


The appropriateness of self-care policy for urinary tract infections among women from racialised minorities and low-income households in the United Kingdom: A qualitative study

Journal of Health Services Research & Policy
2025, Vol. 0(0) 1–9
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DOI: 10.1177/13558196251313736
journals.sagepub.com/home/hsr


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Abstract

Objectives: Urinary tract infections (UTIs) can negatively impact quality of life, especially when recurring. Patients often seek medical advice to relieve painful symptoms. UTIs are also the second most common reason antibiotics are prescribed in English primary care. However, overuse and long-term use of antibiotics for suspected UTIs in women can lead to antibiotic-resistant bacteria, making future treatments less effective. The UK's 2019-24 Antimicrobial Resistance National Action Plan aims to raise public awareness about the risks of overusing antibiotics and encourages self-care for minor infections, like uncomplicated UTIs. We explored how feasible and appropriate this approach is.

Methods: The transcripts from four online focus groups and 19 one-to-one online interviews involving 25 racialised minority and/or low-income women were analysed thematically. Meetings with lay members of the public with similar socio-demographics and experiences to those we planned on recruiting for the research helped to orientate the study, refine its materials and enhance its recruitment strategies.

Results: All participants spoke about UTI-related anxieties, which they experienced differently depending on the frequency and the course of UTI episodes, and how knowledgeable they were about the symptoms. Participants often practised self-care for UTIs before seeking professional advice. They saw consultations with health care professionals as valuable for managing the symptoms of UTIs and navigating self-care options. Those with recurrent UTIs felt they could recognise when they required antibiotics and, therefore, they felt they could take responsibility for minimising over-prescribing. Barriers to self-care included high pressure working days and not being able to take time off work to recover.

Conclusions: Participants in our study were often able to self-diagnose and assess the severity of their symptoms, which makes them partners in efforts to improve antibiotic stewardship. They still valued consulting professionals for advice and support about their UTIs, irrespective of whether they received a prescription.

Keywords

AMR policy, UTIs, health care access

Introduction

Uncomplicated urinary tract infections (UTIs), also known as cystitis or lower urinary tract infections, are among the most common bacterial infections.¹ The incidence of UTIs in women is considerably higher than in men, with an estimated 60% of all women experiencing an uncomplicated UTI at least once during their lifetime.² Even though UTIs are associated with short-term morbidity, they may have negative implications for quality of life, especially if recurrent.^{3,4} Recurrence is common: 27% of women

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experience a confirmed second UTI within 6 months of their first. A cross-sectional survey performed among Dutch women has shown that recurrent UTIs result in 2.4 days of restricted activity and 1.2 days of time off work, and have negative impact on sexual activities and ability to participate in social and sports activities.³

While many cases of uncomplicated UTIs resolve on their own, without treatment, patients often seek medical advice on how to relieve painful symptoms.⁵ In English primary care, UTIs are the second most common condition for an antibiotic prescription.^{6,7} While presumptive treatment with antibiotics has been justified on the grounds that it will reduce the risk of complications,⁸ overtreatment of uncomplicated UTIs with antibiotics has been a concern^{3,8} as improper use and prolonged administration of antibiotics may lead to the development of resistant microorganisms, thereby compromising the effectiveness of antibiotics and posing challenges for future UTI treatment.⁹

Improving antibiotic stewardship in the management of acute infections, such as UTIs, was a goal of the UK 2019-24 Antimicrobial Resistance (AMR) National Action Plan (NAP). The plan included a commitment to '[r]aise public awareness to encourage self-care and reduce expectations of antibiotics.'^{10(p55)} In the case of UTIs, the National Health Service (NHS) website identifies several self-care activities, such as drinking water, attending a pharmacy to purchase painkillers, purchasing over-the-counter (OTC) medications, such as cranberry-based products (sachets, powders, and pills), and ensuring personal hygiene.¹¹ The National Institute for Health and Care Excellence¹² and former Public Health England¹³ have also encouraged self-care practices to improve the symptoms of uncomplicated UTIs for patients who are otherwise healthy before consulting a health care professional. On the other hand, the Scottish Intercollegiate Guidelines Network stresses that decisions on how to manage UTI symptoms, either with antibiotics or self-care, should consider their impact on patients' work responsibilities, responsibilities to care for others and any other daily activities.¹⁴ This consideration was missing in the UK 2019-24 NAP. Yet, for some women, waiting a few days to ascertain whether self-care would be effective is financially, socially, and emotionally unmanageable^{3,15,16}

