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A Qualitative Exploration of Barriers to, and Interventions to Improve, Chlamydia Retesting in England Using the Behavior Change Wheel

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Background: Chlamydia is the most diagnosed sexually transmitted infection among young people in England. Repeat infections are common, and the risk of complications from chlamydia increases with the number of lifetime infections. National guidelines recommend retesting 3 to 6 months after treatment; however, retesting rates remain low at 10% to 14%. The objectives of this study were to explore barriers to, and identify potential interventions to improve, chlamydia retesting among young people in England, using the behavior change wheel.

Methods: Qualitative semistructured interviews were conducted with 22 people aged 16 to 24 years who had previously been diagnosed with chlamydia. Participants were recruited from sexual health services in London, the South West, and the North West of England. An inductive thematic analysis was conducted, followed by thematic categorization to the behavior change wheel.

Results: Barriers to retesting included low awareness and knowledge of the recommendation, and differences in how the term "retest" was interpreted. Participants' experience of the initial test influenced their willingness or intention to retest. Possible interventions to overcome barriers include routine discussions of retesting at diagnosis and the rationale behind the recommendation, retesting reminders from service providers, and opt-in self-sampling kits.

Conclusions: Lack of awareness and varied interpretations of retest present challenges to retesting. Interventions such as routine discussions, text reminders, opt-in self-sampling kits, and clear guidance could improve awareness and understanding, and streamline the process. Future strategies should be developed with stakeholders and patients and assessed for acceptability, practicability, effectiveness, affordability, side-effects, and equity to maximize their real-world implementation and public health impact.

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Acknowledgments: The authors acknowledge members of the National Institute for Health and Care Research Health Protection Research Unit in Blood Borne and Sexually Transmitted Infections Steering Committee: Professor Caroline Sabin (HPRU Director), Dr John Saunders (UKHSA Lead), Professor Catherine Mercer, Professor Gwenda Hughes, Dr Hamish Mohammed, Professor Greta Rait, Dr Ruth Simmons, Professor William Rosenberg, Dr Tamyo Mbisa, Professor Rosalind Raine, Dr Sema Mandal, Dr Rosamund Yu, Dr Samreen Ijaz, Dr Fabiana Lorencatto, Dr Rachel Hunter, Dr Kirsty Foster, and Dr Mamooma Tahir.

Conflict of Interest and Sources of Funding: All authors declare that they have no conflicts of interest. This study was funded by a National institute for Health and Care Research grant (NIHR200911).

Received for publication July 31, 2025, and accepted October 21, 2025.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text, and links to the digital files are provided in the HTML text of this article on the journal's Web site (http://www.stdjournal.com).

DOI: 10.1097/OLQ.0000000000002264

Chlamydia is the most common sexually transmitted infection (STI) in England, accounting for nearly half of all STI diagnoses made at sexual health services (SHS) in 2023,[1] with the highest prevalence of infection in the 15- to 24-year-old age group.[2] There can be serious adverse consequences from chlamydia infection, particularly among women and other people with a womb/ovaries, including pelvic inflammatory disease, tubal factor infertility, and ectopic pregnancy.[3,4] Young people who test positive for chlamydia are at higher risk of subsequently testing positive for chlamydia,[5,6] with repeated infection being a risk for poorer health outcomes. Therefore, UK national guidelines for the management of chlamydia infection recommend that people aged 15 to 25 years retest between 3 and 6 months after treatment.[7] However, retesting rates in England remain low; the audit report from the 2019 National Chlamydia Screening Program (NCSP) showed that the rate of retesting in integrated SHS was 34%, and it is estimated that the retesting rate is 10% to 14% across all services where chlamydia testing is offered.[8,9]

Despite significant work to understand the barriers to, and enablers of, taking an initial chlamydia test[10–12] (i.e., a test without a prior diagnosis in the previous 6 months), there is little research specifically focused on chlamydia retesting as a behavior. Given the potentially serious consequences of repeat infections, it is important to develop theory-guided behavior change interventions to improve rates of retesting.

