<u>Sexual Health Matters!</u>

Learning for Life

Mapping client need and

professional sexual health education

for nurses in England

David Thomas Evans

RN BA(Hons) PGDip Psychol Couns PCGE (*Health Professions*) MPhil

A thesis submitted

in partial fulfilment of the Doctorate in Education

of the University of Greenwich

School of Education

May 2011

ACKNOWLEDGEMENTS

At the time of submitting this thesis, my greatest acknowledgement must go to a most wonderful person, my sister-in-law Sharon Pollitt, over whom, as an ex-Catholic priest, I have just said the prayers for Commendation of The Dying, as she makes her final journey in this life.

My two supervisors, Dr Jill Jameson and Prof Elizabeth Meerabeau have been spectacular. They have inspired and challenged me every step of the way, and constantly encouraged me to explain myself (and Michel Foucault) better. Their attempts to get me writing less "flowery" and with fewer words however, failed, but that is my fault and not theirs.

Through teaching and researching in this wonderful specialty since 1990, I have had the honoured experience of working with more than a few thousand health and social care professionals. The stories some of them recount bear witness to devoted service to their clients, which has often been outstanding. Every time one of these students has told me how they have taken away a little bit of learning to enhance the *art and science* of sexual health care, then, as an educator, I am both humbled and privileged for the role I play. I must also say a big "thank you" to all those who took part in this doctoral research across England, the educational colleagues at various universities and clinical professionals working in patient care.

I also wish to thank my administrative, teaching and managerial colleagues and friends in the School of Health and Social Care at the University of Greenwich, too many to list here individually; likewise the teachers and fellow students on the EdD programme in the School of Education. A special mention must go to my dear friend Martin Wilson. It is also important for me to thank the Royal College of Nursing and University of Greenwich (and the original funders, the Department of Health and Teenage Pregnancy Unit) for giving me the biggest and best job in my life: designing and managing the *Sexual Health Skills* course (2002 - current).

There are also many other people I need to thank, too, and so I say "thank you" to all of them now: you know who you are, even if your name does not appear here! There are some close friends who need to be mentioned by name, including Dr Kathy French, Colin Roberts and Steve Jamieson. Thanks, also, to Karen Stewart who helped me transcribe some of the voluminous data. Over the duration of this doctoral programme, a number of fellow students and friends – especially Mark Cole, Jane Wilson, Terry Ferns and Diana Edgecombe - have seen my weight reduce, muscles develop and fitness increase: that's thanks to the inspirational ex-Royal Marine Commando Rob Blair.

Finally to all my beloved family members, my blood relatives in Wales and in-laws from Northern Ireland, who have shared life and love with me. This doctorate has been a long time in the making and I could never have done it without the love, support, patience and unending hard work of my dear partner and best friend of twenty-one years, John Ellis. *I love you all!*

Abstract

Sexual health matters! This motif underpins the entire thesis. With survey responses from university educators and focus group encounters with clinical professionals undertaking the UK-wide **Sexual Health Skills course**, the study explores ways in which specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England.

Through using a Foucauldian 'lens' and a novel process called crystallisation in sexualities and gender epistemologies (S&GE), it was possible to shed new light on some old problems hindering nurse education. The methodologies facilitated a discursive engagement between the power / knowledge of sexual health sciences (*scientia sexualis*), the orthodox 'regimes of truth', and various silenced voices. The silenced voices pertain to wider, socially and clinically 'invisibilised', needs of clients or patients in relation to the provision of nurse education.

Set against the backdrop of England's first ever Government strategies on teenage pregnancy, sexual health and HIV, statistics on narrow definitions of sexual ill-health are still considered the worst in western Europe. Nurses acknowledge these poor facts, and witness to additional neglect related to sexual well-being in the wider, holistic, domains of a person's life, health and relationships. Respondents recount a lack of formal sexual health education in pre- and post qualifying curricula, including incidents of critical, experiential, 'on the job', learning which are capped and thwarted by clinical

and educational staff who are unable and / or unwilling to explore the full learning potential through reflection and analysis of practice. Respondents acknowledge how their professional education frequently ill-equips them to deal with requirements in practice as well as newer, public health, demands on their roles to increase preventative education and effective health promotion. This thesis gives them a voice in expressing such concerns.

The outcome of this work has led to the conceptualisation of a model of 'learning for life' across a curricular *triptych* for professional education which supports client care. Panels of this *triptych* relate to the foundational or holistic dimensions of sexual health matters; ancillary aspects secondary to other health conditions, and finally, the specifics, those formally defined in epidemiology and strategies of sexual ill-health and associated stigmas.

> *Whether someone qualified twenty-five years ago or within the last three months, the quality and quantity of formal sexual health learning across the curricular triptych model remains negligible and incommensurate with clinical demands on professional nursing care.*

CONTENTS

APPENDICES

FIGURES

Chapter 5

Chapter 6

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
DH	Department of Health (England)
EC	Emergency Contraception
ED	Erectile Dysfunction
ENB	English National Board for Nursing, Midwifery and Health Visiting (pre-2002)
FG	Focus Group (number / location) (part of the empirical study)
FGM	Female Genital Mutilation (the term preferred by WHO)
GU	Genito-Urinary e.g. nursing, medicine or healthcare
GUNA	Genito-Urinary Nurses Association (www.guna.org.uk)
HEI / HEIs	Higher Education Institute(s)
HEI-S	HEI Survey of teachers (part of the empirical study)
HIV+	HIV (Human Immunodeficiency Virus) anti-body positive
HPA	Health Protection Agency (www.hpa.org.uk)
IAG	Her Majesty's Government Independent Advisory Group for Sexual Health (SH-IAG) or Teenage Pregnancy (TP-IAG)
KC60	A UK NHS system of disease classification, renamed as of January 2011 to the Sexual Health and HIV Property Type (SHHAPT) codes
NMC	Nursing and midwifery Council (2002 -)
NMAS	Nursing & Midwifery Admissions Service (www.nmas.ac.uk)
ONS	Office of National Statistics (UK) (www.ons.gov.uk)
P+number	Participant identification number (referring to the FG & QG respondents)
QG	Questionnaire Group (number / location) (part of the empirical study)
R+number	Respondent identification number (referring to the HEI-Survey respondents)
RCN	Royal College of Nursing
S&GE	Sexualities & Gender Epistemologies (coined for this thesis)
SAI	Sexually Acquired Infection(s)

SHS	Sexual Health Skills course (formerly of the RCN, now University of Greenwich with continued RCN Accreditation Unit approval / certification)
STI	Sexually Transmitted infection(s)
TPU	Teenage Pregnancy Unit (currently part of the Department for Education)
UCAS	Universities and Colleges Admission Service (www.ucas.ac.uk)
UG	University of Greenwich
UKCC	United Kingdom Central Council for nursing, Midwifery and Health Visiting (pre-2002)
UREC	University Research Ethics Committee
WHO	World Health Organisation

DEDICATION

In piam memoriam

Sharon Amanda Pollitt

21 February 1963 – 15 August 2011

Between the time of presenting this thesis for examination and successfully completing the doctoral programme, my dear sister in law, Sharon, died after living bravely with breast and brain cancer for eleven years. She was a most wonderful person, a truly loving being, who is painfully missed at this moment in time but so close to us all in the love and memories we share of her. She gave me the honour of planning and 'choreographing' her formal Celebration of Life and Funeral Rites of Passage with her, then presiding at these ceremonies; onerous tasks but ones I will cherish for the rest of my life.

Sharon + Requiescat in pace

Chapter 1

INTRODUCTION

Sexual health is dead:

long live sexual health!

Chapter 1

INTRODUCTION

'Sexual health is dead: long live sexual health'

Introduction: Exploring the topic

'Sexual health is dead: long live sexual health', no doubt this is a strange introductory banner with which to introduce a doctoral thesis. In many ways, the conundrum of the chapter's title reflects key perceptions about sexual health and well-being in England and elsewhere in the United Kingdom. This is all despite various 'regulatory regimes' (Farrell 1996), such as government campaigns, popular representations, mass media *reportage,* and particular moral codes and societal conventions. Many of these discourses appear to tussle with "the end of the double standard and the advent of sexual emancipation" (Tiefer 2006: 273). As with other spheres in health care, such messages frequently emphasise the fact that when most people - medical anthropologists and statisticians included - talk of sexual 'health', they are actually referring to sexual illness and / or problems (Wilson and McAndrew 2000). Although this custom is not unique to sexual health, the effect of this confusion on professional nursing education as well as in clinical practice

frequently detracts from the more holistic implications pertaining to the wider meanings of sexual 'health' as well-being (Challinor 2006, 2008; WHO 2004).

As nurses are part of wider society, they are not immune from cultural stereotypes and social representations of sexual ill-health – the 'iconography' of the science - which abound in the media and popular (lay) and professional images. Such images include those related to problematised teenage pregnancies, abortion, sexual infections and HIV. This thesis demonstrates their effect on professional learning, too. Discourses pertaining to such representations and stereotypes are often a conduit for popular beliefs on given subjects. Recall in medico-scientific motifs and discourses, for example, the significant use of notions of fear, blame, contagion, plague, and the imputation of guilt for the first wave of the then-labelled 'AIDS sufferers' (Sontag 1991). This process, popularly assimilating pseudo medico-scientific 'facts', may be referred to as the 'iconography of a science'. That way the medico-scientific motifs and discourses typify what Myers (1990: 231) said in relation to such representations, that

> "[.] the iconography of a science is more likely to have an impact on the public than the words or mathematics, which may be incomprehensible to them".

Identifying the issues

Allowing for some differences in approach to data collection (Fenton *et al.* 2001), the reporting and hyperbole of the dangers of sexual illness emphasise how the UK continues to have the highest statistics for sexual ill-health among all western European nations (IPPF 2008; Rice *et al.* 2008;

WHO 2006). Unlike this thesis, official statistics of sexual ill-health are usually defined in the narrowest sense of teenage conceptions and sexual infections. Statistics for both teenage conceptions and sexual infections have remained high over at least the past two decades, a point in time when most other western European nations started to see a decline in their own associated poor indices attributed to sexual ill-health (DCSF 2008; HPA 2007a, 2007b; McLeod 2001; SEU 1999). On top of this, when the country is "faced with increasing incidence of STIs, existing STI surveillance systems in England are unable to provide adequate epidemiological data for the fulfilment of basic uses of public health surveillance at the local level" (Ihekweazu *et al.* 2007).

Sexual health in England: a new age?

Sexual health - understood in this thesis as the holistically wider, dynamic, elements of human life and relations - is far from dead in the UK. It is not even close to being moribund, despite often appearing to be in a rather critical state of decline (Pratt 2000). In fact, adapting a popular saying, it could be said that "we've never had it so (potentially) good!" For example, the 1960s were heralded by many as a dawn of freer sexual attitudes in general (Cook 2007). That decade witnessed changes in fertility control, most notably 'the Pill'; second wave feminist and women's movement endeavours leading to the outlawing of gender discrimination; access to legally permitted and safe abortions on mainland UK since 1967 (currently still not permitted in Northern Ireland) and the beginnings of the dismantling of unequal and discriminatory laws against gay and lesbian people, from

1967 onwards. Various gay and lesbian equality laws have now been enshrined, as with transgender people's equality, in accordance with the European Convention of Human Rights (ECHR), the UK's domestic Human Rights Act (1998) and subsequent equality and anti-discriminatory legislation.

Other significant innovations in the four decades since the 1960s include: more widely and freely available methods of contraception and a plethora of differently shaped, sensitively fitting, and flavoured condoms; *in vitro* fertilisation; emergency hormonal contraception (EC), and erectile dysfunction (ED) awareness notably through the advent of sildenafil (*Viagra*®) (Tiefer 2006). To this list can be added the first wave availability of vaccines for young, sexually naïve females, against two and four subtypes of the Human Papilloma Virus (HPV) which are the most significant oncogenic organisms of cervical, and potentially, penile cancers in males, and in both genders: rectal and throat cancers (Thaczuk 2006; Crosbie and Kitchener 2007; Santos 2010). Somewhat controversially on this last matter, the anti-HPV vaccine programme is not yet intended to cover males (Carter 2007).

There are also hitherto unheard of therapeutic innovations and medications, such as 'sperm washing' (Kim *et al*. 1999), Highly Active Anti-Retroviral Therapies (HAART) and Post Exposure Prophylaxis (PEP) (Evans 2005a), necessitated since the naming of AIDS in 1981. Nineteen eighty-one is recorded as the acknowledged start of a global pandemic of HIV infection

and disease, which claimed over twenty-five million lives world-wide in its first 25 years (Annan 2006)[1].

The general approach to many of these post-1960s 'developments' exemplifies what Michel Foucault (1926 – 1984) called the *scientia sexualis*, as opposed to, and often at the expense of, the *ars erotica* (Foucault 1984), both concepts explored below and throughout this work.

Introducing the thesis

This thesis is based on one important aspect of the wider discourses of sexual health care, notably professional nursing education. This chapter highlights a number of key issues which will be investigated and developed more thoroughly, to address the research aims and analyse the empirical data, thus informing the thesis as a whole. They include:

- an exploration of some of the discourses and problems concerning definitions and labelling (identification) and recording (epidemiology) of sexual health and illness, particularly, although not exclusively, over the decade of the relevant English strategies for teenage pregnancy, sexual heath and HIV 2000 – 2010
- the analysis of the relationship between discourses, power, and 'invisibilisation' (explained below), and
- a critical examination of the role of professional education for nurses in advancing sexual health within holistic client care, including certain core issues such as sexuality, the body, the individual as 'the subject', and illness.

---

[1] This number was revised by the UNAIDS Organisation, November 2009, to remain at the same 25 million to compensate for previous over-counting.

The empirical study has three main elements, operationalised across England. One element is a postal survey of sexual health teachers at various higher education institutions, undertaken in February 2008. Also, from July 2007 until August 2008, a further element is the audio-recorded focus groups of registered nurses attending a particular foundation course in sexual health[2]. Finally, the third element comprises semi-structured self-completion questionnaires, administered by cohort facilitators. These used the same themes as in the focus group interviews, to cohorts of the same national course but at geographical centres that I[3] could not physically attend due to a clash of cohort centre dates.

The central research and empirical questions

"In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?"

"In which ways could professional education have adequately prepared nurses for meeting the sexual health needs of their clients?"

The literature review and the three main elements of the empirical study explore professional education for nurses, in England. Various discourses on

---

[2] The RCN Sexual Health Skills distance learning course, which I developed (2002-4) and managed (2004 - 2008) across the UK.

[3] Using first person singular throughout this work is consistent with feminist and certain other theories, not least as a "minimal way to call attention to the researcher as a person with a specific subjectivity" (Sprague 2005: 167). It is also a technique through which the researcher acknowledges and claims their work (for better and for worse), and recognises the author as a doctoral level practitioner, expert to a given standard in their field of study.

sexuality, the body, the individual as 'the subject', and illness are directly related to this professional education for nurses and have been influenced by the primary writings of, and secondary writings on, the French philosopher Michel Foucault (1926 – 1984).

The specific discourses referred to in the research question emanate out of the literature supporting this thesis and the data gathered during the empirical study. Discourses which may appear obvious candidates to inform the need for, and provision of, professional education include official epidemiology, associated government and health policy, and diverse literature regarding sexual infections, HIV infection and disease, and teenage pregnancy.

The literature and data sources informing this work also point out how sexual health has a much wider focus than infections and teenage conceptions. A limited or pathologised focus on sexual *ill*-health is what Foucault (1984: 42) described as "an entire medico-sexual regime [taking] hold of the family milieu". This 'medico-sexual regime' spans an extensive range of competing discursive formations, including discourses relating to gender and sexual orientation – and associated academic theories, such as feminism and masculinities studies, lesbian, gay and Queer theories - as well as sexual health issues for specific, demographically differentiated, people and groups. Such people and groups include those formulated through various age ranges and extremes (young / old); physical and mental abilities; cultures, religions and ethnicities, and educational, social and economic differences.

Importantly, this thesis will include discourses that are not always formally or positively acknowledged or verbalised, as well as those which are promulgated through opposition and suppression. These discourses will be referred to in this text as "invisibilised"; the author is aware, however, that Foucault clearly demonstrated not so much their invisibilisation, but their marginalisation and regulation through power (Foucault 1980; Danaher *et al.* 2000). Foucault analysed how, in relation to specific discourses, especially those pertaining to the sex areas of life, that the power (dynamism) of official, social, and popular discursive parlance, leads some discourses into prohibition and relative obscurity with the effect of virtual, though not 'real', invisibilisation.

> "The conclusion which emerges from Foucault's reflections on the repressive hypothesis is that the past three centuries do not so much reveal a constant and uniform silence over the matter of sexuality as the accumulation of a vast network of discourses on sex."
>
> (Smart 2004: 96)

One example out of the many that could be used is the lack of formal recognition in any UK state epidemiological studies of the number of lesbian women who are HIV positive (HIV+), let alone those with various sexual infections. It will be argued, later, that this is a process emblematic of numerous other 'invisibilised' discourses surrounding lesbians and their health (Weston 1994; Arnold 1997; White and Martinez 1997).

Why Michel Foucault?

Foucault's 'tool box'

Numerous aspects of the life and works of Michel Foucault are pertinent to the subject matter of this thesis. A clear rationale for 'working with' Foucauldian theories in this study is explored in the methods chapter (3). The eclectic nature of the research methods employed for this EdD, including some quantitative statistics and comparative analyses in the surveys, preclude me from claiming that this study is exclusively Foucauldian. What this study will do, however, is make use of some of Foucault's 'tools', as he himself encouraged people to do (Kendall and Wickham 1999; O'Farrell 2005), as a principal way of making sense of the discourses gathered and explored in the literature and data sources during the construction of this thesis.

It can be argued that much of Foucault's impetus in life revolved around his personal *angst* and understanding of 'sexuality' – a constructed concept he endlessly contested - as well as his evolving notions of power, ethics and illness (Halperin 1997). Indeed, although he claimed that "sex is boring" (Gutting 2005: 101), he actually revelled in exploring the heavier side of sado-masochistic sex. Foucault died as a result of HIV disease in 1984 (Miller 1993; O'Farrell 2005). On the theme of power, as with the discourses on the HPV vaccine and lesbian health, both referred to above, Foucault's concern was not that some people have power and others do not; that is a central contention of Marxism. Rather, Foucault saw power as an attribute of connections and relations, not as something to have and wield over others.

This 'slipperiness' is what makes the use of the term 'power' in a Foucauldian context so difficult (Cole 2006).

Foucault did not only write on sexuality, of course. His authorship is voluminous, including on other issues directly related to the subject matter of this thesis, such as: health and illness; the construction and regulation of the self-as-subject including surveillance and "governmentality" (Pryce 2000; Pryce 2001), and the social construction of the sexual *persona* as the sexual identity of 'the subject'. All of these he envisaged being related to power / knowledge (Foucault 1980).

During his life, Foucault had an abundance of same-sex experiences and relationships, which he saw no need to conceal. At the same time, however, he vigorously and perpetually eschewed notions of sexual identity and any consequent liberation or self-proclamatory 'coming out'. Nevertheless, elements of the Gay and Lesbian Liberation Movement, and later Gay, Lesbian and Queer Theories, trace their origins or impetus to his works (Sullivan 2003). He viewed notions of sexual identity not as "merely a set of biological promptings which either do or do not find direct release" (Giddens 1997: 23) but as a wider influence grounded in false social constructs related to, and regulated by, hegemonic power.

Problems with language

Much to the displeasure of certain feminists, as explored by Ramazanoglu (1993), some of Foucault's works - notably <u>The History of Sexuality</u>[4] - are accused of being androcentric (male-focused). At the same time, there are others within feminist movements who have forgiven him *(sic)* for this, modifying and adapting his analytical methods for their own benefit (Martin 1988; Diamond and Quinby 1998). Claire O'Farrell (2005) attributes much of this apparent gender-blindness to translations from the original French into English. French, unlike English, is grammatically grounded in dyadic gendered nouns and pronouns, often without any relation to or discrimination about biological sex. According to O'Farrell (2005), whose expertise extends into being a significant translator of Foucault's works from French into English, masculine nouns and pronouns are read as gender neutral in French but pose a problem for English translators / translations which may therefore yield a total mis-reading of the original author's intentions. Another criticism, which Allen (2004) explores and refutes, is that his tortuous writing style is too cerebral and detached from the practicalities involved in every-day health and caring.

Despite all of this, probably even because of it, I will argue in chapter 3 that the scholarly work of Michel Foucault is pre-eminently suited as the epistemological bedrock underpinning much of this work. The philosophical analysis of key themes utilised in this doctoral study: sexuality, power / knowledge and discourse, have been changed significantly by the writings of

---

[4] Only volumes 1 – 3, of a proposed 6, were completed and published before his death.

Foucault and subsequent authors who have engaged with his work, both for and against (Ramazanoglu 1993; Giddens 1997; Diamond and Quinby 1998).

Scientia sexualis

In relation to the educational discourses for this thesis, the Foucauldian concept of *scientia sexualis* highlights Foucault's (1984) ideas on the way in which various male / male dominated professions have been promulgated. Foucault charted their rise from the 18th century onwards, especially in the post-Enlightenment West and parts of the world most affected by the influences of the Victorian empire (Corfield 2000). These professions included medicine, psychiatry, certain branches of the Christian clergy, law and enforcement, politics and education (Evans 2004a). According to Foucault, the creeds enshrined and practised by these professions, part of the "apparatus of State" (Foucault 1980: 60), enacted certain relations of power-over-others (hegemony), which has the propensity for internalisation within the individual, and the subsequent practice of self-policing (*surveillance* and *governmentality*). This is especially so in relation to core issues for this research and thesis such as sexuality, the body, the individual as 'the subject', and illness (Danaher *et al.* 2000).