The emphasis on self-care is also likely to have been encouraged by the current difficulties faced by patients in seeing their general practitioners (GPs) in the National Health Service (NHS) due to high levels of demand and shortages of GPs.¹⁷⁻¹⁹ UK UTI and AMR policy is not the only place where framing of self-care as a solution to a stretched health workforce can be seen. The World Health Organization has framed self-care as a promising answer to the global shortage of health workers, which would help realise universal care²⁰ Yet, it has been argued that the way in which the self-care narrative in health care policy relies on self-reliance is potentially harmful when it ignores pre-

existing social and economic inequalities, which often contribute to poorer health.^{21,22} Racialised minority groups in the UK experience poorer clinical outcomes,²³ partly due to unequal access to health care and discrimination when using services.²⁴ Those with limited resources or unstable jobs may also struggle to take time off for recovery or afford OTCs for self-care. Managing health is especially difficult for individuals who cannot afford basic needs like food and heating, with stress and anxiety further hindering their ability to prioritise their health.²⁵

While the UK 2019-24 AMR NAP presented self-care as a tool for antibiotic stewardship, this approach must be understood within the broader context of growing challenges in health care access. To explore its feasibility and appropriateness, we examined how women from racialised minorities and low-income households—those most at risk of not being able to engage with this policy. In this paper, we explore their experiences with UTIs, their approaches to self-care and to accessing professional care for treatment and symptom relief, and thus whether a policy of self-care is appropriate for these women.

Methods

We advertised the study on the Call For Participants online platform (www.callforparticipants.com), social media platforms, through word of mouth and through leafleting in two shopping centres in south London, stating that we were looking for women who had experience of UTIs (professional diagnosis was not required) and who identified themselves as from racialised minorities and/or lived in a household with an income below £19,000, and were living in the United Kingdom. Twenty-one participants were recruited through the Call For Participants platform and four were recruited through word of mouth. We conducted four focus groups with 20 women: one with women from low-income households (FG1), one with women from racialised minorities (FG2), and two with women who identified themselves as belonging to both groups (FG3, FG4). Fourteen focus group members then took part in a follow-up in-depth semi-structured online interview. In addition, we interviewed another five women who expressed a wish to participate in the study after we had finished conducting the focus groups. Focus groups were one hour long and interviews lasted between 30 and 60min. Participants were offered £25 each time they participated.

Focus groups are a qualitative method used to gain in-depth insights into social issues from a selected group rather than a statistically representative sample. Online focus groups, in particular, help reduce barriers for low-income and minority groups, as they eliminate the need for resources like childcare and transport.²⁶ Although we could cover these costs, participants would still have to pay

upfront and engage in the unpaid labour of arranging childcare. Moreover, taking time off work could be difficult, especially for those in unstable employment.

Focus groups provided insights into shared experiences with UTIs, self-care practices and access to professional care, while semi-structured interviews allowed participants to express personal views more freely in private. During the online focus groups, most participants kept their cameras off, which can enhance anonymity and encourage openness,²⁷ but the lack of visual cues made interpreting silences difficult. As a result, the facilitator had to guide the conversation more actively, prompting individuals to speak. This made the dynamics of the focus groups similar to those of individual interviews, with participants sharing as openly in groups as in one-on-one settings.

Online focus groups were facilitated by AP, accompanied by a colleague who took notes. AP, a white woman in her late 30s with over 10 years of experience in qualitative research, introduced herself to participants as a university researcher without medical knowledge of UTIs, and independent of policymakers and the NHS. During the discussions, participants shared their medical histories regarding UTIs, how they sought and accessed advice from health care professionals and others, their self-care practices, and the role of self-care in their lives. The focus group discussions and interviews were transcribed verbatim and thematically analysed through a collaborative coding process by AP and REG.