The Behavior Change Wheel

The behavior change wheel (BCW) is one such framework for the design of behavior change interventions (File, Supplemental Digital Content 1, http://links.lww.com/OLQ/B289).[13] The BCW is underpinned by the Capability, Opportunity, Motivation—Behavior (COM-B) system at its hub, a model of behavior and the factors that influence it. In this system, capability (the capacity to engage in the behavior) and opportunity (factors that lie

outside the individual that prompt the behavior or make it possible) interact to generate a behavior, and motivation (brain process that energize and direct behavior) and behavior can, in turn, interact with and impact these domains. The next tier of the BCW contains intervention functions, which describe potential ways to impact or address deficits in the COM-B domains. The outer tier contains policy categories that can enable or support the implementation of interventions to bring about a desired behavior change.

Study Aims

The aims of this study were to explore barriers and enablers to chlamydia retesting and identify potential interventions to address barriers and support retesting, using the BCW.

METHODS

Positionality and Design

This qualitative research was conducted by a multidisciplinary team of experienced qualitative researchers and primary care and sexual health clinicians. The research was designed from a health service delivery and improvement perspective. The lead author (M.C.) explained to study participants that the information and experiences shared during interviews would be used to identify ways to improve chlamydia management and retesting rates. All members of the research team were older than 25 years.

Patient and public involvement representatives (aged 18–28 years) provided input on the recruitment methods and reviewed and provided feedback on the interview topic guide. Ethical approval was granted by the Health Research Authority (IRAS project ID: 319194; REC reference: 23/NW/0186). The Standards for Reporting Qualitative Research[14] were used to report this study (see File, Supplemental Digital Content 2, http://links.lww.com/OLQ/B290, for the checklist).

Participants and Recruitment

Individuals aged 16 to 24 years who had previously tested positive for chlamydia and lived in England were eligible to participate. Participants were identified and referred from specialist SHS in 3 Patient Identification Centres in the North West and South West of England and in London. Local clinical and research teams identified potential participants during clinic attendance and through clinical records searches. Potential participants were invited to complete an online expression of interest form and contacted by a researcher (M.C. or T.W.) who provided more information about the study and scheduled interviews. Leaflets and posters with a link to the online form were also on display in some services to allow eligible individuals to self-refer to the study. Purposive sampling was used to ensure that different age groups, genders, and geographic locations were represented in the study population. Participants gave informed consent to take part and had the opportunity to ask the researchers questions before participating.

Procedure

Data were collected via semistructured, one-to-one interviews, guided by an interview topic guide (see File, Supplemental Digital Content 3, http://links.lww.com/OLQ/B291). The topic guide was developed by T.W. and M.C., based on expert consensus and with input from the study team. Interviews explored participants' usual testing habits, their experiences of testing positive for chlamydia (e.g., accessing testing, treatment, and follow-up), their awareness and knowledge of the retesting recommendation, and their perspectives on how to improve retesting rates. Interviews were audio recorded and conducted by an experienced researcher (M.C.) via Microsoft Teams or telephone, depending on participant preference, and lasted between 20 and 80 minutes. Participants were offered a £30 voucher as appreciation for taking part. Data collection continued until the research team judged that sufficient information power had been achieved to address the research question.[15]

Analysis

Data collection and analysis were conducted simultaneously to allow developing topics of interest to be discussed in future interviews. Initially, an inductive thematic analysis was conducted to code and generate themes and subthemes, supported by the software NVivo 14. The themes were validated by discussion between the research team, and subthemes were mapped onto the appropriate tier of the BCW; that is, barriers and facilitators to retesting were mapped to the COM-B system, and possible interventions to improve retesting rates were mapped to the appropriate intervention and policy categories.

RESULTS

One hundred sixty people completed an expression of interest, of whom 22 were recruited to the study and retained in the final analysis (see File, Supplemental Digital Content 4, http://links.lww.com/OLQ/B292). Participant demographics and the reason for their initial chlamydia test are included in Table 1. The intervening time between testing positive for chlamydia and the interview date ranged from 2 weeks to 7 years. Around half of the participants had had a repeat chlamydia test between 3 and 6 months after testing positive and taking treatment, whereas 5 participants participated in the interviews less than 3 months since testing and treatment and had not entered the retest window.

