

# Understanding Service Preferences among Consensually Non-Monogamous Individuals Seeking Sexual Healthcare

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## Abstract

Despite consensually non-monogamous people being a minority population with specific healthcare needs, research on this group is minimal, especially in relation to sexual healthcare. This study explores the motivations behind consensually non-monogamous individuals' choices of sexual healthcare service options. Qualitative survey data was collected from 67 consensual non-monogamists and analysed using thematic analysis. Two key themes captured participant perspectives on the selection of sexual healthcare services. "Feeling Comfortable" highlighted preferences for sexually inclusive clinics and LGBT+ focused services due to perceived better quality of care and comfort. "Practicalities" emphasised convenience, proximity and the availability of STI testing options as critical factors influencing service selection. Accordingly, this research provides insight into the specific sexual healthcare service needs, desires and motivations of those who are consensually non-monogamous. Suggestions are made for increased training and awareness when working with relationship diverse patients.

**Keywords:** barriers to healthcare; consensual non-monogamy; sexual health; sexual healthcare services; STI testing

Consensual non-monogamy (CNM), sometimes called ethical non-monogamy, is an umbrella term which refers to romantic and/or sexual relationships in which people have more than one sexual partner with the informed agreement of everyone else in those relationships (Grunt-Mejer and Campbell 2016). There is a wide variety of CNM relationships, with examples such as polyamory, swinging and open relationships (Conley, Ziegler, et al. 2013). It has been estimated that around 3-7% of the North American population currently in a relationship are in a CNM relationship (Hauptert, Moors, et al. 2017). Other studies also indicate notable levels of lifetime engagement. A nationally representative Canadian sample found approximately 20% of people have been in some form of CNM relationship over their lifetime (Fairbrother, Hart and Fairbrother 2019). Hauptert, Gesselman, et al.'s (2017) demographically representative samples of single US residents also found that approximately 20% of participants had at some point engaged in CNM. Public interest, engagement and experiences with CNM are also considerable (Levine et al. 2018). Whilst academic research has begun to investigate various aspects of CNM (Scoats and Campbell 2022), little attention has been focused on physical health.

### **Sexual healthcare is particularly important for CNM practitioners**

In 2016, the National Institute on Minority Health and Health Disparities (NIMHD) in the USA formally designated sexual and gender minorities as a health disparity population (Pérez-Stable 2016) in response to research which has shown that LGBT+ people experience barriers in access to healthcare and poorer health outcomes. Sexual and gender minorities are defined by NIMHD as 'lesbian, gay, bisexual, and transgender populations, as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms' (Pérez-Stable 2016). Levine et al. (2018) argue that consensually non-monogamous people should similarly be considered a vulnerable group that would benefit from further research and health interventions. They share similarities with LGBT+ minorities, in that they too are subject to stigma (Conley, Moors, et al. 2013; Grunt-Mejer and Campbell 2016; Scoats 2020), experience barriers to healthcare (Campbell Scoats, and Wignall 2023; Vaughan and Burnes 2022), and arguably represent a relationship minority (Füllgrabe and Smith 2023) – that is, a sexual and/or romantic configuration that varies from wider socio-cultural norms.

Despite CNM practitioners being identified as a sexual minority with concurrent barriers to health, and very likely being more numerous than all LGBT+ identifying individuals combined (Barton, 2023), research and practice focussing on their healthcare needs is conspicuously lacking (Levine et al. 2018). There is some literature on CNM practitioners experience of stigma in therapeutic settings, which is often explained as a result of therapists viewing CNM as pathological and hence trying to treat it as a problem to be solved (Shernoff 2006; Weitzman 2006; Zimmerman 2012). This stigma laden characterisation of CNM is mirrored in the few papers which exist on CNM individuals' experiences accessing physical healthcare: they are pathologised by medical practitioners in ways that interfere with their receipt of 'medically accurate care relevant to their unique needs and experiences' (Vaughan et al. 2019, 42). For example, Arseneau, Landry and Darling (2019) reported that polyamorous families experienced a presumption of monogamy whereby admission forms only provided the option to identify one partner. The lack of research is surprising, considering that this population has specific healthcare needs as a function of their identifying characteristics. Consensual non-monogamy facilitates the accrual of sexual partners (Lehmiller 2015) and it

is well known that this is significantly correlated with sexually transmitted infections (Niekamp et al. 2011).