Patient and public involvement and engagement (PPIE)

The study design and recruitment methods were discussed in three meetings with lay members of the public who shared similar socio-demographics and experiences as the target participants. These meetings helped refine the study materials, shape recruitment strategies, and identify challenges faced by potential participants. For example, we were advised to avoid asking about residence due to possible homelessness among low-income women, so we inquired about their health care access instead. We also invited PPIE members to co-lead focus groups and interviews. Although two initially volunteered, they later chose to stay in advisory roles after deciding they were not ready for direct research involvement, despite our offer to provide methods training.

Results

Out of the 25 participants, eight lived in households with an income below £19,000, seven identified as belonging to a racialised minority and 10 belonged to both groups, meaning that they lived in a low-income household and belonged to a racialised minority group. Among the 17 participants who

belonged to racialised minorities, 14 identified as Black and three as South Asian. Most participants accessed NHS services in London (76%), others accessed services in Southeast England (8%), Northwest England (8%), Southwest England (4%) and Wales (4%). All participants had been diagnosed with a UTI at least once and most reported recurring UTIs, with symptoms including pain, increased urgency to urinate and ‘unpleasant’ smell. Most participants were able to access knowledge about self-care for UTIs before accessing professional advice and treatment. Self-care strategies they employed included increased water intake, taking time to rest and being more mindful about hygiene. Only one participant had never accessed NHS services for UTI symptoms.

Our thematic analysis of the transcripts revealed four main themes: (1) anxieties related to UTIs; (2) the assumption of personal responsibility for health, often accompanied by feelings of guilt or blame for not maintaining *good* health; (3) facilitators to self-care practices adopted by participants; and (4) the barriers to effective self-care. Across these themes, the significance of support—whether from health care professionals or informal networks such as friends and family—became evident in how well participants managed their UTI symptoms, the impact of these infections on their lives, and the speed of their recovery.

Anxiety related to UTIs

Women spoke about UTI-related anxieties, which they experienced differently depending on the frequency and the course of their UTI episodes, and how knowledgeable they perceived themselves to be about the condition. Experiencing UTI symptoms for the first time seemed to induce most anxiety, but subsequent episodes were also described as distressing. The initial anxiety often resulted from not knowing the cause of the symptoms, and other anxiety stemmed from (perceived or feared) judgment and potential future health consequences. Most participants admitted to not having heard of UTIs before being diagnosed:

Yes, I was worried because the symptoms for UTI are very, very rare to come across, and once I started feeling pain and itchy, I was worried maybe I had contracted something that did not even have a cure. (P15)

Well, I was kind of hesitant to even Google because it’s a new thing for me, I won’t lie: it’s the first experience, so I felt fearful. (P9)

Some participants described their distress as caused by the perceived unpredictable nature of UTIs, especially when symptoms changed during the infection:

My worry was that it wouldn’t go away. Or that it would become more intense, and I wouldn’t know what to do ... Some

days I would wake up feeling better, but some days I would feel worse. (P22)

Every time it flares up again I kind of fear that it will last that long, so I kind of do everything in my own ability to kind of make sure it doesn't, and then it goes away and then that's very confusing because I don't really know what that means. (P23)

Recurrent UTIs were particularly feared as potentially indicating more severe health problems. In those instances, participants indicated that they would benefit from being reassured about their health by being tested:

My biggest fear is the kidneys because once it affects the kidneys, then it means it's something serious, and, yes, it might lead to a big problem. So that's my biggest fear: it causing a kidney infection, because, due to the reoccurrence, I'm worried that it might be something serious. (P9)

If something is wrong with your urine, passing urine, if you're having difficulties, it's all related like, connected to your kidneys. So, I think, if I had something for quite a long time and it wasn't going, I would be more inclined to get more tests done, just because I would be worried about is something wrong with my kidneys. (P6)

