Maximising sexual wellbeing in cancer care: findings from a qualitative process evaluation exploring healthcare professionals’ views on acceptability and usability of an eLearning resource

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Research Article

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Abstract

Background

Provision of healthcare professional (HP)-led sexual support in cancer care is lacking. Guidelines recommend that HPs should lead on provision of sexual support; however, HPs report considerable challenges providing this care. Barriers include a lack of awareness around sexual concerns and strategies to help patients with cancer and partners cope, coupled with a lack of relevant training, access to supportive resources and signposting opportunities. To address this gap, the Maximising Sexual Wellbeing | Cancer Care eLearning resource (MSW|CC) was developed. Quantitative evaluation of the MSW|CC has demonstrated efficacy in reducing HPs attitudinal barriers to the provision of sexual support. This qualitative process evaluation seeks to explore the mechanisms that may influence HP engagement with MSW|CC and adoption into practice.

Methods

Semi-structured interviews were conducted with HPs who had completed the MSW|CC and were providing routine cancer care in health and social care settings in Northern Ireland. Interviews were audio-recorded, transcribed verbatim and analysed using reflective thematic analysis.

Results

Seventeen participants were interviewed and four key themes were identified. [1] MSW|CC raises HPs awareness of the need for holistic sexual support as part of routine clinical care, [2] MSW|CC prepares and equips HPs to provide sexual support in cancer care, [3] MSW|CC is coherent, engaging and acceptable and [4] MSW|CC: Moving forward.

Conclusion

Important insights were provided into HPs perspectives on the MSW|CC, lending explanation for attrition rates within a previous study. Participants derived benefits from MSW|CC, deeming it an acceptable resource for implementation and integration by HPs across cancer care settings.

Background

The impact of cancer and its treatment on biopsychosocial aspects of sexual wellbeing (SW) is well-documented [1–2], resulting in a myriad of challenges to sexual function, body image, emotions and confidence [1–2]. This impacts upon relationship dynamics and intimacy and therefore quality of life [3–5].

Current provision of healthcare professional (HP)-led sexual support in cancer care has been deemed as inadequate by patients [6–7]. HPs find it difficult to provide sexual support in cancer care, with multiple barriers including perceptions of being ill-equipped to address sexual concerns, lack of relevant education on sexual concerns specific to cancer care, lack of awareness of the HP role to provide sexual support, personal embarrassment around the topic, lack of policy and guidance to direct workplace culture [8–9]. Despite this, HPs have a responsibility to provide sexual support as part of routine care [10–12]. HPs identify a need for training, access to supportive resources and referral pathways to improve provision of sexual support [9, 13].

Responding to the lack of available training and supportive resources, The Maximising Sexual Wellbeing | Cancer Care (MSW|CC) eLearning resource, grounded in theory and evidence, was developed to address attitudinal barriers and equip HPs with tools to initiate and provide sexual support to patients and their partners [14]. Full details of the planning and development of MSW /CC has been published [14]. Recent quantitative evaluation of MSW|CC identified its potential to reduce HP attitudinal barriers to the provision of sexual support in cancer care [15]. Qualitative process evaluation has an important role to enable exploration on the mechanisms behind intervention success and to identify barriers to future implementation [16–18].
study aims to explore HPs engagement with the MSW|CC to determine if and how HPs perceive the MSW|CC impacts their role and provision of sexual support, identify mechanisms through which the intervention has effect, influencing factors and considerations for future implementation.

**Methods**

**Study design**

A qualitative approach was adopted utilising semi-structured interviews. This study is reported following the Consolidated Criteria for Reporting Qualitative (COREQ) Research guidelines [19]. Ethical approvals were obtained at institutional and national levels [REC: 19/NI/0175].

**Sampling and recruitment**

Study eligibility included participants who were a registered HP, routinely providing direct care to patients with cancer in either a hospital or community setting, with no limits set on length of service. Purposeful sampling identified HPs working across a range of professional disciplines in cancer care (nursing, physiotherapy, speech and language therapy, medicine), delivering care across several tumour groups within five Health and Social Care Trusts (HSCTs) in Northern Ireland. The lead researcher (CC) communicated through Local Collaborators (Clinical Nurse Specialists) at each HSCT, informing of study aim and inclusion criteria. Local collaborators sent a recruitment email to potential participants with participant information, consent form and researcher contact details attached, for potential participants to opt in using the contact details provided. Written consent was obtained in advance of interviews.