A clear example incorporating all four of these core issues of life is demonstrated in one of the UK Government's late-1980s television 'AIDS campaigns'. The advertisement showed a young couple, from initial meeting in a bar to a bedroom scene. There was clear sexual chemistry between the

man and woman, with a passionate use of their bodies. They appeared self-assured individuals who knew what they wanted and were prepared to 'go for it'! Finally, the point of the advertisement: the couple made no mention of safer sex or condoms, to protect themselves from infections. The inferences for self-surveillance and governmentality were proclaimed at the end of the ad: "AIDS – you know the risks, the decision is yours!" (Wellings and Field 1996: 253). In a similar vein Mills (2003: 81) highlights how for Foucault "the body is that site on which discourses are enacted and where they are contested", especially as exemplified in relation to females, where "the disciplinary power that inscribes femininity onto the female body is everywhere and nowhere" (Mills 2003: 94).

In light of Foucault, some theorists argue for an analysis of the very powers which regulate 'femininity' and consequently construct the medico-biological 'feminine body'. Three examples of this medico-construction of the 'feminine body' include:

1) an adaptation of Butler's (2004) 'undiagnosing gender', in respect of (trans-)gender identities
2) the 'myth of the vaginal orgasm', in Koedt (1998), and, conversely,
3) the call for medical attention into a matter often "dismissed" solely as psychogenic, i.e. implying female histrionics, in the subject of 'female sexual function and dysfunction' (Graziottin 2001).

'Docile bodies'

In relation to a key focus of this thesis, i.e. sex and sexual health, there are numerous other examples where the notion of 'the feminine (body)' is constructed and written upon. According to Rabinow (1991: 182), this is in order to produce sexually "docile bodies" which are compliant and acquiescent to the predominant dyadic counterpart, the (heterosexual) male. From such a position, these bodies are then treated as culpable when judged transgressive (Few 1997). As with the 'feminine body' similar observations could be made regarding both the non-heterosexual (body), evocative in the very title of Adler's (1988) monograph, Diseases in The Homosexual Male, and the body of the child / teenage youth (Foucault 1984; Grey 1993). Sexual matters relating to the latter two: children and teenage youths, are currently witnessed in the UK through various social constructions most notably the 'childhood innocence', 'pædophilia' and the problematisation of 'teenage' pregnancy (Bonell 2004; Coleman and Cater 2006).

Mills (2003: 93) describes constructions of such 'bodies' as "a disciplinary regime [in which] one's comportment is overseen and subjected to a series of rules and regulations relating to control of appetite, movement and emotions". According to Foucault, this position is frequently associated with "biological reduction and medical authority" (Tiefer 2006: 273), which relates to the epidemiologic / demographic regulation of young people and their sexual activities. The latter include themes of teenage and other pregnancies conceived outside 'wedlock' or a stable relationship. Foucault (1984: 117) identifies discourses on these conceptions as examples of what

is construed as the "frauds against procreation". Gutting (2005: 94) similarly likens this process of social categorisation to that of naming *the* delinquent / kleptomaniac / homosexual "simultaneously [as] sources of knowledge and control regarding their 'subjects'".

By way of example of the *scientia sexualis*, an historical overview of sex in the UK cited in Adler (1988) highlights how a controversial law enacted in 1917, the Defence of the Realm Act (DORA), made it illegal for any *woman* with a sexual infection[5] to have sex with a man. DORA was motivated by an aspiration to curtail 'the female', utilising morally-constructed notions of women as corrupting. These discourses place 'promiscuity' (a moral term) within the diatribes of "the 'war against filth' [with the effect of] stigmatising the 'harlot'" (Evans 2005b: 4). As Llewellyn-Jones (1974: 82) poignantly reminds us, however,

> "[.] syphilis can affect a bishop or a '*bagage*' and neither kings nor the rulers of the earth have been spared".

A science of sex

The post-Enlightenment 'sciences' identified 'disorders', ranging from physical maladies to moral disapprovals, such as unmarried - especially working class - women having sex; masturbation and non-procreative sex. All off of these, according to Grey (1993: 45), became

---

[5] In 1917, sexual infections were referred to as "VD", Venereal Diseases, from notions of the supra-clitoral region of the female body, named as the *mons veneris* or 'mountain of Venus', being symbolically the 'well of (lustful) desire' (the Biblical notion of concupiscence; Latin: *concupiscentia*, Greek: *epithumia* - ἐπιθυμια - 1 John 2:16) and hence the source of infections.

"the playground of assorted quacks with their dubious remedies for venereal diseases, impotence and so forth and many of the remedies were as harmful as the conditions they purported to cure".

Foucault would expose the *scientia sexualis*, the science of sex and sexuality, as in many ways a pseudo or false science, with its pathologisation of sex and sexualities wholly contrary to the glorification of the pleasures of sex in, in what he called the *ars erotica*. Evans (2004b: 189) describes the *scientia sexualis* as "principally an amalgam of erotophobic superstition, religion, psychiatry, medicine and associated myopic elements of reproductive and heteronormative moral systems".

According to the practice of this *scientia sexualis*, there is both an "increasing organisation of population and welfare for the sake of increased force and productivity" (Mills 2003: 81) what Foucault called "bio-power". At the same time, there is a shift from the ancient Christian discipline of confession to a priest, to the mechanisms of self-regulation, surveillance and governmentality, of all aspects of life (Pryce 2000; Pryce 2001). This included particularly the sexual pleasures which these 'scientific' professional theories deemed deviant, as objects worthy of their moral solicitude. On this note, Foucault (1984: 9) poignantly asked "why we burden ourselves today with so much guilt for having once made sex a sin" noting how perpetual self-surveillance and confession (Marchetti and Salomoni 2003) supplanted any notions of a *lingua silentii*, that is, a language or discourse of silence. Foucault's evidence for this claim resonates through his methodological

processes of archaeology and / or genealogy of discursive formations, examined later at various points throughout this thesis. Foucault employs both of these processes or tools, to varying degrees of clarity and success, at numerous times throughout his career (Danaher *et al.* 2000; O'Farrell 2005). Of relevance to this study, these methodological processes underscore his three volumes of <u>The History of Sexuality</u> (Foucault 1984; 1985; 1986).

Scientia sexualis and the world of healthcare

Under the aegis of the *scientia sexualis*, Foucault explored how both homosexuality in particular, and all of human sexuality in general, were constructed (Halperin 1997). In the world of clinical healthcare, this has had numerous and ongoing implications, everything from:

- the epidemiological categorisation of pathogenic modes of transmission of HIV[6]
- to the relatively recent (1980s) de-categorisation of homosexuality as a mental illness (DSM-IV[7])
- and to the shifting-sands pathologisation of certain modes of sexual being.

Foucault's analysis of matters sexual includes quasi-religious discourses and motifs of 'the immoral', through various psychiatric pathologisations, and up to more current notions of social problematisation. Witness, as one example of the latter, the changes in stigmatisation and welfare reform regarding

---

[6] The Health Protection Agency (www.hpa.org.uk) categorisations for 'known modes of HIV transmission' include male to male (homosexual) irrespective of whether partner is from outside the UK, especially from places of higher epidemiological significance, or injecting drug user (IDU) etc. Whereas heterosexual transmission is broken down into numerous sub-categories of varying degrees of 'sex with high risk partner', including a bisexual person, person from endemic area, or IDU. The results paint two very different pictures, and the outcomes of which might have differing statistical and health promotion targeting implications.

[7] *Diagnostic and Statistical Manual of Psychiatric Disorders – IV.*

'teenage pregnancy' in the UK over the past 100 years (Hadley 1999; Chambers *et al.* 2001; Bonell 2004).

In certain current discourses, despite the fact that the over-all trend for the English teenage pregnancy statistics is downwards, there is a declared "evidence" of epidemiological "hot-spots" (Hadley 2007). The language characterises a clear discursive profile of an emerging 'type' of individual who best epitomises *the* pregnant teenager and her co-progenitor. Even the "hot spots" are defined as "problematic districts" in local government wards "defying" the strategic efforts of government to reverse the *incidences* of teenage pregnancy (DCSF 2007). Notice the language used and the way it is constructing this discourse. Contrary to the profile of such a teenager, the person who does *not* epitomise this character (or characterisation) is anecdotally said to follow the mantra "ambition is the greatest form of contraception" (Jackson-Hayward and Mullen 2006). These latter individuals are typically the socio-economically and educationally affluent, who are much more likely to access timely emergency contraception (EC) and legal abortion (McLeod 2001).

Demographics at the ultimate extreme of this discursive continuum, of the pregnant teenager, highlight the fact that 39% of females in Her Majesty's Young Offenders Institutions (YOI) have had babies (DCSF 2007: 11) and 25% of male youths in YOIs have equally 'fathered a child' by the time they enter the criminal justice system. Discourses on 'teenage pregnancy' at all stages of the continuum are reminiscent of those concerning other 'social

problems', as highlighted in the works of Foucault, especially <u>The History of</u> <u>Sexuality</u> volume 1. This is particularly so regarding sex and women / social class / children / and 'the' homosexual. These identity-formulating processes of pathologisation and / or socio-moral problematisation are wholly consistent with Foucault's exposition of three axes for the construction of 'sexuality', *viz.*:

1) knowledge about sexual behaviour
2) systems of power which regulate the practice of sex acts
3) the forms within which individuals are able, and obliged, to recognise themselves as subjects of their sexuality.

Foucault (1984: 4) and Mills (2003: 87)

Such discourses on sexual health in the UK can equally, and inversely, highlight other problems with negative reporting and popular representations. These include mixed messages and moral panic (Sontag 1990). An example of a mixed message can be seen in a BBC documentary in 2007 which claimed that "Britain is post-AIDS". This claim is despite the numbers of both new HIV diagnoses and infections going up year on year without any sign of abatement (HPA 2007a; Rice *et al.* 2008). An example of a moral panic was the blaming of AIDS on gay men, and subsequent persecutions, including the efforts in America to halt gay sex, for example through the closing of spaces where recreational sex took place (Shilts 1988).

Scientia sexualis and its relevance to nursing

According to contemporary philosophies of holistic nursing care, sexual health and well-being can be viewed as being as totally pervasive in a

20

person's life as their mental health and well-being (RCN 2001). Holistic implications of sexual health can expand into such personal domains as an individual's perception of their self-esteem and their capacity to experience sex simply for the sake of pleasure and enjoyment. This is evocative of Foucault's discourses on the *ars erotica*. However, media *reportage*, popular opinion, and epidemiological statistics rarely give equal attention to many of the positive aspects of sexual health and well-being.

Compare these positive aspects of holistic sexual health and well-being and the usual problematisation and pathologisation of various aspects of sexual ill-health with the highly sexualised elements of the media. According to Gill (2003) many media discourses, especially those at the more tabloid-end of the market and those specifically targeting young people, clearly focus on promoting the early sexualisation of certain youth, disproportionately targeting females. Somewhat hypocritically, it might be said, it is often these same media that then bemoan the fact when things 'go wrong', as exemplified through manifestations and statistics on sexual ill-health.

If problems of the *scientia sexualis* are associated with official statistics, media *reportage* and popular perceptions of sexual health, then, by default, nursing is likely to be influenced by this coverage on these matters, given that nurses also live in this same sexualised world (Evans 2004c). Over and above this, in fact, there are numerous other ways in which professional nursing is influenced. One of the most obvious ways is through the various holistic philosophies and definitions of health and nursing care as actualised,

for example, in procedures and documentation called 'the activities of daily living' (ADL). Various ADL documents enquire how the patient's 'sexuality' is related to nursing care. Anecdotes abound on how the 'sexuality box' on a patient's notes is routinely filled in with meaningless statements, such as 'wears makeup', 'lives at home with husband and children', 'N/A' (not applicable) or "over 40" (Evans, in *Issues in Practice 1,* RCN 2004). As one of this study's Focus Group (**FG**) Participants (**P**) said:

> **FG16 / P02**   Activities of Daily Living!?   Sexuality!?   You used to put things like "likes to brush her hair" and that was it!

Examples of the mis-use and under-use of the 'sexuality box' are particularly prevalent in certain areas of care.   These include care of older people, people with disabilities, or those who happen to be receiving care from a service that simply does not have the time or inclination to address such matters. This minimalist practice accentuates the prevalence of reductionism, the exact opposite of holistic care, and is akin to Foucault's "biological reduction and medical authority" (Tiefer 2006: 273). Reductionism 'treats' the condition of the individual, for example, their breast cancer, without seeing the wider (holistic) implications of how the breast cancer may affect the other areas of the person's life, including their sexual and reproductive health and well-being.

An absent presence in the literature

Chapter 2 will analyse findings from a number of (nursing) publications related to issues of care.   These will show the wider sexual health components of client care which are glossed over in favour of targeted,

reductionist, treatments of bio-medical service provision. A clear example of this, in a paper on prostate cancer, contains just one passing reference to sexual health:

> "Nurses therefore have a primary role in promoting and maintaining the patient's sexual health."

(Turner 2007: 55)

Unfortunately, Turner's (2007) reference is the closest many texts on prostate cancer / male urological surgery actually get to mentioning various iatrogenic consequences for the individual's holistic well-being and their sexual relations. Such consequences include treatment side-effects and surgical sequelae that lead to erectile dysfunction and retrograde ejaculation. Similarly, professional and academic publications highlight potential earlier-in-life prophylaxes against prostate cancer, such as taking vitamins and eating pomegranates, but fail to mention significant research evidence from Australia and the USA on the similar prophylactic health benefits of masturbation throughout life (Giles *et al.* 2003; Leitzmann *et al.* 2004). The wider holistic dimensions of sexual health frequently appear to be 'invisibilised' in services focused on achieving set targets, including those set on reducing teenage and unplanned conceptions or new incidents of sexual infections and HIV (DH 2002).

For individual nurses, the problems highlighted in this current chapter can be exacerbated by personal feelings of embarrassment at merely talking about sexual matters, especially when embarrassment is compounded by various (multi-) cultural and religious influences, their own or others.   This

embarrassment highlights how, on the one hand, many patients would generally prefer nurses and other healthcare practitioners to be the first to mention topics of sexual health. At the same time, however, other studies conclude the opposite: that many nurses would rather wait until the patients mention such issues first.

The literature review and data analysis will identify certain clinical areas where holistic sexual health could be proactively discussed, but frequently is not. These clinical areas include midwifery, gynæcology, urology, cardiology, endocrinology (diabetes), travel health, post-trauma and before / after radical body disfiguring or disabling therapy or surgery, such as in cancer care. The findings point towards the lack of meaning and understandings of sexual health within the philosophies of holistic care, begging the question *what really 'is' sexual health?* Similarly, they highlight the need for a workable definition of sexual health in, and for, nursing care and nurse education. To this end, the World Health Organisation (WHO 2004) has developed a number of perspectives for defining sexual - and reproductive - health, moving on from its often-quoted 1975 definition, which claimed sexual health to be

> "the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love".

Later WHO definitions (WHO 2004) incorporate numerous anti-discriminatory statements as well as rights to consent; freedom from coercion, violence and

abuse; all of this whilst continually juggling respect from competing cultural beliefs and influences.

Sexual health challenges in nursing care and education

Issues highlighted in this chapter are some of those that make sexual health in nursing care challenging. There are three other matters of key importance, which are directly related to the educational work of this thesis:

1) healthcare patients with sexual health problems could be helped more by greater numbers of nurses, if these professional carers were confident and competent to deliver such care: clearly an issue for professional education;

2) many associated issues of sexual health are frequently related to matters of sex - such as sex for pleasure and not solely for reproduction - and non-heterosexual identities and their related healthcare needs. These are traditionally 'invisibilised' or discriminated against in clinical practice as well as in professional education;

3) as data in this thesis reveal, professional nursing education in England, at both pre- and post-registration levels, is statistically weak on the numbers of nurses it is educating and training in relation to the specific problems defined as sexual ill-health (unplanned / teenage conceptions, sexual infections and HIV). This situation is even more profound in relation to the wider aspects of holistic sexual health and well-being, often invisibilised.

Finally, it is important to set this somewhat bleak backdrop against the contrary examples of excellence developing practice in sexual health nursing.

These developments include the emerging specialist professional roles and career pathways within the key sub-specialities of sexual health. These roles are expanding right through the professional career trajectory, from 'novice to expert', up to consultant nurse, as never before (RCN 2009). The Higher Education Institutions Survey (HEI-S) and Genito-Urinary Nurses' Association (GUNA) website reveal a few individual HEIs that are attempting to provide courses and programmes which assist these clinical career pathways. Recommended ways of supporting the professional trajectory with appropriate academic qualifications was clearly outlined (by me) in the RCN (2001) <u>Sexual Health Strategy: guidance for nursing staff</u>. In the education section of this document, I recommended that, in the not too distant future, consultant nurses could be encouraged to support their practice with research either through traditional MPhil / PhD studies or in professional doctorates in nursing, similar to this EdD programme or the DClinPsy. The benefits of such academic credence supporting this high level of practice are outlined in Figure 1: 1.

Figure 1: 1   Some benefits of nursing research degrees
　　　　　　from RCN (2001) Section 2 Figure 11

- to create greater parity among senior professionals
- to enhance specialist areas of knowledge, and the ability to contribute to other research-based programmes (on a multidisciplinary level)
- to raise the academic profile of sexual health nursing
- to act as an incentive to achieve academic excellence
- to imbue the post of nurse consultant with traditional academic credibility
- to ensure the post is clearly situated in a research framework
- to develop and enhance further studies into this relatively new area of health care and education.

Nursing education and Foucault's triple edict

Issues of sexual health, especially those linked to the performativity of sex and non-majoritarian sexual identities, have been, throughout various histories and cultures, regularly attended by what Foucault referred to as "the triple edict of taboo, non-existence and silence" (Foucault 1984 : 4-5). In this thesis, the "triple edict" is acknowledged as being akin to stigmatisation in its process of concealability or 'invisibilisation' (Evans 2001; ICN 2003). Many of the stigmas attached to these differing aspects of sexual health are constructed within times, cultures and faith communities which still have influence in the UK today (ICN 2003).

Foucault's (1984) "triple edict", read through the nursing practice of some respondents quoted later in this doctoral study, can be witnessed not least in the on-going hostility to condom use by the Vatican, even as a prophylactic against HIV infection (Evans 2005c; Quattrocchi 2010). This has a profound impact on the education and services which can be provided by many school nurses working in Catholic and other faith schools in the UK, where they are 'forbidden' to talk about condoms (Martino 1999; Forrest 2003; Kidger 2006; Selwyn and Powell 2007). As one participant stated:

> **FG12 / P04**   We can't talk about sex, it does't happen! We are not allowed to have condoms on the premises. We just managed to sort of, you know, get this sexual health committee set up, urm but how far that will go is difficult to say, it'll be a long process.

It could be argued that the government has hitherto colluded with this stance, albeit inadvertently, through various Sex and Relationship Education (SRE)

policies (DfEE 2000). These permit individual schools, faith schools in particular, to limit the information and resources provided by nurses, teachers and others, on proven methods of harm-minimisation / infection control, not least on effective safer sex education and resources. It does this by not insisting on teaching of the benefits of condom use in the prevention of transmitting sexual infections, contrary to the spirit of the UNAIDS (2004) 'position paper' on condoms. This perennial problem poses an ethical dilemma for many respondents, as explored in chapters 4 & 5, a dilemma which their professional education often ill-equips them to challenge and overcome.

Setting the scene: sexual ill-health in England 2010 onwards

Using epidemiology to narrowly define 'client need'

Techniques of statistical representation and analysis sit comfortably within the practices of self-respecting positivistic bio-medical and nursing research (Holloway and Walker 2000). These methods are far removed from the practices of Foucault, however, and remain *anathema* to his followers and other post-structuralist thinkers. This is because

> "[a]n emphasis on the heterogeneity and discontinuity of representational formats, and on the local and contextual basis of their production, has become a familiar refrain in 'postmodernist' critiques of traditional views of science and language."
>
> Lynch and Woolgar (1990: 2)

For this reason, their use within this thesis is limited.

As highlighted in the opening paragraphs of this chapter, there are acknowledged problems with the collection of epidemiological data on sexual infections within genito-urinary services across England (Ihekweazu *et al.* 2007). These problems are compounded when the methods used are compared with Europe-wide surveillance techniques (Fenton *et al.* 2001). Traditionally in the UK, the data are collected and presented to the Health Protection Agency (HPA) in the form of KC60 reporting (called SHHAPT after January 2011). In present-day England, however, there is now much wider access to testing, diagnosing and treating sexual infections such as in Primary Care, General Practice, certain pharmacies (for Chlamydia testing), outreach services for sexual infections and HIV voluntary testing and counselling (VTC), abortion services, as well as private healthcare providers. Only registered genito-urinary clinics are mandated to submit KC60 data; therefore, an increasing amount of under-reporting is inevitable.

A similar example is found in the official statistics for HIV infections. These figures show an apparent low incidence in the under-24 year old male heterosexual transmission category. This is despite this age group being overwhelmingly highest for many other sexual infections and, of course, their role played in teenage conceptions. The sexual infection and teenage pregnancy statistics are indicative of high levels of unprotected intercourse – the cause of both. However, the under-24 year old male heterosexual group is disproportionately under-represented in HIV testing opportunities when compared with gay, bisexual and other males having sex with males (MSM), and females who have sex with males.

The role of epidemiology in relation to the e-survey

In an earlier successful study for a Master of Philosophy degree (Evans 1997), I explored "the psychic shadows of HIV and AIDS and the role of social representations in post-registration nurse education". These representations demonstrated clearly how they could often be better thought of as *mis*-representations. Revisiting that work now, it is possible to assert that much of the theory explored for that earlier study – but now re-applied to the wider field of sexual health - is still valid in relation to 'scientific' discourses of 'facts' and 'figures' explored in this current study. The reason for this "rests on the fact that for many of these images, they have their origins and *dynamism* in a life which transcends [the discourses of sexual health in itself] but have conveniently attached themselves to it" (Evans 1997: 306). These include evolving discourses such as stigma, guilt, (self-)blame and pathologisation (Hodgson 2003).