Participants often reported feeling uncomfortable about disclosing their symptoms to a medical professional. They admitted fearing being judged for lack of hygiene or having multiple sexual partners. For those reasons, some participants expressed preferences regarding the gender of their GP:

For me, I think I would probably find it easier talking to a female doctor or female nurse. I think the thing that's changed for me is, as I said to you before, I recently had a baby. So now, I have no qualms about talking about anything to do with bodies because I just tell everyone about everything all the time, but I think before, it felt very private, very intimate given the area that you're talking about and the circumstances by which you might get UTIs. (P7, FG2)

I personally prefer talking to a male doctor compared to a female doctor ... I find it weird talking to female doctors because I tend to take them as judgemental. They tend to judge. I'm sorry to say that ... Maybe some cases reoccur from sexual activity. So, talking to female doctors, they would think that it's because they are maybe sexually active, which is not the case at some point. (P11, FG2)

I'd prefer a female doctor. Yes, because I believe once in every female's lifetime, they go through the same issue. So, I believe they have an idea of what I'm going through. (P10, FG2)

Due to the nature of UTI symptoms, participants told us that when experiencing them for the first time, some had misread the symptoms as indicating sexually transmitted

infections (STIs). As a result, they expressed worries typically related to STIs, such as concern about their intimate relationships and their partners' unfaithfulness. In one case, the participant found herself at risk of divorce when her husband assumed she had contracted an STI outside their relationship:

My husband was, 'You are sleeping with other men outside there. No, this is STI.' He could not understand the difference between a UTI and an STI ... I told him we shall see the doctor. That's when he said, 'If it is an STI, I'm calling for a divorce.' I also didn't know the difference between the STI and the UTI. So, I was also confused - now my marriage is going to crash. But the doctor made it clear between the difference and I had a UTI, which is now treated. (P14)

This participant also described how she and her husband had safely received mediated partner disclosure (where the GP invited both the interviewee and her husband to explain the diagnosis). This ensured they both understood that UTIs are not sexually transmitted.

Personal responsibility

Themes of responsibility for one's health and, as often followed, blame for failing to maintain *good* health, were prominent in our focus groups and interviews. Some participants blamed themselves for acquiring UTIs, seeing it as resulting from poor hygiene:

Maybe sometimes by mistake, something happened and maybe I am not so clean, yes, something like that. But I think most of the time, I keep a good hygiene. (P17, FG3)

Women would sometimes reassure us about the ways in which they practised what they saw as *good* personal hygiene:

I'm very hygienic. If I'm off from work [because of UTI symptoms], the first thing I do is shower. I don't sleep on - I use cotton panties, I sleep with no panties as well, so there is more aeration. When I'm having my periods, I tend to use - to change them frequently, like five times or six times a day, and I don't have a heavy flow, so you see. Also, I don't shave completely, I just trim a little bit ... So I feel like I've used extra care and taken care of myself, and I'm very careful. (P2, FG1)

Participants had different strategies to ensure that they sought professional help in what they saw as a responsible manner. In particular, participants who experienced recurring UTIs told us that they knew when home remedies were insufficient, and they needed medical attention. For example, a woman who had been experiencing episodes of UTIs for the past 12 years, told us:

When I first started getting them, I would see the GP. But, I don't know, I just don't anymore. I just feel like I'm OK, like I can just sort it out myself now most of the time ... If it doesn't go, then I would contact the GP and get antibiotics. (P1)

Despite taking on the task of risk assessment, some participants felt that the knowledge they had of their bodies and the responsibility they took to minimise overprescribing of antibiotics were not recognised by health care professionals:

They usually tell me to wait a few days, whereas, like, I know in my experience that can go on to my kidney, and I'm very sensitive to that. So, kind of, when I'm telling them that it feels as though they're not really, like, trusting that I have done what I can do up until that point to kind of try to resolve it. And as if I haven't waited, kind of, to know that it's a UTI and it's, like, not trusting that I know in, like, I know my body enough to know what the difference between like thrush and a UTI, and or just being like irritated, kind of, like the difference between all those things. (P23)