Three key themes were generated from the analysis: retesting information gaps, experiences of chlamydia testing, and the consequent impact on retesting and improving chlamydia retesting. The first 2 themes explore participant's perspectives on the barriers and enablers to chlamydia retesting, whereas the third

TABLE 1. Participant Demographics

	n	%
Age group		
16–20	9	40.9
21–25	13	59.1
Ethnicity		
Asian/Asian British	2	9.1
Black/Black African/Black British	2	9.1
Mixed	2	9.1
White/White British/White European	16	72.3
Gender		
Female	12	54.6
Nonbinary	3	13.6
Male	7	31.8
Sexuality		
Bisexual	7	31.8
Heterosexual	11	50
Gay	4	18.2
Recruitment site		
North West	10	45.5
South West	7	31.8
London	5	22.7
Reason for initial chlamydia test		
Symptoms	9	40.9
Sexual behavior (new partner)	2	9.1
Partner notification	4	18.2
Testing habit/peace of mind	4	18.2
Opportunistic test	3	13.6

theme presents possible interventions to improve rates of retesting. A summary of the themes and subthemes for the barriers and enablers to retesting, mapped to the corresponding COM-B domains, is provided in Table 2. Interventions, mapped to the barriers they address and the corresponding BCW intervention functions and policy categories, are presented in Table 3 (for supporting quotes for all themes, see Table, Supplemental Digital Content 5, http://links.lww.com/OLQ/B293).

Retesting Information Gaps

Awareness and Knowledge of Retesting: Psychological Capability

Few participants were aware of the recommendation to retest or that people who had tested positive for chlamydia had higher positivity rates in subsequent tests. When asked what they thought the purpose of the recommendation was, many speculated that the primary reason was to ensure that the treatment had cleared the infection rather than to test for reinfection.

Interpretation of the Term "Retest": Psychological Capability

Interpretations of the term "retest" varied. During interviews, the researcher used the term "retest" specifically to refer to a repeat test taken 3 to 6 months after treatment (Table 4), whereas many participants interpreted or used the term to refer to a test of cure (TOC; a repeat test taken 3–5 weeks after treatment),[7] or to refer to a test taken any length of time after treatment; that is, any subsequent test was referred to as a retest. In some instances, participants were surprised to learn about the recommendation to retest, as they had been told not to take a retest during treatment and follow-up discussions. This was because some health care professionals would use the term "retest" when discussing a TOC.

Forgetfulness: Psychological Capability

After a discussion of the retesting recommendation and rationale, feelings and intentions to retest were mixed among the sample, although this, in part, related to the individual circumstances and experiences of each individual's initial test (see the "Experiences of Chlamydia Testing and the Impact on Retesting" section hereinafter). Even when participants were positive about retesting or expressed intentions to retest, there were concerns that they would forget to book a test after 3 to 6 months.

Retesting Recommendation: Social Opportunity

Participants expressed that they were given enough information and support around some aspects of chlamydia management and had discussions about partner notification and treatment with health care practitioners after their diagnosis. However, few participants recalled being specifically told about the recommendation to retest, and if retesting was discussed, it was usually referring to a TOC (see previous discussion). Participants felt that the recommendation to, and advice around, retesting should come

TABLE 2. Barriers and Enablers to Chlamydia Retesting

Theme	COM-B Domain	Subtheme	Description
Retesting information gaps	Psychological capability	Awareness of retesting	Participants were not aware of the recommendation to test again between 3- and 6-mo completing treatment.
		Knowledge of retesting	The rationale for taking a repeat test 3–6 mo after treatment was not clear.
		Interpretation of the term "retest"	The term "retest" was ambiguous and was used to refer to a number of different scenarios (e.g., any repeat test, test of cure).
		Forgetfulness	Some participants felt they would not remember to take a test again 3–6 mo after treatment.
	Social opportunity	Retesting recommendation	Health care professionals were perceived as experts in chlamydia management, and specifically being told about the recommendation made a difference to participant's willingness and intentions to retest.
Experiences of chlamydia testing and the impact on retesting	Reflective motivation	Reason for the initial test: Testing because of partner notification, sexual behavior or symptoms	When reason for seeking out the test that led to the positive diagnosis was resolved by that test and treatment, patients may lack motivation to test again.
	Automatic motivation	Reasons for initial test: Testing out of habit or for peace of mind	Participants who had an established testing habit are likely to test again within 3–6 mo after treatment, but not as an intentional retest.
	Physical opportunity	Opportunistic test	Participants who were offered an opportunistic test (i.e., as part of another appointment) expressed intentions to retest and establish a testing habit
		Difficulties booking initial tests	Encountering difficulties when booking an initial test impacted participant's willingness or intentions to book a retest.

