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Barriers and Enablers to Accessing Sexual Health Services Among Underserved Communities: Community Organisations' Perspectives on Sexual Health Inequalities

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Abstract

Background

Inequalities in access to sexual health services persist among underserved populations, with barriers shaped by intersecting structural, cultural and psychosocial factors. This study explored organisational perspectives on barriers and enablers to accessing sexual health services across Kent, with a particular focus on communities experiencing disadvantage and marginalisation.

Methods

An interpretivist qualitative design was adopted. Semi-structured interviews were conducted with representatives from 26 voluntary and community sector organisations supporting underserved populations across Kent. Interviews, conducted between May and June 2026, were informed by the Barriers and Enablers Framework and analysed thematically using the six-phase approach of Braun and Clarke. Additional qualitative evidence submitted by participating organisations was also considered.

Results

Participants identified multiple, intersecting barriers to equitable access, including limited appointment availability, clinic closures, poor transport, digital exclusion, competing life circumstances, uncertainty about confidentiality, stigma, cultural and language barriers, limited awareness and mistrust of statutory services. These barriers were particularly pronounced among ethnic minority and migrant communities, Gypsy, Roma and Traveller communities, people experiencing homelessness or substance use, LGBTQ+ communities, disabled people, young people and those affected by domestic abuse or contact with the criminal justice system. Community organisations were identified as important enablers through trusted relationships, practical support, culturally adapted communication, outreach and service navigation. Participants advocated flexible, community-based and co-produced models of care, supported by cross-sector collaboration, trauma-informed practice and community champions.

Conclusion

Equitable sexual health provision requires a shift beyond predominantly clinic-centred models towards flexible, culturally responsive and community-embedded approaches. Sustained investment in voluntary and community sector partnerships and meaningful co-production could strengthen accessibility, acceptability and engagement among underserved populations.

Introduction

This study set out to explore the barriers and enablers to accessing sexual health services across Kent, drawing on in-depth qualitative interviews with representatives from 26 voluntary and community sector organisations working with some of the county's most underserved and at-risk groups and communities.

Sexual health is a fundamental component of overall health and wellbeing, encompassing the prevention and treatment of sexually transmitted infections (STIs), contraception, HIV prevention and care, psychosexual support, cervical screening, and sexual health promotion (World Health Organization, 2006). In the United Kingdom, these services are delivered through NHS sexual health clinics, general practice, community pharmacies and voluntary sector organisations. However, access to sexual health services remains unequal, with underserved populations experiencing disproportionate barriers to timely and appropriate care.

The COVID-19 pandemic further exposed and exacerbated existing inequalities in sexual healthcare (Nori et al., 2020; ee, 2021). The rapid transition to remote consultations and online testing maintained some service provision but created additional barriers for individuals experiencing digital exclusion, including older adults, those living in deprived communities and people without access to private spaces or digital technologies. Reduced face-to-face provision also contributed to substantial declines in STI testing and diagnoses, reflecting reduced service accessibility rather than reduced transmission.

Evidence consistently demonstrates that sexual health inequalities are shaped by intersecting social, cultural and structural factors (Crenshaw, 1989; Bowleg, 2012). Young people continue to experience barriers associated with stigma, confidentiality concerns and limited health literacy despite accounting for a large proportion of STI diagnoses (UK Health Security Agency, 2023). Older adults remain largely overlooked within sexual health policy despite increasing STI rates, while ethnic minority communities experience additional barriers related to structural inequalities, language, cultural stigma and mistrust of healthcare services. These findings highlight the importance of culturally competent, community-centred approaches that are responsive to the diverse needs of underserved populations.

The Kent Sexual Health Needs Assessment 2024 (Dougall et al. 2024) gave invaluable insights and found 12 at risk and under-served groups who need particular focus and dedicated efforts in plans going forward. The groups were: Young People, Women and girls, Black Ethnic and minority groups, LGBTQ+, Gypsy Roma Traveller & Transient Communities, Sex workers, Deprived areas, People who use drugs and/or alcohol, People in contact with justice system, People experiencing mental health conditions, People with learning disabilities, Homeless population.