In one instance, the delay in treatment resulted in a difficult-to-treat kidney infection:

I know what symptoms feel like, and I knew that it was worse. I knew that it was something much, like, it was more than just a regular one ... I think they were very convinced it was just a regular UTI. (P24)

One woman believed that health professionals tend to dismiss or undervalue patients' health worries and disregard patients' knowledge of their own bodies. She identified this as a systemic issue affecting women:

It's, like, quite prominent on my mind at the minute speaking with one of my friends, because she's currently just been taken to hospital for an infection and, kind of, has been trying to get an appointment with doctors and trying to get an emergency appointment. And it turned out not to be a UTI, but everyone on the phone and 111, the GPs, the sexual health clinics, were all kind of telling her just not to use perfumed soap and to use like hot compresses and stuff like that. And it's been like a main topic with all me and my friends at the minute because ... of not having taken her seriously and, kind of, women's health seriously. (P23)

Faced with barriers to timely access to professional health care, participants told us about the strategies they employed to ensure they would not be left without necessary help. One of the participants told us how she would contact her general practice as soon as she got the first symptoms – only in this way she could be sure that she was going to see her GP if and when the infection progressed:

It is best to do it earlier because for the first couple of days they will tell me to take paracetamol. But I would still go to the GP. I think there is no point in waiting it out, it's best to act on it as soon as the problem arises rather than to wait until it gets worse and then have to go through all the bureaucratic system of getting access to a doctor and to medication. (P25)

Despite the reported challenges associated with accessing health care services, certain participants blamed themselves for the consequences of untreated UTIs when they resulted in more severe health complications:

It was only later that I realised I was actually not comfortable, and it kept recurring. So, yes, at first ... [it was] probably my fault a little bit. I just thought having fluids would be enough and it would pass. (P22)

UTI self-care: practices and facilitators

As already demonstrated, participants frequently chose to attempt home remedies before seeking guidance from health care professionals. Approaches to exploring self-care options were similar. Experiencing symptoms of UTIs for the first time, participants often relied on information from friends who possessed knowledge or personal experience of UTIs:

I never wanted to know what I had until later when I shared with my friend the symptoms. I still have it and I'm still undergoing medication, but I'm happy to hear that I'm not the only one who has had it and it's quite normal. ... Actually, you need someone to talk to, someone who can reassure you that it's not something serious, because if you don't have someone who you can talk to or open up to, you might end up being depressed or stressed, thinking it's something serious. ...Hearing it from someone who has experienced it before is even better than even sometimes a GP. (P9, FG2)

Seeking advice and confiding in friends proved to be more common than resorting to online research or seeking assistance from pharmacies. In fact, participants were sceptical regarding the effectiveness of over-the-counter remedies and the expertise of pharmacists:

The cystitis relief packets and stuff like that: definitely have tried, but I don't always find that they work, or that they work short term and it comes back quite quickly. So, ... I wouldn't opt for those. (P24)

When at first it started, I went to a pharmacist, explained to him and told him how I'm feeling. I had some pain in my lower abdomen. And I explained to him and told him I'm not feeling well. And the only thing he gave me was just painkillers, which didn't help. He didn't do any sample. He didn't have enough

time with me to ask me my past history. So he just told me that it's normal for the women, maybe it's your menses, you can get it. So, he just gave me painkillers, and the pain stopped for a while, but the UTI was growing. So, I wish he had done this analysis earlier, maybe it wouldn't have developed to that extent. So, OTC drugs are the worst. (P18)

While the above quote indicates a strong preference to have clinical tests before treatment is recommended, other participants suspected that some of the remedies sold OTC in pharmacies and self-care practices recommended on online forums for participants suffering with recurring UTIs had no scientific basis. Instead, they sometimes adopted a trial-and-error approach when selecting them, recognising the need to experiment and assess the effectiveness of different strategies:

I recently learned that this ... is a myth, but, like, I never ever sit on a public toilet. Always, if I just only ever, like, squat over there. (P22)