Importantly, CNM practitioners appear to be sensitive to their heightened opportunity for risk and prioritise safer sex behaviours. For example, rates of people in CNM relationships who report discussing STI testing history or who use condoms with their extradyadic partner are significantly higher than people who are in non-consensual non-monogamous relationships (Conley et al. 2012). Likewise, CNM practitioners are likely to use sexual health services more than the general population. In Lehmillers (2015) sample of 351 participants, sixty nine percent of monogamous participants answered yes to the question, 'Have you ever been tested for an STI' compared to 77.5% of 205 CNM practitioners. This pattern was replicated in Levine et al.'s (2018) analysis of National Survey of Sexual Health and Behaviour data from the US. Although the size of their CNM group was smaller (N = 83) they reported having tested for STIs in the last six months more frequently than monogamous people (17% vs 7%).

Thus, we have a picture of CNM practitioners as existing in high numbers, being subject to similar healthcare barriers as other gender and sexual minorities (while not being formally recognised as such) and seeking sexual-health testing at higher rates than monogamous people. These factors mean it is important for sexual healthcare providers to understand how and why CNM practitioners engage with their services.

### **Sexual healthcare choices**

Sexual health services can be accessed in a number of ways, from specialist STI-related services such as those to be found in genitourinary medicine and sexual and reproductive health clinics, to young people's services, Internet services, pregnancy and termination of pregnancy services, pharmacies, outreach, and general practice (Ratna et al. 2021). In the UK approximately 50% of the general population access sexual healthcare via their general practitioners, although numbers are lower in people who have previously attended a specialist sexual health clinic (Tanton et al. 2018). However, these data are from general population samples and minority groups (including CNM practitioners) must weigh up additional factors when choosing their sexual healthcare providers (e.g. Hudak and Bates 2019; Martos et al. 2018)

Minority groups, such as gay and lesbian people, have particular difficulties in accessing healthcare as a result of heteronormative attitudes held by health professionals (Alencar Albuquerque et al. 2016). So much so that two-thirds of bisexual and one-third of gay/lesbian people have never discussed their sexual and gender identity with medical staff. This reticence is justified since 84.9% of a sample of medical students in the UK report having no training in working with LGBT+ patients (Ching et al. 2021). Qureshi et al. (2018) reports that in New Jersey, USA at least, there is a scarcity of health professionals competent in LGBT+ health (Qureshi et al. 2018), but the percentage of medical staff who have been trained to work with CNM patients is likely to be even less (Elaut 2023).

Existing studies which have examined CNM practitioners' experiences seeking sexual healthcare paint a similar picture to that for LGBT+ patients. Campbell et al. (2023) found that only 63% of UK and North American participants reported disclosing their relationship status to a clinician when accessing sexual health services, mainly due to anticipation of, or past experience with, negative judgements and behaviours on the part of clinicians. Arseneau et al. (2019) found that polyamorous families in Canada experienced similar marginalisation when accessing pregnancy care. Vaughan et al. (2019, 48) highlighted how CNM patients in

the USA often relied on recommendation from their CNM networks to help find care providers that would fulfil their desires for acceptance, accurate medical care, and ‘an open and collaborative relationship with providers about their sexual health’.

It is important for patients to be able to disclose sexual, gender and relationship identity so they can receive appropriate healthcare. In 2016, the UK NHS launched “Pride in Practice”, offering support for staff and LGBT+ patients in advocacy, advice and training. This has improved sexuality and gender identity monitoring (87% of the services involved now record this information) but no part of the initiative was focussed on relationship minority patients (Ching et al. 2021).

Acknowledgement of CNM practitioners as a specific group with additional sexual health needs compared to the general population has been lacking. Indeed, the number of clinics that record relationship status is small. A study conducted by clinicians at an STI clinic in The Netherlands reported that they have systematically registered whether a visitor is a swinger or not since 2007, but this is not common (Spauwen et al. 2015). To date, no research has investigated which types of sexual healthcare services CNM people choose to access or the reasoning behind those decisions.