**Data collection**

A topic guide informed by the literature, study objectives and the expert research group (authors) was developed, tested and modified accordingly. Interviews were conducted by first author (CC), a senior cancer nurse and postgraduate researcher between December 2021 and April 2022, either in-person (n = 7) or online (n = 10), were audio-recorded and transcribed verbatim. Interviews lasted 18–35 minutes. Interviews were concluded, upon discussion between research team members (expert in qualitative and intervention research) when yielding no further major themes.

**Data analysis**

Data was analysed using reflexive thematic analysis [20] enabling reflection and engagement with the data, alongside generation of themes from codes using mind mapping techniques. Transcripts were read by all authors to promote credibility, trustworthiness and enhance rigour. After initial coding by CC, using NVivo v.12 inductive descriptive codes were identified, shared with research team, critiqued and refined during meetings. Authors have added detail within ‘[]’ to help reader understand quotes presented.

**Results**

Seventeen participants representing 5 HSCTs were recruited. Participant demographics are presented in Table 1.

Four themes identified HPs perceptions of MSW|CC and factors that hindered or enabled the delivery of SW in routine care. These were: (1) MSW|CC raises HPs’ awareness of the need for holistic sexual support as part of routine clinical care, (2) MSW|CC prepares and equips HPs to provide sexual support in cancer care, (3) MSW|CC is a coherent, engaging and acceptable eLearning resource for HPs and (4) MSW|CC: Moving forward.

1. **MSW|CC raises HPs awareness of the need for holistic sexual support as part of routine clinical care**
Engagement with MSW|CC created an increased awareness of both the necessity of HP-led sexual support and viewing sexuality within a biopsychosocial context. Prior to engagement with the MSW|CC, sexual support (if considered as part of the HPs role), was viewed narrowly within the physical realm of sexual intercourse. Participating in MSW|CC training challenged this view, with participants reporting greater awareness of the value of intimacy, especially emotional closeness through touch and communication, and its importance for both patient and partner.

“I suppose after reading the resource it’s the sexuality is more than intercourse, it’s about being intimate and touch, and all the rest of it. I suppose it’s made me open my mind up to that and talk to patients about becoming closer and sharing things etc. So, I found the resource useful for that.” (HP 12)

Prior to accessing MSW|CC, sexual support was often avoided and seldom initiated by HPs. On the infrequent occasions when HPs did provide patients with sexual support, the focus was reported as limited and superficial, not addressing the emotional and psychological elements. Participants reported feelings of awkwardness and anxiety about discussing sexual concerns with patients, needing education and training to address this issue.

“We would have conversations about mental health, anxiety speaking, eating, working, swallowing, physical things like walking, so why don’t we have a conversation about this? [We need to] use the training to try and help or lose that stigma.” (HP 05)

Most HPs reported avoiding the provision of sexual support for fear it could “open a can of worms” (HP 06) attributing this to their perceived lack of knowledge, experience and not feeling equipped. HPs identified a lack of formal training and inclusion of sexual support into clinical practice, which increased anxiety about the quality of information and provision of supportive resources available for patients and their partners.
“I would feel underprepared because I did so infrequently...I'm not educated in this, you know, it's not really something I'm au fait with.” (HP 17)

Completion of the MSW|CC helped HPs recognised the importance of normalising sexual support at a societal level and for HPs delivering care to cancer patients.

“We talk about normalising it for the patient, we need to talk about normalising it for ourselves maybe sometimes because culturally we’re poor at it.” (HP 10)

The MSW|CC also raised awareness of the need for HP-led sexual support as opposed to waiting for the patient to raise the topic. HPs subsequently reported inspiration and motivation, denoting the importance of a standardised approach to the delivery of sexual support as part of routine survivorship care.

