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A qualitative exploration of how university students access sexual health services.

Lyndsay Hainey

Dissertation submitted for Master of Nursing Science, School of Nursing, Faculty of Medicine and Health Science, University of Nottingham

‘I declare that this dissertation is my own work’

Signed: Lyndsay Hainey        Date: 22/02/2011
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Abstract

Current trends show only a measured reduction in the number of newly acquired sexually transmitted infections despite an increase in the level of funding to sexual health services and more extensive sex education in schools (DH 2009b; DH2007a). Factors that influence and motivate vulnerable individuals to access sexual health services are key determinants in the reduction of sexually transmitted infections (Dixon-Wood et al, 2001). This study took a qualitative methodological approach to understanding how non-healthcare related university students access sexual health services. This included an exploration of the influences and motivations behind service access as well as participants’ suggestions for improvement to sexual health services. Such research is valuable in understanding the factors which influence service accessibility and the high prevalence of sexually transmitted infections within the student population. Data was gathered using a semi-structured, face to face interview process. A saturation of data was achieved after eleven interviews. Findings indicated that there were two key factors which influenced access to sexual health services: whether services allowed participants to retain control over their health experience; and services known for the non-judgemental attitudes of the professionals involved in service provision. Participants also suggested a number of improvements to sexual health services such as ensuring a greater commitment to the empowerment of service users and tailoring sexual health services to the individual. Several recommendations for future research and nursing practice were made to improve service uptake and the overall satisfaction of service users which is vital if individuals are to continue using sexual health facilities. Recommendations for nursing practice include providing mandatory sexual health training for service providers and granting greater service user autonomy. Recommendations for future research include investigating how the motivations of individuals who have never accessed sexual health services before compare to experienced service users.
Chapter 1:
Introduction
1. Introduction

Sexual health is “the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love”.

(World Health Organisation (WHO), 1974, p.06).

Sexual health is a socially complex issue which has traditionally been marginalised by both society and healthcare providers (White and Mortensen, 2003). Marginalisation and the implicit nature of sexual health stems from the historical perception of sexually transmitted infections (STIs), which on the whole were incurable and the cause of debilitating illnesses (White and Mortensen, 2003). Although today’s society would like to believe that we have since undergone a sexual revolution, whereby individuals today are afforded greater sexual freedom, it appears that the issue of STI prevention and treatment is still very much taboo (Grigg, 2000).

The issue of sexual health, education and STI prevention has come under increasing scrutiny in the last few decades predominantly because of the continued high levels of unintended pregnancies, abortions and contraction of STIs. Government statistics have shown that there is a particular prevalence in young people (Health Protection Agency (HPA), 2008a). Young people as defined by the World Health Organisation (1999) are individuals aged between 10 and 24 years old. In this age category it is the latter end of the chronological scale (ages 16-24), that appear at most risk (Office for National Statistics (ONS), 2009). When considering the rationale for such prevalence it is important to consider the context within which young people live. The majority of individuals in this age category will be in further or higher education which invariably exposes them to new experiences. One particular subgroup within this category which is especially vulnerable is university
students. Going to university grants individuals an unprecedented level of independence which enables them to be experimental and impulsive with their sexuality (Lear 1995; Paul, McManus and Hayes 2000). University life also invariably exposes individuals to drugs and alcohol, two factors synonymous with reduced inhibitions and risky sexual behaviours (Weinhardt and Carey 2000; Paul, McManus and Hayes 2000). Therefore it is unsurprising that levels of sexually transmitted infections are becoming increasingly prevalent within the student population.

Sexual health has clear implications for both physical and psychological aspects of wellbeing (Department of Health (DH), 2009a). Our earliest sexual and romantic experiences shape our emotional expectations of intimacy and ultimately the formation of healthy adult relationships (Hazan and Shaver 1987; and Alfasi, Gramzow and Carnelley 2010). Good sexual health enables individuals to make sound, informed choices regarding sexual practices and develop a deep sense of self-worth (DH, 2009a). Yet despite health professionals recognising the benefits of good sexual health for psychological and physiological wellbeing, discussion of sexual health with patients is still not a regular feature of general nursing practice (Serrant-Green, 2001). It is the duty of all health professionals to be at the forefront of sexual health promotion and to understand some of the factors that influence risky sexual practices (Warriner and Power, 2009).
In 2001 the Government published its first ever sexual health strategy: *Better Prevention, Better Services, Better Sexual Health* (DH, 2001). This strategy was intended to modernise and unify sexual health services in England and reduce levels of STIs, HIV and unintended pregnancies (DH, 2009a). This strategy has witnessed the successful introduction of schemes such as: Condoms: Essential Wear, RU Thinking? and the C Card system.