## **Materials and Methods**

### ***Participants***

This research article took place as part of a larger study on consensual non-monogamy and engagement with sexual healthcare (see: Campbell et al. 2023). Participants were gathered using snowball sampling via the researchers’ personal networks, postings on social media including relevant hashtags, and sharing with relevant communities and groups via social media. Participants could be anyone who recognised themselves as consensually non-monogamous including but not limited to swingers, polyamorous individuals, relationship anarchists etc. irrespective of whether they were currently in a relationship or not, or whether they aligned with a specific identity label. Participants were able to describe their consensual non-monogamy using free-text responses which were subsequently cleaned and coded into categories by the authors.

After data cleaning we were left with 67 participants’ data. The broad categorisation of CNM types expressed included: 48% polyamorous; 42% relationship anarchy/solo polyamory; 6% swingers; 4% uncategorised. Most participants identified as British (57%), white (90%), bi/pansexual (67%) and currently resident in the UK (76%). For a more detailed overview of participant demographics, see Campbell et al. (2023). In this paper, an individual’s demographic information is included after participant quotations in the format of age, self-described sexuality, gender identity, and relationship structure/setup.

### ***Data collection***

Participants were directed to an online survey hosted on [onlinesurveys.ac.uk](https://onlinesurveys.ac.uk) which was open between the 25 February 2020 and the 31 December 2020. They were provided with the following information about the study:

Welcome to this survey on the sexual healthcare needs of consensually non-monogamous people... We’d like to invite people who identify as consensually non-

monogamous to answer this online survey about their experiences talking to their personal doctors, to staff in hospitals and in sexual health clinics...There are no restrictions on the type of consensual non-monogamy that we're expecting: swinging, polyamory, relationship anarchy, for example, are all interesting to us. You also don't have to currently be in a relationship. If you consider yourself to have had, or to currently be in a consensually non-monogamous relationship, we're interested in hearing about your experiences.

The survey included a mixture of demographic, quantitative, and qualitative questions. This article focuses on the findings from two free-text questions regarding healthcare service provider preferences: namely, 'how frequently do you use sexual healthcare services and what sort of services are they', and 'is there a reason you choose one type of service over another?'. Ethical approval for the study was received from St Mary's University ethics review board (ref SMEC\_2018-19\_053). Informed consent was obtained from all participants. No monetary incentive or reward for taking part in the research was offered. All names and identifying information have been changed.

### **Data analysis**

Data underwent reflexive thematic analysis (Braun and Clarke 2021), selected for its flexible approach to exploring participants' experiences and meaning making (Braun and Clarke 2006). Employing an inductive approach (Nowell et al. 2017), we grounded our themes in participants' accounts rather than imposing a pre-existing framework. Initially, both authors immersed themselves in the data independently to create the first set of codes.

Together, the authors then discussed and collaboratively refined these codes to explore potential latent codes. At this stage, initial themes were generated (Braun and Clarke 2006). Discrepancies in author analysis were addressed by revisiting the data and discussing how coding and themes were supported by the data. Themes were (re)organised until it was agreed that we had captured 'patterns of shared meaning' (Braun and Clarke 2019, 592) and the data were meaningfully and accurately represented by the chosen themes (Nowell et al. 2017).

Data analysis was conducted collaboratively by both authors. The first author is a sociology academic with expertise in researching CNM and a wealth of experience conducting thematic analysis. The second author is a psychology academic with similar expertise in CNM and qualitative analysis.

### **Findings**

Participants responses to the questions 'how frequently do you use sexual healthcare services and what sort of services are they?' and 'is there a reason you choose one type of service over another?' have been organised into two core themes. The first theme highlights how participants perceived and experienced different healthcare venues and practitioners as being more inclusive, thus increasing the likelihood that they would choose to use those services. The second theme demonstrates the (in)convenience of some services, often contextualised in terms of time-commitment, influences care choices and how the current lack of choices remove any meaningful selection in service use.