I will just drink a whole carton of sugar free cranberry juice. I don't know if that's myth, it does work for me sometimes, I have been in like a lecture at the beginning of a UTI and just downed the whole thing and then it's gone within a day, so I don't know what that means. (P23)

It was frequently acknowledged by participants that they required support in implementing self-care strategies for UTIs. Self-care was commonly perceived as a collaborative effort, involving informal help and advice from friends and family. Recognising the importance of a support network, participants acknowledged that engaging with those around them was essential in helping them effectively manage their UTIs:

I think in terms of what you do for yourself, and how you make yourself feel looked after, but also that you're able to reach out for help when you need it. I think that's also a part of self-care, in being able to seek help, and get it when you need it the most versus when a very specific symptom tells you that you need it. (P22)

While participants appreciated the presence of informal support networks, they expressed a strong preference to have access to health care professionals to ensure the effectiveness and safety of their self-care approaches:

The best self-care for me, whenever I have UTI, I think would be to go and see a specialist so that I can get the first-hand information from them so that I can avoid assuming things, and to get a clear direction on what I'm supposed to do, what I'm supposed to avoid. (P15)

I know that antibiotics do work for me. I think sometimes when it's not that bad I, kind of, I'm OK with them just like giving me antibiotics. But I think when they're, like, telling me to wait, I

would, kind of, like to see someone in person to be, like, can you, like, listen to me. (P23)

Barriers to UTI self-care

Study participants valued access to health care professionals who could provide information about UTIs and reassure them about their health, recognising these consultations as supportive of their self-care efforts. Interestingly, participants were more likely to report barriers to accessing advice from GPs than accessing treatment itself:

I found it really hard to access the GP in general – to even get an appointment to get any antibiotics. And I always knew that I had one [a UTI], and I'd need antibiotics. But I think it was always really hard to get an appointment. So then, over time, because I was getting them so frequently, it became easier to get an appointment because ... they wouldn't usually have to call me and talk about my symptoms. Like, they would just know and sometimes would prescribe without really having that much of a chat about it. (P24)

In this context, restricted access to health care professionals paradoxically can increase the risk of antibiotic prescribing for UTIs—an issue the UK's AMR policy aims to address. Improved access to GPs when experiencing UTI symptoms may not necessarily lead to more prescriptions, but rather to enhanced self-care and reduced anxiety for those affected.

At the same time, participants perceived UTIs as disruptive to their daily obligations and routines, and recognised that antibiotics could dramatically shorten the recovery time:

My GP, the antibiotics that he gave me last time, they are very quick. Within 24 hours I didn't have that painful or the burning sensation anymore, it had reduced so. (P2, FG1)

Further, the nature of UTI self-care, which includes increased water intake and, therefore, more frequent toilet breaks, meant that participants did not feel comfortable being around their colleagues:

I had to take some time off work because passing urine at work was very, very hectic. Sometimes you might even pass urine on yourself, yeah. So it was that hectic, and I had to take one week off work. (P11)

Simultaneously, participants did not always feel it was possible for them to take time off study or work to properly recover from UTIs:

Ultimate self-care would probably be making sure that I have reduced stress levels: [Having] systems put in place so that

universities and workplaces are a lot less guilt-inducing [when not able to attend lectures or go to work] (P23)

Further, the nature of their work and reported high pressure working days impeded participants' capacity to prevent UTI recurrences and maintain overall good health. As one participant, who was a teacher, explained:

When you work in a school and you work with kids, it's really hard to go to the toilet regularly. And I think one of the one things that does worry me, and has become more of a preventative thing that I've tried to be better at, is actually going to the toilet when I need to go, rather than just holding it for ages. Because it is so hard. I think lots of teachers especially really struggle with this. It's just actually just being able to go when you need to. (P24)

I mean, I guess [self-care] it's just looking after yourself. For me, it would be making sure I'm eating well, cooking for myself and putting the effort in to making nutritious meals, having time to yourself to relax and getting a good night's sleep. Like, all the things that I don't do. (P1)