Condoms: Essential Wear was a campaign launched in 2006 by the Department of Health aimed at individuals aged 18-25, its objective was to normalise condom use (DH, 2008). RU Thinking? was another government-led campaign launched in 2007 by the then Department of Children, Schools and Families in association with the Teenage Pregnancy Partnership. RU Thinking? also targeted young people aged 18-25, its primary focus was the prevention of unintended pregnancies as well as tackling a wide range of issues relating to young people, contraception and sexual health (Nottingham City Teenage Pregnancy Partnership, 2007). The C Card is a nationally recognised condom distribution scheme which allows individuals, once registered, to obtain a supply of condoms free of charge at designated points across the country (Nottingham City Teenage Pregnancy Partnership, 2007). The C Card scheme is still operational today. The most recent sexual health campaign to be implemented as part of a national strategy is the National Chlamydia Screening Programme (NCSP). The NCSP allows sexually active individuals under the age of 25 to obtain Chlamydia home testing kits free of charge by signposting local distribution sites on the internet (National Chlamydia Screening Programme, 2010).
However, whilst the introduction of the strategy has helped individuals’ access better services and clinics sooner, there is still an unacceptably high incidence of reported STIs (HPA, 2008b). Current trends show only a measured reduction in the number of new reported cases of STIs (DH, 2009b). This is in spite of an incremental rise in funding of four percent each year since 1997 and the implementation of more in depth sexual education in secondary schools (DH, 2007a). One particular concern is the number of new/first time STI diagnoses, which have steadily risen each year from 261,608 cases in 2000 to 399,738 in 2008 (HPA, 2008a). However, it is important to question whether this high incidence of STIs is due to an improvement in the health service’s ability to detect STIs, rather than an increase in the spread of disease. A major concern regarding the interpretation of current statistics is that they are based upon individuals who access secondary prevention services, such as Genitourinary Medicine (GUM) Clinics, when only a small minority of those reporting risk markers actually attend those clinics. (Dixon-Woods, Stokes, Young, Phelps, Windridge and Shukla, 2001). Therefore it is conceivable that current statistics are far from comprehensive and that the health service potentially faces an even greater challenge.
1.1 Summary of chapter

In order to better inform governmental strategies, there needs to be a comprehensive study of the uptake of sexual health provision and an understanding of what informs individual’s decisions when considering suitable services. This insight could help the relevant authorities tailor sexual health strategies to the specific needs and preferences of the majority. Research as it currently stands shows that there are very few UK studies whose aim is to understand the informed reasoning behind service uptake, particularly in relation to University students. Therefore the proposed aim of this research is to understand the factors which influence non-healthcare university students’ choices when accessing sexual health services, in order to determine how accessibility to sexual health services could be improved. It is preferable that participants for the research undertake a non-healthcare related degree as individuals with a healthcare background may be more aware of the issues surrounding access to sexual health services and therefore provide less subjective views.

In order to facilitate the synthesis and critical appraisal of existing knowledge relating to this topic of investigation, an extensive review of existing literature follows this chapter. In chapter three, the methodology chapter, there is a full description and rationale supporting the decisions surrounding sampling techniques, methods of data collection and analysis. All findings are displayed in chapter four. In the fifth chapter, all findings are discussed, implications for nursing practice considered and recommendations for future research are made. In chapter six, the overall conclusions of the study are drawn together with a critical reflection of the research process.
Chapter 2: Literature Review
2. Literature Review

The literature reviewed in this study considers both empirical research and government strategies. Relevant literature was identified through the use of online journal databases: the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Scopus, the Applied Social Sciences Index and the British Nursing Index. Any further citations were identified by hand-searching literature and policy. Key search terms included: “sexual health”, “university”, “students”, “access” and “sexually transmitted infections”. Combinations of these terms were also used to yield more specific literature. Three key themes emerged from the reviewed literature. These are listed in Figure 2.1. The vast majority of studies identified focused on just one aspect of limited access, rather than taking a multi-perspective view of the current status of sexual health services.

Figure 2.1: Themes identified from literature review.

1. Exploring the models of service delivery: collaborative integration of existing sexual health services or One Stop Shop style clinics.

2. Exploring barriers to accessing sexual health services: Stigma. Waiting times.

3. Examining the motivations of existing users of sexual health services/clinics.
2.1 Exploring the models of service delivery: collaborative integration of existing sexual health services or One Stop Shop style clinics.

GUM services have developed principally independent of one and other for decades (DH, 2007a). Traditionally STIs have been a centralised speciality of GUM, whereas contraception and family planning has predominantly been nurse led clinics with minimal medical consultation. Consequently, contraceptive services and GUM clinics have become large independent sectors of sexual health, with varying levels of quality, despite a commonality of issues (DH, 2007a). Escalated rates of teenage pregnancy and STIs, compounded by increasing demands on sexual health services has led to close scrutiny regarding the effectiveness of two isolated services (DH, 2007a).

Currently there are two main modes of delivery of sexual health services: the one stop shop model (OSS); and the collaborative integration of existing specialist services (French, Coope, Graham, Gerrissu, Salisbury, Stephenson and the One-Stop Shop Evaluation Team, 2006). The purpose of the OSS is to provide all sexual and reproductive health services on a single site. The rationale behind implementing the OSS model is to eliminate barriers to accessing services, such as the location and logistics of sexual health clinics. In essence the OSS integrates contraceptive and genitourinary medicine in primary and secondary healthcare settings (French et al, 2006 and Berer, 2003). Practical examples of OSS models of sexual health in the Nottingham area include: The Glasshouse, Base 51 and the Health Shop. These services are committed to providing contraceptive advice, various methods of contraception, pregnancy tests, STI screening and general sexual health advice and support (NHS Choices, 2010).

Conversely, the collaborative integration of specialist services aims to draw existing sexual health services together without compromising the specialist nature of each component (French et al, 2006). Each of the specialist components provide independent services that focus on specific aspects of sexual and reproductive health, for example genitourinary medicine services are more likely to
place a greater emphasis on the diagnosis and treatment of STIs rather than prevention. Existing specialist services include: community contraceptive services, Genitourinary Medicine Clinics, Young People’s services and general practice (GP) services (French et al, 2006). The collaborative integration of specialist services would unite each of these independent services through standardised frameworks for planning and structuring, common aims and integrated user pathways between services (French et al, 2006).