“I’m sitting thinking this is something that is within my role that I should be bringing up. And not leaving it to the patient” (HP 07)

2. MSW|CC prepares and equips HPs to provide sexual support in cancer care

HPs shared an overwhelming consensus that having completed MSW|CC they felt empowered and equipped, with increased confidence to provide sexual support. HPs equated this to numerous components such as providing the necessary language for sexual support conversations, communication framework, patient resources, signposting and strategies to move knowledge to practice.

“It [the MSW|CC] has empowered me with tools ... which makes it easier, I wasn’t familiar with [supportive resources and referral pathways] so it has made me more confident because I can go to the tools and refer to them” (HP 14)
Videos were reported as helpful, providing opportunities for experiential learning, alongside gaining insight into patient and the partner perspectives.

“They’re brilliant [the videos] because well you’ve got your professional videos and your patient videos. I think they’re brilliant because you’re getting all the different perspectives and I do think you learn better if you hear from other people. Personally, that’s how I learn better. You hear other people’s experiences of it all, professional and patient.” (HP 04)

The language from the videos proved especially useful, giving HPs ideas on how to initiate and approach the conversation, with HP02 reporting “I am more able to actually open the conversation” (HP 02)

HPs reported that the EASSi communication framework as STEP 2 in MSW I CC provided a straightforward structure and flow to engaging, assessing, tailoring sexual support and signposting patient when necessary. The framework was described as relatable, having helpful tips easy translated into practice, with some HPs having printed and laminated it so they could refer to it easily when with patients. HPs considered the EASSi framework could enable standardisation of sexual support, providing HPs with a stepwise approach to sexual support conversations.

"If you do have a framework that supports you in terms of engaging with the whole process and then assessing what the need it [is], whether it's information or signposting or different support, that you allow and assessed that and see what you can best help them with, so I think it's [the EASSi framework] good in the sense that it gives you something to work through as opposed to trying to like scramble in your head you know what do I talk about here, or how do I approach this, so it gives you an element of confidence." (HP06)

Most HPs reported printing or downloading resources and signposting sheets for use with patients during consultations and for patients to take home. Knowledge of options for signposting of patients with more
complex issues contributed to HPs’ increased confidence to initiate sexual support conversations.

The inherent value of the MSW|CC for HPs was often realised upon completion. For HPs who were more experienced in discussing sexual concerns, the MSW|CC was still regarded as beneficial, providing reassurance and increasing confidence that their current care was evidence-based. A HP with more sexual support experience reported:

“It did inform of things I was unaware of and ‘it also highlighted to me that you know that my knowledge was good ‘and yet there were still takeaways ‘I was very experienced’. It maybe gave me better ways in which maybe to speak to someone you, know to a patient” (HP 08)

3. MSW|CC is a coherent, engaging and acceptable eLearning resource for HPs

Most HPs found the resource straightforward, engaging, motivating and well-structured with good flow, often reported as ‘easy to navigate’ (HP11).

“It’s [The MSW|CC is] engaging that way and I think there’s a really good use of colour, picture, all those things that draw you in and want to click the button and keep moving forward, because you know yourself you do so many online training sessions in a day, your head’s busting, your eyes are knitting whereas that’s nice and clean and it’s a good mixture of videos and written material, so it’s not boring.” (P04)

All HPs found the information within the MSW|CC to be adequate, appropriate, and holistic; pitched at the right level to benefit a range of disciplines and tumour groups. Inclusivity was highly valued, with the MSW|CC providing information on LGBT and single person’ perspectives. Having this training in eLearning format was viewed positively, allowed participating HPs to work at their individual pace. A small minority of HPs critiqued videos as too long in duration, but this was not a widely reported sentiment.
HPs valued the completion certificate for revalidation and appraisal purposes. Some HPs however reported difficulty accessing their certificate (which was dependant on viewing most of the content), citing that despite engaging with all content, the programme did not recognise this. Participants concluded that it would be useful if outstanding components necessitating completion to obtain certificate could be highlighted to users.

HPs acknowledged the MSW|CC to be a useful intervention to return to as clinical situations arose, or to further consolidate learning and to access printable resources. The MSW|CC was considered to assist with reflective practice, providing a resource for HPs to use when reflecting on specific clinical scenarios.