Discussion

When formulating self-care as a tool of antibiotic stewardship, there needs to be much more explicit consideration of how self-care and professional care relate to each other. Contrasting self-care with antibiotic treatments without explicitly mentioning the role of professional advice and guidance made available to patients practising self-care may imply that self-care is separate from, or even in opposition to, professional care. Such a conceptualisation and, following from it, enactment of self-care becomes more likely in the context of continued decline in ready access to GP services.^{17,18}

Women from racialised minorities and women in low-income households already face challenges in accessing health care services and obtaining the necessary resources for self-care.^{23–25} They are therefore at risk of being poorly served by the AMR policy commitment to self-care. For example, participants in our study reported that high pressure working days made it difficult or impossible to practise preventive UTI self-care, which comprises increased fluid intake and regular toilet breaks.

Our research shows that a policy encouraging self-care needs to consider implementing mitigation strategies. Those that could potentially address concerns expressed by participants in our study are easier access to professional advice and antibiotic treatment, when necessary. In addition, as participants spoke about difficulties with taking time off from work, we propose that easier access to an official diagnosis would enable women to obtain Statements of Fitness for Work ('fit notes'). Only then might self-care be

considered to be a policy that supports women in embracing self-care practices without putting their wellbeing at risk.

Our findings indicate that, despite challenges, women often acquire informal knowledge and advice that informs their self-care strategies for UTIs before seeking professional health services. Informal networks of friends and family play a crucial role in self-diagnosis, with women particularly valuing conversations with those who have experienced UTIs themselves. While self-care was typically the first choice, participants recognised the value of consulting health care professionals for managing UTI symptoms and understanding the scope and limitations of self-care options. These consultations also provided opportunities for broader discussions about overall and sexual health, given the symptom overlap between UTIs and STIs. Additionally, our findings highlight women's knowledge of their bodies, especially in the context of recurrent UTIs, aligning with evidence that patients are aware of the limitations and potential side effects of antibiotics.²⁸ Consequently, women's ability to self-diagnose and assess symptom severity positions them as partners in improving antibiotic stewardship rather than passive recipients of prescriptive policies.

Limitations

There are two main limitations to our research. First, most participants accessed NHS services in London. Therefore, we were not able to comment on any potential differences in accessing professional health services for UTIs and resources for self-care in other parts of the UK, especially rural areas.

Second, the fact our interviewer was White may have meant some participants were less forthcoming than they might otherwise have been. Indeed, despite research indicating that people from racialised minorities experience specific difficulties when accessing health services,^{23,24} participants from racialised minority groups in our study did not express such concerns.

Conclusions

A policy promoting self-care as a tool for improving antibiotic stewardship is inadequate and misdirected when systemic barriers prevent individuals from effectively engaging in prevention and self-care practices. Women in our study were often able to self-diagnose and assess the severity of their symptoms, which should make them partners in efforts to improve antibiotic stewardship. Yet, they still valued consulting professionals for advice and support about their UTIs, irrespective of whether or not they received a prescription. The consultation was seen as valuable for alleviating anxieties induced by UTIs, navigating the symptoms of UTIs and identifying self-care options.

Notably, a formal UTI diagnosis and a ‘fit note’ is necessary to enable poor and marginalised patients to take time off work without losing pay and worsening their financial hardship.

Acknowledgments

We would like to thank team members Mustafa Al-Haboubi and Houda Bennani for comments on the questionnaire and support running focus groups. We also thank Jennifer Bostock for helping in developing and running of the public engagement meetings and CJ Iliopoulos for supporting day-to-day running of the study. We are grateful to the lay representatives who helped shaped the study and the research participants.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The research was funded by the NIHR Policy Research Programme through its core support to the Policy Innovation and Evaluation Research Unit (Project No: PR-PRU-1217-20602). The views expressed are those of the authors and are not necessarily those of the NIHR or the Department of Health and Social Care.

Ethical statement

Ethical approval

This study was reviewed and approved by the Health Research Authority (REC ref: 22/HRA/3073) and the London School of Hygiene and Tropical Medicine Ethics Committee (LSHTM Ethics Ref: 27930).

Informed consent

Informed consent was obtained from all participants each time they participated.

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