The perceived benefits of a wholly integrated approach like the OSS include greater cost-effectiveness due to a reduced need for referrals to other services and health professionals, which inevitably necessitates additional time and administrative effort (Berer, 2003). Ever increasing demands on sexual health services has resulted in cost effectiveness becoming a crucial factor in the commission and design of health services. More fundamental reasons for complete integration include the notion that because sexual and reproductive health are intrinsically linked, sexual and reproductive services should emulate this relationship in order to provide service users with a greater holistic approach (French et al, 2006). Another potential benefit of total integration would be an ability to target and track ‘at risk’ individuals due to the proximity of services and a reduction in onward referrals. These measures would facilitate and promote continuity of care (Berer, 2003).

As with all models of service delivery there are shortcomings. The success of the OSS model is dependent upon a number of factors: a commitment by service providers to the concept of integration and a firm multidisciplinary approach (French et al, 2006). Meaningful integration demands the acceptance of core values and principles, rather than simply establishing facilities under one roof. The location of one stop shop facilities is fundamental to the uptake of services and an efficient use of resources (French et al, 2006). Therefore urban areas may be better suited to this model, due to more concentrated populations and an optimal use of resources, whereas rural areas may benefit from less centralised services. However some could argue that by building a OSS in the
rural environment this concern could be overcome, as patients would not have to travel far to and between services. There is also considerable resistance from professionals in the different service areas as a result of some fearing the potential loss of specialist skills (French et al, 2006). By centralising all services it is feared that there may be less scope for maintaining high numbers of specialist staff.

The collaborative integration of existing sexual health services may be more attractive to many patients who prefer to use mainstream medical services to avoid the stigma and association synonymous with STIs. By attending mainstream medical services individuals are better able to conceal the purpose of their consultation (French et al, 2006). Older individuals in particular may feel that the traditional process of GP consultation with potential for further referrals is a more accepted process and one that they are more familiar with. Also, most independent specialist sexual health services do not have specific target groups therefore individuals do not feel discouraged and deterred by population specific criteria such as: age, gender and socioeconomic background (French et al, 2006). Collaborative integration of existing services also provide service users with much greater choice: should service users dislike the service provided by one clinic they are able to find numerous others within their local area, with one stop shop clinics this is unlikely to be the case. With this in mind, a wide choice of collaborative services is more likely to ensure that fewer individuals delay seeking help and advice on issues of sexual health, thus improving service uptake (French et al, 2006).

Having implemented both schemes in the UK as part of the National Strategy for Sexual Health and HIV in 2001; Better Prevention, Better Services, Better Sexual Health, the Department of Health undertook an evaluation of the one stop shop model in 2007. The main aim of the evaluation was to assess the impact of the newly introduced OSS model on local communities, not to make direct comparisons between traditional options of service provision and the OSS (DH, 2007a). Findings
from the DH’s (2007a) study showed that none of the sites they identified were entirely OSSs despite categorising themselves as such, many of them had either established or maintained strong referral links with mainstream services in order to function (DH, 2007a). Despite this, areas with OSS in general practice were consumed more than integrated sexual health services. Therefore recommendations from the DH’s (2007a) evaluation of the effectiveness of the OSS suggests possible integration of both the OSS and collaborative integration of existing specialist services into a hub and spoke model of service provision, or else undertaking thorough assessments of local demands for either model of service delivery (DH, 2007a).

French et al’s (2006) study, ‘One Stop Shop versus Collaborative Integration’, provides a vast wealth of material on this aspect of sexual health and has greatly informed much of the overall analysis of how models of service delivery influence service uptake. French et al’s (2006) study used much of the theory and policy surrounding service delivery to conduct a number of interviews with the key individuals involved in the development of the National Strategy for Sexual Health and HIV (DH, 2001). Whilst the literature review for this research appears relatively extensive in approach with a broad inclusion criterion, some of the literature used dates back to 1990. As much of the resulting interviews were heavily dependent upon that literature, the validity of the study may be compromised. The interviews following this extensive literature review involved key informants from the development of the National Strategy for Sexual Health and HIV (DH, 2001), who acted as representatives of all of the relevant health professionals involved in service provision. Since these individuals are experts in the field of sexual health, it is likely that any issues of invalidity as a result of out-dated literature would have been raised and eliminated at this stage. Therefore validity is unlikely to be an issue with this study.
A further limitation of this study is that French et al (2006) do not disclose how many interviews were undertaken and this could have had a significant effect on their findings. French et al state that the interviewees were chosen for their knowledge and experience in sexual health services but do not offer a breakdown of how many or who these people are. For example, French et al (2006) could have interviewed anyone from the Head of Sexual health at the Department of Health to a Commissioning Officer in the local PCT; both people would be relevant but not significant enough alone to base the recommendations of a study on, no matter how relevant they might be.

Another limitation of French et al’s (2006) study is the fact that its key informants make claims about service users’ opinions of the two approaches without actual consultation. Whilst these key informants may be well placed to make speculative claims about service user satisfaction with each of the approaches, to make assertions that “many consumers appreciate advantages of OSS” without service user involvement in the study is misleading and consequently threatens the overall generalisability of the research (French et al, 2006 p.203).

In spite of its shortcomings French et al’s (2006) study is one of the few pieces of research which actively compare the One Stop Shop and Collaborative Integration models, thus making it an essential source of information for this study.
2.2 Exploring barriers to accessing sexual health services: Stigma.

Sexually Transmitted Infections (STIs) and sexual health services have a long-suffering association with stigma and fear (Grigg, 2000). As far back as the 16th and 17th centuries when STIs were incurable and under Puritan influence those infected were ostracised from their community, the issue of sexual health was fundamentally misunderstood (Grigg, 2000). Subsequent generations continued to isolate victims, often through punitive measures. For example, in the 19th Century simply contracting a venereal disease was a criminal offence (Grigg, 2000). In the 21st Century, although we no longer formally penalise those who contract STIs, studies such as Foster and Byers’ (2008) ‘Predictors of Stigma and Shame’ demonstrate that some draconian attitudes are still in evidence. Participants in this study were able to identify at least one individual they associate with who had had an STI and experienced moderate levels of STI-related discrimination (Foster and Byers, 2008). As this study was conducted fairly recently, in 2008, it would be fair to surmise that STI contraction, prevention and treatment is still very much partisan.