TABLE 3. Proposed Interventions to Improve Chlamydia Retesting Rates, Mapped to the Corresponding Behavior Change Wheel Intervention Functions and Policy Categories

Proposed Intervention	Description	Barriers Addressed (COM-B Domain)	Intervention Function(s)	Policy Category
Discussion of testing frequency	A discussion of when to take another chlamydia test as a routine part of chlamydia management. The discussion should include information on when to next test, and the rationale for testing again.	Psychological capability (awareness, knowledge, and understanding of the recommendation) Reflective motivation (reason to test again after 3–6 mo) Social opportunity (explicit recommendation from a health care practitioner)	Education, persuasion	Guidelines, service provision
Service reminders	Text message, email, or telephone prompts reminding patients to book a follow up test sent approximately 3 mo after receiving treatment. Reminders could include information on testing frequency and/or information on how to book a test.	Psychological capability (forgetfulness) Physical opportunity (difficulties booking tests)	Enablement	Service provision, communication
Opt-in at home self-sampling kits	There is an option for a self-sampling kit to be sent to patient's homes approximately 3 mo after completion of treatment.	Psychological capability (forgetfulness) Physical opportunity (difficulties booking tests)	Enablement, environmental restructuring	Service provision
Testing flowchart	The flowchart describes the recommended testing frequency for sexually active 15–25-yr-olds (Fig. 1).	Psychological capability (awareness and knowledge) Social opportunity (retesting recommendation)	Modeling	Communication

from health care practitioners, who they perceived as trusted sources of information and experts in chlamydia management. Because of this, some participants felt that the lack of encouragement to retest from health care practitioners meant they were less likely to prioritize or remember to retest.

Experiences of Chlamydia Testing and the Impact on Retesting

The reason for the participant's initial test (i.e., when they tested positive for chlamydia) and their experiences booking, attending, and receiving treatment had an impact on their intentions and willingness to take a retest.

Reason for the Initial Test: Reflective Motivation

Many of the participants took their initial test for a specific reason; that is, they were experiencing symptoms because of partner notification (i.e., a sex partner had tested positive), or they wanted to test after having sex with a new partner. In these cases, the reason why they sought out the test was addressed and resolved with treatment (e.g., their symptoms were resolved, or they had not had sex again with the same partner), and so they would not plan to, or did not feel the need to retest, or no longer felt testing was relevant to their circumstances.

Reason for the Initial Test: Automatic Motivation

Other participants described habitually testing at regular intervals (e.g., every 3 months), sporadically for "peace of mind" when they remembered to or when they felt there had been a long enough interval since their last test. When participants were not testing to resolve a specific circumstance or issue, they were more willing or expressed stronger intentions to take a repeat chlamydia test. Overall, although these repeat tests would tend to be within the recommended retest window of 3 to 6 months, they would not be taken intentionally as a retest, rather as part of an established testing habit.

Reason for the Initial Test: Physical Opportunity

Two participants were offered a test while attending SHS for a contraception appointment. Participant neither had symptoms nor had tested for chlamydia before accepting the offer of a test. The opportunistic test introduced these participants to chlamydia testing, and both participants expressed intentions to retest and to establish a testing habit after having sex with new partners.

Diversity of Experiences at the Initial Test: Physical Opportunity

Participants described a diversity of experiences when booking and taking their initial chlamydia test. These differences existed both between and within the services in which they had been seen. Some participants found the process of booking and taking the test straightforward and therefore did not foresee any issues booking a retest. However, others had experienced difficulties trying to access testing. Some participants preferred to use at-home self-sampling kits, but it was not always possible for them

TABLE 4. Chlamydia Testing Terminology

Terminology	Definition
Repeat test	A test taken any length of time after a diagnosis with chlamydia and completing treatment. Repeat tests including retests and tests of cure
Retest	A repeat test taken 3–6 mo after completing treatment to test for reinfection
Test of cure	A repeat test taken 3–5 wk after completing treatment to test for treatment failure