Take, for example, the problematisation which frequently accompanies the term 'teenage pregnancy'. In relation to teenage conceptions, the picture can get rather complicated. Except for physiological issues related to the age and size of the pregnant girl / woman, the term 'teenage pregnancy' is relatively devoid of its usual characteristic stigma if, for example, the young woman is from a culture where she is married young and expected to have a baby as soon as possible (Cook 2007). Another example relates to (lack of) statistical evidence on the experience of *felt* or *perceived* stigma which relate to sexual infections and HIV (Evans 2001; Hodgson 2003), 'teenage pregnancies' and abortion (Astbury-Ward 2008).

The primary aim for using epidemiology, albeit limited, in this otherwise qualitative thesis is to enable a (re-)presentation of various official statistical maps and tables. This will be done in order to highlight variations of sexual ill-health and associated problems, defined in the <u>National Strategy for Sexual Health and HIV</u> (<u>NSSHH</u>) (DH 2001) as sexually transmitted infections, HIV and teenage pregnancy, in the ten English regions. The statistical map will then be analysed in critical comparison with the amount of formal sexual health education provided by HEIs within the same boundaries of official English Regions / Strategic Health Authorities (StHAs). That way, a picture can be drawn identifying a quantifiable amount of client need, in correlation with formal educational provision required to address that need.

Sexual health in England's nursing curricula

The analysis of literature in chapter 2 will demonstrate a clear and lamentable absence of published texts, in various nursing journals for the UK, on formal professional sexual health education and learning. Later chapters will corroborate this absence by examining discourses from supporting literature and data gathered during the empirical study both from teachers of nursing at HEIs across England, and through the personal stories of individual nurses trying to redress this balance for themselves, their professional practice and their patients, by undertaking a particular foundational course in sexual health.

Given the multiplicity of discourses surrounding the meanings of sexual health and the breadth of its influence in practice, there are likewise

numerous clarifications that need to be made regarding 'sexual health' in the nursing curriculum. These may be envisaged as a triptych, outlined in Figure 1: 2.

Figure 1: 2   Educational triptych for sexual health in nursing curricula

Sexual health associated dimensions of general health & well-being

• Related or secondary to specific conditions of patients / clients' health and illness, e.g. travel health, diabetes, cancer

• Associated to the clinical needs of practice areas / courses, e.g. mental health, young / old people etc.

Holistic foundations in sexual health

• Generic across the pre-registration programme

• Adapted, as appropriate, in post registration studies

Specialist sexual health studies, including:

• Contraception and reproductive health

• Sex & Relationship Education (SRE) and teenage pregnancy

• Sexually acquired infections

• HIV

• Psychosexual counselling skills etc.

Firstly, as shown in the central panel, sexual health refers to an aspect or domain of life, health and well-being, found in various holistic philosophies of personhood underpinning most pre- and post-registration programmes of learning (WHO 2004).

Secondly, as shown in the left hand panel, it refers to the associated dimensions of how holistic sexual well-being can be disrupted in particular or special ways, resulting from all manner of illness, disease and disability. This includes everything from painful intercourse for a woman (dyspareunia) such as caused by post-menopausal vaginal dryness and 'friability', to an inability to conceive due to chronic complications of earlier, undiagnosed, *Chlamydia trachomatis* infection. Or again, it could refer to a person's inability to insist on safer sex and / or contraception due to cultural or religious reasons, or simply because of the intransigence and domination of a violent and abusive partner. It might also include the loss of sexual desire and / or performativity (Butler 2004) accompanying trauma, surgery or a wide range of illnesses and medications, all compounded when healthcare professionals appear unwilling, unable or too embarrassed to address these issues as part of holistic client care (Meerabeau 1999). Such matters will be explored in depth in the data.

Thirdly, as shown in the right hand panel, it might refer to the narrowly categorised but obvious specialist definitions of sexual health pathologies and problems. Those include sexual infections; HIV; unintended, unwanted and 'teenage pregnancies', and matters requiring psycho-sexual counselling interventions, including dealing with related stigmas.

A curricular triptych

The nursing curricula can likewise be envisaged as three panels of a triptych. Firstly, there is the pre-registration / pre-qualifying, curriculum. This is, to an

extent, regulated by statute in the <u>Nursing and Midwifery Order</u> (OPSI 2001) via the generic guidelines for professional practice outlined by the regulatory authority, the Nursing and Midwifery Council (NMC). The NMC was established 'to protect the public through professional standards'.

Secondly, there are various post-qualifying specialist-focused curricula (see Figure 1: 2), which could profitably include related elements of the three aspects of sexual health outlined above, namely:

1) holistic philosophies of care, including sexual health and well-being
2) health conditions and deficits which impact negatively on aspects of sexual health and well-being
3) the specific, identified, issues of sexual ill-health (teenage / unplanned conceptions, sexual infections and HIV).

Related or customised issues for these specialist post-registration focused curricula might include negotiating the 'mechanics' of sexual activity for a person newly paralysed (Trauma & Orthopædics courses); the implications of ageing on sexual health (Care of Older People courses); loss of desire and the wider sexual implications of performativity with psychiatric medications and illnesses (Mental Health Nursing) and counselling skills and forensic interventions for a person who has been raped or sexually abused (Emergency Nursing courses). Even these limited examples show that the implications of sex, sexualities and sexual health can have relevance for almost every aspect of nursing care and its associated professional education.

The third panel of this triptych shows the specific, specialist courses of various sub-specialities within sexual health itself. These are defined here as contraception and reproductive health, genito-urinary and HIV nursing, and psycho-sexual nursing (see Figure 2: 2 *The sexual health umbrella*, in chapter 2). This list can be expanded to include fertility and infertility nursing. For these sub-specialities within the sexual health umbrella, the statutory change-over from the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) to the NMC in 2002 also witnessed the dissolution of the four former national boards within the UK. One of these boards, the English National Board (ENB), produced various 'core curricula' documents recommending at least an essential transferability between courses on the same speciality, even though there may be significant variation across courses provided. For example, although one Higher Education Institution may have a 20 credit academic course entitled 'the family planning certificate', and another offer a 15 credit course called 'contraceptive and reproductive health', one could be assured that, from the professional / clinical point of view, both these courses had an equitable and transferable 'core' that was acknowledged in clinical service areas through its English National Board certification. Such courses were assigned a code and number, which helped them be nationally recognised (see Appendix 1). Other than the provision of the RCN Approved Sexual Health Skills course[8], a 15 week programme offered UK-wide, this nationally recognised system of core curricular courses no longer exists.

---

[8] The former RCN Sexual Health Skills course, with University of Greenwich academic credit rating 2004 – 2008, is now owned and provided in e-learning format, with RCN Accreditation, as part of the University of Greenwich's portfolio of sexual health courses (2008 -).

Client need versus curricular provision: feast or famine?

The various data responses explored throughout this study focus on discourses pertaining to professional education for nurses, especially those which have a direct bearing on client need and care. Even limiting sexual health to its most narrow definitions, namely unplanned teenage conceptions, sexual infections, HIV, and associated sexual stigmas (SEU 1999; DH 2001; DH 2002), the data identify how the clinical statistics (client / patient need) are overwhelmingly disproportionate to the number of corresponding courses offered across England to equip nurses for addressing these needs. Indeed, the Government's Independent Advisory Group (IAG) on Sexual Health stated that it is "very encouraged by the take up of the RCN distance learning course on sexual health for nurses, and sees this as a very effective way of developing and upgrading skills in sexual health" (IAG-SH 2007: 17). At the same time, however, the IAG recommends that

> "there also needs to be greater emphasis on sexual health within nurses' basic training which includes addressing attitudes and values, and working with people around deeply personal issues."
>
> IAG-SH (2007 : 17)

The problems of inadequate provision of sexual health education for nurses are exacerbated when their professional remit is widened, in contemporary nursing, to include a more proactive public health role. This is clearly demonstrated in the emphasis on primary and secondary illness prevention and corresponding health promotion initiatives. Prime examples include the increased provision of nurses' involvement in Chlamydia testing; the dispensing of emergency hormonal contraception (EC) under Patient Group

Directions (PGD) or Independent Prescribing; partner notification from General Practice settings, hitherto the domain of sexual health advisors in GU services; and assisting new teenage parents with matters of contraception to avoid a second conception in rapid succession or later in the remaining teenage years.   This latter example is potentially a key role for midwives, health visitors and sometimes school nurses.

Client need versus the educational preparedness of nurses

In relation to client need in the form of prevention, treatment and care - even if only that which is identified through the <u>National Strategy for Sexual Health and HIV</u> (DH 2002) for reducing numbers of teenage conceptions, sexual infections and stigma – the educational preparedness of nurses in England, as reported later in this work, is seen in urgent need of redress. Devolution of courses to HEIs, combined with the absence of nationally agreed core curricula, often result in the responsibility for providing courses falling either to individually interested teachers and institutions, or in reaction to requests from the purchasers of such courses such as local Primary Care Trusts (PCTs) especially in sexual ill-health 'hot spots'. Certain forms of training are obviously attractive to some purchasers, managers and practitioners, as they are short, and 'to the point'. These include, for example, brief training interventions for the England-wide roll out of the 'National Chlamydia Screening Programme'. They also include attendance, by nurses, at various medical courses such as the 'STIF' course[9] and DFFP[10].   What such

---

[9] STIF: Sexually Transmitted Infections Foundation course, usually an intensive two day theoretical course, validated by the medical organisation BASHH, the British Association for Sexual Health and HIV, and franchised to HEIs and various Primary and Acute Care Trust training departments.

provision clearly misses out on, due to the brevity of such courses, are the wider holistic dimensions of sexual health for nursing education and practice. Such dimensions of care are more than can be obtained in brief periods of training reduced solely to specific sexual infections (Chlamydia; STIF) or methods of contraception (DFFP).

Repeating the triptych motif

Three fundamental aspects of sexual health are analysed in the data, with an evaluation of the extent to which they are present in the learning experiences of the various respondents. These three aspects include:

1) the holistic dimensions of sexual health, especially pertaining to the nurse's role in prevention / treatment / care
2) the ways in which sexual health can be customised in specialities, to address particular matters relevant to their domain of clinical care (e.g. care of people with diabetes / cancer / learning disabilities etc), and
3) the specialist expertise required for the formal sub-specialities of sexual health.

In summary, the analysis of literature and data together explores a number of pertinent discourses which have relevance to the provision of formal sexual health learning within the nursing curricula of England's Higher Education Institutions.

---

[10] DFFP: Diploma of the Faculty of Sexual and Reproductive Healthcare (FSRH) – a subdivision of the Royal College of Obstetricians and Gynæcologists (RCOG). Despite its grand title of "diploma", this is a two and a half day theoretical course, with a small number of clinical sessions; opened out from medics-only to nurses in 2006.

Conclusion

The aim for this chapter was to begin the process of outlining and exploring some of the complexities involved in discourses addressing the sexual health needs of clients in England, as related to clinical nursing's professional curricula, in ways which are inclusive of 'invisibilised' client need (as defined above).

Despite the endpoint of the thesis (as with all nurse education) being client need / patient care, numerous ethical and practical difficulties involved in research with patient involvement means that no direct clients of sexual health nursing services were involved in the empirical study for this thesis. These difficulties are acknowledged by government with a lamentable lack of any formally recognised 'patient voice' across the spectrum of sexual health services. Client needs will therefore be 'read out of' the discursive formations analysed, at length and in depth, both in the literature surveyed and the discourses gathered from the study's respondents, namely registered nurses and *their* perceptions of *their* clients' needs.

This introductory chapter serves by way of drawing attention to numerous discourses, particularly those most clearly affecting sexual health nursing care and its associated professional education across England. These discourses include policy, epidemiology, culture, society, as well as those this thesis explores as 'invisibilised'. Clear examples of the discursive formations to be further explored were highlighted at numerous points throughout the chapter, including those emanating from literature as well as those drawn

from the empirical data collection. Such discourses will be explored and analysed more fully in chapters 2 , 4 and 5 respectively, whilst the beginnings of a rationale for applying some 'tools' from the philosophies of Michel Foucault will be elaborated more fully in Chapter 3.

Chapter 2

LITERATURE REVIEW

Discourses in the literature

Chapter 2

LITERATURE REVIEW

Discourses in the Literature

Chapter 2 thematic outline

- ➢ Difficulties defining the speciality
- ➢ Problems conducting a traditional literature search
- ➢ Paucity of literature and other methodological concerns
- ➢ The sexual health 'umbrella' of specialist services
- ➢ A genealogy reading a plethora of stigma discourses
- ➢ Implications for education and Conclusion

Introduction

Chapter 1 opened with an exploration of discourses associated with sexual health and illness. The chapter:

a) explored problems associated with developing a universal working definition of sexual health

b) provisionally outlined discourses for this review chapter which are developed further throughout the thesis, and

c) suggested that nurses and the providers of their professional education could do more to address this significant, yet often disregarded, element of holistic health and well-being (Dattilo and Brewer 2005; Garcia 2005; French 2009a).

The aim of this second chapter is to review discourses in the literature that have implications related to learning and professional education. Such an endeavour sits well with the role of the literature review, "providing a *background source* rather than the essential starting point for research

designs" [italics original] (Robson 1994: 23). Murray (2003: 103) asserts that this process should "synthesise the work of key authors" with one's own.

There are two fundamental problems with reviewing the literature, however. The first includes difficulties defining the subject area and outlining its parameters. The second is the dearth of studies and publications specifically in nurse education. According to the sexual health researcher Laura Serrant-Green "sexual health nursing as a distinct area of practice does not really exist" (Serrant-Green 2005: 515). To be precise, she claims it does not exist so much as a separate entity or discrete speciality of care, commenting how

> "on closer inspection, the scope of nursing care in this area remains shackled to the stigmatized and fixed approaches to sexual health in the past."
>
> (Serrant-Green 2005: 515)

Defining sexual health – or not

The World Health Organisation (WHO 2004) has developed clear suggestions for defining sexual health *per se* that include definitions of 'sexual and reproductive health' and 'sexual health and anti-discrimination'. Evans (2003 and cited in Dattilo and Brewer 2005) holds that sexual health ought to be of "paramount importance to every practitioner as a component of holistic client assessment". This is in part to overturn what Dattilo and Brewer (2005: 210) later refer to as the "general discomfort [that] exists when addressing a client's sexual health and concerns". Nursing is not the only profession with this problem. In a study by Jayasuriya and Dennick (2011: 99), their scrutiny of medical training considers it weak, especially on sexual history-taking skills. They state that "modern medical curricula fail to prioritise

this essential clinical skill [...]. Additionally, the training that does exist tends to emphasise the factual, 'clinical' aspects of sexual health, with far less emphasis on sexuality, sexual dysfunction or attitudes to sexual health. López-Sosa and Tévar (2005: 146) explain that

> "[sexuality itself] refers to a fundamental dimension of the fact of being a human being, based on sex, including gender, the identities of sex and gender, sexual orientation, eroticism, affective linking, and love and reproduction."

Presumably Serrant-Green (2005) was highlighting problems of defining a broad term, such as sexual health, which has multiple dimensions and a plethora of related stigmas. Stigmas are provisionally outlined below and explored at relevant points in chapters 4 and 5. The problems of clarification are even more evident when traditional and strategic definitions, such as in the English National Strategy for Sexual Health and HIV (DH 2001), reduce sexual health solely to the problematisation of teenage sex and conceptions (West 1999; Buhi and Goodson 2007) and the pathologisation of sexual health (Lichtenstein *et al* 2005). The problems of concept clarification are compounded further when dimensions of sexual health are integrated within more generic, holistic, philosophies of health and well-being. Given this confusion, there is no wonder that sexual health appears as something rather difficult to pin down and analyse.

At first reading and *apropos* of the above, for those working in the various sub-specialities of sexual health, Serrant-Green's hypothesis - that sexual health nursing does not exist - might be difficult to understand. No doubt this

conundrum is even more difficult for those 'looking in' from outside. The difficulty in understanding can be accentuated because of the number of sub-specialities as well as their diverse extremes, such as:

fertility	⟵⟶	infertility
sexual health	⟵⟶	sexual illness and disease
psychosexual and relational well-being	⟵⟶	criminal and forensic sexual pathologies; sexual violence, abuse and rape
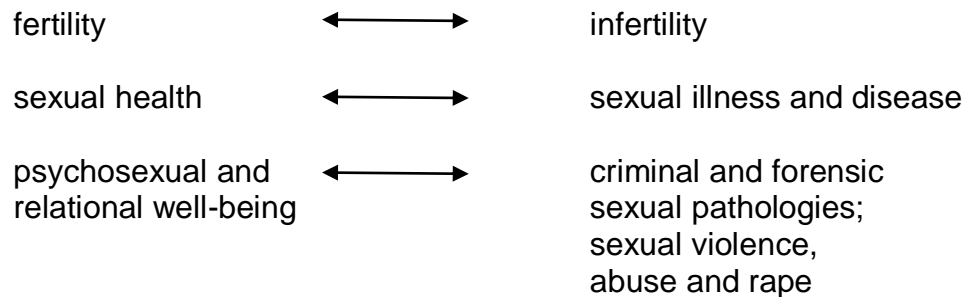
and other dyadic opposites such as assisted fertility programmes / legally permitted abortion. To compound matters further, since the naming of AIDS in 1981, even conditions normally outside of traditional 'sexual' health, such as certain opportunistic infections (OI) and tumours (OT), now come under its remit (Adler 2001). A prime example is a pulmonary infection caused by the *mycobacterium tuberculosis* (TB). This illness is defined as an AIDS indicator condition in someone co-infected with HIV (CDC 1993). Difficulties in naming a speciality or concept, so often highlighted in various writings of Michel Foucault (1984), lead to one of the reasons why undertaking a formal literature search for this thesis has proved so difficult and why a genealogical analysis (explained below) is more apt.

Difficulties sourcing appropriate literature

Difficulties in obtaining sufficient literature sources are emblematic of the low levels of professional education provided across the spectrum of sexual health nursing. One reason for this, it may be argued, is the effects of stigma on the broader domains of sex and sexualities as well as sexual ill- / health. Stigmas are manifest in a wrestling of power and dominating forces between

elements of what Michel Foucault (1984: 4-5) referred to as "the triple edict of taboo, non-existence and silence". Such forces are analysed more fully as constituents of stigma in the final part of this current chapter.

The literature review: top down or bottom up?

> "A literature review provides a means for grounding your research and explaining its relevance."
>
> (Burgess *et al.* 2006: 19)

A traditional 'top down' search of the literature would have included:

- defining appropriate concepts, such as "sexual health" AND "nurse education / learning" OR "courses"
- clarifying limiting parameters for inclusion / exclusion of materials
- selecting relevant databases, and
- setting dates through which to operationalise retrieval (Hart 2003), traditionally towards the beginning of the research process (Dunleavy 2003).

Given the difficulties with concept definitions as outlined above and in chapter 1, however, a traditional process has proved exceptionally difficult. An alternative 'bottom up' approach starts from the *grass roots* of clinical practice in various sub-specialities of sexual health, permitting a genealogical "history of the present" (Foucault in Rabinow 1991: 118; Meadmore *et al.* 2000) with an inductive reading-out of the implications for nurse education. According to O'Farrell (2005: 69) "genealogy is about the 'constraints' that limit the orders of knowledge" with "culture [forming] its identity in relation to what it rejects".

Over and above the systematic searches of electronic databases and journals, as outlined below, searches for this professional doctorate have taken a number of other approaches, too, that have occurred incrementally over the time of the programme, "synthesising layers of intensity and perspectives" (Burgess *et al.* 2006). Given that the subject area for this thesis is the same as my area of professional practice, my knowledge of pertinent literature has to be constantly updated. This knowledge is redefined and developed when facing the challenges of delivering new sessions such as conference presentations[1] and courses[2]; updating teaching materials; advancing discourses with current on-line Bachelor and Masters students; writing for publications and specific audiences, and when requested to offer expert advice to government departments[3]. Reviewing the literature has also been developed for each of the course assignments and disseminations forming part of this doctoral programme, not least in the mini-literature review on "stigmas related to sexual health and illness" (ACAD 1064)[4].

---

[1] An example: two workshop presentations I ran at a conference of the Royal College of General Practitioners, Manchester, February 2009. My title was From boys to men: engaging and working with half of the population's sexual health in primary care, in which participants explored the concept of masturbation as a health promotion initiative.

[2] Michaelmas Term 2009-10 I developed and wrote 90% of a new Masters level e-learning compulsory core course, Contemporary Issues in Sexual Health, University of Greenwich (course code OMED 1259). Between 2009 – 10 I authored 4 e-learning modules of an on-line course entitled Sexual and Reproductive Health and Safety for Mental Health Professionals, for the Social Care Institute for Excellence, www.scie.org.uk, launched May 2011.

[3] I have participated in a sexual health education mapping / advisory exercise for the Department of Health (on pre-registration learning); made a presentation on nurse education to the Government's Independent Advisory Group on Sexual Health and the London Assembly, and been involved in a closed meeting on this subject, by personal invitation, in the House of Lords (November 2009).

[4] ACAD 1064: Critical Review course.

Despite the problems outlined here with definitions and paucity of results when searching with the 'top down' models, various searches were attempted, incorporating a combination of relevant terms (see Figure 2: 1).

Figure 2: 1   Primary search terms and combinations

Primary search terms	Combined with
(Nurse) Education	Sexual health
AND / OR	Contraception / family planning
	Sexually Transmitted Infections (STI)
Learning	HIV
AND / OR	AIDS
Course	Teenage pregnancy
	Stigma (associated to any of the above)

Over and above these searches, with the 'combination' terms referring to the five aims of the National Strategy for Sexual Health and HIV for England (DH 2001, 2002), the geographical region for this research study, I also searched for (nurse / nursing) education AND sex / sexuality / lesbian / masturbation; the rationale for which is outlined below.