The stigma relating to STIs results from the wide perception that to contract an STI is irresponsible, avoidable and sinful (Kinghorn, 2001 and Grigg, 2000). STI related stigma is often exaggerated because of the way in which these diseases manifest themselves. Distinguishing manifestations compounded with the contagious nature of some STIs has created a climate of hysteria, fuelled by historical ignorance which is slowly being eroded (Kinghorn, 2001). Any association with an STI or use of sexual health services has always had the potential to tarnish an individual’s reputation or become the focal point of their character. Therefore the diagnoses of STIs bring a significant psychological and social burden to bear upon the individuals concerned (Foster and Byers, 2008).
STI related stigma has considerable implications for the uptake of services and the effectiveness of sexual health promotion. Research has shown that stigma significantly reduces the uptake of screening services and even influences individual’s disclosure of their STI to sexual partners (Foster and Byer, 2008). Recent statistics from the Health Protection Agency would at first glance appear to contradict the notion that STI screening services have a limited uptake, as first time STI diagnoses have risen by 138,130 in the period from 2000 to 2008 (HPA, 2008a). An increase in the uptake of services this size suggests marginal progress in tackling sexual health issues, despite this, evidence reports that screening services are under-used by those most at risk, for example: young people aged 16-25 and men who have sex with men (MSM) (Dixon-Woods et al, 2001). Thus undermining the management and control of sexually transmitted disease. Although Dixon-Woods et al’s (2001) research is ten years old and many critics would question its relevance, current literature searches show that its findings are yet to be disputed.

Foster and Byers (2008) conducted a quantitative survey to examine the relationship between a number of attitudes associated with STI-related stigma in a non-clinical sample of participants. It considered the implication of these attitudes in terms of maximising the uptake of sexual health services universally. Foster and Byers (2008) recruited 218 undergraduate students from a Canadian university. Students were required to complete a 40 minute survey which involved questionnaires on five topics relating to attitudes. Topic areas included: sexual conservatism, social conservatism, STI knowledge and perceptions of school based and home based sexual education. Psychosocial scales were employed to measure each of the different attitudes: the STI Knowledge Scale, the Sexual Attitudes Scale, the Sex-Anxiety Inventory, Right Wing Authoritarianism Scale, Attitudes Toward Women Scale and the STI-related Stigma and Shame Scale. Foster and Byers (2008) conclude that sexual conservatism and dissatisfaction with school based sexual education are uniquely associated with STI-related stigma and that, surprisingly, STI knowledge and the quality of home based sexual education had no particular influence upon STI-related stigma. The findings of
Foster and Byers’ (2008) research highlight the importance of social attitudes in the understanding of STIs, the significant impact of social attitudes on the incidence of STI-care seeking behaviours and the potential ramifications for the design of STI programs.

However, stigma alone is often not significant enough to be a barrier to good sexual health, but if reinforced by negative attitudes amongst health professionals, who act as gatekeepers to services; it can become a much greater hindrance (Evans, 2004). Health professionals are not immune from the influence of stigma, they too are part of the society and culture from which these stigmas originate and have been equally guilty of allowing their own personal moral beliefs to influence their approach to STIs and sexual health (Evans, 2004). At a primary care level many GPs and practice nurses are reluctant to even broach the subject of sexual health and dysfunction unless the patient initiates it, through fear of personal embarrassment and confronting sexual beliefs and practices that challenged their own (Gott, Galena, Hinchliff and Elford 2004). Stigma and societal pressures emerge from literature as the most prominent barrier to good sexual health and services but there are others that require consideration.
2.3 Exploring barriers to accessing sexual health services: Waiting times.

Current policy and guidance stresses the importance of quick and easy access to every sexual health service. Much of the research surrounding waiting times focus specifically upon GUM services and give very little indication of how other sexual health services operate. The Department of Health’s National Strategy for Sexual Health and HIV (2001) states that all sexual health services should be prompt and easily accessible as a minimum standard. However, the relatively sustained levels in the incidence of STIs have raised concerns over the ability of sexual health services to cope with increased demands. In light of these concerns it has been suggested that possible capacity constraints, specifically waiting times, may be adversely affecting service users (Foley, Patel, Green and Rowen 2001; Djuretic, Catchpole, Bingham, Robinson, Hughes and Kinghorn 2001; Clarke, Christodouilides and Taylor 2006).

A study conducted by Djuretic et al (2001) assessed the capacity of GUM services to meet patient demands for routine and emergency consultations. Djuretic et al (2001) oversaw a postal survey in which questionnaires were sent to all lead GUM physicians in the UK. The findings of the questionnaire revealed that on average patients would be expected to wait up to twenty-eight days for a routine appointment and that only fifty-four percent of GUM clinics in the UK were able to see patients requiring urgent appointments within twenty-four hours. In five percent of clinics patients had to wait at least seven days for urgent appointments (Djuretic et al, 2001). Djuretic et al’s (2001) research concluded that the majority GUM services in the UK are failing to cope with the increasing demands associated with a high incidence of STIs. Prolonged delay in STI diagnosis and management increases the risk of transmission to others and the likelihood of costly complications, therefore failing to treat STIs will exacerbate an already increasing prevalence, and intensify the existing burden on sexual health services (Djuretic et al, 2001). The findings, conclusions and recommendations of Djuretic et al’s (2001) research are also echoed by Clarke et al (2006). Clarke et al (2006) similarly conducted research assessing the demand for access to sexual health services
within a 48 hour target period, in a specific clinic in Leeds. They discovered that 626 appointments would be required in an average week, when the maximum capacity for appointments was only 181. This meant that this particular clinic would have to triple/quadruple its current service capacity to meet demand (Clarke et al, 2006). Both Clarke et al (2006) and Djuretic et al’s (2001) studies indicate that the demand for GUM services far outstrips capacity.