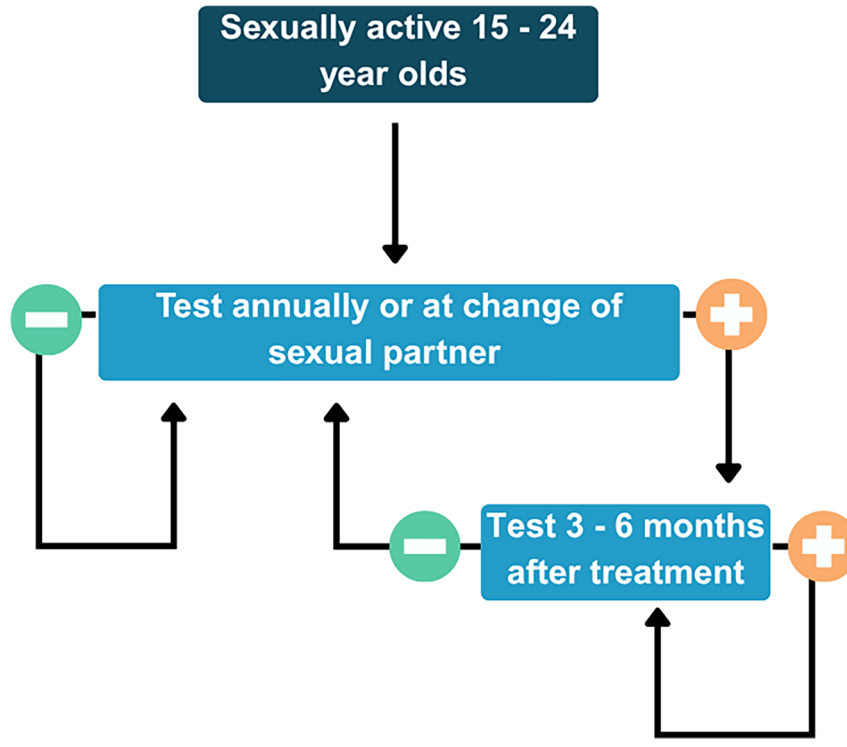

Figure 1. Prototype flowchart to illustrate testing frequency recommendations.

to access them, as the daily allocation of tests from their local SHS would run out before they could request one. Participants described setting alarms to ensure they could request a kit as soon as they became available each day, and still having to retry over several days before they were successful. In other cases, participants were unable to schedule appointments or attend SHS at a convenient time, which was difficult for those enrolled in education and/or in employment. Participants who encountered difficulties booking their initial test expressed reluctance in booking a retest, particularly when the reasons or circumstances for attending were resolved by the initial test (see Reason for the Initial Test: Reflective Motivation).

Proposed Interventions to Facilitate Retesting

Participants discussed ways to make retesting easier and more accessible. The full table of interventions, including the barriers/enablers they address, the BCW intervention functions they include, and the policy categories that would enable the interventions, are provided in Table 3.

Discussion of Testing Frequency

Participants felt that recommendation to take a retest should be a routine part of chlamydia management and discussed after receiving a chlamydia diagnosis. Discussions should include the rationale behind the recommendation and information on how/where to book a retest.

Service Reminders

Email, text message, and telephone prompts sent approximately 3 months after treatment were seen as acceptable ways to remind individuals to book a retest. Many participants indicated that they would welcome service reminders, particularly those who did not have an established testing habit. Messages that included weblinks to book an appointment were preferred, especially by participants who had experienced difficulties booking tests in the past.

Opt-in at Home Self-Sampling Kits

A few participants had been instructed to have a TOC and were sent an at-home self-sampling kit a few weeks after completion of treatment. Many participants suggested that this strategy could also be used to improve rates of retesting if kits were sent closer to or during the retesting window, as it would bypass some of the difficulties that were encountered in trying to book a test and take away the burden of remembering to retest. It was important that the test kits were opt in, as some participants were not comfortable receiving a kit to their residence.