The parameters of the searches

Despite the difficulties highlighted above, attempts were made to undertake foundational searches using the terms sexual health and nurse education (or the other way around) in the category fields 'article title' and / or 'abstract'. Any wider than this, for example searching the 'key words' or 'full text' fields, yielded hundreds of irrelevant articles, by retrieving works with any of these four words in them. The start and end dates were 2000, the year before the publication of England's NSSHH, to September 2010 (and continuously

developed since then opportunistically). Articles selected were those in English, preferably (although – due again to paucity - not exclusively) concerning England, on the searched terms only or related to a theme within the wider thesis. This study is not alone in finding a lamentable dearth of directly relevant and timely studies and results. Higgins *et al*. (2009: 362) recount how

> "an analysis of participants' accounts in this study [.] suggests that the issues could best be described as 'absence / presence'. By privileging discourses within the biological, medical and theological paradigm, the status quo was maintained and other discourses, which could have provided an alternative view, were subjugated and marginalised."

These comments by Higgins *et al*. (2009) are evocative of the *scientia sexualis* / *ars erotica* discourses in Foucauldian parlance, employed throughout this work.

The searches of various health, social science and educational research databases also specifically included the journals Nurse Education Today, Nurse Education in Practice, International Journal of Nursing Education Scholarship and the British and Irish Index of Theses. Some independent sources also included various gender studies journals and opportunistic searches, such as in the British Journal of Urology International (BJUI), in the limited hope of finding and extrapolating pertinent materials. The majority of relevant articles retrieved are professional and / or clinical rather than educational / research based programmes. For example, in a final search of relevant electronic databases conducted in September 2010, the main databases used on that occasion were as outlined in Figure 2: 2.

Figure 2: 2   Final electronic database search, September 2010

```
┌──────────┐     ┌────────────┐    ┌─────────────┐   ┌──────────────┐
│  EBSCO   │     │Science Direct│   │   Wiley     │   │ InformaWorld │
│          │     │            │    │ InterScience │   │              │
└────┬─────┘     └─────┬──────┘    └──────┬──────┘   └──────┬───────┘
     │                 │                  │                 │
 ┌───┴──────┐     ┌────┴───────┐    ┌─────┴──────┐    ┌─────┴──────┐
 │ British  │     │   Nurse    │    │ Journal of │    │    Sex     │
 │ Nursing  │     │ Education  │    │  Advanced  │    │ Education  │
 │  Index   │     │   Today    │    │  Nursing   │    └────────────┘
 │  (BNI)   │     └────────────┘    └────────────┘
 └──────────┘     ┌────────────┐
 ┌──────────┐     │   Nurse    │
 │Cumulative│     │ Education in│
 │ Index to │     │  Practice  │
 │ Nursing  │     └────────────┘
 │and Allied│
 │  Health  │
 │Literature│
 │ (CINAHL) │
 └──────────┘
 ┌──────────┐
 │Gender and│
 │ Sexuality│
 └──────────┘
```
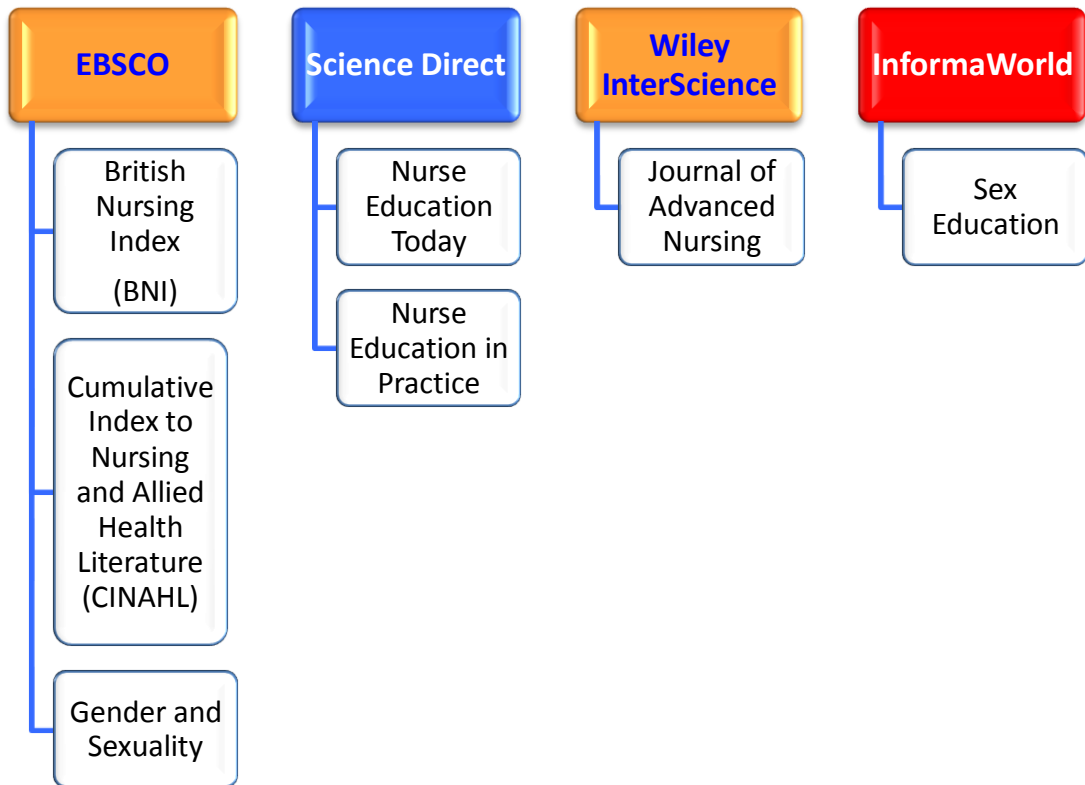
Within the *Informaworld* <u>Sex Education</u> journal search, the terms used were simply <u>nurse</u> OR <u>nurse education</u>, given that the publication is focused specifically on sex education. Twenty results were returned, with only two directly relevant to this study. These were on *Teachers' and pupils' perceptions of the school nurse in relation to sexual health education* (Westwood and Mullan 2009) and McAlister and Neill's (2009) *"The L Pack": Addressing the Sexual Health Needs of Young Lesbians.* More will be said in relation to the literature on both these topics in chapter 4, in respect of the data findings.

Particular discourses out of the paucity of literature

During this final search of the literature, using the terms <u>sexual health</u> AND <u>nurse education</u> anywhere in the documents retrieved over 1000 articles. Sadly, the majority of these are simply retrieved for having any of the four words somewhere in the article, e.g. an article that mentions the word 'sexual' or 'education', and are therefore excluded here for being irrelevant. Figure 2: 3 outlines the search results.

Figure 2: 3   Current paucity of relevant literature

Database	Search terms with Boolean connectors	Total number of hits	Number of relevant articles
EBSCO: gender and sexuality	Sexual health	> 500	15
	Nurse education	0	0
	Sexual health AND nurse education	0	0
Science Direct (Database includes the journals Nurse Education Today & Nurse Education in Practice	Sexual health	> 500	0 Except for Johnston (2009) *below*
	Sexual health AND nurse education	16	1 Johnston (2009) on *Addressing diversity in clinical nursing education: Support for preceptors*
WileyInterScience (Journal of Advanced Nursing)	Sexual health AND nurse education	32	3 Earle (2001) on disability; Jolly (2001) on gynæcology nurses and their teenage sexual health

			knowledge; Serrant-Green on sexual health and ethnicity (2005).
WileyInterScience (Journal of Advanced Nursing)	Sexual	16	(1 listed / inappropriate) Hawley and Taylor (2003) 'Using research skills to inform the teaching of spirituality'
International Journal of Sexual Health (IJSH)	Nurse	0	0

Two final problems with a traditional literature review

There are two final methodological problems confronting a traditional literature review which need to be considered here. The first problem is a working definition of Foucauldian terms as used in this thesis. These include *ars erotica / scientia sexualis* (see chapter 1) and **discourse analysis** (DA); **genealogy**; **knowledge / power**, **governmentality** and a number of subsidiary concepts to each. These are fully explained and interwoven with qualitative data responses in chapter 4, which acts as a substantive framework for analysis and understanding of the data.

The second problem relates to the aspects of sexual health this work is most particularly interested in, which, as explained in chapter 1, are referred to throughout the thesis as 'invisibilised'. Hicks and Watson (2003: 2.2) refer to invisibilisation as "virtually absent"; sometimes just "added in" simply to tick the boxes of "political correctness". As outlined above, the 'invisibilised' are

included in, but not exclusive to, the search for works on <u>sexual health</u> AND <u>lesbian</u> (for sexual identity) and <u>masturbation</u> (for sexual practice). If it is difficult enough to perform literature searches on terms such as <u>nurse education</u> AND <u>sexual health</u> OR <u>contraceptive courses</u>, how much more so on <u>nurse education</u> AND <u>invisibilised aspects of sexual health</u>? This is a perfect example of Jean Paul Sartre's 'presence of an absence' or Slavoj Žižek's *apophasis*[5] – 'absent presence' - i.e. the "whole [*sic*] at the centre of discourse" (Lee *et al*. 2008). As Lee *et al*. (2008: 155) explain, this is like saying "we won't mention X at this point" when the whole discursive formation is then constructed around the presence of something that cannot be mentioned: the elephant in the room. This gives it a totally new and 'other' constructed identity. The 'absent presence' is reminiscent of Foucault's analysis of childhood masturbation in Victorian Britain (Foucault 1984). He explained how adults acknowledged the practice only by simultaneously invisibilising all discourses of it, except those that condemned or (psycho-)pathologised it, or through the promotion of various 'quack' restraints and contraptions, surveillance and 'therapies' that prohibited and demonised *onanism* (Howe 1995). These two methodological problems – understanding of Foucauldian terms and identifying the 'invisibilised - accentuate the wider institutionalised effects of invisibilisation on this subject matter both in nurse education and associated publications; this is a key point of study for this thesis.

---

[5] ʼαποφασις / *apophasis,* according to the <u>OnLine Etymology Dictionary</u> (<u>www.etymonline.com</u>) "involving a mention of something one feigns to deny; knowledge obtained by negation" or "mentioning by not mentioning" (<u>www.wikipedia.com</u>).

Sexual health: the umbrella and the curriculum

It could be argued that it was due to the emergence of HIV onto the world stage, initially named 'GRID' (Gay Related Immune Deficiency) then 'AIDS' in 1981, that the definitions and philosophies of 'sexual health', as a core element of being, subsequently emerged into their current state of healthcare prominence (Grmek 1990; Berridge 1996). As Lawler (1991: 64) remarked in her 'somology', "the AIDS epidemic is having the effect of making the body more explicit as a social entity". Until then, the various sub-specialties of sexual health worked predominantly in separate and isolated silos, contrary to more contemporary and preferred UK practice of amalgamation into differing combinations of various 'one stop shops' (Miles and French 2008; HM Government 2010).

In 2001 I outlined key clinical areas of sexual health care, diagrammatically, as an umbrella in the RCN Sexual Health Strategy (RCN 2001). The diagram encompasses a number of primary and associated sub-specialities. Note, however, that even this limited example omitted a number of related areas of care such as forensic sexual health and female and male rape and sexual abuse (Figure 2: 4). The canopy of this umbrella definition highlights clinical areas which traditionally see themselves, and / or are seen by others, as being essential to the definitions of 'sexual health', namely: contraception and reproductive health care (often, and increasingly inappropriately, called 'family planning'), genito-urinary (GU) / STI and HIV health care, and psycho-sexual counselling. Beneath the canopy of the umbrella are certain other areas which, to varying degrees and acknowledgement, have their own

specific relations to sexual health and well-being in specialities as diverse as midwifery, through gynæcology and men's health, to aspects of personality and sexual performativity (*sic*) in mental health care.

Figure 2: 4   The sexual health umbrella in nursing care

The Sexual Health Umbrella
Diagram by David T Evans, published in (2001)
RCN Sexual Health Strategy – guidance for
nursing staff, London, Royal College of Nursing.
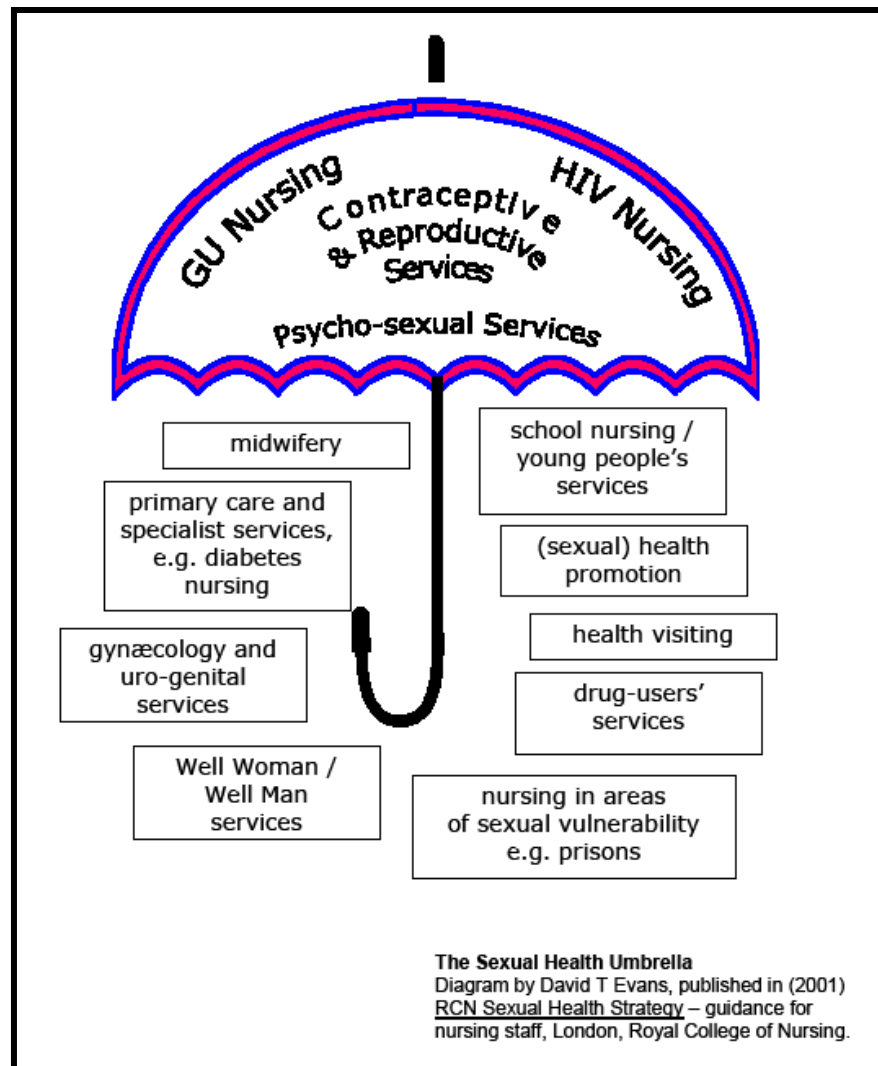
Notice the significant absence of "abortion" in this diagram.   Abortion services, especially within the NHS, are traditionally covered under gynæcology and contraception services (Astbury-Ward 2009; Focus Group data in chapters 4 & 5).   Despite the legal status of abortion in the UK,

abortion is a classic area of care affected by Foucault's "triple edict of taboo, non-existence and silence". From a nursing perspective, in her doctoral thesis, Astbury-Ward (2010) considers this invisibility to be caused in part by the methodological difficulties. These difficulties, she reported earlier, when exploring "women's emotional and psychological experiences of abortion" (2008: 181). As with so many other areas of sexual health care, it is also because of a lack of an active patient voice, due to the specific or sometimes "abject" (Eadie 2004: 1) – 'dirty' or distasteful - nature of sex, sexualities and sexual health.

Outside the core sub-specialities in the umbrella diagram, many of which predominantly address women's issues, are those areas of care which obviously do affect sexual health but which, for some reason or another, do not consider themselves essentially a sexual health service. These typically include many of the traditional women's services such as midwifery, gynæcology plus male uro-genital surgery (Jolley 2001; Turner 2007 and Astbury-Ward 2010). There are many other services identified in the literature here which have varying degrees of general (holistic) sexual health as outlined in the WHO definitions, which are often bemoaned in the literature for their lack of attention to sexual health implications affecting a client's life. These broader healthcare services and specialities include those highlighted in Figure 2: 5 below, which is not intended to be exhaustive. A notable absence (invisibilisation) is the sexual health of old / older people's services and related professional education, despite the UK's ever-growing and ever-aging population RCN (2009a).

Figure 2: 5 Sexual health in some broader healthcare services

General Practice / Primary Care

- often the first point of access for many patients with primary and secondary, or associated, sexual health needs
- References: Keogh *et al*. (2004); Challinor (2006); Challinor (2008); Miles and French (2008); French (2009a)

Cancer Services

- especially breast, prostate and other cancers which are deemed to have a negative impact on sexual and / or reproductive capabilities and performance. This list also includes the effects on poor body image or abject physical changes or functions such as through genital surgery, colostomy, retrograde ejaculation following prostatectomy etc. or treatments that cause body changes or fertility issues
- References: Turner (2007); Kelly (2009)

Young People's Services (including school nursing)

- relating to sex and relationships
- specific health promotion strategies appropriate to boys such as "what [boys] want to know. The areas of feelings and emotions, sexuality, sexual techniques, sexually transmitted infections, pornography and the effects of the 'boy culture'" (Hilton 2007)
- References: Fallon (2003); French (2009b)

Mental Health

- everything from sexuality issues, self-esteem / harm, substance abuse, and the sexually adverse effects of numerous medications and 'therapies' (*sic*)
- References: Sachs and Chan (2000); Maurice (2003); Itzin (2006); Higgins *et al.* (2009); TheBody (2009)

Care of Men …

- with diabetes, coronary heart disease (CHD) and hypertension, with secondary erectile dysfunction
- References: Cameron and Bernardes (1998); Evans (2004d); Tiefer (2006); Holroyd *et al*. (2008); Roberts & Evans (2007); Evans & Stapley (2010a, b).

Focused examples from the literature reviewed: 1

School nurses and their professional learning and education

After practice nurses, school nurses made up the second largest group of participants on the RCN Sexual Health Skills course 2004-2008; subsequently they are respondents in this thesis, too. One key study on school nurses analysed here was by Westwood and Mullan (2009). As clarified below, their research is not alone in confirming my original hypothesis: that there is a scarcity of professional sexual health education for nurses. In essence, Westwood and Mullan's (2009: 294) study of "3420 pupils and 456 teachers from every secondary school within a UK geographical county" found that:

- **there is insufficient research evidence** to suggest that (school) nurses are sufficiently prepared to be the most appropriate healthcare professionals to have a positive impact on, and competently assist with, sexual health education in schools (Westwood and Mullan 2009: 293).
  - This is particularly so for more vulnerable and excluded young people; confirmed in a study by Selwyn and Powell (2007)

- **the findings are consistent across the decade** of 2000 - 2010. The lack of appropriate training was reported by Evans (2000a), on data gathered from across the UK and Northern Ireland by the Royal College of Nursing[6]. This same message is reiterated by Cleaver and

---

[6] Evans (2000a) 'From nits to crabs: school nurses and sexual health', British Journal of Nursing. While not wishing to demean the role of school nurses, or to play on erroneous stereotypes, I was trying to make the point that they were sometimes referred to, in the past, as the "nit nurse". Today, conversely, they are expected to shift expertise from *pediculosis capitis* to *pediculosis pubis.* A crucial sentence of explanation was not published in the article, however. The publication was unofficially based on a research report I was commissioned to write for the RCN School Nurses Forum. As the report outlined a number of weaknesses, the Royal College decided that it could not be seen to be criticising members, and so the report was authorised for internal circulation only.

Rich (2005), in their study of school nurses in 12 Primary Care Trusts (PCTs) in south east England.

- o Conversely, Ingram and Salmon (2007) report findings that there is a greater effectiveness when school / young people's nurses are appropriately trained

- **availability of school nurses**, e.g. in rural areas or where they serve a large number of schools, is frequently so *ad hoc* as to be minimal in the amount of sexual health curriculum education and / or service provision they can offer.

  - o This remains as reported earlier by Evans (2000a), Cleaver and Rich (2005) and also Hayter *et al.* (2007)

- **the general (pre-registration) education regarding sexual health for most nurses is lacking.** This statement is supported by Westwood and Mullan and their cited sources. It is also supported by Jolly (2001) in relation to gynæcology nurses; by Lees and Crouch (2003) in relation to accident and emergency nurses; McFadyen (2004) on school nurses in Scotland; Higgins *et al.* (2006) in mental health, and Irwin (1997), Johnston (2009) and Van Loon (2008) in relation to the specialist knowledge and skills deemed necessary for children and young people's sexual health promotion professionals.

- **recommendations** by Westwood and Mullan (2009) call for "adequate training in sexual health [and] appropriate teaching methods and counselling skills". They continue: "[t]his will require a more concentrated financial commitment to training and a more vigorous policy of school nursing recruitment" (p 304). Funding is a moot point in respect of new CPPD arrangements envisaged by the Department of Health (DH 2010), where training budgets for many non-clinical learning opportunities are curtailed.

  - o Adequate training is also, arguably, required by the various school nurses' "gate-keepers" (Cleaver and Rich 2005), not least for the management issues of recruitment, training and financing but also in freeing the

nurses to 'do their job' without negative (moral) policing (governmentality) of selected subjects, e.g. in particular faith schools (Hayter *et al.* 2007).

On this later point, Evans (2000a: 2024) contends that

"Sexual problems do not respect religious boundaries. School nurses working in sex-negative schools can recount numerous cases of pupils actually suffering because of a lack of skills or knowledge to protect their own sexual health [...] Saying "no" to sex may be the school's motto but, in reality, pupils of religious schools are still having sex, getting pregnant, and acquiring sexually acquired infections."