The gold standard currently set by the Department of Health in 2007 is for all first time GUM attendees to be offered an appointment within 48 hours (DH, 2007b). In June 2010 the percentage of appointment based GUM clinics able to match that gold standard stood at 99.94% (DH, 2010a). Whilst this statistic appears to show relative success and rebuke the findings of previous studies, in June 2010 alone GUM clinics were unable to offer some 6043 patients an appointment within 48 hours, with 1459 attendees having to wait until ten days after the initial referral (DH, 2010a). This suggests that on average, 4500 attendees per month not seen or offered an appointment within the 48 hours fail to pursue their referral (DH, 2010a). Agencies responsible for the collection of data measure waiting times differently and discount within statistics those who defer their referral or go elsewhere, which can result in a more positive reflection of demand and availability (Ward and Robinson, 2006). Therefore it appears that the issue of prolonged waiting times is still a significant obstacle to accessing sexual health services.
2.4 Examining the motivations of existing users of sexual health services/clinics.

When searching the literature surrounding sexual health it is apparent that much of the research on sexually transmitted infections and service uptake focuses upon the barriers to access. By comparison there are relatively few examples of research which seek to understand the help seeking behaviour that motivates and engages existing users of sexual health services.

Very little is known about why individuals choose to seek professional help for suspected STIs (Dixon-Woods et al, 2001). The few studies that consider engagement with existing service users highlight a number of themes which influence service uptake. Central themes include: a scare from information given by a sexual partner who may have had an STI diagnosed; the manifestation of unfamiliar symptoms associated with sexual contact; screening as part of a general health maintenance; having a new sexual partner; obtaining free contraceptives; and a failure of home remedies (Flannigan, Carter and Robertson 2009; Stone and Ingham 2003; Dixon-Woods et al 2001).

A study by Dixon-Woods et al (2001) explored 37 women’s accounts of choosing and using specialist sexual health services through the use of semi-structured interviews, from this they found that there were specific symptoms that would prompt women to seek professional help. These symptoms included pain and discomfort during sexual intercourse, frequent urination, abnormal bleeding, rashes, abdominal pain and abnormal discharge. However, women stated that these symptoms would have to become so intolerable and frightening that they would be galvanised into seeking professional help, whatever the cost (Dixon-Woods et al, 2001). For some women, the initial scare and trigger would come from an awareness of their partner or ex-partner’s sexual promiscuity.

Flannigan et al (2009) found that the same was true for men, that individuals required a catalyst to encourage them to attend sexual health services. However, with men the catalyst could be as simple as accessing free contraceptives.
Some women in Dixon-Woods et al’s (2001) study also reported that they would use sexual health services as part of a means of regular health maintenance. For some women this involves regular testing between partners or as a preventative measure following a period of risky sexual behaviour themselves. However, the majority of individuals who regularly use sexual health services as a measure of health maintenance do so without necessarily recognising the significance of this health seeking behaviour – the main motivation is so that individuals can assure new sexual partners that they are free from infection, rather than a recognition of the asymptomatic nature of some STIs and thus the importance of regular screening (Flannigan et al, 2009). However, those individuals who purposely access routine screening services are very much in the minority, particularly amongst groups considered vulnerable such as: males, young people, and individuals from bisexual and homosexual sexual orientations.

A large proportion of individuals that access sexual health services do not seek help for actual or suspected STIs in the first instance, but actually seek medical attention for other health matters (Dixon-Woods et al, 2001). For example over a quarter of women in Dixon-Woods et al (2001) research reported initially accessing sexual health services for issues such as smear testing and contraception, but once in consultation felt able to legitimately raise questions about STI symptoms or risky sexual behaviour. Many people reported questions about STI symptoms and screening either too embarrassing or not important enough to warrant a separate consultation (Dixon-Woods et al, 2001). Obviously not all individuals recognise and capitalise on these opportunities, for example many people don’t even realise that they are able to access free contraception from sexual health services, therefore it is perhaps unwise to depend upon this (Flannigan et al, 2009).
2.5 Summary of chapter

As highlighted throughout this chapter there is a scarcity of empirical research in relation to this specific topic area. Research, as it currently stands, focuses on particular aspects of sexual health and service uptake. Very few UK studies actually seek to understand the full rationale behind service uptake, particularly in relation to university students. Such gaps in the literature provide rationale for further investigation into this topic area to ensure improved service uptake and patient-centred care. Therefore this study seeks to understand the factors which influence non-healthcare university students’ choices when accessing sexual health services, in order to improve their overall accessibility.
Chapter 3: Methodology
3. Methodology

The term methodology simply describes a plan which outlines how, when and why data is collected and analysed for research (Polit, Hungler and Beck, 2001). This chapter seeks to examine and give a full rationale for decisions made surrounding sampling techniques, methods of data collection and proposed methods of data analysis. The methods used will be appropriately critiqued in order to ensure reliability and validity.