“It [The MSW|CC] would be good to come back to as a reflective tool to kind of go over what happened there?” (HP04)

4. MSW|CC: Moving forward

Overwhelmingly HPs stated that the provision of routine sexual support should be normalised within cancer care. To aid this, HPs reported that the MSW|CC should be completed by HPs across all cancer care teams. Mandatory training status was deemed as helpful to achieving this, however, HPs recognised the need to strike a balance between a directing HPs to engage with the eLearning resource and providing a rationale for them to engage of their own volition.

“I think just make it mandatory training, something that you have to do like your advanced communication skills, because it's just as important as that.” (HP 13)

As part of ongoing training, HPs suggested the need for a refresher course. Furthermore, there was recognition that the MSW|CC needed to remain cutting-edge and evidence-based, and to do so re-launched versions of the resource could help.

“I do think it’s not just a one-off thing, I do think it’s good to go onto it every year or every couple of years just to refresh yourself and just to
have it as part of your mandatory training as part of routine training.” (HP 11)

All HPs also highlighted the need for an implementation strategy, which would include promoting awareness using adverts, social media, face-to-face and online awareness sessions, targeted at cancer teams and directorate managers. Clinical champions were also denoted as an effective way to influence implementation of the MSW|CC.

“I think the biggest thing for any kind of implementation is awareness of it, so it’s certainly trying to circulate that around certain teams and things like that.” (HP 06)

Active and targeted dissemination of the MSW|CC was deemed an important implementation strategy, consequently raising the profile of, and inherent value in the provision of sexual support, therefore increasing the likelihood of embedding MSW|CC into cancer care.

“I suppose it’s all about dissemination in our teams first of all and then the more people you get doing the actual training the more people will be invested in it”. (HP 11)

HPs also identified the utility of interdisciplinary training opportunities within cancer care teams, using peer support and or supervision agendas to discuss experiences of providing sexual support and build confidence within teams. Although some HPs highlighted limited time within busy clinical roles could be a barrier to engaging with the MSW|CC, the online asynchronous approach to the resource was thought to counter this issue.

“An online resource is always much better than any kind of formal face to face thing because people can do it at home, they can do it in the office, they can do it when they have time.” (HP 06)

Discussion

Process evaluation has improved understanding of the mechanisms by which the MSW|CC reduces HPs attitudinal barriers to providing sexual support in cancer care, whilst highlighting strategies for future implementation. Principally, HP engagement
with this eLearning resource increased their awareness of the importance of providing biopsychosocial sexual support in cancer care, alongside motivating and equipping HPs to have sexual support conversations with cancer patients and their partners.

Qualitative process evaluation can help establish if the central tenets of an intervention are applicable across different populations, establish if appropriate for the settings it is intended, avoiding mismatches [21–22]. There was a diverse variation of HP roles purposefully included in the study (e.g., surgical and medical oncologists, nurses, radiotherapists, physiotherapists), delivering care across different tumour groups, which allowed the nuanced experience following engagement with MSW|CC to be explored. This was important given the diverse HP roles requiring upskilling and training on this topic [8, 23–24]. Findings demonstrated that irrespective of professional background, cancer care experience or tumour specialism, HPs found the MSW|CC beneficial, acceptable and usable, extending the potential reach and significance of this interdisciplinary training resource.