In the literature reviewed for this chapter, various authors show how the vulnerability of children is affected by differences in age; gender; minority sexual orientations (especially bullying and suicidality for gay children); stigmas and social exclusion; being in care; previous or current sexual violence, abuse or rape; bullying and victims or witnesses of domestic violence; high 'risk-taking' proclivities; mental health problems; alcohol and substance abuse and being known to the criminal justice services (Campbell 2006; DH 2009; Higgins *et al.* 2006 and 2009; Johnston and Mohide 2009).

Focused examples from the literature reviewed: 2

Three discourses of sexual performativity and identities

In many ways, whilst not coterminous with one another, sex, sexualities and sexual health are to a great extent co-dependent. Below are three discourses which are outlined briefly here and elaborated by respondents in chapters 4 and 5. They clarify how sexual health is intrinsic to the expression and performativity of sex, as well as an essential element of sexuality and

identity (Wilson and McAndrew 2000). Performativity, as used throughout this thesis, includes the wider dimensions of gender, sex (acts) and orientation that frequently require a conformity to / or acting against culturally expected ways of being (Butler 2004; Mooney 2004a, 2004b).

Discourse 1: female genital mutilation (FGM). Pratt (2000: 4) describes FGM as "the antithesis of sexual health, an obscene assault in which women often collude with men in its perpetuation". FGM is inextricably linked to beliefs about sexual(-ised) identities, primarily in the nature and *persona* of the female (Gruenbaum 2005). It is imbued with beliefs and customs alien to most people in the world but evidently linked to what it means to be a woman (in relation to man), and a sexual being at that. Due to the trauma of the procedure and the implications throughout life, FGM is also intimately connected to pleasure (for the male but not for the female) and to complications of sexual and reproductive / obstetric capability (RCN 2006). FGM is not just a woman's or a girl's issue, however. Its whole *raison d'être* is entwined in binary relations between two genders and, it is argued, the hegemonic patriarchal and cultural power / dynamics between 'the sexes' (WHO 2008). This power often excludes 'uncut' females from their own communities as a form of cultural excommunication and ethnic sequestration, whereby they are ostracised by family and the wider community. Frequently, these females are deprived of their all-important cultural *marriageability* status if they do not have the obligatory cutting performed. Finally, FGM is also clearly and inescapably an educational issue because of the clinical ramifications for clients / patients affected. WHO (2001) reiterates how it is

incumbent on professional education for registered nurses and midwives for them to have a sufficient understanding of the clinical, psychological and the ethico-legal implications of FGM. This education is critical for nurses in areas with large numbers of women with FGM and where domestic laws prohibit it (as in the UK).

This brief reference to FGM epitomises some of the problems identified in this chapter for categorising the specialities of sexual health. It shows a blurring of the dividing line between differences of sexual 'health' and sexual 'illness'. At the same time, the confusion accentuates difficulties with exploring many of these issues for reasons similar to those outlined by Astbury-Ward (2010), on the theme of abortion, which are further complicated by stigma and invisibilisation (see chapters 4 and 5).

Discourse 2: the underlying power controlling sex. According to Foucault (1980: 190) "power created sexuality as a device to say no to sex". He was possibly referring to the ever-increasing regulation of sexual acts within the discourses of the post-Enlightenment West's *scientia sexualis*. Frequently, not saying 'no' to certain sexual practices is used to justify blame for unplanned consequences of sexual ill-health. It would be too simplistic a view of sex, however, to consider it as just involving a 'yes' or 'no'. As Herdt (1997: 5) suggests, we need to investigate the wider influences within a person's "history and cultural lifeways". An overwhelming impression from the literature reviewed is that higher priority is given to forms of official knowledge, exercised through power and restriction (governmentality); least

attention in the literature is given to the health benefits of the joys and pleasures of sex (*ars erotica*), such as sex for recreation or intimacy or simply as a mode of de-stressing. Evidence from the empirical data, in chapters 4 and 5, explores these themes further.

Discourse 3: specific stigmas: gender, sex, sexualities and infections. Green and Platt (1997) suggest that where HIV and AIDS are becoming more prevalent in the world, then the enacted stigma towards individuals diminishes. This is understandable as part of a process of normalisation (Evans 2004e), but is not in fact borne out by evidence of stigma across the world, where blame still plays a significant role in stigmatisation. For example, a study by Lichtenstein *et al.* (2005) reveals that amongst African Americans, gender blame for the transmission of any sexual infection was still overly directed towards women. Seventy six percent of respondents in their study blame women as the instigators for transmitting sexual infections; only 56% blamed men as the source of onward transmission. The Lichtenstein *et al.* (2005) study is further evidence of blame and poorer knowledge (lack of education) about the actual modes of transmission of sexual infections correlating positively with higher religiosity of respondents. Similarly Ward's (2005) findings provide confirmatory evidence that homophobia within black nationalist ideology is theologically-driven. From this perspective, being 'cool' is "a coping strategy black men use to allay and triumph over the anxieties and stresses of racism and related blocked social opportunities, as well as a means to express bitterness, contempt and rage toward the dominant society" (Ward 2005: 497). Given the multi-ethnic,

cultural and religious make up of nursing and healthcare in the United Kingdom, the beliefs of people from other cultures clearly need to be acknowledged and explored in professional education. A positive challenge for anti-discriminatory education is urgently needed where certain customs and belief systems of carers practicing in the UK are at odds with domestic equality and diversity legislation.

The brief focus on school nurses, above, and three other discourses witness to some of the themes pertaining to the formation of power dynamics interlinking aspects of culture and personal being, with the wider, holistic, notions of sexual health. Despite the fact that these topics are absent in major educational research and literature for this thesis, the *grass roots* clinical implications are what make them applicable for the education of nurses, as will be more evident in the process of data analysis in chapters 4 and 5.

Genealogy, discourse and the *curriculum vitae*

The discourses throughout this work are concerned with mapping the dissonance over the terrain of client needs (nursing practice) on the one hand, and professional sexual health education on the other. This mapping is facilitated by employing some of Foucault's 'tools', especially discourse analysis and *genealogy* (explored more fully in chapter 4). The literature and empirical data informing this thesis are concerned with examining such discourses that (may) influence sexual health curricula for nurses, whether this is in the formal educational setting or, experientially, in learning through

life in clinical practice. It has already been shown, however, that the subject matter itself is not too easy to identify, let alone incorporate into professional, academic, programmes of healthcare learning. This is especially so in the face of competing claims on curricular time by the more medico-scientific subjects, what Foucault referred to as "bio-techno-power" (O'Farrell 2005, and chapter 4), including the patho-physiological aspects of sexual health under the guise of the *scientia sexualis*.

This chapter has therefore introduced particular clinical and epistemological discourses that are relevant to the thesis as a whole. Broadly speaking, these discourses relate to aspects of sexual health education for nurses, adequate or commensurate provision of which is questionably lacking with regards to clinical need. As this thesis makes sense of the discourses by utilising certain Foucauldian methods, the reviewed literature has itself been subjected to a genealogical analysis of sexual health relevant to the curriculum. This process, according to Meadmore *et al.* (2000: 467), pays particular attention to the "emergences, discontinuities and events" pertaining to a discourse, through its formation and practice.

Continuing the theme of genealogy, Meadmore *et al.* (2000: 463) explain that "[it] seeks to inquire into processes, procedures, and techniques through which truth, knowledge, and belief are produced". It is this latter part of the sentence – "techniques through which truth, knowledge, and belief are produced" - that makes this process of genealogy so Foucauldian. One might ask how the current discourses relating to sexual health actually

become the accepted 'truths' of the matter, to the exclusion / suppression of others? Genealogy is thus an examination of the nuances of a given discourse that highlights the ways in which it is originally developed, then changed, then accepted and promoted as *the* truth of the matter. Meadmore *et al.* (2000: 464-5) insist how this focus on the "present orientation" (Foucault's *history of the present*) requires what Queer Theory might call a 'reproblematization' of the very concepts that appear to be given as the natural outcome of truth and development, the very ways in which most people see the world (Lee *et al.* 2008). Foucauldian genealogy avoids using a customary historico-chronological approach which results in a teleology of development, such as from the primitive (unenlightened) to the advanced (e.g. the technologically affluent). Instead, as Foucault himself suggested, there is a constant mapping of "the hazardous play of dominations" (Meadmore *et al.* 2000: 469). Seven of the many clear examples of this process that have influence in this thesis concern the subjects of:

- **abortion**, which, according to Astbury-Ward (2010), is the outcome of 1 in 5 conceptions in the UK
- **homosexuality** (Hicks and Watson 2003)
- **HIV and AIDS** (Evans 1997 and Hodgson 2003)
- **stigmas** related to sex, sexualities or sexual (ill-)health, including the moralist notions of "promiscuity" (Evans 2000b)
- the national preoccupation with '**teenage pregnancy**' and what I have called elsewhere the UK's "contraceptive mentality" (Evans 2005c)
- **certain non-heterosexual identities** (lesbian females)
- and a particular act of **non-procreative sex**, namely masturbation or *Onanism*.

By way of example of this process, the final part of this chapter will focus on a sexual health stigma, to show clear evidence of the "emergences, discontinuities and events" referred to above, which exemplify certain epistemic changes, a term similar to paradigm shifts (see chapter 4), in relation to client need and professional education for nurses.

Genealogy and sexual health stigma discourses

There will be a clear exposition of Foucault's "triple edict of taboo, non-existence and silence" (Foucault 1984: 4-5), in specific relation to key aspects of the empirical data, in chapters 4 and 5. Here in this review of literature, however, the *triple edict* is epitomised via a certain other concept frequently used in health and social care: stigma.

Across the literature, stigma is variously described as a mark or sign; an indicator; an identifier; a reason for certain actions and a relationship. Fear of the stigma can force people to hide it from family and colleagues, leading to a 'double-life'. Warren (2003: 500) referred to this 'double-life' as "sociability", i.e. the "recreational co-participation in an alternative environment". For example, when people are turned away from their family-by-birth because of a stigmatising condition, such as a non-acceptable sexual orientation, and move to a more accepting milieu - more often of 'people like them' - the latter being referred to as a family-by-choice; this corresponds with the notions of "sociability".

Unlike the term 'stigmata', which often, although not always, has positive religious connotations, the concept of stigma has numerous effects on those who are stigmatised as well as those doing the stigmatising. Parker and Aggleton (2003: 14) consider it essential to "critically evaluate the available literature […] in order to develop a more adequate conceptual framework for thinking about the nature of these processes" relating to markers and marked. A classic text by Jones *et al.* (1984) refers to stigmatised people as 'the marked' and those doing the stigmatising as 'the markers'. Of necessity, the problems pertaining to stigma relate to wider fields of "social and human sciences, [with a] deep involvement in issues of gender, culture, and marginalized groups. The topics about which we write are emotion laden, close to people, and practical" (Creswell 1998: 19).

In Erving Goffman's 1963 seminal work on stigma (reprinted 1990), he referred to stigma as an identifying mark of spoiled identity, that is either 'enacted', i.e. from another / others (the marker) towards a stigmatised other, or 'felt'. 'Felt' is stigma which is internalised and perceived within the 'marked' individual (Taylor 2001). Goffman's theories were later elaborated by the aforesaid Jones *et al* (1984), when they highlighted stigma's dynamic process of 'concealability and course' in particular relation to such marked or spoiled identities (more, on which, below). This work of Jones *et al* (1984) is then applied specifically to <u>Stigma: social exclusion in healthcare</u>, in the monograph of the same name, edited by Mason *et al.* in 2001. Relevant chapters of that work refer to four particular aspects of sexual health: teenage pregnancy; HIV / AIDS; involuntary childlessness, and sexuality

(Jacono and Jacono 2001; Carlisle 2001; Blythe and Moore 2001 and Evans 2001, respectively). Goffman (1990) commented how stigmas have their origin and are manifest in specific life domains, such as the physical, mental, moral and / or socio-cultural. Mason *et al* (2001) explore this further to show how they frequently cross many or all of these life domains, particularly when relating to the spectrum of sexual health and illness.

What's in a word?

Goffman (1990: 9) declared that stigma involves the "situation of the individual who is disqualified from full social acceptance". He analysed three constituent elements that were considered crucial: stigma pertaining to physical deformities or 'abominations of the body'; blemishes of character (moral), and 'tribal' i.e. social / cultural / ethnic or group membership stigmas, such as surrounding or categorising '*the* homosexual'. Clearly, all three of these qualify in relation to both HIV and AIDS stigmas the world over. Manzo (2004: 406) adds a further four characteristics of stigma to Goffman's original three:

- a quality of behaviours or conditions that must be knowable even if they are not currently known
- a phenomenon that must be managed by those they pertain to and institutions that process them
- almost always having negative outcomes and inverse proportions of stigma and power; and
- victimisation of those with stigmas to a state of relative powerlessness.

Jones *et al.* (1984) chose to emphasise the relational nature of stigma, in particular, its 'concealability and course'. The 'concealability' refers to whether or not the stigma is easily identifiable by others or not. HIV infection *per se* would be hidden, but HIV wasting syndrome or a visible Kaposi sarcoma lesion (both labelled as AIDS indicator conditions) would be blatantly evident to others. Whether the stigma is hidden (concealed) or revealed, the dynamic processes are then to do with the subsequent 'course' (process outcomes) of keeping it hidden or managing the reactions of self and others to its epiphany. Manzo (2004: 402) protests that stigma, however, has become an under-defined and over used concept, which has "evolved as an analytic and discursive resource in sociological, versus every day, reasoning and description". Despite this, he still considers the term and concept a "potent force".

Searching the electronic databases for the various stigmas proved as problematic as it was for the general theme of <u>sexual health</u> in <u>nurse education</u>. Clearly, there are a number of works on stigma pertaining to some of the main sub-specialities of sexual health, such as gender, abortion, teenage pregnancy, non-majoritarian sexual identities and sexual infections including HIV (MedFASH 2005: 3.11). What is traditionally more difficult to find, and, what is conversely aided by employing genealogical methods in Foucault's 'toolbox', are the various discourses that inform or underpin so many of these stigmas. These include wider themes such as ugliness and beauty, disfigurement, sexually reviled or "abject" acts or relations (Eadie 2004: 1), extremes of age or any form of 'mixing and matching' between what

Goffman (1990) called "we normals" (the markers) and those of a person with a "spoiled identity" (the marked).

In some ways, this genealogical mapping is akin to constructing a matrix of acceptable / non-acceptable traits related to "we normals" and those of us with "spoiled identities". Some people, based on the number of positive attributes, are higher up the order, so to speak, of socio-cultural acceptability than others. Alternatively, this matrix could be viewed as a game of 'snakes and ladders', where concealability often hides a stigmatised or marked identity, thus permitting the individual higher ranking on the socio-cultural matrix of acceptability. Such acceptability may be overturned with the *course* of the stigma, resulting in a sliding down to the status to non-acceptable person, i.e. one with a spoiled identity.

This genealogical matrix highlights the cultural, situational and relatively fluid dependence on a stigma's 'concealability and course'. For example, discourses in this thesis explore a number of different life-ways affected by the whole theme of teenage pregnancy. For some, teenage pregnancy is exceptionalised and consequently problematised (Bonell 2004). For others, teenage pregnancy is completely normalised within the individual's cultural life-ways (Coleman and Cater 2006). One of the key characteristics for stigma is to do with its apparent abject or discrediting status, i.e. its non-acceptability within cultures and individuals, or its socially anathematising deployment (Evans 2004d). Such negative condemnation is found to the extent that teenage pregnancy is problematised; contrariwise, it is absent in

acceptable cases, i.e. those devoid of stigma. Jacono and Jacono (2001) actually trace the stigmatisation of pregnant teenagers back to the sixteenth century, whilst Graziottin (2001) explores teen pregnancy's contribution to the (stigmatising) medicalisation of female sexuality.

Stigma in a genealogical matrix

There are a number of examples of stigma's adaptability. Firstly, stigmas pertaining to the individual can be read out of Foucault's analysis of the deployment of sexuality. In his analysis, he envisaged sexuality as something inscribed directly onto the physical body (Lupton 2000). Pryce (2001) moves wider than this, viewing bodily stigmas transposed onto geographical places. He describes genito-urinary clinics themselves as "sites of stigma", which thus cause important barriers to service access (MedFASH 2005: 3:11). With another shift in focus, Green and Platt (1997) assert that healthcare workers themselves can be part of the stigmatising problem, especially given their lack of appropriate anti-discriminatory / diversity education and training. Without appropriate education, healthcare professionals can continue simply perpetuating the socio-cultural, stigmatising, *status quo*. Finally, in respect of these wider associated stigmas, attention has been paid to those related to HIV and AIDS and sexuality, as outlined by Carlisle (2001) and Evans (2001) respectively.

Another way of approaching the concept of stigma relating to wider aspects of sexual health is with Grbich's (1999) use of discourse analysis. Grbich's method explores problematic phenomena that may differ according to

speaker / writer (the 'marker') and the listener / reader (the 'marked'). "Discourses are dynamic dialogues in which meaning is socially and historically produced, reproduced and transformed in interactions" (Grbich 1999: 153). This corroborates Usher's (2002a: 14) belief in them being "culturally specific, historically located and value-laden". Discourse around sexual stigmas cannot fail to highlight the dichotomy of attitudes between genders and sexualities. As Kelly (2003: 9) recalls of Victorian Britain:

> "sexual hypocrisy meant that middle-class women were not supposed to enjoy sexual contact, while their husbands, partners in promoting the family values of thrift, sobriety and piety, used prostitutes in their thousands".

As with this last example, according to Beard and Henderson (1997), similar dichotomies or double standards are still found today in various perceptions of society towards female and male commercial sex workers.

A plethora of stigma discourses

There are too many different aspects of each stigma pertaining to the holistic dimensions of sexual health to be covered in any great depth in this current project. For example the stigmas, or Foucault's "taboo, non-existence and silence", about abortion in the UK will be different in so many ways from those in the Republic of Ireland (Inglis 2002; Hoggart and Philips 2010). Likewise, in societies that place absolute cultural esteem on procreation and parenthood, the prospect of temporary, delayed or permanent childlessness is similarly viewed in a number of negative ways across cultures (Blythe and Moore 2001).

Underpinning most sexual health stigmas, however, problems exist, almost the world over, around the majority of non-heterosexual identities (Ward 2005; Irwin 2007; Koll and Gutierrez 2010). Likewise, stigmas exist in relation to various non-procreative sexual practices, such as masturbation and condom usage. Stigmas are also evident in all that is euphemistically treated as ugly. Such ugliness historically and sometimes religiously associates physical or mental illness with the morally bad (Llewellyn-Jones 1974). Consequently 'ugliness' is often equated with this moral badness, and then employs contagion motifs as 'meriting' sexual infections (Sontag 1991; UNAIDS 2001). Various 'ugly stigmas', predominantly researched in "marginalised discourses" (Serrant-Green 2011: 350), are frequently found in individual characteristics that identify (mark) them as 'other'. This stereotyping 'otherness', which differentiates one from an "arbitrary norm" (Serrant-Green 2011: 350), may include, but is not limited to, sex in old age, sex for people with physical and / or learning disabilities and even the sexual practices of the minority cultural and ethnic 'other'. One brief example: Ward (2005) discusses the effects of colonial sexualisation of black males and females as somewhat attributable for subsequent homophobia and hyper-masculinity in the US black church. In this way, and as outlined by Tremain (2000), Sherry (2004), Serrant-Green (2004) and RCN (2009a), it is possible to see how many of life's stigmas can all interrelate with aspects of sex, sexualities and sexual health. The inequalities inherent in singular stigmas are then multiplied and build layer-upon-layer. Serrant-Green (2011: 347) suggests these hidden voices constitute "screaming silences" which can

benefit from her framework "for researching sensitive issues or marginalised perspectives in health".

Finally the differences in stigmas, locally (geographically) in England as opposed to other parts of the world, in relation to both HIV infection and AIDS-indicator conditions, are clearly emblematic of "spoiled identities" (Goffman 1990) which suffer at the hands of stigma in the form of "taboo, non-existence and silence", as outlined by Foucault (1984). Although Foucault's treatise in the <u>History of Sexuality</u> does not deal with stigma by name, exploring some major stigma theories, as referred to in this thesis, clearly demonstrates its relevance to subjects treated as taboo. That which is taboo – unmentionable or even unthinkable – is then, by default, something which is viewed as non-existent (hidden and invisibilised). Finally, if something is viewed as non-existent and is unmentionable, it is subsequently shrouded in silence. Hence, I contest here that stigmas are related to the key aspects of Foucault's "triple edict".

Stigma's relevance

In many ways, the concept of stigma is a 'left-over' from 1960s labelling theories, situated within the epistemologies of deviance. Goffman (1990) declared 'we normals' as merely the majority; however, the 'abnormal' needs to exist for the normal, just as much as the 'unnatural' for the 'natural' (Parker and Aggleton 2003). This leads to "a position of domination only in relation to that which is [...] 'other'" (Nakayama 1998: 117). Thus, Parker and Aggleton (2003) are not alone in bemoaning the over-use of the term 'stigma' without a

commensurate understanding of its nature and manifestations, as a relational concept, amenable to study and transformation. It is notable how, in various works of Michel Foucault on sexuality, 'stigma', the concept, is not defined, although the writings of Foucault overflow with its essence as the social construction of difference. He does show how

> "for the state to function in the way that it does, there must be, between male and female or adult and child, quite specific relations of domination which have their own configuration and relative autonomy"

(Foucault 1980: 188).

HIV infection and disease are two of the clearly identifiable stigma discourses which resonate with wider gender, sexual and sexuality stereotypes. Daly *et al.* (1994: 6) claim that "qualitative method is indispensable for the study of those aspects of health care which depend upon the social interactions between individuals or groups". The stigmatising stereotypes witnessed throughout this work include perceptions and expectations of people related to matters of sexual health, illness and professional education which, in various times and places, have been the subject of other hegemonic stigmatising relations. Hegemony is understood here as:

> "a complex interlocking of political, social and cultural forces which organize dominant meanings and values across the social field in order to legitimize the structures of social inequality, even to those who are the objects of domination"
>
> (Parker and Aggleton 2003: 18).