## ***Feeling Comfortable***

This first theme highlights the importance of both organisations and individuals in fostering welcoming sexual-healthcare environments for sexually active CNM people. In particular, it was found that both sexual health clinics and services focused on providing care to LGBT+ groups were generally perceived as being most likely to offer inclusive, non-judgemental sexual healthcare. In addition to the perceived focus and reputation of the organisation, it was also clear that individual clinicians could have a positive impact on patients' experiences of comfort regardless of the organisational context clinicians worked in..

Many participants highlighted that they felt sexual health clinics were more likely to be understanding of their CNM. One participant described a clinic which they worked in (and used themselves) that was actively 'open to non-monogamy without judgement' (28, gay, trans man, polyamorous). They went on to explain that this was a motivating factor for some of the clients attending: 'I have many service users who come to our services specifically because we are non-monogamy friendly and they have received negative reactions to their polyamory'. More commonly, however, participants contrasted their preference for a sexual health clinic with seeing their general practitioner (GP). As one participant said, 'I prefer going to sexual health clinics rather than seeing a GP, simply because the clinics will be much more open and understanding' (30, bisexual, female, solo poly/relationship anarchy). Another participant echoed this sentiment: 'The sexual health clinic is non-judgemental and more anonymous than the family GP' (42, bisexual, cisfemale, swinging). This perceived reduction in judgment was potentially a result of sexual health clinics being more accustomed to dealing with a diversity of patient sexual histories: 'I trust sexual health clinics more and I feel more at ease than with the GP as they see more patients and are used to all kinds of sexual history' (40, bisexual, female, relationship anarchy/polyamory). However, not all participants experienced sexual health clinics as being accepting, just posing potentially fewer risks than seeing their GP: 'Sexual Health clinics are informal—you get average judgement... [The] GP would be too familiar and I'd rather not risk being judged or outed' (22, bisexual, female, triad)

Although sexual health clinics were often considered preferable than going to a GP, participants emphasised how services catering to other marginalised groups, such as the LGBT+ community, were also more likely to be inclusive: 'I go to this clinic because of its stated and proven commitment to non-judgementally serving marginalised communities (gender and sexual minorities, sex workers, immigrants and those without access to health insurance)' (30, bisexual, female, open marriage). The perception of enhanced acceptance at LGBT+ focused venues also meant that some people would disclose rather than withhold their CNM status:

Generally, when seeing [specific sexual health charity] they ask about gender of partners, not number or relationship model. However, they feel more familiar/safe due to being an LGBT charity, so I have disclosed [my CNM] to them. Generally, when seeing NHS sexual health services, I am asked about number of partners/recent sexual experience but do not disclose my full poly status. (34, pansexual, female, polyamory/relationship anarchy)

Highlighting the difference between different types of sexual health services, one participant described prior negative experiences: 'In previous sexual health clinics I have received judgement both for being trans and for being polyamorous. It has only been in LGBT spaces where I have not experienced judgement.' (28, gay, trans man, polyamorous).

In addition to the perception of specific venues being better suited to their healthcare desires, some participants cited good relationships with specific clinician: 'I am new to [ethical non-monogamy] (in the last year) but I feel comfortable with my current doctor' (41, bisexual, female, polyamorous), and 'I go to my obgyn bi-yearly. He is aware of and is supportive of my lifestyle. Is open to any questions and has given me permission to call of I need anything outside my normal visits' (34, bicurious, female, monogamish/swingers/sometimes poly). Another participant described an encounter a clinician who they then made a specific effort to seek out in the future: 'I had an appointment randomly with this nurse and she told me what days she worked on. She made me feel so empowered about my lifestyle choices that I always book an appointment on the days she's working' (25, bisexual, female, polyamory). Clearly these sorts of dynamics are desirable. Another another participant described actively searching for this sort of relationship:

I'm touring gynaecologists trying to find one who is open and non-judgy. I prefer using them as there is more space to create a custom consultation and I'm hoping to ultimately build a relationship where I don't have to explain my life. Haven't found a perfect person yet (31, bisexual, cisfemale, hierarchical open relationship).