Based on these findings Kent County Council's *Maximising Impact Initiative* was established to address inequalities in sexual health. As part of this initiative, Canterbury Christ Church University was commissioned to evaluate the experiences of community organisations delivering services to these populations. This article explores the organisational perspectives on the barriers and enablers influencing access to sexual health services across Kent and to identify opportunities for improving equitable service delivery.

Methods

Study design

This study adopted a qualitative research design informed by an interpretivist paradigm to explore community organisations' experiences of supporting underserved populations to access sexual health services. Semi-structured interviews were selected to facilitate an in-depth understanding of organisational perspectives and the contextual factors influencing service access. Ethical approval was granted by the Canterbury Christ Church University Research Ethics Committee (ETH2526-0206).

Participants and recruitment

Purposive sampling was used to recruit organisations that had previously participated in Kent County Council's *Maximising Impact Initiative*. Twenty-six organisations were interviewed between May and June 2026. Participating organisations represented a diverse range of statutory, voluntary and community sectors, collectively supporting a broad spectrum of underserved populations, including ethnic minority communities, older adults, young people, people experiencing homelessness, individuals affected by substance misuse, disabled people, domestic abuse survivors, LGBTQ+ communities and people involved with the criminal justice system.

Data collection

Semi-structured interviews were informed by the Barriers and Enablers Framework (Grol & Grimshaw, 2003), enabling systematic exploration of factors influencing access to sexual health services. Interviews were conducted virtually via Microsoft Teams, lasted between 30 and 60 minutes, and in some cases included two representatives from the same organisation to capture complementary perspectives. All interviews were audio-recorded, transcribed verbatim, anonymised and stored securely in accordance with data protection requirements.

Data analysis

Interview recordings were transcribed, quality-checked for accuracy, and subsequently uploaded to QSR NVivo qualitative data analysis software, where a systematic process of coding and full thematic analysis was undertaken to identify patterns, themes and divergences across the dataset, following the six-phase approach to thematic analysis outlined by Braun and Clarke (2006). This analytical approach enabled the identification of shared and divergent experiences relating to barriers and facilitators of sexual health service access across participating organisations.

Secondary Data

Additional evidence was submitted by 26 organisations across Kent, based on a range of insight-gathering mechanisms, including surveys, informal feedback collected during one-to-one support sessions, group discussions within domestic abuse recovery programmes, and casework observations from frontline practitioners, as well as workshops. While these approaches provided valuable qualitative and experiential insights, there were significant variation in how data had been collected, recorded, and reported.

Results

Interview Findings

Through deductive and inductive thematic analysis, a range of sub-themes emerged under the core themes: 1) Service type and key roles, 2) Barriers to access, 3) Enablers, 4) Underserved groups, 5) Good practice approaches, 6) Solutions and recommendations, and 7) Maximising Impact Initiative.

1. Sexual Health Services (Type)

Community organisations played a pivotal role in facilitating access to sexual health services, primarily through advice, signposting and awareness-raising rather than direct service provision, reflecting Nagington & King's (2022) emphasis on service-user involvement as central to effective support. Many organisations supported individuals to navigate referral pathways, book appointments and access online services, while condom and safer sex resource distribution formed an important component of community outreach. Participants expressed concern that the withdrawal of condom supplies by Metro had reduced local preventative capacity. Although only a small number of organisations offered on-site drop-in sexual health testing, these services were consistently identified as an effective model for engaging individuals who were unlikely or unable to access traditional clinic-based provision.

2. Barriers to Accessing Sexual Health Services in Kent

Participants identified multiple, intersecting barriers that limited equitable access to sexual health services across Kent. Structural barriers were most prominent and included limited appointment availability, reliance on online booking systems, clinic closures, reduced service provision, and poor transport links, particularly in rural and socioeconomically deprived areas.

These challenges were compounded by digital exclusion, competing life priorities such as employment, caring responsibilities, homelessness and substance use, and uncertainty surrounding service eligibility and confidentiality. Ogaz et al. (2026) found similar barriers surrounding accessibility in their cross-sectional community survey in 2024.

Organisations also described widespread confusion resulting from changes to service provision, including the withdrawal of community-based resources such as free condom distribution, which further reduced opportunities for prevention and engagement.