Stigmatising, hegemonic, relations operate to "keep people in their place" (Dodds *et al.* 2005: 40) or, as Foucault stated in relation to sexuality:

76

> "[.] sexuality, through thus becoming an object of analysis and concern, surveillance and control, engenders at the same time an intensification of each individual's desire, for, in and over his *[sic]* body"

> (Foucault 1980: 56-7).

The matter of stigma is complicated further by certain stereotypes which have culturally specific and inverse meanings according to certain other indices. For example, 'promiscuity' – argued to be a moral, not a sexual, concept by Evans (2000b) - is often a prized appellation for young heterosexual males wanting to be perceived as "studs"; however, the opposite is true when applied to heterosexual females, when it equates to the pejorative terms "slags" and "whores" (Jinks and Bradley 2004).

Stigma's place in this review of literature

According to Holloway and Walker (2000) and Gilbert (1995), the literature review is seen to assist as a critical survey relevant to the field of study, facilitating a professional engagement in academic debate which leads to a clarification of concepts for the construction of meaningful theories. From this perspective, it is important to understand "language and its work of constructing a world to be researched" (Usher 2002b: 39), particularly given the fluidity and dynamism of the concepts under investigation (Anderson and McCann 2002). In relation to stigma, Reidpath and Chan (2005) measured it as a function or proxy of social distance. Usher (2002b: 51) measured it through "intersubjective transactions". These differences reveal how reflexivity in the research process is essential. As Booth *et al.* (2003: 101 state: reflexivity "is 'finding out' about how meanings, including the meanings

given to and generated by research, are discursively constructed within the practice of research".

The International Council of Nurses (ICN 2003) highlights how the deployment of stigma distinguishes and labels difference; for example associating human difference with negative attributes, separating 'them' from 'us'. Stigma subsequently loses the recipient their status in life, and discriminates against them. Even before this happens, however, Alonzo and Reynolds (1995) propose a pre-stigmatic stage to AIDS stigmas in particular, that of "risk" before diagnosis, latency and disease manifestation. This is similar to Mann's (UNAIDS 2001) period of hidden HIV infection (Evans 2005d; Appendix 2, slide & notes page 7). Similarly, Gamson's (2003: 574) reference to "the everyday experience of marginality" corresponds, in many ways, to Seale's (2004) 'cycle of stigma' (Figure 2: 6 below).

Figure 2: 6 conforms with Novick's (1997a) 'three layers of stigma damage':
  ➤ to those already stigmatised and with truncated human rights,
    leading to
    ➤ the development of alternate societies and cultural life-ways (Novick 1997b),
      leading to
      ➤ the inhibiting or proscribing of certain prevention initiatives, for
        fear of colluding with that which is stigmatised.

The House of Commons Health Committee Report (HCHC 2003 2:26) describes this as evidence of health inequalities based on stigma.

**Figure 2: 6   The cycle of stigma, discrimination
and human rights violations**

(Adapted from Seale, 2004,
by Evans 2010)
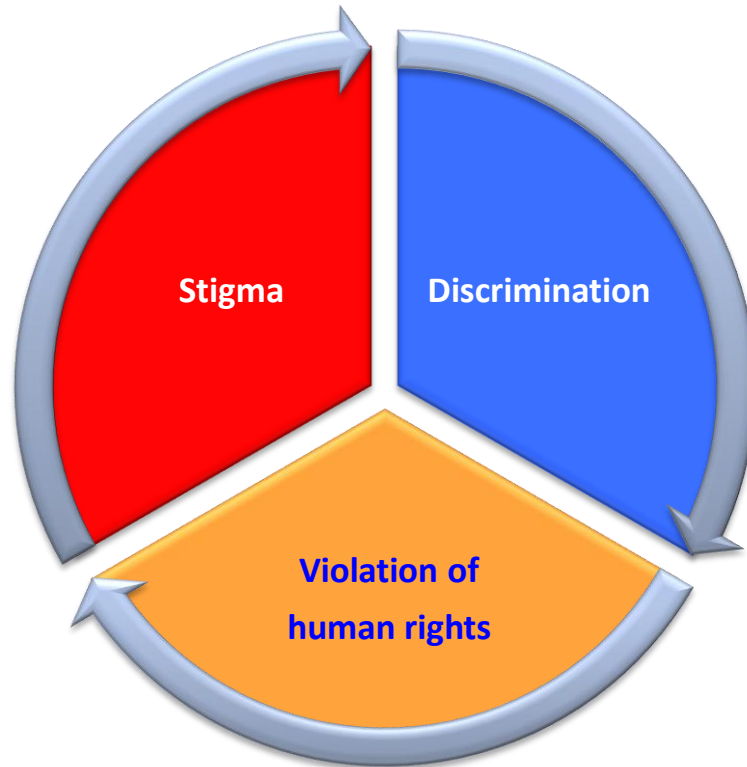
Back to genealogy: to increase understanding and knowledge

Stigma effects are wide and include embarrassment and the reinforcement of social norms through definitions of deviance (Taylor 2001). Embarrassment, a key aspect of erotophobia (Evans 2004f), "lies at the heart of social organisation" (Meerabeau 1999: 1510).   All of this is contrary to the emancipatory acceptance of sexual diversity[7].   This embarrassment has influence across all aspects of life, not least the mental health of individuals, when it is compounded or layered (Maurice 2003). Cohen and Farley (2004)

---

[7] See, for example, Evans and McKenzie 2004 on *sado-masochism*; Evans 2004g & 2004h on the difference between *sexual orientation* and *sexual preference* and Evans 2004i on *situational homosexuality*.

highlight how a world shortage of condoms is fuelling the HIV pandemic, but the resistance to their use, through various stigmas, is equally life-threatening if a sexually active person cannot obtain them or is reluctant to use them (UNAIDS 2004). Compounding the problems further – layers upon layers of stigma - are the facts that many sexually stigmatized people are from already stigmatized groups, as Novick (1997b: 53) shows of HIV in the 1990s USA: "Ninety five percent of infected people were from discriminated groups, with curtailed or limited citizenship rights." Téllez *et al.* (1999) demonstrate how stigma problems are aggravated when a fifth of physicians in their study were reluctant to treat lesbian and gay people, with correspondingly adverse effects on public health practice (Stine 2002), especially in relation to primary care and GP services in the UK (Keogh *et al.* 2004 and Neville and Henrickson 2006 respectively).

The processes of stigmatisation can be explored further with Foucault's concept of genealogy. Here there is a mapping of relations between labelling and the construction of such personages, for example in the way in which he explains the historical developments which led to the pathological naming of "*the* homosexual" (Foucault 1984: 101). His genealogies analysed not so much the concepts themselves but the powers driving the institutions and resistances to them that produced such labelling. In naming something, for example a stigmatised condition or entity, these dynamic powers / resistances, knowledge and institutions also tried to repress and hide or invisibilise that which is (not) spoken of. This is clearly evidenced in Foucault's exposition of the discourses on masturbation. This example of

masturbation is demonstrated even today through a general invisibility in the nursing studies and database searches employed for this thesis (Kontula and Haavio-Mannila 2002), and referred to later in the data, in chapters 4 & 5. The powers produced by these stigmatised and 'silenced' discourses, for example, powers of repression, then take on a life of their own which includes defining that which is subsequently deemed worthy or unworthy of professional knowledge and education. Howe (1995) and Coleman (2002) are the only two examples of 'positive', normalising, expositions of masturbation found in the relevant nursing literature searches.

Special focus on discourses of HIV stigmas and AIDS stigmas

As it would be outside the remit of this thesis to tackle each of these individual sexual health stigmas and their relation to professional education, the focus in the final part of this chapter will be solely concerned with the different stigmas pertaining to HIV and to AIDS. Elements of these two stigmas can relate, to one degree or another, to many of the various other sexual health stigmas[8]. It must be stated clearly, however, that Foucault was not interested in the actual label of a stigma as such. He was concerned with the relations of power and knowledge that are at work to produce the stigmatising labels or marks of a "spoiled identity" in the first place, and the resulting way in which the marked individual is given a personal identity e.g. hysterical woman, masturbating child or *the* homosexual (Foucault 1984; Turner 2006).

---

[8] Evans, D.T. (2005), Dissemination for ACAD 1064, <u>Anti-Stigma Campaign: strategies to combat stigma and create stigma-free health services</u>, International Council of Nurses Congress, (Workshop presentation), Taipei, Taiwan; Appendix 2.

Dynamic, relational and discursive stigmatic qualities

Stigmas surrounding both HIV infection and disease (including the specific AIDS indicator conditions[9]) are clearly dynamic, relational and discursive. They frequently tap in to stigmas from throughout the ages which pre-exist the discovery of this viral infection and subsequent illness (Davenport-Hines 1991). For centuries, if not longer, accusations, blame and maltreatment, including social isolation and death, have surrounded variously perceived sexual transgressions and / or illnesses (Foucault 1984; Sontag 1991). Some of these have even been attributed to divine retribution, the 'sins of the fathers (and mothers)' visited on subsequent generations (Paglia 1990; Fee 2000). Therefore, it might be easy to say there is nothing new about sexually related stigmas. It is worth noting that wherever and whenever there have been significant stigmatisations relating to health and illness: the bubonic plague, leprosy, tuberculosis, to name but three, many of them have "surprising parallels with the incidence of HIV" (Hodgson 2003: 23), nurses have traditionally been in the forefront in providing care (Pratt 1995). Sadly, at the same time, many other nurses have equally been noticeable in their hostility and reluctance to care (Hodgson 1997), with *enacted* stigmatising discrimination *felt* by patients as "dehumanising" (Dodds 2006: 475).

From 2000 onwards, the sexual health strategies of the four UK Health Departments highlighted stigma as being intimately related to key aspects of sexual health and illness, including sexual infections, unplanned conceptions and teenage pregnancies, and HIV infection and disease (NAW/CCC 2000;

---

[9] I personally chose not to use the popular technique of combining "HIV/AIDS", as though these are interchangeable or one and the same condition.

DH 2001, 2002; DHSSPSNI 2003; Scottish-Executive 2003). The aims of all four strategies include the management and overcoming of stigmas through the work of health and social care professionals. To achieve these aims, appropriate professional education is therefore crucial.

> *"The successful mainstreaming of sexual health will depend substantially on success in reducing the prevalence and impact of stigma and prejudice, among the general population and among professional groups."*

<div align="right">(DH 2002: 1.6. iv)</div>

The United Nations AIDS organisation (UNAIDS) has dedicated numerous international campaigns to the removal of stigma worldwide. This is witness to stigma's continued existence and its on-going problematic nature for people affected by various manifestations of sexual illness. These manifestations of sexual illness may be present physically, psychologically, 'morally', culturally or socially. In relation to HIV and AIDS, for example, Jonathan Mann (UNAIDS 2001) said that there are three pandemics operating simultaneously[10]: silent HIV infection; demonstrable AIDS defining illnesses, and the stigmas that interrelate with the two. Figure 2: 7 (below) outlines these stigmas and some of their preeminent characteristics, which, sadly, are also present in healthcare, nursing and professional education (ICN 2003).

---

[10] This theme is expanded in Evans (2005d), Appendix 2 slide 7.

**Figure 2: 7   Diagrammatic version of Jonathan Mann's
(UNAIDS 2001)** *three pandemics* **HIV, AIDS, Stigma**

(Diagram conceptualised by Evans, 2010)
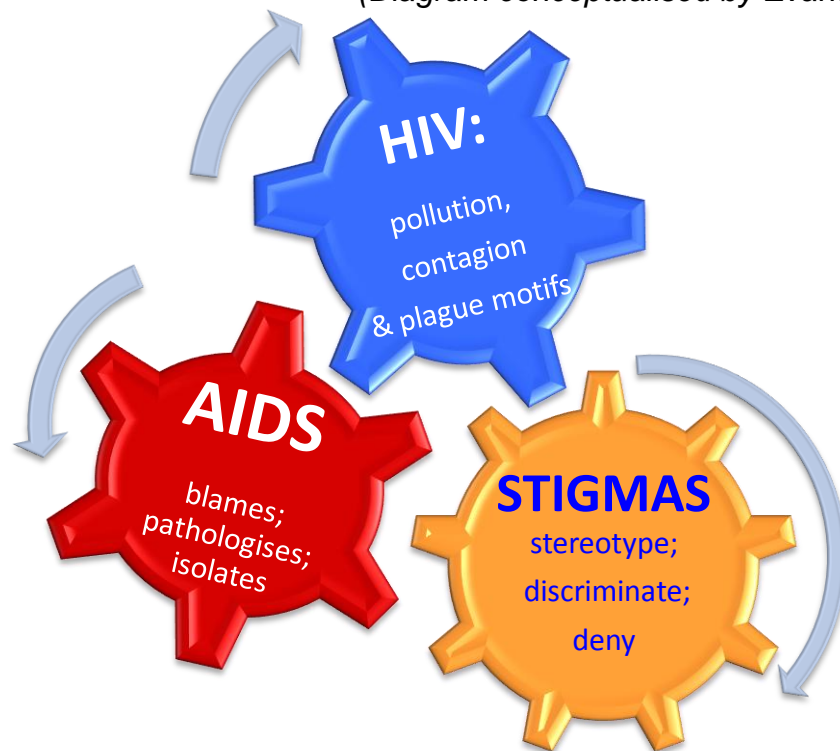
Understanding stigma and the relationships between marker and marked, through the methods of a genealogical analysis, reveals how the relations are inseparably bound with attitudes. These attitudes, as outlined in Figure 2: 7, relate dynamically with one's perceived knowledge (or lack, thereof), as well as with subsequent feelings, actions or behaviours between 'the markers' and 'the marked'. Procter (1995: 116) declared such attitudes, however, to be a hypothetical construct: "no one has ever seen or touched [them and their] existence and properties must be inferred directly". Yet fear and revulsion, for example in relation to AIDS, are strong emotional responses against stigma-affiliated medical conditions (Taylor 2001). Analysing attitudes must also involve this wide-ranging or "multiple indicator approach". The rigour of Foucault's genealogy strives to do this, in order "to ensure

efficient reliability and validity of the instruments, analysis and findings"
(Procter 1995: 133).

Procter's (1995: 133) "multiple indicator approach" would need to be cognisant of cross-cultural attitudes towards gender and sexuality differences, too, especially as the majority of people living with HIV throughout the world have acquired the infection through sex. Early identification of gay males in relation to AIDS and then HIV has added to the continuous stigmatisation of these individuals across times and cultures (Koll and Gutierrez 2010).

Demographics of stigmatising persons

According to the various sources reviewed and analysed here, sexual health and HIV stigmas are, more often than not, acted upon by nurses and other people who have certain beliefs or characteristics. These beliefs, personal characteristics or demographics are typical across the literature; they are summarised in Figure 2: 8 (below).

Figure 2: 8 Demographics of persons who characteristically act negatively upon sexual health and HIV stigmas

older people rather than younger

heterosexual males rather than females

those more religiously and politically conservative

those with lower academic and socio-economic achievements

more prevalent in certain ethnic communities

in persons without personal knowledge of, or relationship with, non-heterosexual people

in persons who would be intolerant of such desires, practices and life-ways if present in themselves (usually because of one or more of the above characterisitics)

- based on Haddock and Zanna (1998), Hite and Whitkey (1998), Anderson *et al.* (1999) Cohen *et al.* (2000), Forrest (2003) and Irwin (2007).

Historical research by Cohen *et al.* (2000: 159) "embrace[s] a kaleidoscope of evidence" relating to people who act negatively upon stigmas, those called 'the markers' by Jones *et al.* (1984). This broad spectrum or "kaleidoscope of evidence" explores the subject of stigma from multiple angles with clear evidence of what Warren (2003: 499) perceives as forms of "intransigent pro-stigma resistance". She says that even decades after the 1970s, "the terrains of gender, sexuality and stigma have changed, yet pockets of pro-stigma resistance remain". Discourses of stigma in healthcare (Mason *et al.* 2001) confirm that nurses and other healthcare professionals continue to collude in negative behaviours which reinforce stigmas; this is clearly a matter for effective anti-stigma and diversity education and is outlined by the

author in Appendix 2. In understanding stigmas, however, it is also important to note that a stigma does not always have to be negative:

> "the label of infection or 'disease' given by a doctor does not necessarily define an experience of 'illness'; some individuals, so labelled, feel empowered to take greater control of their life"

> (Taylor 2001: 793).

Especially in relation to HIV, labelling or stigmatisation is not always a negative phenomenon. Taylor (2001) highlights the potentially double-edged sword that (HIV-labelled) patients are often more well-informed and highly educated on their conditions and medications than nurses. This identifies a further gap in professional education as well as unintentionally usurping the advocacy or mediatorial role between physician and patient traditionally held by many nurses.

As Goffman (1990) affirms, being part of a stigmatised group can also bring strengths for people, as a result of the process of social identification with similarly 'marked' people. Differing cultures, however, can totally disprove this point in HIV client care, where people from the same cultural, geographical region, or ethnic group often try their utmost to keep their status concealed from others of the same group, including nurses and other professional carers. Hodgson (2003: 12) states "even in countries where HIV is prevalent, people who are seen as being infected because of 'unacceptable' behaviours are stigmatised."

The trajectory of both HIV and AIDS stigmas can be seen as emanating from beliefs about deviant behaviour, personal responsibility, lives or practices tainted with immorality, perceived contagiousness and unæsthetic deaths (Alonzo and Reynolds 1995). The high stigmatisation of sexually acquired infections also occurs partly because of their "symbolic significance in terms of trust and betrayal in intimate relationships" (Lichtenstein *et al.* 2005: 52). Green and Platt (1997) equate these aforesaid sentiments of stigmatisation to a misunderstanding which manifests as fear and loathing of the individual concerned, even by healthcare professionals and their educators.

Final epistemological considerations of sexual health stigmas

The analysis of discourses throughout this thesis, on sex, sexualities and sexual health, reveals that many of the topics studied are affiliated with and frequently compounded by stigma and the process of invisibilisation associated with other inequalities in life. Serrant-Green (2011: 348) suggests how these discourses of inequalities, often the invisibilised and 'silenced' dyadic opposite or 'other' to the strong majoritarian voice, form the "screaming silences" to be heard in research on the margins of traditional studies. Such invisibilised or silent "screaming voices" are evidenced in, but not limited to, inequalities around gender, sexualities, cultures, race and ethnicities, and disabilities studies. One clear example of a marginalised, invisibilised voice, from a mental health perspective, is shown through the discourses of medical history; it concerns 'shell shock' in World War I. At the time (1914-1918), shell shock was not considered a legal excuse for deserting the war-effort of the Armed Forces. In fact desertion was treason,

punishable as a capital offence. Almost 100 years on, in contemporary UK society, shell shock is redefined / re-labelled and diagnosed as Post-Traumatic Stress Syndrome or Disorder (PTSS / PTSD). It is treated quite differently now as a significant and 'real' mental illness. Similarly in the history of some sexual stigmas, 19th and early 20th century white colonialist research on the sexual, erotic and reproductive practices of various 'natives' under study would not have considered the methodologies of their day as stigmatising in the way that post-colonial thought and practice does (Anderson and McCann 2002). Queer Theory, too, highlights these shifting sands of academic thought regarding the way in which sexuality is considered not "a stable phenomenon of nature to be studied like plants or cells, but a set of meanings attached to bodies and desires by individuals, groups, and societies" (Gamson 2003: 549).

In the various discourses of sexual health, HIV and AIDS stigmas explored in this chapter, the concept of stigma itself is viewed as endemic in the dynamism of oftentimes concealed "hegemonic masculinities" (Franklin 1998: 9). For this reason, there is great benefit in revisiting past stigma theories in the light of current emancipatory, stigma-aware, epistemologies, firstly: to deconstruct; secondly, to reconstruct the ideas of other people (Hart 2003). In this regard, Foucault (1984) asked not only what made the different kinds of discourses on sexuality possible in the first place, but, significantly for stigma, how the discourses have been employed and adapted throughout different generations to support hegemonic power relations. From this perspective, stigma is clearly seen operating at the level of defining deviance

and reinforcing social norms (Taylor 2001), such as through sexism, heterosexism, homophobia, biphobia, transphobia, erotophobia and even with consensual sexual 'crimes' (Evans 2001).

Utilizing educational methods to overcome sexual health stigmas

Parker and Aggleton (2003: 16) call for a move beyond the stigma theories of the past, to understand it as part of "broader notions of *power* and *domination"* (italics original). My interest, given, as Taylor (2001) affirms, the potential influence nursing can have on society as well as individuals, is "to investigate teaching and learning strategies that meet the changing needs of clients or services, [and] the relationship between theory and practice" (Holloway and Walker 2000: 45). Nursing alone is not going to change the world and eradicate sexual stigmas (AIDS-action 2001), but promoting transformative knowledge which legitimises the voices of those who have been marginalized (Anderson and McCann 2002) – as nursing boasts it can do (Dattilo and Brewer 2005) – means that nursing education should, theoretically, be able to:

- assist nurses and researchers overcome the 'courtesy' stigma, (Murphy *et al.* 2002) i.e. stigma by association and a 'backlash' from pro-stigma forces (Warren 2003)
- harness accurate knowledge to empower the disempowered (Pryce 2000)
- capitalise on the "comfortable experiences", which Durkin (2003: 129) explains as other positive advances made in overcoming stigma to date
- combine political activism that promotes strategies for stigma management, which, as Taylor (2001) states, includes 'reclaiming' terms. Current examples include some black people reclaiming the

term 'nigger', gay people using 'queer', feminists using 'cunt', and, as Stenvoll (2002) recounts of limited success, prostitutes using 'whore'.