Less frequently, the opposite scenario was also true; particular people impacted on how and when patients would use specific services: 'I use the "walk in Local clinic" rather than the GP for STI screening due to a bad experience with the GP' (43, pansexual, gender non-conforming, relationship anarchist). Another participant said the difficulty in finding a non-judgemental gynaecologist meant they were attending appointments less than they might otherwise: 'I admit only going to the gynaecologist once a year or less, since it is a struggle to find someone that is non-judgmental about my sexual orientations and that consequently does treat me with care during examination' (36, heteroflexible, female, open non-monogamous relationships).

Some participants specifically described LGBT+ clinicians as more likely to be understanding: '[I] find LGBTQ people are far more accustomed to and accepting of [CNM] so it's easier when going to LGBTQ-specific services' (37, gay, male, open relationship). Another participant described a similar situation with their GP: 'I did start going to my GPs because one of my partners told me they were nice, and gay, and catered to LGBTIQ+ individuals. That wasn't directly connected to our non-monogamy, but I think it's still relevant' (31, queer, non-binary/genderqueer, antihierarchical queer relationship). This same participant went on to describe the greater ease they felt when talking about sex with the clinician because they were gay, although they still perceived the practitioners in the service as somewhat (homo)normative in other respects:

My (equivalent to a) GP's office is run by two gay men, and it's focused on LGBTIQ+ people, which makes talking to them about sexuality-related so much easier....I both trust my GPs more because they're gay and have a primarily LGBTIQ+ clientele, and it's convenient to not have to go to specialised clinics. (Though I don't trust them unconditionally. Like, I did sometimes get the impression that they didn't \*really\*

understand or were maybe also limited by their still relatively mainstream gay rather than queer perspective).

In summary, participants perceived some services and individuals as more likely to be welcoming and non-judgemental of their CNM. Although acceptance could be found across a range of services and staff, most commonly in sexual health clinics, those services geared towards LGBT population and LGBT staff were perceived as being the most welcoming.

### **Practicalities**

The second theme relates to the practicalities of getting tested for STIs as a factor influencing participants' choice of service. Practicality considerations acted as both push and pull factors, and it was common for participants to highlight multiple factors in explanations of their decisions stressing both convenience and lack of alternatives.

### **Convenience**

Overwhelmingly, participants spoke about convenience as a reason why they used specific services. Although some participants simply responded with a one-word answer ('convenience') when asked 'is there a reason you choose one type of service over another?', others were more explicit about what this meant. Participants' choice was often framed in terms of efficiency and the time commitment needed to engage with a particular service of venue.

For some, convenience meant whatever was geographically close to them, thus saving time and effort: 'Proximity to work, home, to save time' (38, bisexual, female, polyamorous); 'Sexual health clinic is local and knows our dynamic' (32, bisexual, female, non-hierarchical polyamory); 'GP is easiest to get to and [I] can fit sexual health things into other appointments for different issues' (27, pansexual, non-binary, ethical non-monogamy/polyamorous). Typically, participants preferred several reasons for their choice of where to attend. For example, venues needed to provide an adequate range of testing options as well as being accessible: 'Easily accessible and offers a wider range of services' (27, gay, male, polyamorous); 'Accessibility and range of testing' (43, heterosexual, male, hinge in a vee).

Participants were also deliberate in their selection of services, utilising different services for different needs as well as engaging with less time intensive options (such as self-tests) when these were deemed likely to meet their needs. STI self-tests kits were commonly used as a regular precautionary measure either when people had new partners or at regular points throughout the year; GPs were for specific needs to be met; and sexual health clinics for both the former and the latter: 'Sexual health clinic for screening annually. GP for thrush, perimenopause' (40, homoflexible, femme dyke, relationship anarchy); 'Postal testing every time there's been a new person, GP if something is wrong, Sexual health clinic every 3-6 months for contraceptives' (28, pansexual, female, open polyamory); 'I get tested regularly via sexual health clinics and postal testing. I use sexual clinics if I have any symptoms and follow up with my GP if needed' (40, bisexual, cisfemale, relationship anarchy/polyamory).