Alongside structural barriers, participants consistently highlighted social and cultural factors that discouraged service use. Sexual health remained highly stigmatised across all age groups and communities, with embarrassment, fear of judgement and concerns about confidentiality undermining willingness to seek support. Stigma was often highlighted in the evaluation and Maximising Impact Initiative work as a key barrier amongst the culturally diverse communities, in line with a lack of willingness, cultural norm or safety to talk openly about 'sexual health'. From the perspective of those seeking support, studies also consistently identify stigma as a primary barrier to help-seeking, alongside concerns about confidentiality, low health literacy and digital exclusion (Hibbert et al., 2021; Jaspal, 2022, Ogaz et al., 2026).

These issues were further exacerbated by cultural and language barriers, limited awareness of available services, low trust in statutory healthcare, and a lack of culturally appropriate resources. This is consistent with barriers identified by Hibbert et al. (2021) in their study considering service provision and barriers to care for men who have sex with men engaging in chemsex and sexualised drug use in England.

Participants also expressed growing concern about the influence of online misinformation and harmful social media narratives, which perpetuated misconceptions about sexual health and discouraged evidence-based decision-making. Collectively, these findings demonstrate that barriers to sexual health access are not isolated but arise from the interaction of structural, cultural and psychosocial factors, disproportionately affecting individuals already experiencing social disadvantage.

3. Enablers for Accessing Sexual Health Services in Kent

Organisations identified a range of factors that facilitated engagement with sexual health services, with community-based, relationship-centred approaches emerging as the most influential. Long-standing relationships between community organisations and local populations fostered trust, enabling sensitive conversations around sexual health to occur in familiar, non-judgemental environments. Integrating sexual health within existing community programmes, such as youth services, women's groups and substance misuse support, helped to normalise discussions and reduce stigma. Cultural adaptation also enhanced engagement, with organisations tailoring language, resources and outreach to reflect the values, languages and practices of the communities they served, reinforcing the need for integrated, culturally competent models of care (Wilson and Williamson, 2024).

Practical support provided by community organisations further reduced barriers to access. Participants described assisting individuals with appointment booking, translation, navigating services, accompanying people to clinics and facilitating home testing, particularly for those experiencing vulnerability or low confidence. Co-produced resources, culturally appropriate terminology and opportunities for communities to shape service design were viewed as essential to improving accessibility and acceptability. The pivotal role of trusted community organisations in bridging the gap between underserved populations and statutory sexual health services through culturally competent, person-centred and community-embedded approaches was highlighted.

4. Underserved and At-Risk Groups

Substantial inequalities in sexual health access across a diverse range of underserved populations was consistently identified. Ethnic minority and migrant communities, including Gypsy, Roma and Traveller groups, were perceived to experience persistent barriers related to language, cultural stigma, confidentiality concerns and limited awareness of available services. Rather than viewing these communities as "hard to reach", participants argued that services often failed to engage effectively, emphasising the importance of sustained outreach, culturally competent practice and long-term relationship building within trusted community settings. Other groups experiencing significant unmet need included people affected by homelessness, substance use and addiction, disabled and neurodiverse young people, and older adults, whose sexual health needs were frequently overlooked by mainstream services and existing educational resources. Across these populations, participants highlighted the need for flexible, trauma-informed and accessible approaches that recognised the complex social and structural factors influencing engagement.

Several groups were identified as being at particularly high risk of poor sexual health outcomes due to intersecting vulnerabilities. Women experiencing domestic abuse, coercive control and honour-based violence often faced restricted autonomy and limited opportunities to access confidential care, while trans communities described ongoing experiences of stigma, discrimination and inadequate understanding within healthcare settings. Women involved in the criminal justice system and those affected by substance use encountered compounded stigma, trauma and concerns about confidentiality, reducing engagement with preventative services. Young people also emerged as a priority population, particularly those experiencing parental barriers, disengagement from mainstream education or identifying as LGBTQ+, who frequently reported uncertainty about confidentiality, limited access to appropriate information and gaps in tailored sexual health education. These findings demonstrate that sexual health inequalities are shaped by intersecting forms of social exclusion, requiring targeted, culturally responsive and community-centred approaches rather than universal models of service provision.