Testing Flowchart

The different interpretations of the term "retest" among participants and health care professionals meant that there was a lack of certainty around repeat testing. To address these barriers, the research theme developed a prototype flowchart as a visual aide for discussions around testing frequency that bypasses the term "retesting" altogether (Fig. 1). The flowchart begins with a chlamydia test and proposes 2 divergent paths, depending on the test results. Unlike the other interventions discussed previously, the flowchart was developed over the course of the data analysis, rather than discussed in interviews with participants.

DISCUSSION

Lack of awareness, varied interpretations of the term retest, and difficulties booking tests present challenges to retesting. This study found that the circumstances of a patient's initial test can impact their intention and willingness to take a retest. These findings highlight the needs for interventions, such as routine discussions of retesting as part of chlamydia management and service reminders, to improve the rates of repeat testing 3 to 6 months after a positive diagnosis.

Beyond changes to service delivery, the results of this research highlight how the term "retesting" is ambiguous and is

not used or interpreted consistently among patients or practitioners. This ambiguity itself presents a barrier, particularly as there are different recommendations around repeat resting for chlamydia and other STIs such as gonorrhea. The case for consistent nomenclature has previously been made to reduce confusion around terminology in reproductive medicine[16] and for self-sampling and self-testing for STIs and HIV.[17] We propose that a similar strategy is adopted for repeat testing after a positive chlamydia diagnosis. This could be achieved by adopting a new term that is specific for testing 3 to 6 months after treatment or by avoiding the use of term "retesting" when discussing testing frequency for chlamydia, as demonstrated in the prototype flowchart presented. Consistent terminology not only would support patient's understanding but also could help improve the training, service delivery, and evaluation of chlamydia treatment and management. Any guidelines and materials intended to support, including the prototype flowchart presented previously, must be generated, refined, and/or assessed by stakeholders for acceptability, practicability, and effectiveness before being implemented in practice.

Some of the interventions discussed previously are already in practice in some services,[18] including text message service reminders and verbal offers of retesting when test results are delivered. Active recall strategies (i.e., reminders to return for a repeat test) are associated with higher reattendance/retesting rates for HIV and STIs generally,[19] and this research shows that not only these models of practice could address some of the barriers to retesting that patients experience, but also patients are likely to find them acceptable. However, the success of these strategies relies on robust and equitable digital infrastructure, and it is not known how widely they are adopted in services where chlamydia testing is offered.

Unlike other aspects of chlamydia management (e.g., results notification, time to treatment, partner notification), retesting is not currently an auditable outcome measure and there is no national standard for the proportion of young people returning for a test 3 to 6 months after treatment. In addition to the strategies to improve retesting rates among patients, it may be important to design and implement additional interventions that enable services to prioritize retesting, for example, by establishing audit and feedback[20] standards for retesting in line with other aspects of chlamydia management. Although this study focused on individual and service-level barriers, wider structural factors such as regional service provision, digital access, and resource constraints may also impact retesting opportunities and should be considered in intervention design.

The inclusion of participants who were previously diagnosed with chlamydia is a strength of this research, as it highlighted the impact that the initial test has on an individual's intentions and willingness to retest. However, all participants were recruited from SHS, and therefore, the experiences of people who test in other settings, such as in primary care or pharmacies, have not been captured. Although some of the results of this study may be transferable to other settings, particularly those concerned with improving awareness and understanding of the retesting recommendation, people tested in settings outside SHS may encounter different or additional barriers to testing. It will be especially important to design interventions that are effective in a range of settings. The 2019 NCSP audit report showed rates of retesting from general practitioners, and those form other community settings were less than 3%, compared with 34% from integrated SHS.[9] The NCSP guidelines state that all sexually active women and other people with a womb or ovaries aged 15 to 24 years should be offered an opportunistic chlamydia test in general practitioners,[21] and interventions may need to be tailored to different settings to ensure that all patients have the information and access they need after testing positive for chlamydia.

CONCLUSIONS

Low rates of retesting after a chlamydia diagnosis present a missed opportunity to reduce the reproductive harms of a common STI. This study suggests that low rates may be driven by low awareness, lack of clarity around language, and difficulties accessing services. Interventions such as routine discussions, text reminders, opt-in home testing, and clear guidance could improve awareness and understanding of retesting and streamline the process. Future strategies should be co-designed with stakeholders and patients and assessed for acceptability, practicability, effectiveness, affordability, side effects, and equity, to maximize their real-world implementation and public health impact.

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