Summary implications for professional education of nurses

This review of pertinent discourses in the literature has been related to some wider themes of sexual health education for nurses. It contains a movement away from standard approaches of literature reviews. The rationale for this move has been in order to focus on the key aspect of sexual health, HIV and AIDS-related stigmas. This approach has addressed the impact of stigmas on patient / client care, service provision and, importantly, associated professional education and research. Other detailed elements, such as discourses on masturbation, will be explored more in chapters 4 and 5. This literature review has:

a) demonstrated difficulties of traditional literature searches for materials on topics that are hard to define, often non-existent, or shrouded in what Foucault (1984: 4-5) would call "taboo, non-existence and silence";

b) provided an explanation for the textual non-existence or 'invisibility' of appropriate studies and publications. It has traced through a genealogical analysis of constructing social powers, which define and diagnose the subject matter for this thesis in the first place as well as its application to learning;

c) analysed an under-current of stigma, as taboo, non-existence and silence, in many of the sub-specialities of sexual health and within the wider domains of its holistic definitions.

Therefore the very breadth of this topic area, its impossibility to neatly define and categorise, and the multiplicity of related discourses contribute to the on-going open-endedness outlined here in this chapter. The implications for the professional education of nurses, as with the sources reviewed in here, need to be 'read out of' the discursive experiences of 'grass roots' nursing care. This 'grass roots care' occurs within the very clinical practice that often misses or invisibilises aspects of sexual health, so the whole matter is therefore in need of being holistically and specifically addressed.

Conclusion

This analysis of sexual health and related stigma literature has highlighted particular issues that will all be explored further, methodologically, in chapter 3 and, most significantly, in relation to the data presentation and analysis thereafter. The issues highlighted include difficulties of defining sexual health; viewing its holistic relevance to clinical practice; its absence in educational / research literature, as well as the conceptualisations of related stigmas. The process of continuous critical (literature) review with data analysis will inform strategies for nurse education which can contribute positively to clinical discourses and associated practice needs. In particular this contribution will be, in part, through an emancipation from stigmas. Such emancipation from stigmas includes freedom from both their effects on individuals and from structural barriers to the provision of adequate and appropriate professional education for nurses. An optimum educational provision must be commensurate with client / clinical need in both holistic and specific sexual health service provision.

Finally, the numerous discourses pertaining to sexual health and associated stigmas are of direct relevance to professional learning for nurses. Most of the stigmas operate in compound fashion and include a number of inter-related discourses. Some of the stigma discourses, for example, may employ dynamics relating to pollution and contagion, fear and 'phobias', blame and punishment or notions of (innocent) victim and (deserving) guilty. These may be compounded further in themselves, or related to power / knowledge discourses utilised within wider gender, sexualities, ethnicities, cultures and religions. This chapter has therefore evolved to focus on the dynamics of these relational discourses as they relate to sexual health learning and associated stigmas and will now progress through chapter 3, on the methods employed to operationalise this particular study.

Chapter 3

<u>METHODS</u>

Constructing a research paradigm for

Sexualities and Gender Epistemologies

(S&GE)

<center>Chapter 3</center>

<center>## METHODS</center>

<center>*Constructing a research paradigm for*</center>

<center>*Sexualities and Gender Epistemologies (S&GE)*</center>

Chapter 3 thematic outline

- ➢ Constructing a research paradigm
- ➢ Philosophical principals in educational research
- ➢ Crystallisation not triangulation
- ➢ Ethics and reflexivity
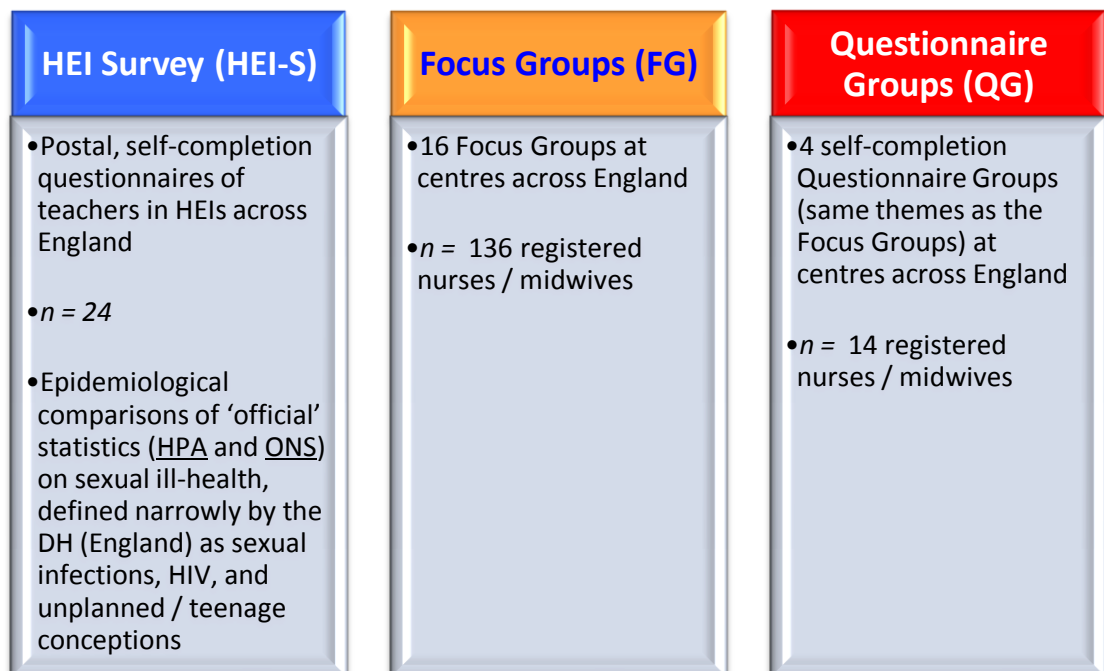- ➢ The empirical study
- ➢ Conclusion

Introduction

This current chapter explains the inter-relationship between three equally important elements used to operationalise this study. The first element comes from the **'epistemologies'**, the ways of thinking about the issues which inform the whole of this project. Secondly, there are the **'methodologies'** or "the terrain where philosophy and actions meet" (Sprague 2005: 5). Finally, there are the specific **'methods'** or tools through which I have conducted this research. The study combines an eclectic synthesis of epistemologies through which to view the data, with a mixed or *multimethods* approach employed throughout. The work is, to a major extent, qualitative, with a small contribution from a quantitative data analysis. The quantitative data focus on the provision of courses by the Higher Education Institutions (HEIs) within the English regions (Appendix 3) set against the epidemiology of sexual infections, HIV and teenage conceptions across these same regions. The survey (**HEI-S**) of sexual health nursing and

midwifery teachers also explores a number of qualitative themes, in order to compare and contrast them – to enhance confirmation and completeness (Coyle and Williams 2000) - with the discourses emanating from the various focus groups and questionnaire groups (**FG** / **QG**), also held across England.

The qualitative data have been analysed in line with Foucauldian strategies (Kendall and Wickham 1999; Mills 2003; Hodges *et al.* 2008). The analysis, as explained with a thorough glossary of terms combined with data examples in chapter 4, facilitates an in-depth exploration of significant matters in sexual health, especially the barriers to effective professional education related to client need and its commensurate service provision. The individual methods or tools used in this study are outlined in Figure 3: 1.

Figure 3: 1   Methods for the empirical study

HEI Survey (HEI-S)	Focus Groups (FG)	Questionnaire Groups (QG)
• Postal, self-completion questionnaires of teachers in HEIs across England • *n = 24* • Epidemiological comparisons of 'official' statistics (HPA and ONS) on sexual ill-health, defined narrowly by the DH (England) as sexual infections, HIV, and unplanned / teenage conceptions	• 16 Focus Groups at centres across England • *n =* 136 registered nurses / midwives	• 4 self-completion Questionnaire Groups (same themes as the Focus Groups) at centres across England • *n =* 14 registered nurses / midwives

The episto-methodologies will consist of a 'crystallisation' - a term clarified below - in mainly qualitative, particularly interpretative, genres. These will be augmented by the small amount of quantitative data analysis by which to illustrate the points at hand and contribute towards greater qualitative, in-depth, discursive analyses. The result is a "research *bricolage* […] a combination of multiple methods, empirical materials, perspectives and participants in a single study […] a strategy that adds rigor, breadth, and depth to any investigation" (Denzin and Lincoln 2003a: 5).

Constructing a research paradigm

> "A range of contemporary critical theories suggest that it is from those who have suffered the sentence of history - subjugation, domination, diaspora, displacement – that we learn our most enduring lessons for living and thinking."

> (Bhabha 1994: 264)

Education and healthcare have both been areas with a traditional preference for (post-)positivist and empirical research paradigms. The disciplines frequently treat such research in a technologically deterministic way, as an applied science (Clarke 2004: 289). Some authors argue that this is "in an attempt to prove the scientific 'credentials'" of the field (Usher 2002a: 14). Coupled with this trend, current epidemiological representations of sexual *ill*-health are fundamentally biomedical and often 'essentialist', i.e. beliefs that sex (male / female) and orientations are biologically determined, all of which are equally positivist in approach (Serrant-Green and McLuskey 2008). This not only overlooks "the importance of desires operating in [sex] itself" (Holmes and Warner 2005: 11), but has a tendency to disregard constructive

96

self-affirmation in favour of being "pathologizing, stigmatizing, seeking the 'cause' of deviant sexualities and, by implication, their cure." (Gamson 2003: 542). Such an approach is contrary to prevailing notions in nursing and nurse education[1], which aim, in theory at least, to strive towards more holistic and emancipatory theories to client care (Wilson and McAndrew 2000; Roberts and Evans 2007).

This EdD research could have been carried out using quantitative data methods alone. In line with current government practice (Department of Health, England) the researcher could have narrowly defined sexual health in line with the National Strategy for Sexual Health and HIV as sexual infections, HIV and unplanned / teenage pregnancies (DH 2002). Likewise, I could have then cross-tabulated indices of these phenomena with the (lack of) HEI provision of quantifiable learning opportunities for nurses. I believe, however, that this would have missed out on *the* key aspect of educational research into sexual health, which is the very person to whom the sexual health or illness pertains. This thesis therefore moves unashamedly away from (post-)positivism.

My research focuses on understanding more about what is *not* said, what Parker (2009: 262) refers to as a "discursive silence", i.e. that which is problematised, marginalized and invisibilised, over and above that which is traditionally said in relation to sexual health and illness. This research analyses "explanations, relationships, comparisons, predictions,

---

[1] In this work, nurse / nursing and nurse education are used as an abbreviation which also covers midwifery, community practitioners / health visiting education.

generalisations and theories" (Phillips and Pugh 1996: 47), by which to investigate the theoretical and empirical research questions, respectively:

"In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?"

"In which ways could professional education have adequately prepared nurses for meeting the sexual health needs of their clients?"

Mapping client need

'Mapping client need and professional sexual health education for nurses' does not intend to focus on a gap, a deficit, but, more importantly, to explore the discursive questions 'why' and 'what'. 'Why' do such gaps exist? 'What': a) are the implications of, and from, these gaps between client need and professional carers, and b) what can be done, educationally, to redress them? This means framing the research "around an intellectual problem or a paradox […], on phenomena that ask for explanation" (Dunleavy 2003: 23).

Expressed in Foucauldian terms (Foucault 1980), the study incorporates a discursive analysis of the power / knowledge between, on the one hand, clients or patients and their holistic sexual health needs, and on the other, professional carers (nurses and midwives) and their perceived educational preparedness commensurately to address these needs (Hodges *et al.* 2008). At the same time, it will be demonstrated that these various power / knowledge discourses are sometimes related to Foucauldian notions of *governmentality* (Pryce 2001; Gutting 2005; Van Loon 2008) including their

position within sexuality and sexual ("ill"-) health (Pryce 2000), that may equate with the "structural violence" of "differentials in power" (Parker 2009: 259 - 260).

Educational research

Underlying philosophical principles

My chosen framework is a multi-paradigmatic synthesis of relevant theoretical aspects of Sexualities and Gender Epistemologies[2]. Such a stance is both consistent with social scientific practice (Silverman 1994) and recommended by it (Robson 1994; Squires 1999). These various epistemologies include "several distinct – and at times competing - intellectual traditions" (Voss 2000: 180). This is to ensure maximum benefit for the particular study. It is also to provide alternative understandings from the traditional "monolithic hegemony of cultural representations" (Burman 1995: 54) and the political / power / economics of sexual health care provision and education, oftentimes arguably driven by "hegemonic mainstream sexual moralities" (Parker 2009: 261; *see also* Foucault 1985: 24).

It would be too simplistic to say that the epistemies are a conglomeration of feminist, masculinities, gay / lesbian and Queer theories. Firstly, because each of these genres have multiple aspects which not all proponents agree on; secondly, they are sometimes internally conflicting, and thirdly, because the origins, applications and outcomes of these theories are often

---

[2] Sexualities & Gender Epistemologies: abbreviated in this thesis as 'S&GE'.

contradictory, too. Examples range from the work of some feminists who "remain largely unsure what to make of transgender people" (Wilchins 2004: 28), to elements of many of these theories, especially in their formative developments, that would grapple with the notions of (biological) essentialism.

What is 'truth'?

Theories of essentialism affirm their 'reality' or 'truth' in certain "binary systems" (Foucault 1984: 83), such as those biologically determining the sexes: male and female, or sexualities: straight and gay. Martin (2003: 28) sees such determinism as carried over into sexual health discourses. She explains this in the presumed genetic predisposition for the "cult of motherhood and domesticity" i.e. that all females are solely predetermined to the role of motherhood and a life of domestic servitude. Likewise, Martin (2003: 28) also sees this in the often problematised "anti-school working-class 'lads' blocking teaching" mentality. Taylor (2005: 378) develops these themes and issues a warning for researchers, to challenge what is frequently perceived both as biological determinism and, as with "working class 'lads'" and their negative reactions to education, including SRE, a social class normativity or essentialism, too.

Biological essentialism is evident across much of healthcare research, providing "the dominant framework for the investigation and understanding of human sexuality across both time and space" (Parker 2009: 253-4). This is despite being challenged by more contemporary theories such as social

constructionism and post-structuralism (Plummer 2003). The methods of deconstruction found in such post-structuralist and other postmodernist theories, particularly as employed by many Queer Theorists (Seidman 1996; Warner 1999), strenuously challenge the need to find 'truth' in notions of definable identity (Foucault 1984; Walters 2005).

Critical research epistemologies, also called critical realism (Coyle and Williams 2000), take their starting point a step before biological essentialism / determinism. Rather than asking "what is 'reality'?", "what is 'truth'?", critical realism's starting point challenges "the naturalness of existing inequalities" (Sprague 2005: 114). Brookey and Miller (2001: 144) claim that "any search for 'true' identity [essentialism] is guaranteed to produce conflicting and often contradictory discourses". Dunleavy (2003: 119) claims a search for 'true' identity has led historically to the "archetypal singular" i.e. the stereotyped collective, such as *the* virgin, *the* whore, *the* homosexual. This current study challenges such stereotypes through the theories employed here, especially in applying concepts from some of the gay male and lesbian female studies, many of which have been reformulated through later post-modern Queer Theories (Spargo 1999; Sullivan 2003).

Ironically, despite coming from totally divergent angles, the two opposing epistemologies of essentialism and social constructionism could both be used to argue in favour of "identity politics" (Brookey and Miller 2001: 140). Identity politics, something akin to minority ethnic rights (Wintemute 1995), underpin UK legislation conferring equality on gender and sexuality

citizenship and rights. In regard to minority sexualities, these politics focus on whether or not sexuality is immutable; clearly an essentialist construct. An inherent danger with identity politics is that rather than problematising "inequality and privilege" (Sprague 2005: 114), such theories might instead lead to assimilation with the very cultures of oppression that the various theories eschew.

Searching alternative 'truths'

Plummer (1973; 2003) equates Queer Theory with the application of post-structuralism and postmodernism to the theories of sexualities and genders. Sullivan (2003) elaborates this and posits 'Queer' not as identity or being (noun), but as positionality, referring to the activity of 'doing' something that is challenging, that is to take a queer stance or position. Linné (2003) supports this by referencing 'queer' to imply that which is transgressive of the heteronormative, especially heteronormative society and culture. He uses the noun gay as an identity that one – the "proto-queer" - comes out into. Gamson (1996: 593) likewise views queer as a *doing something*, a direct action verb, such as taking an "anti-assimilationist stance, in opposition to the mainstream inclusionary goals of the dominant gay rights movement". Voss (2000: 184) explains this as an "inclusive standpoint based on difference from or opposition to the ideology of heteronormativity". And yet, it is also important to remember

> "[.] our science will never progress if we simply assume that all
> those white middle-class male heterosexuals leading orderly
> lives represent some sinister force opposed to our underdog

heroes or heroines and never acknowledge that they too are human beings making their way in an uncertain world."

<div align="right">(Dingwall 1994: 172)</div>

What about the boys and the men?

What is missing from the list of feminism, gay / lesbian / Queer theories, but included here, is frequently referred to as "masculinity studies" (Holroyd, Richardson and Webb 2008; Hearn and Morgan 1990). Gender studies cannot be truncated solely into feminism. Serrant-Green and McLuskey (2008) hold that the 'mainstream' society / culture that feminism often takes issue with, may – though in very different ways – also be disadvantageous to some males, notably in health service provision. Male invisibilisation is a constant challenge taken up by the advocacy charity the Men's Health Forum; such invisibilisation in health services is now also contrary to UK law. The 'gender equality duty' of the Equality Act (2006; 2010) requires health services "to develop and deliver effective work to improve men's health on a wide-ranging and systematic basis", to stop what it calls "gender mainstreaming" and "mov[e] beyond the assumption that 'gender' is limited to occasional awareness campaigns on sex-specific issues."

Like Brown (2001) and Evans (2004j), Cameron and Bernardes (1998: 689) show how "research into men's health can be hindered by assumptions that all males are equivalent in the gender order or in the social construction of their gender. Disaggregating gender from sex, therefore, is a good starting point". From the masculinity studies perspective, and "in a Foucauldian

sense, sexuality becomes a mechanism by which the limits of a desirable masculinity can be proscribed" (Martino 1999: 245).

At home with Foucault

> "Foucault's project – in both his politics and his histories – was not to lay out solutions, but rather to identify and characterize problems."
>
> (Halperin 1997: 54)

Aspects of the theories used in this work find a home in the extensive *opus* of Michel Foucault, who clearly influenced my area of work and research possibly more than any other theorist of the late 20th century. The diverse mix of epistemologies clearly incorporates influences from academic disciplines, history, politics, management and professionalisation[3]. This mix of epistemologies is also influenced by theories relating to ethnicities, class, cultures and (post-) colonialism (Parker 2009), as well as the impact on health of notions of beauty, pornography, (dis-) abilities, age and stigma[4] (Paechter 2003).

---

[3] Reference my other relevant courses assignments from the EdD programme:

ACAD 1060 Research Methods (1): Experiences in searching historical sources: *Bad girls and naughty boys!* From 'Venereal Diseases' to 'sexual health': the transformation of epistemies, stigma and (in)visibilisation

ACAD 1064 Critical Review: A new experience: writing in a Queer theoretical genre - *Alexander 'the Gay',* American audiences boycott a film on an historical character because of his 'sexuality'; Queer theorists question the whole notion of the trans-historical and sexual identities

ACAD 1070 Professionals in Society: "*Professionalisation in sexual health nursing: sexual and gender theoretical perspectives -* From the "world's 'oldest' profession" to the professionalisation of 'Cinderella'

[4] See dissemination paper No. 2 **Anti-stigma campaign: strategies to combat (HIV and AIDS) stigma and create stigma-free health services**, presented at the International Council of Nurses Congress, Taipei 2005. Appendix 2.

Finally, this thesis addresses the paradox of cultural, societal and professional erotophobia (Evans 2004f). This fear of sex hides behind the slogan 'ignorance is bliss' and imagines, contrary to sound research, that the more people know about sex – especially young people – the more they will do and the more danger they will be in (Petersen and Wilkinson 2008; Blake and Frances 2001). This approach culminates in "too little, too late" to promote good sexual health and well-being for too many people (TPIAG 2008).

Justifying my choice of paradigm

On reflection, and as Bryar (2000) suggests, I consider that rather than adhering to one school of thought, the eclectic synthesis of epistemologies used here will contribute well to address the specific issues studied. The eclectic synthesis will enable "authentic fairness" (Lincoln and Guba 2003: 278) by allowing me to listen to all voices, excluding none, as well as to problematising gender and (hetero-)sexuality, such as in seeing the ways in which gender, in particular, is routinely equated epidemiologically with binary biomedical 'sex' differentiation. Ultimately, this process will help explore the discourses around current hidden, or invisibilised, areas of sexual health education and care. As Anderson and McCann (2002) claim

> transformative knowledge is produced by research that analyses
> the complex factors that shape healthcare learning and policy,
> paying particular attention to liberating the voices that are
> traditionally marginalized.

This is akin to Clegg's (1999: 170) "systematic critique of oppression" from which many of the epistemologies employed throughout this work emanate. I

aim to 'listen theoretically' to the various power / knowledge acts of discrimination, which include omission (invisibilisation), as much as commission.

This 'listening theoretically' to instances of invisibilisation will have an important message for non-existent services and education, as well as challenging the various discriminations, such as erotophobia, that, for one, deny equal access to effective sexual health promotion for all people (Evans 2005b).

Reasons for choosing this eclectic, multi-dimensional, paradigm

The reasons for choosing the paradigm presented here result from working for many years with professional carers of people with recurrent, but oftentimes preventable, problems of sexual ill-health. These problems have included low self esteem, predisposition to unsafe sex, and feelings of being violated and downtrodden simply because of their gender or sexuality. Having considered the problems of these patients, I recognised that there was a need to underpin these professional experiences with theoretical perspectives and to explore the research questions in ways that combined theory with practice. It is essential to be grounded in theoretical perspectives, because research without epistemology is simply a skilled technology. A key focus of this research - the hidden or invisibilised in relation to sexual health education and client care, and the attendant power / knowledge discourses – demonstrates the "societal devaluation" (Hassouneh-Phillips and McNeff 2005) of the marginalised *Other*. The epistemologies used in this study act

as a "counter-hegemonic logic" (Sullivan 2003: 38) which respond to Foucault's (1984: 84) claim that

> "to deal with sex, power employs nothing more than a law of prohibition. [...] The logic of power exerted on sex is the paradoxical logic of a law that might be expressed as an injunction of non-existence, non-manifestation, and silence."