3.1. Aims and Objectives

The aim of this research is to explore the factors influencing non-healthcare university student’s choice when seeking sexual health advice, information and services. The objectives of the study focus upon particular characteristics of accessing sexual health services. These include:

- Determining the types of sexual health services students are able to identify.
- Identifying the factors that influence students’ choice when seeking sexual health advice, information and services.
- Exploring any barriers to accessing sexual health advice, information and services.
- Discussing any recommendations for improving access to sexual health services.
3.2. Research approach

There are principally two approaches to research: quantitative and qualitative. The two approaches can be used independently or combined in a ‘mixed methods research’ approach (Adamson, 2009). The qualitative approach to research essentially seeks to understand human experience through the examination of motivations and phenomena unique to an individual (Marvasti, 2004). Traditionally, qualitative research uses human speech, writing and behaviours as a means of understanding the thoughts, feelings, attitudes and experiences of participants (Porter, 2000). Qualitative research methods include: semi-structured and in depth interviews or focus groups. These methods of data collection lend themselves to more subjective findings; they encourage participants to use their own interpretation and terminology (Hansen, 2006).

The qualitative approach has become increasingly popular as a mode of research, particularly within social sciences and healthcare, due to the fact that the methodology is well suited to understanding complex health related behaviours (Thomas, Harden, Oakley, Oliver, Sutcliffe, Rees, Brunton and Kavanagh 2004; Power 2002). In order to better understand the qualitative approach Ely, Anzul, Friedman, Garner and SteinMetz (1991) devised a tool which outlines six of the characteristics that are quintessentially qualitative.
Events can only be understood adequately if they are seen in context. Therefore a qualitative researcher must immerse him/herself in the setting.

The contexts of enquiry are not contrived: they are natural. Nothing is predefined or taken for granted.

Qualitative researchers want those who are studied to speak for themselves, to provide their perspectives in words and other actions. Therefore qualitative research is an interactive process in which the persons studied teach the researcher about their lives.

Qualitative researchers attend to the experience as a whole, not as separate variables. The aim of qualitative research is to understand experience as unified.

Qualitative methods are appropriate to the above statements. There is no one generalised method.

For many qualitative researchers, the process entails appraisal about what was studied.

By contrast, a quantitative approach to research is better suited to objectivity, whereby facts and findings are presented in a manner untainted by feelings and opinions (Porter, 2000). The quantitative approach to research requires greater structure with responses often represented in a numerical format. Many researchers use the quantitative approach as a means of identifying and explaining correlations between measures (Porter, 2000). The quantitative research is often considered to be reductionist in approach, whereby complex behaviour is broken down into simplified components that are more readily examined (Carter, 2000). Components observed are either accepted or rejected through the formation of a hypothesis – a statement of ‘truth’ which is quantified through statistical analysis (Carter, 2000).

Although there are significant differences between quantitative and qualitative research it is important to recognise that styles of research do not easily lend themselves to either
methodological approach. Criteria used to outline these methodological approaches are underlying assumptions and are by no means definitive (Porter, 2000 and Hansen, 2006). It is also important to note that there is no right or wrong approach and that research should be invariably specific to the research question (Porter, 2000).

This proposed research seeks to understand factors which affect individuals help seeking behaviours in relation to sexual health services. Both methodological approaches are suitable for the research specification; however the fundamental aim of this research is to understand a human phenomenon, which naturally lends itself more to subjective measurements. For this reason qualitative methodology appears to be more appropriate. Using a qualitative approach will enable participants to articulate their experiences using their own interpretations, which should consequently result in a greater understanding of the motivating factors behind participant’s behaviours.

3.3. Research Method
A qualitative approach to research typically enables researchers to be more flexible with their method of data collection. Qualitative research is much less structured and enables individuals to express thoughts and experiences however feels most comfortable to them (Carter, 2000). As this study is an exploration of the factors which influence non-healthcare university students’ choices when accessing sexual health services, the focus of the study must be on the motivations of students. In searching for this understanding, two potential research tools were contemplated: focus groups and interviews.

Interviews have the potential to provide rich and revealing material as participants are not bound by set questions and expectations (Hansen, 2006). Interviewing as a method of data collection is a particularly useful way of eliciting a more relaxed and conversational atmosphere in which sensitive topics can be discussed (Warren, Narnes-Brus, Burgess, Wiebold-Lippisch, Hackney, Harkness, Kennedy, Dingwall, Rosenblatt, Ryen and Shuy, 2003). This method also provides participants with an opportunity to elaborate upon given responses and for the researcher to clarify any areas of uncertainty (Hansen, 2006). The sensitive nature of sexual health readily lends itself to the use of interviews. Therefore it was decided that within the qualitative approach, interviews would be the most appropriate method of data collection for this study.

There are four definitive styles of interviewing, these are: structured interviews, semi-structured interviews, unstructured in-depth interviews and short informal interviews (Hansen, 2006). Interviews can also be conducted through a number of different means: face to face, over the telephone, online or via email. Each of the different approaches to interviewing are associated with certain methodological perspectives (Hansen, 2006). The semi structured approach to interviewing is closely associated with inductive methodologies such as grounded theory, whereby themes for consideration and observation naturally emerge from any data collected (Hansen, 2006). The
concept and method of semi-structured interviews are particularly suited to the proposed research question as there is no proposed hypothesis or expected outcome.

Semi-structured interviews have also been proven to be complementary to the study of sexually transmitted infections, lifestyle and contextual factors in sexual health. Research by the Institute for Social Science Research (2010) has shown that individual participants are more likely to give honest and in-depth responses about sensitive issues such as sexual health to an interviewer’s question when in an intimate, one–to-one, semi-structured interview. These considerations greatly influenced the selection of methodology.

However, like many methods of data collection there are some limitations to using the semi-structured interview approach which need to be considered. Interviews are very time consuming as they involve setting up meetings, conducting the interview process, debriefing participants and then transcribing any data collected. This can ultimately limit the number of subjects that can be used in the study (Carter and Henderson, 2009). However, one could counter this by acknowledging that the depth of the data collected from each participant will be much more substantial than other methods of data collection which involve a greater number of participants (Carter and Henderson, 2009). Since the depth and intensity of data is more fundamental to understanding the research question, a small participant number should not adversely affect this study.