5. Good Practice Approaches

Participants identified several examples of effective practice that facilitated engagement with underserved communities. Central to these was strong cross-sector collaboration between community organisations, sexual health providers and statutory agencies, which enhanced knowledge sharing, coordinated outreach and strengthened local service capacity. Trust emerged as the cornerstone of successful engagement, with organisations emphasising the importance of employing staff, volunteers and community champions who reflected the cultural backgrounds, languages or lived experiences of the populations they served. Representation and established relationships were viewed as essential for engaging communities that had historically experienced marginalisation or mistrust of statutory services.

Participants also highlighted the value of trauma-informed, person-centred and non-judgemental approaches, arguing that the manner in which sexual health conversations were initiated was as important as the information provided. Creating safe, respectful and culturally sensitive environments enabled more open discussions and increased willingness to engage with services. Finally, organisations suggested that sexual health promotion could benefit from adopting successful strategies used in other areas of public health, such as dementia, cancer screening and mental health, where sustained awareness campaigns, community champions and adapted messaging have helped normalise previously stigmatised health issues. These findings indicate that effective sexual health provision extends beyond service availability to encompass collaborative partnerships, trusted relationships and culturally responsive models of care.

6. Evidence-led solutions and Recommendations

Participants proposed a range of evidence-informed recommendations to improve equitable access to sexual health services, with a strong emphasis on strengthening community-based delivery models. Central to these recommendations was the need to build upon existing relationships between voluntary, community and statutory organisations, recognising that trusted community networks provide an established foundation for engaging underserved populations. Participants advocated for greater collaboration across sectors, improved sharing of community-level data to inform commissioning and service planning, and the co-production of services and resources with the communities they are intended to serve. Outreach through culturally relevant settings, including places of worship, community centres and local events, was viewed as essential to reducing barriers and increasing engagement.

Participants also recommended redesigning service delivery to improve accessibility and responsiveness. Flexible appointment systems, including drop-in provision and outreach clinics located within trusted community settings, were consistently identified as priorities, alongside greater visibility of sexual health professionals within existing community services. Additional recommendations included expanding community champion programmes, developing targeted and culturally appropriate resources for underserved populations, providing trauma-informed training for frontline staff, and ensuring educational materials remain current, accessible and representative of diverse communities. Finally, organisations highlighted the importance of normalising sexual health through sustained public awareness campaigns and co-produced digital content, particularly via social media, to counter misinformation and improve engagement among younger populations. A shift from clinic-centred models towards integrated, community-based and culturally responsive approaches to sexual health promotion and service delivery was recommended.

7. The Maximising Impact Initiative: Reflections

Participants viewed the Maximising Impact Initiative positively, describing it as a valuable catalyst for initiating sexual health conversations that had previously been difficult to facilitate. Many organisations reported increased confidence, strengthened knowledge and a greater willingness to integrate sexual health into their routine practice, with several suggesting that the initiative had created lasting

organisational change. The collaborative workshops and cross-sector engagement were widely praised for fostering shared learning and strengthening partnerships across Kent.

Despite these benefits, participants identified several areas for improvement. Many felt that the project timescale was insufficient to establish deeper community relationships or achieve sustained impact, particularly for organisations joining later in the initiative. Delays in the provision of promised engagement resources and limited communication regarding their availability were reported to have constrained community engagement and, in some cases, affected organisational credibility. Participants also emphasised the importance of providing ongoing feedback and demonstrating how community contributions informed service development, noting that visible outcomes would strengthen future engagement. Collectively, these findings suggest that while the initiative established strong foundations for community-based sexual health promotion, its long-term impact would be enhanced through sustained investment, improved coordination, longer delivery timeframes and continued partnership with community organisations.

Discussion

Themes of this research around sexual health inequalities due to access barriers, cultural taboos and stigma, are mirrored in current UK focused sexual health literature. Analysis of data from “Reducing inequalities in Sexual Health 2024”, Ogaz et al. (2026) argues that one-in-eight reported unmet need for in-person sexual health services. The common barriers to accessing sexual health services were unavailable or inconvenient appointment times. It is suggested that data from local and joint strategic needs assessments could help address unmet needs for sexual health services. Mcgaughey, Richardson and Vera (2023) discuss the usefulness of integration of harm reduction information into other services and appropriate pathways, as well as a need for services outside of typical business hours. Nagington and King (2022) suggest learning from patients and their peers and engaging in collaborative approaches to practice development, which is in line with findings of this study. Ultimately, this study represents a genuinely novel contribution to the understanding of sexual health equity at a local level, and the research process itself was a rewarding and energising experience. The interviews were rich, candid and deeply informative, with participants demonstrating remarkable passion, insight and dedication to the communities they serve. The MII community workshops brought organisations together in ways that sparked real connection, shared learning and collective enthusiasm. The knowledge generated through this process, both in terms of evidence and in terms of the relationships, confidence and awareness that have been built at grassroots level, represents a significant and asset. There is now a compelling and timely opportunity for a consortium of these organisations to build on this foundation, continuing to develop capacity, sustain the ripple effects of awareness raising that the initiative has already set in motion, and collectively drive the kind of community-led, ground up change that statutory services alone have never been able to achieve.