Another aspect of convenience related to the ability of users to get an appointment, or book easily: 'Availability of appts [sic] and range of tests offered' (30, bi/pan, female, ethical non-monogamy); '[I] go to the NHS clinic, [I] can get appointments there as opposed to the other services' (30, gay, male, polyamorous). There was some indication that the ability to

secure an appointment was connected to the time saved: 'I use the local GUM clinic as it's convenient and if I book an appointment in advance, the wait isn't too bad' (53, heterosexual, male, polyamorous). Another participant described how the inability to get an appointment as well as time-constraints encouraging them to engage with self-test, take-home STI kits: 'In my area of [city name] you can't get a GUM clinic appointment unless you're presenting symptoms and walk-in centres are inconvenient (because of the waiting times), so home kits are the best way for me to get checked' (36, bisexual, cisfemale, hierarchical polyamory). Postal testing was described by some participants as 'convenient' and 'easy', thus saving time over a trip to physical clinic, but other participants described difficulties with the home tests, particularly blood collection: '[I] can't do a blood test reliably with the home kit' (37, bisexual, agender, relationship anarchy). Another participant described their frustration both with the home tests and being able to fit in an appointment at a clinic:

I tried postal testing but found it very frustrating. I was unable to get enough blood for the blood test and ended up having to go to the clinic anyway. I tend to go every six months or so or if I have unprotected sex with someone or whenever one of my partners had unprotected sex with someone else. It's getting increasingly harder to find time to do this, though, as my job is a demanding 8am to 6pm affair... I'd prefer to do postal tests, but as mentioned before, found it too difficult to do these. I wish there were more clinics with longer openings hours. As it is, I'll have to take time off work to go to an upcoming appointment. The only time I could book in advance was during work hours. (30, bisexual, female, solo poly/relationship anarchy)

### ***No alternatives***

Sometimes, participants did not have to make a choice because of limited available options: 'There is only one service' (47, bisexual, female, relationship anarchy); 'Only option available in my area' (27, bi/pan/queer, woman/grey gender, polyamory); 'Don't know how to access any other options' (23, bisexual, female, polyamorous/fidelitous polyamory). Others described an absence of particular options, such as self-test kits, implying that these would be used if available: 'Convenience and lack of availability of self-test kits in my borough' (27, pansexual, non-binary, non-hierarchical polyamory); 'Easiest to access, GP does not offer testing, not aware of a postal service' (56, pansexual, male, polyamorous). Equally common, however, there were compromises that patients were unwilling to make, such as long waiting times or the inability to get certain tests done, which limited the perceived options available and created a feeling of there being no alternatives: 'Can't do a blood test reliably with the home kit. Sexual health clinic is right near my office and open every day. The [other] one ... the doctors' surgery in the village I live in has opening hours that are useless to me' (37, bisexual, agender, relationship anarchy). Accordingly, some participants explained their selection of care provider in terms of it being the least bad option:

We did have a [sexual health] clinic right on our road, but it closed and then the only local option was in a hugely oversubscribed hospital service. I would have to attend multiple days and times in order to get an appointment. They had a phone booking service but were always too busy to actually book in this way. In our previous home the local council did not support postal testing, so we didn't have this option available. We have since moved house and so tried the postal kits. Unfortunately, getting the

blood required from finger pricks is really difficult and so those tests couldn't be run this time. (34, bicurious, cisfemale, swinger)

Another participant described the difficulty of long wait-times, but they had yet to find a comparable service elsewhere so had continued to attend the same service despite the problems:

I use a drop-in clinic in the centre of [city name], every 3-6 months depending on sexual activity. I have been looking into postal services because the drop in is always very busy and you have to arrive very early to guarantee being seen, and then wait around often for several hours to be seen. The postal offers I have found haven't offered as comprehensive [a range of] testing as the drop in, so I haven't switched yet. (30, bi/pan, female, ethical non-monogamy)

## Discussion

This paper has focused on the sexual healthcare service preferences of consensually non-monogamous individuals, exploring the services participants used and why. The findings highlight that although there were clear preferences for some services over others—in particular, LGBT+ services and staff were perceived as more desirable as they were less likely to stigmatise participants' CNM—choices were made within the wider context of what was practical or what was available. Accordingly, while some participants were able to engage with services based on whether or not they met their needs, others effectively had little choice. This research builds upon the limited previous research into the physical healthcare needs of CNM groups (See: Vaughan et al. 2019; Campbell et al. 2023) but is the first to provide an in-depth exploration of the wider context of service provisions as a factor in sexual healthcare decisions.