Interview bias also has the potential to be a significant limitation, with participants giving accounts which respond to what they assume the researcher would wish to hear, rather than stating their actual thoughts and beliefs (Carter and Henderson, 2009). One way in which interview bias can be overcome is by ensuring that the interview questions are simple, unambiguous and open-ended. By carefully constructing interview questions in this way participants are able to explain their perspectives in an honest and impartial manner (Carter and Henderson, 2009). The aim of a good
qualitative researcher is not to make judgements about the ‘truth’ or other statements, but to understand how the participant’s thoughts and beliefs make sense within a social context (Potter and Wetherell 1994, Carter and Henderson 2009). Therefore if researchers are to collect the best data from their participants’ interviewers must be careful not to appear judgemental.

In order to rule out potential interviewer bias in the current research study, several measured steps were taken in the construction of the research tool – these will be outlined later in this chapter (see subsection 3.5. Construction of research tool).
3.4. Study population and sample

Participant samples should be representative of the selected population (Carter and Porter, 2000). For this study the population selected are current university students undertaking a non-healthcare related education programme within the University of Nottingham. The rationale behind selecting non-healthcare student participants is that individuals with a healthcare background may be more aware of the issues surrounding access to sexual health services and therefore provide less subjective views. Willing participants can be from any age group, at any stage in their programme and be undergraduate or postgraduate. Students will not be grouped into similar faculties, educational or social backgrounds. A broad inclusion criterion will ensure that the population sample is as representative as possible, thus promoting external validity (LoBiondo-Wood and Haber, 2002).

Participants will be recruited opportunistically; this involves selecting participants on the basis of their availability rather than by any other means (Eysenck, 2003). In order to recruit participants’ posters will be placed in the busiest student environments throughout the university with the aim of obtaining volunteers. A copy of the poster used to recruit participants can be found in appendix 4.

The aim of qualitative research is to obtain a rich account of the phenomenon (Carter, 2000). The number of participants required for this study will be dependent on the point at which saturation of data occurs. Saturation involves the repetition of all discovered information and the confirmation of previously collected data (Morse, 1994). It is conceivable that only a small number of participants will be required for a topic of this nature; however recruitment will only be terminated when saturation is reached. Sexual health has a significant associated stigma and is an intensely sensitive topic which may discourage individuals from participating. To encourage students to respond to recruitment, it will state clearly on the posters and information sheets that all participant details will remain entirely confidential. A copy of the participant information sheet can be found in appendix 2.
3.5. *Construction of research tool*

Participants will be required to attend a one off anonymous and confidential one to one semi-structured interview. The duration of the interview will be largely directed by the participant according to the depth and direction of dialogue although it is anticipated that interviews will be a minimum of fifteen minutes in duration based upon the proposed content in the interview schedule. Interviews will be arranged at the participants’ convenience in order to generate maximum interest.

Participants will be required to draw upon their experiences of seeking access to sexual health services. The interviewer will use a few open-ended questions to seek information from the participants. All questions posed by the interviewer are standardised, of a simple nature, open-ended, unambiguous and devoid of any technical jargon. There are a total of five open-ended questions for this interview, with subsequent probes if necessary.

**Figure 2.3: Questions related to the study.**

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>- What sexual health services are you able to name?</td>
</tr>
<tr>
<td>- Have you ever accessed any sexual health services?</td>
</tr>
<tr>
<td>- If so, which services?</td>
</tr>
<tr>
<td>- Why did you access this particular service?</td>
</tr>
<tr>
<td>- What was your impression of this service?</td>
</tr>
<tr>
<td>- What influences your choices when seeking access to these particular services?</td>
</tr>
<tr>
<td>- Are there any influences that you consider more important than others?</td>
</tr>
<tr>
<td>- What prevents/would prevent you from accessing sexual health services?</td>
</tr>
<tr>
<td>- How could access to sexual health services be improved?</td>
</tr>
</tbody>
</table>
A copy of the full interview schedule, including an introduction to the participant, can be found in appendix 1.

The careful formulation of questions should minimise the effects of interviewer bias, by enabling participants to explain their perceptions in detail without any perceived expectations from the interviewer (Carter and Henderson, 2009). Although the researcher will work from a pre-planned topic it is likely that the need for supplementary questions will arise throughout the session, in the event of this, the interviewer’s supplementary probes and questioning will be guided by the interviewee’s responses. This method of investigative questioning is referred to as a receptive approach whereby the interviewer asks participants “Can you tell me a little more about that?” This approach to interview construction has very much influenced the construction of this research tool. All interviews will be digitally recorded using a dictaphone and then fully transcribed verbatim into a script format to facilitate analysis.
3.6. Validity, Reliability and Reflexivity

As defined by Carter and Porter (2000), validity and reliability are criteria upon which the integrity of research findings is assessed. Validity specifically refers to the extent to which a test measures what it claims to measure (Hansen, 2006). For example, for research to be considered valid the data collected must be deemed to accurately reflect reality. Validity is usually achieved through the application of strict guidance on sampling, measurement, statistical method and data analysis (Hansen, 2006). However, whilst these definitions may be true for quantitative research, a qualitative approach generally views the collection of research results as an interactive and constructive process between participant and researcher (Hansen, 2006). Consequently, the application of guidance on aspects of the research design such as measurement and data analysis may invariably be less precise (Hansen, 2006).