The effectiveness [15] and now demonstrable usability and acceptability of MSW|CC can be attributable to systematic and rigorous planning and development of this complex intervention [36], guided by the person-based approach [25], integrating theory and evidence and involving a diverse group of end-users. The value of an intervention development framework embedding co-production approaches is paramount [14]. Current and established guidance on intervention development [26–27] clearly outlines that complex interventions should be developed systematically, guided by appropriate theory and based on latest evidence to identify and affect behaviour change [28]. Findings from this study provided valuable insights into end-user perspectives [29] identifying aspects of the MSW|CC potentially influencing HPs attitudes, environment and behaviour; key facets of theory used in the development of the resource [30–31]. For example, in relation to Theory of Planned Behaviour [30] one's behavioural, normative and control beliefs influencing attitudes to a behaviour are impacted by background factors such as values, experience, education, knowledge and resources. HPs in this study cited that following engagement with the MSW|CC they had both a greater awareness of their role and were equipped with knowledge, language and resources to provide sexual support. Other online theory-based resources for HPs that have demonstrated acceptability and feasibility, alongside potential to impact clinical practice, often omit identifying or disseminating mechanisms by which they achieve success [32–33]. Theory-based digital interventions require further synthesis of behaviour change techniques and mechanisms of action to comprehensively understand, and to inform behaviour change ontology [28]. However, evidence demonstrates that despite interventions being effective [34], this does not necessarily mean successful and seamless translation into practice [35]. Factors influencing uptake of interventions tend to be different than those that determine effectiveness. Intervention uptake is influenced by HP buy-in, perceived relative advantage, individual's stage of behavioural change, workplace culture, networks and communications [36–37].

Implementation processes are complex and involve actions that occur between establishing effectiveness and routine employment in practice [38]. Moreover, in healthcare there are additional complexities, with individual and moving parts, numerous stakeholders as well as diverse clients, hence, a complex system itself [39]. With complexity foreseen, it is important to also have end-user involvement within a required implementation strategy. Strategies suggested in this study included protected time for HPs to undertake the training, similarly, echoed by other studies [40–41], and awarding the MSW|CC with mandatory training status. Furthermore, prioritising training on management agendas and use of clinical champions can also influence adoption [41–42]. Clinical champions are being increasingly utilised in healthcare settings to overcome organisational implementation barriers [40]. Wood et al. [43] in their systematic review highlights that clinical champions assist with faster initiation and persistence in the application of new interventions, helping to overcome system barriers, enhancing staff engagement and motivation.

Quantitative evaluation of the MSW|CC identified a higher-than-expected attrition rate for completion of the post-treatment survey [15]. Poor intervention retention rates could undermine the effectiveness of an intervention [44] or lead to wrong conclusions about the acceptability of MSW|CC, potentially indicating that users regarded the resource as lacking quality [45]. This study supported the belief that behaviour should not be included as a measure of acceptability [45], as HPs in this study reported problems with the eLearning resource’s ‘progress bar’ failing to recognise completion of activities. This resulted in HPs being unable to access the final survey and subsequently the continuing professional development certificate. This requires
modification to ensure HPs are rewarded with certificates, being a motivating factor to engagement in learning supporting professional revalidation.

**Future work**

Adoption of MSW|CC across organisations could be an important step towards standardised sexual support in practice. Further evaluation within a randomised controlled trial is required to determine the effectiveness of the MSW|CC on clinical practice, prior to widespread implementation.

**Limitations**

All participants held specialist roles, mainly in secondary care within Northern Ireland, which may lack representation outside of United Kingdom. Intervention to interview timeframe was short (~ 1 month), a longer time period may have provided greater in-depth reflections.

**Conclusion**

Qualitative process evaluation has yielded important insights into HPs perspectives on the benefits derived following completion of MSW I CC, highlighting acceptability and utility of this eLearning resource to promote and standardise sexual support in routine cancer care. Importantly, high attrition rates within a previous MSW |CC effectiveness study, would appear to be attributed to a software problem as opposed to unacceptability of MSW I CC resource, requiring modifications before testing in a full trial. Informing an implementation strategy for MSW |CC, cognisance should be given to focused and active dissemination of the MSC |CC eLearning resource, highlighting interdisciplinary utility across cancer care.

**Declarations**

**Acknowledgements:** n/a

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**Ethics Approval**

Ethical approval was granted by the Office for Research Ethics Committee Northern Ireland (ORECNI), IRAS ID: 259926.

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**Conflict of Interest Statement**

The authors have declared no competing interests and have no conflicts of interest regarding the research described in this submission.

**Availability of data and material**

The data that support the findings of this study are available from the corresponding author upon reasonable request.
Code availability

N/a

Ethics approval

The study was approved by the Research Ethics Committee for Northern Ireland (IRAS project number 259926)

Consent to participate

Informed consent was obtained from all individual participants included in the study.

Consent to publication

Participants consented to the publication of research.

References


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