Overall, many participants did not want to seek sexual healthcare from their GP. Participants were of the view that, compared to a sexual health clinic, GPs would be less accustomed to dealing with issues relating to sexual behaviour and so were less likely to be non-judgemental or open in these discussions. Participants also spoke about the value of anonymity versus the GP being “too familiar” (Baker et al. 2013), suggesting that some wanted to keep a distance between their CNM status and other areas of their life.

Sexual health clinic workers were also perceived as being more used to sexual diversity, and consequently less likely to be surprised by CNM. Additionally, participants highlighted a preference for sexual health clinics and services that catered for other marginalised populations and, in particular, the LGBT+ community. Given the higher frequency of CNM within the LGBT+ population compared to those who are heterosexual (Levine et al. 2018) it seems likely that those working in LGBT+ focused environments will already have more experience of working with CNM clients.

Like other marginalised groups (e.g. gay, bisexual, and transgender men; Scheim and Travers 2017), when choosing healthcare CNM practitioners must weigh up the risks (and fears) of stigma in addition to the other practical concerns—long wait times, types of testing, and range of services available (Martin et al. 2022; McDonagh et al. 2018).

Despite participants' general preference for sexual health clinics over GPs, and LGBT+ focused sexual health clinics over generic clinics, individual clinicians could still make a

positive impact on participants regardless of where they practiced. Writing about sexual minorities, Alencar Albuquerque et al. (2016) note that welcoming attitudes helps improve access to healthcare. There are numerous things that individual clinicians can do to increase levels of trust between themselves and service users. Using inclusive language, not making assumptions about relationship structures, familiarising themselves with terminology and practices within communities, can all improve the relationship between practitioner and patient and make it more likely that patients will reveal treatment relevant information (Flicker 2019).

There are also adaptations that clinics can make to administrative procedures which would make it more likely that CNM practitioners would feel safer and less likely to experience stigma. For example, Waldura's kinky participants were positive about a suggestion that clinicians could add a catch-all question like "what else would you like me to know about your sexuality, so I can take best possible care of you" to the end of a sexual history intake form (Waldura et al. 2016). Clinics and surgeries could also make structural changes such as making provision for more than one partner to attend appointments with a patient rather than assuming there is only one.

In summary, this research highlights how and why individuals who practice CNM choose the sexual healthcare services they engage with. Although motivations for service selection were multi-faceted and shared many of the features found in broader research on sexual healthcare, decision-making processes were more similar to those found among other groups such as LGBT+ patients. Thus, when considering facilitators and barriers to CNM healthcare it is important to recognise that practitioners have distinctive needs and concerns beyond those of the general population. As others (Flicker 2019; Waldura et al. 2016) have recommended, when planning future provision service providers need to reflect on and understand the needs of this population as well as the barriers individuals may face. By active consideration of both facilitators and barriers to care, services can help provide a more inclusive care environment for the CNM population and ensure their needs are met.

## **Limitations**

Similar to other studies using open-text responses, there are limitations relating to the possible lack of context and the inability to clarify participant responses further. Data is thus subject to potential misinterpretation or over-interpretation. Despite these challenges, the themes are consistent with other research on this topic (e.g. Vaughan et al. 2019). Furthermore, while snowball sampling may be effective in accessing hidden populations this approach may contribute to the lack of diversity within samples (Scoats and Campbell 2022). As the majority of our sample is white, identifies as British, and lives in the U.K., it is important to recognise that patient identities, socio-cultural contexts, and institutional differences may impact patient experiences and motivations.

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