Validity is usually measured on the basis of statistical generalizability – ability to extrapolate findings to the population at large on the basis of statistical significance (Donovan and Sanders, 2009). However, the non-probabilistic basis of sampling in qualitative research such as this, means that it is very difficult for researchers to claim statistical generalizability because relatively small samples are investigated (Donovan and Sanders, 2009). Many qualitative researchers would argue that qualitative research does not seek statistical generalizability in any case. In qualitative research much of the emphasis surrounding the legitimacy of findings is on the need to establish ‘plausibility’ of the research. Plausibility is an interpretive judgement used by researchers to ascertain ‘truth’ rather than validity (Donovan and Sanders, 2009).
Therefore the validity of this research study will very much be open to interpretation as there are no criteria that can be adopted to assess the degree to which the findings can reflect reality. For issues such as sexual health much of the social reality is mind-constructed and there are multiple realities, therefore different claims about reality may not be as a direct result of incorrect procedure but from one investigator’s interpretation of reality versus another’s (Smith, 1984 and Cormack, 2000). Consequently to apply criteria would be inappropriate and do an injustice to the research findings.

Reliability refers to the level of consistency with which an instrument accurately measures that for which it was designed (Cormack, 2000; Polit and Hungler, 2001). With regards to the interview process, it relates to the consistency with which participants are able to understand, respond and elaborate on questions (LoBiondo-Wood and Haber, 2002). As stated previously in this chapter (subsection 3.5. construction of research tool), questions involved in the investigation will be pre-planned and any supplementary questioning will be guided by interviewee responses. This format of questioning will remain the same for all interviews to ensure some level of reliability is retained. However, as with all semi-structured interviews there may be elements of inconsistency dependent upon the direction of discussion.

Reflexivity is also an important consideration for qualitative research. Reflexivity is the acknowledgement that researchers are shaped by the social world they seek to investigate (Pontin 2000, Hansen, 2006). By acknowledging this the researcher aims to achieve an ‘explicit, self-aware analysis of their role’ and the influence it exerts on the research process (Finlay 2002, pp.531). The self-awareness aspect of reflexivity encourages researchers to improve the study design and the way in which they conduct themselves throughout the study (Hansen, 2006). Reflexivity also enables the researcher to question their own underlying assumptions about the topic area. In this study credibility in data collection will depend upon closeness, mutual respect, the interviewing skills of the researcher and the impact of the researcher as a student health professional. Ultimately,
closeness and mutual respect could be enhanced by the fact that both participants and researcher are students and similar in age. One potential challenge to this particular consideration is that the researcher will be female and so male participants may find talking to someone of the opposite sex very difficult, particularly considering the sensitive nature of the topic - consequently data may reflect this. A further consideration is the fact that the researcher is new to the role of interviewer and therefore the interview process may not be as rigorous as an experienced qualitative researcher.

3.7. Ethical Considerations

There are a number of ethical considerations for any proposed research study. All research studies must be ethically credible in order to protect both participants and researchers. This research study has raised many key concerns. The main ethical consideration is the sensitive nature of the topic under investigation as sexual health and welfare is generally considered a private issue. Careful consideration was therefore given to the formulation of questions. Questions used in the study will be simple and open-ended, which should enable participants to add as much or as little detail as they would like, without making them feel pressurised. Straightforward, pre-planned questions should also guard against the interviewer appearing judgemental, as it would be unethical and totally inappropriate to ask participants to be frank and open about their thoughts if they were then open to criticism. As a further measure to minimise potential stigma and discrimination participant’s identities will remain strictly confidential. All interview recordings and transcripts of data will be totally anonymised.

Informed consent is usually a prerequisite of qualitative studies. It simply ensures that all participants have received adequate information about the study and are happy to participate. Upon volunteering for the study participants will receive an information sheet detailing the aim of the research, an outline of what the study will involve and what to expect from the researcher. The
information sheet also stresses that participants are free to withdraw themselves from the study at any point up until the point of publication. However should participants be happy with the information provided they will be invited to attend an interview, at which they will be asked to give both written and verbal consent. Verbal consent will be recorded and stored as part of the participant’s transcript. All written consent forms, with a copy of the interview transcripts will be securely stored for up to seven years in accordance with the University of Nottingham’s data retention policy.

A copy of the participant information sheet can be found in appendix 2, and a blank copy of the written consent forms can be found in appendix 3.

Prior to commencement of this study, an application for ethical approval was gained from the University of Nottingham Medical School ethics committee. One of the foreseen ethical issues highlighted by the ethics committee was that it is conceivable during the interview process that some individuals may disclose unsafe or vulnerable sexual practices. Should this occur the interviewer would inform those individuals that aspects of the interview may no longer be confidential, in the interests of safeguarding vulnerable people.

A copy of the notification of ethics approval can be found in appendix 5.
3.8. Analysis of data

Subsequent to collection all interview recordings will be transcribed verbatim and data will be fully analysed using a thematic approach. The approach used to analyse data will be loosely based upon grounded theory in which data is coded according to systematic procedures (Hansen, 2006). The first stage of analysis, often referred to as Open Coding, will involve breaking data down into a more manageable format i.e. arranging data according to identifiable properties and categories. Following this, connections between categories will be identified and integrated according to core headings. These core headings will correspond to themes to be discussed in subsequent chapters. Within each of these themes, sub-themes may be identified. All findings will be presented in chapter 4, subsequent chapters will seek to make sense of the findings and possibly go some way to answering the research question.

3.9. Summary of Chapter

This chapter has outlined the different stages involved in the data collection process of this study. Issues raised have been critiqued where possible using credible, published literature. All aspects of the research methodology have been studied and justified throughout the chapter. The methodology considered in this chapter is comprehensive enough to allow the research to be conducted.