Two case studies were identified to demonstrate how comparable community-based approaches have successfully improved uptake of sexual health services:

- **Co-production with the Black Caribbean community**

A useful UK example is the NIHR Health Protection Research Unit collaboration between the UK Health Security Agency and University College London, which co-produced culturally appropriate sexual health guidance with Black Caribbean communities (Woode Owusu et al., 2023). By involving service users, community representatives, practitioners and commissioners throughout the process, the initiative emphasised lived experience, cultural competence and collaborative programme design, demonstrating the value of culturally grounded, co-produced approaches to reducing sexual health inequalities.

- **Terrence Higgins Trust — Share Pot, Teesside Share Pot**

The Share Pot project, delivered by Terrence Higgins Trust in Teesside (Terrence Higgins Trust, n.d.), used shared meals to create informal, culturally safe spaces where women from Black and other minority ethnic communities could discuss sexual health. By embedding conversations within familiar community activities, the project successfully reduced barriers to engagement, demonstrating the effectiveness of culturally grounded, community-based approaches that closely reflect the findings of this study.

These findings suggest that community organisations extend the reach of statutory sexual health services by providing trusted access points, facilitating navigation through healthcare systems and embedding preventative sexual health support within existing community relationships. The findings also demonstrate how reductions in community-based resources can undermine this important enabling role and further restrict access for underserved populations.

Conclusion

This study demonstrates that inequalities in access to sexual health services are shaped by a complex interplay of structural, cultural and social barriers that disproportionately affect underserved populations. Participants consistently identified stigma, limited accessibility, lack of culturally appropriate provision and insufficient community engagement as key obstacles to equitable care. At the same time, the findings highlight the considerable potential of community organisations to improve engagement through trusted relationships, culturally responsive practice and co-produced approaches.

The study provides evidence that more equitable sexual health provision requires a shift from predominantly clinic-based models towards flexible, community-embedded services developed in partnership with the voluntary and community sector. Strengthening cross-sector collaboration, investing in culturally competent and trauma-informed practice, and embedding co-production within service design are likely to improve both accessibility and acceptability for underserved populations. These findings offer practical insights for commissioners, policymakers and service providers seeking to reduce sexual health inequalities and support the development of more inclusive, person-centred models of care.

Other information:

The study was conducted in accordance with the British Educational Research Association's Ethical Guidelines for Educational Research (BERA, 2018) and Canterbury Christ Church University's institutional research ethics requirements. Ethical approval was sought from the Canterbury Christ Church University Research Ethics Committee, and approval was granted on the 27/04/2026 approval number ETH2526-0206, and to identify the ethical framework following during the research. Good data protection practices were deployed throughout the research, with all information gathered being held securely at all times.

Declarations

Consent to Participate:

Informed consent was obtained from all individual interview participants. The study involved qualitative interviews with representatives of community and voluntary sector organisations across Kent. Interview data were anonymised, and participant identifiers were used when reporting quotations to maintain confidentiality.

Declarations

of conflicting interest:

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Author Contribution

R.F., N.P. and H.W. wrote the main manuscript. All authors reviewed the manuscript.

Data Availability

The data generated and analysed during this study are not publicly available due to ethical and confidentiality considerations. The data contain information that could potentially identify individual participants and were collected under the terms of informed consent, which did not include permission for public data sharing. The data may be available from the corresponding author on reasonable request,

subject to appropriate ethical and confidentiality safeguards.Ethical approval was granted by the Canterbury Christ Church University Research Ethics Committee (ETH2526-0206).

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