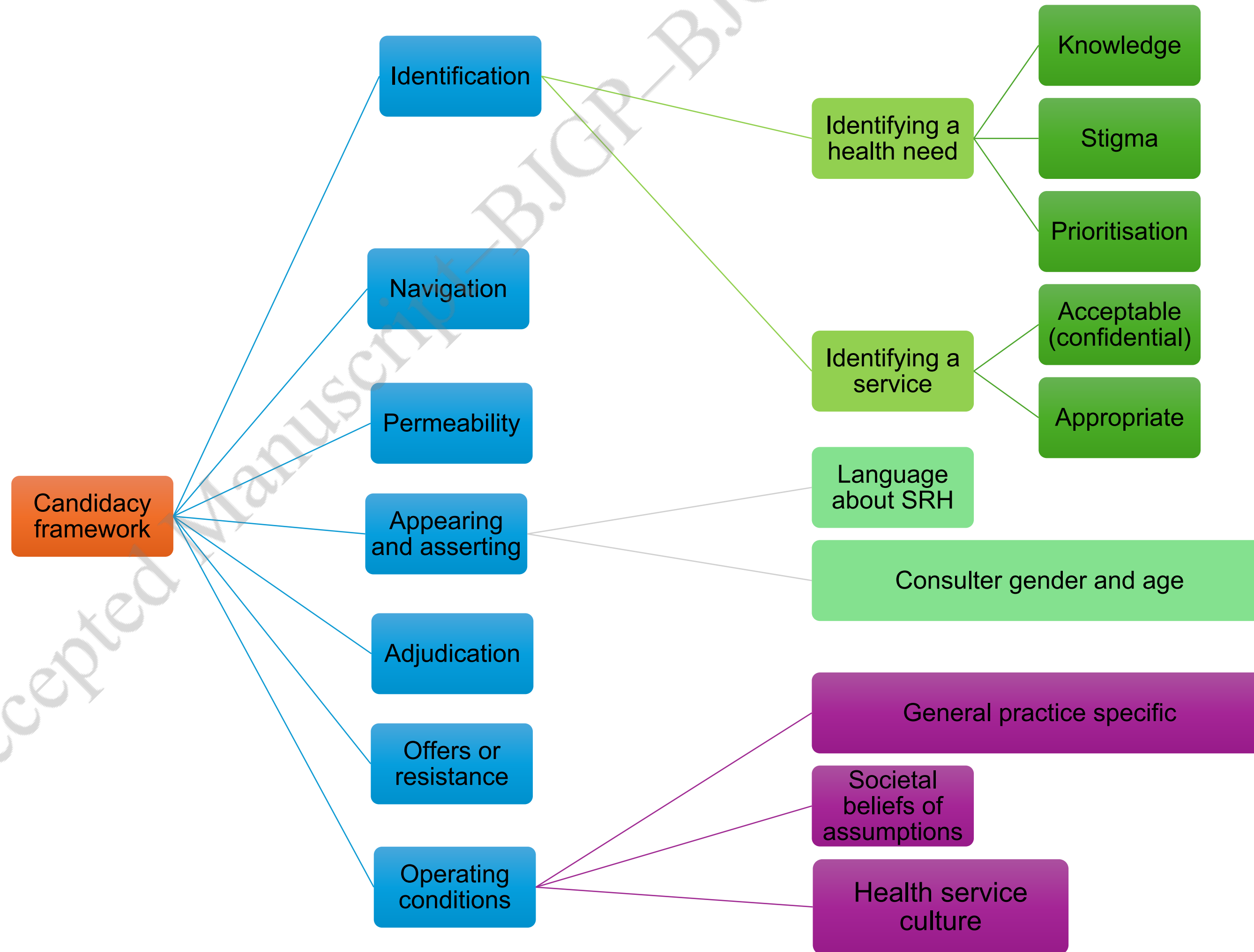
Figure 2 – Summary of candidacy themes developed in the synthesis.



Accepted Manuscript–BJGP–BJGP.2024.