As Cohen *et al.* (2000: 35) state in relation to feminist research, the sexualities and gender epistemologies used throughout this work will recognise "the necessity for foregrounding issues of power, silencing and voicing, ideology critique and a questioning of the legitimacy of research that does not emancipate hitherto disempowered groups". Similar to Queer Theory, such an endeavour challenges "hegemonic understandings between identity, sex, gender and sexuality" (Morland and Willox 2005: 4) and the "trappings of privilege". Norris Lance and Tanesini (2005: 183) see such "trappings of privilege" as the outcome of traditional heteronormative society and healthcare, that is, "dominant social attitudes – the normalizing power of hegemony" (Knox 2006: 2) and their associated systems of learning. I do not intend this so as to design some sort of alternative curriculum or minority health service, rather, it is to "*queer* all (hetero-)sexualised spaces and discourses within learning" (Sumara and Davis 1999: 203). This will help "transform and promote the eradication of gender [and sexualities'] inequalities" (Povey 2000: 220). Such inequalities are linked to discrimination, which, as Stine (2002: 82) affirms, "is a public health issue [as] good public health practice is impeded by bigotry". Simply for one example of the latter: look at the societal and cultural barriers to young

women carrying condoms to practice safer sex. Holland *et al.* (1996: 119) state that the problem with this is the implication that she is "going against the construction of sexual intercourse as man's natural pleasure, and women's natural duty". There are numerous epistemologies, practices centred on knowledge (Tanesini 1999), that could support this research, some of which I have considered but reject for the reasons outlined here.

Figure 3: 2   Alternative epistemologies – rejected

(Empirical) Positivism:

- **Rationale for use:** quantifiable data, such as the number of courses offered, number of nurses attending them, etc.
- **Comment:** I consider this wholly inappropriate; it would miss out on mapping educational provision in line with local, national, and, more importantly, personal needs of clients. It would also fail to address issues of invisibilisation in sexual health, i.e. the people who are missed out of the official statistics, people 'without a voice'; the individuals I am particularly interested in for this work. As Huntingdon and Gilmour (2001: 907) state, "allowing the person to 'speak' shifts the balance of power from that usually experienced through traditional biomedical representations of illness and health".

Critical Theory (CT)

- **Rationale for use:** CT might offer insights for a critique of the data from a certain feminist perspective; it is possibly too sociological for a specifically nurse educational standpoint.
- **Comment:** On examination, I consider this approach too narrow. Feminist CT epistemologies are concerned with particular aspects of gender. These aspects may not pay commensurate attention to a number of wholly different sexual health issues for heterosexual males (as identified in some masculinity theories) or sexuality (as opposed to gender) issues, identified by some of the lesbian and gay studies. Both masculinities studies and gay and lesbian studies can highlight a disenfranchisement from health services of their respective constituencies on wholly different grounds from those studied by feminism.

Motivational Theory (MT)

- **Rationale for use:** includes ideas on de-motivation, such as in practising safer sex. De-motivation might be demonstrated as personal low self-esteem.
- **Comment:** MT is focused on psychology than S&GE; importantly, I do not have a specialist psychological background. Also, there is an inherent danger of attributing unsafe sexual practices to low self esteem, disempowerment, or lack of powerful 'voice'. As Holmes and Warner (2005) make clear, what (heteronormative) public health may ascribe to de-motivation to practice "unsafe" sex, may, in fact be quite the opposite – for example a conscious choice by an individual - which therefore challenges health and education to deal with the consequences of having made the wrong assumptions.

Triangulation, kaleidoscopy, prism or crystallisation?

In earlier assignments of this programme and my original research proposal, I had suggested using a process of triangulation for three elements of the study: the epistemological genres, the methodological strategies and the operationalising methods.   However, on reflection and further critical investigation, there are two other related concepts which can challenge the appropriateness of the triangle.   These concepts include the kaleidoscope (Pellowe 2004; Barrett and Barrett 2003; Pratt *et al.* 2001) and the prism or crystal (Janesick 2003; Richardson 2003).   'Crystallisation' – a concept clarified below - appears to be of far greater utility to this study than the others.

The case for and against 'triangulation'

Triangulation in research offers an unprecedented opportunity of using multiple paradigms, methodologies and / or methods, some of which may not 'naturally' appear suited e.g. being from differing methodological backgrounds: qualitative / quantitative; or within and between various methods. Magnusson *et al.* (2005: 30) claim such a combination can "enrich the research process".   French Adami and Kiger (2005) contend that triangulation can also incorporate more than one researcher on a programme, as well as using multiple methods of analysing the same data sets; analysing data across time; similar data from different places, and data from different hierarchies of research subjects, e.g. managers / employees.

An obvious benefit is the way in which triangulation compensates "for the weaknesses of any single strategy towards achieving completeness or confirmation of findings" (Ramprogus 2005: 4). Paraphrasing Williamson (2005: 7), it broadens the perspective of understanding the study, transcends singular inadequacies of one-method research and produces a more comprehensive, all-round, or fuller view of the research subject. It also contributes towards great rigour in the procedures used. This may lead to the belief that triangulation can be more efficient at exploring "breadth of knowledge and depth of understanding" (Crowe 2005: 55), revealing greater levels of 'truth' and objectivity, and overcoming the shortcomings of single-method studies. However, it does not eliminate the problems of individual single methods; it incorporates them alongside short-comings of all the other methods used, too. Neither is it able to reveal more 'truth', as, from the poststructuralist perspective of this work, 'truth' in itself would be a contested concept. As for objectivity, as Lincoln and Guba (2003: 279) claim

> "objectivity is a chimera: a mythological creature that never existed, save in the imaginations of those who believe that knowing can be separated from the knower".

Another benefit of triangulation is that it permits differing dimensions of a study to be explored, which would be missed with one-dimensional methods. This is similar to the precision of pin-pointing a geographical spot from two alternative standpoints, with surveyor's instruments. Triangulation is not "a tool or strategy for [a research study's] validation, but an alternative to validation" (French Adami and Kiger 2005: 20) in that it contributes more to completeness of view rather than confirmation of findings. Herein lie some of

the criticisms of this approach. Firstly, the term 'triangulation' has been borrowed, inappropriately, some would claim, from positivist, physical, sciences that have differing understandings regarding what the three sides of the triangle represent. Some researchers adapt the traditional three-sided model and transpose them with qualitative concepts of "validity, generalizability and reliability". Janesick (2003: 69), however, argues this is an unnecessary "veritable trinity of positivist referents"; unnecessary in reference to social sciences borrowing an external model and redefining it to make it appropriate for its own use. Triangulation, it could be said, discovers or pinpoints something; the methods preferred in this study are supported by the metaphors of crystallisation, to shed light on.

Metaphors of the prism: kaleidoscope or crystal

French Adami and Kiger (2005) reiterate what they see as appropriate alternatives to triangulation. Firstly, they discuss the prismic, ever-changing dimensions of the kaleidoscope; secondly, likewise, for the crystal. They describe the functions of both the prism of a kaleidoscope and the crystal. A kaleidoscope is peered into; it reveals functional shadows which are evocative of metaphors used in *The Allegory of the Cave* (Plato 1974: 316-325). The crystal, by contrast, takes light in and then refracts it outwards, revealing alternative views on the target areas enlightened. I will hereafter use the notion of the crystal. The process involved in using the metaphor of the crystal is frequently referred to as 'crystallisation'. Etymologically, this concept predominantly signifies

1   some sort of convergence, a focusing-in process

111

2   a re-formation of products to form a new entity, e.g. a fluid to a solid, or

    3   a type of covering e.g. sugary, crystallised fruits.

However, it can also refer to 4) the refracted light being transposed outwards, illuminating the environs dynamically and uniquely. It is this last interpretation, number 4, I will use within this doctoral study. This understanding of crystallisation demonstrates how the process of my research draws together, synthesises, three crucial elements under investigation and inter-relates them together for the practical application of shedding light on particular matters, revealing new ways of looking at them. The practical application is similar, in this regard, to Lawler's (1991) understanding of the human (and sexualised) body in nursing, her theory of *somology*, and Serrant-Green's (2004; 2011) voicing of "screaming silences".

The process of crystallisation, as employed here, starts with bringing together three elements of the study, namely: (a) the various philosophical concepts and theories, (b) particular research methodological tools, and (c) the resultant 'voices' from a range of empirical data respondents. The wide range of epistemological concepts (a) has been influenced predominantly by works of or on Michael Foucault and numerous sexualities and gender epistemologies: feminism and masculinities studies, Queer Theory, lesbian and gay studies. Each of these epistemologies frequently deals with aspects pertaining to other minority voices, such as those of stereotypically non-sexualised peoples: the old, disabled and mentally challenged people, to name but three. Once these three elements of the study converge thus, the outcome of crystallisation is to shed light on the subject at hand in new and

innovative ways, revealing a range of implications for learning across the three elements of the curricular triptych outlined in this work. Janesych (2003: 71) holds that the methodologies of crystallisation can provide the "human and passionate element of research", through acknowledging that there is no one truth of a study, and no one way of looking at 'reality'. The manifold, dynamic, aspects of crystallization, everything from prismic light refraction to the colourful choreography of transposed reflection, are therefore evocative of a mixed genre approach to research. Richardson (2003: 517) claims such a mixed genre approach doubles as "a postmodernist deconstruction of triangulation".

Ethical considerations

The ethical process and journey for this study

Ethical approval for this study has been granted in full and followed unconditionally (Appendix 4). The first stage of the journey for approval began with reflection on the proposed stages and methods of data collection, accompanied by an anticipation of points for consideration or concern. During a supervision session, one supervisor raised concerns about the possibility for the semi-structured focus groups to 'open a can of worms' (not the supervisor's exact words) when exploring various sexual health matters pertinent to the study. I needed to reassure my supervisors and the University Research Ethics Committee that

   a) the proposed questions of the focus groups were on sexual
      health learning, not on individual personal sexual health

b) that my knowledge and skills to deal with the unexpected (through 20 years of sexual health teaching, and sometimes counselling practice) were sufficient for the tasks at hand.

In educational research, ethical considerations and adoption of the most appropriate epistemological framework take precedence over all other aspects of the work (Clarke 2004).   The various sex and gender epistemologies used in this thesis are equally consistent with sound educational and healthcare research studies.   Personally, and upon critical reflection, I also judge that the ethical considerations for this study were rigorously addressed by my personal and professional expertise in these matters, given my experiences with the various codes of practice incumbent on me as a Registered Nurse, former Roman Catholic priest, psychological counsellor, researcher, and health professions educator.

Holloway and Walker (2000: 58) suggest that research ethics, based on Beauchamp and Childress (1994), which aim at

1 respecting autonomy of research subjects (independence, self-determination)
2 the researcher being non-maleficent (doing no harm) to the subjects
3 promoting beneficence (doing good), and
4 advancing justice (fair treatment).

From a Foucauldian perspective, however, it is possible to challenge some of the concepts used here from Holloway and Walker (2000). For example, 'not doing harm' is open to debate when many of the theories employed in this

work will actively challenge the tenets of various (hetero-)normative belief systems, which, for some, may ' rock the boat' or bring feelings of chaos and confusion. 'Promoting beneficence' has also been questioned by a number of feminists for being patronisingly disempowering, as though it is in the gift of the researcher to do good or bad to anyone (Usher 2002a). The British Educational Research Association talks, instead, of an ethics of respect for: the person, knowledge, democratic values, the quality of educational research and academic freedom (BERA 2004).

Professional educational research ethics also include the necessity to disseminate the findings of research in order to promote policies that will emancipate education, for example, from the current biomedical stance, and thus prove transformative of clinical practice (Burgess *et al.* 2006; Creswell 1998; Scott 1996).

The application process for ethical approval proved rather tortuous and time consuming due to one main point: the role of numerous focus group respondents in relation to their NHS employment. Initial ethical permission was sought from the School's Ethics Committee - a sub-group of UREC, the wider University Research Ethics Committee. Given that many of the proposed respondents to the focus groups and self-completion questionnaire groups were employed by the National Health Service (NHS), the local committee deemed my request outside its remit, and referred my application to UREC for possible NHS Research Ethics Committee approval. Expert opinion from one of my supervisors clarified this issue prior to UREC's

decision. As the research respondents were from different employers (some from the NHS, others from the private sector, Home Office, Department for Education, Her Majesty's Armed Forces etc., with over 50% self funding) and all were participants on a course provided not by the NHS but by the professional organisation, the Royal College of Nursing, and credit-rated by the University of Greenwich, the need for specific NHS ethical approval was deemed unnecessary. Added to this, the prospective respondents of the HEI survey were also employed outside the NHS. This situation was eventually resolved, successfully, as shown in the letters of approval (Appendix 4).

The paramount need for reflexivity

The need to be reflexive arises particularly in post-modernism and S&GE. This is particularly so when trying to move away from the dominant and "inherently culture-bound" discourses and ways of knowing, characteristic of value-laden research (Usher 2002a: 29). In this regard, reflexivity is understood here as "'finding out' about how meanings, including the meanings given to and generated by research, are discursively constructed within the practice of research" (Usher 2002b: 39).

Finally, in response to any charges against a male using some feminist concepts and theories, throughout this work I aim to be

> "a man who is not claiming a space in or asking feminism to include him, but a man who is deconstructively reflexive on gender and power after his encounter with feminism."
>
> (Pillow 2002: 547)

Reflexivity in educational research

Critical reflection is an essential element of professional care delivery as well as teaching and research practice (Clegg 1999). It is therefore an integral element in my roles and responsibilities as ethical researcher and educator, as well as, indirectly, through example and proficient guidance for those whom I educate in the art and science of (sexual) health care. In relation to the process of research for this thesis, most particularly in: the choice of subject matter; the design of the study; the practice and performativity of data collection; as well as the interpretation, presentation and dissemination of the research findings, the ethical practice of reflexivity is paramount at each and every stage.

The ethical responsibilities of researchers in the social sciences would be diminished if they failed adequately to address the implications of subjectivity / objectivity. In this work, these themes are seen as being relational to the very concept of reflexivity itself. Without an honest application of reflection to the practice and implications of this research, the boundaries of a personalised subjectivity with objectivity would be blurred and confused.

Subjectivity, especially as 'The Author', is something on which Foucault had much to say (Danaher *et al.* 2000). He claimed, at times, to want the writings of The Author - through the process of the written word's absorption by The Reader - to be of paramount importance. From this position, The Author could, in effect, be any nameless 'other'. It is ironic, given Foucault's critique of religion, that this Foucauldian motif is essentially reminiscent of a particular

Christian Scriptural imperative, on how the individual needs to be subsumed into, or by, a Greater Other (The Bible, Galatians 2: 19-20) "it is not I who live, but Christ who lives within me". Given Foucault's idiosyncratic style of authorship, his cult following and his writings which theoretically try to hide Paul Michel Foucault the Author - the Author as Subject - this is no easy task (O'Farrell 2005).

For different reasons, positivist / natural scientists also try to eschew the subjectivity of the author in favour of a desired, totally rational objective 'truth'. This objective truth is meant to be independently verifiable and untainted by the subject of the researcher / author (Denzin and Lincoln 2003a). Feminist authors, however, explore the implications of this desire for non-subjectivity, which is equivalent to a 'disembodied' objectivity, and judge it to be a false search for some sort of a research Holy Grail, under the guise of independent, untainted, "truth" (Huntingdon and Gilmour 2001). They see this quest for an objective truth as an actual construct of mainstream (pro-masculinist) academia and research epistemology which further disenfranchises (already) silent voices. These silenced 'voices' are particularly the non-male, non-heteronormative and otherwise non-majoritarian in any given society (Sprague 2005). Striving for an ethical balance between the subjectivity of the researcher-author, therefore, and realistically appropriate objectivity, is a goal to be aspired towards and perpetually reflected upon.

There were moments during some of the focus group sessions of this project, for example, when I, as an expert in my field of academic knowledge and educational practice, could have 'jumped in' to rescue struggling respondents out of their difficulties in trying to explore certain issues. For a number of reasons, they appeared to be constrained in both their thought processes and enunciations (see chapters 4 and 5). Personal insights gained from former counselling practice, aided by my prior decision to offer a balanced amount of exploratory prompts and considered suggestions, whilst, simultaneously, avoiding answering on behalf of others, clearly allowed respondents to have a voice of their own. This was despite my supporting knowledge and expertise, considering that these responses were sometimes rather superficial, and could have been more in more depth.

Searching for the invisibilised

Even the desire to probe the 'invisibilised' in this research project proved to be a double bind. Certain issues, for example, the proven benefits to health of elements of the *ars erotica*, were almost totally invisible in the various focus groups' responses. The invisibilisation is akin to Parker's (2009: 253) "discursive silence" referred to above. Parker (2009: 253) states: "the silence that results from the questions that we, as investigators, fail to ask and the discursive silence that is perhaps produced by what may be our own (over) attention in recent years to issues of discourse and culture". These "issues" include medicalisation and the pathologisation of sexual health. Witness how these two participants from focus group (**FG**) 16 grapple with the problems of promoting the *ars erotica* for health improvement.

> **FG16 / P15** Um … it's not … we need to make them aware that it's not just about teaching about how to promote um … and to prevent sexual ill health. It's about promoting positive sexual experiences, saying that having … nearly everybody has sex so … you know, okay, yeah we've got to prevent sexually transmitted infections but what about saying "we are doing this to make sure that you're well but you know sex is fun!" And say you can bring this into your practice so … and focus different areas and say you know … say somebody has had a stroke: "okay, we can help you get well enough again to have a positive sexual experience again". It's about making it fun!

> **FG16 / P04** Yeah. Anybody that … as somebody said earlier ... [sex] affects us all in one way or another, it's part of human nature so we should address it, and recognise it, and deal with it.

Conversely, evidence of this invisibilisation on certain matters, as here, the *ars erotica*, helped confirm various pressures and powers of majoritarian discourses that affect this hiddenness. On reflection, it is important to note that 'I', representing the subjectivity of the researcher, with my prior knowledge of related issues, was sorely tempted to offer suggestions and encourage deeper probing. Prior anticipatory consideration and in-practice 'on the spot' reflection about the best way to conduct these events skilfully guided me to go at the respondents' pace, with gentle probing only, but clear personal acknowledgement of what *could* have been said by me, through expert intervention, but was not.

Another example of walking the ethical tightrope for me as researcher, between contaminating the research process and data with disproportionate subjectivity on the one hand and yet maintaining a clear presence in it on the other, is demonstrated in the HEI questionnaire survey (see Appendix 5). There are elements of this part of the study which inquired into objectively

verifiable 'facts'. For example, a number of questions ask for clear factual responses, such as job title, whether the job is primarily a sexual health role, and ways in which the respondent's HEI actually addressed the five key aims of the <u>National Strategy for Sexual Health and HIV</u> (questions 1-series and 3a, respectively). Aspects of the survey which gave voice to the respondent, as Subject, can be found in a number of other questions, such as those that asked whether the respondent personally thought that their HEI was doing enough to help achieve the <u>Strategy</u> locally, or in addressing the sexual health needs of their own students (questions 4e & f; 5a; 5g - j respectively).

Reflexive educational research practice

To be able to ask critically appropriate questions, through all three elements of the empirical study, indicates the need for a degree of reflexivity. This reflexivity is on the current issues at hand (the knowledge), the practice (of research facilitation) and interpretation of data (authorship). Based on this triangulation of knowledge, facilitation and authorship, the ethical balance of subjectivity / objectivity has therefore been incumbent on the researcher through every stage of the process. These stages include designing and executing the study; reflecting, analysing and reporting on the findings, and facilitating the balance in all three elements of the study, that is in the persons of the respondents and their individual standpoints.

Motivation and bias

Numerous research theorists agree that personal motivation to investigate aspects of life is beneficial for seeing a project through from start to finish

(Phillips and Pugh 1996; Silverman 1994). As Strauss and Corbin (1990: 42) claim, "the more professional experience of a concept the researcher has, the richer the knowledge base and insight available to draw upon in the research". On the other hand, too much experience can also have the disadvantage of blocking one from seeing things that have become routine or 'obvious'. As suggested by Cole (2006 & 2004), the actual motivating forces themselves have been reflected upon and explored at each stage of this research, to avoid this particular bias.

Similarly, recommendations on how to avoid 'contaminating' the data with overly subjective emotions have been followed from methodologists such as O'Rourke (1998); Walker and Avant (1995) and Strauss and Corbin (1990). The current project is therefore undertaken with full recognition of the responsibilities on me, the researcher, to work in an objective and unbiased a manner as possible.

> "The understanding of 'objective', however, is not the presumed 'value-neutral' use of reason, devoid of human engagement, but will include an apt employment of emotions and a critical reflection of interests."
>
> (Tanesini, 1999: 29)

This ensures "the relationship between the instrument[s] and a set of social realities at one point in time" (Coyle and Williams 2000: 1238) provide the required reliability and validity for this study.

The pilot study

The survey questionnaire and semi-structured focus / questionnaire group schedules were grounded in educational themes from literature, policy and practice, and from privileged insider knowledge of the researcher in evaluating data from the RCN <u>Sexual Health Skills</u> course evaluations and in the preparation of the annual reports to the Government Independent Advisory Groups for Sexual Health and Teenage Pregnancy. These course evaluations address discourses around the aims of the <u>National Strategy for Sexual Health and HIV</u> and the spectrum of sexual health learning for nurses in England.

Thus, the pilot study, or 'preliminary investigation' (<u>ACAD</u> 1065), was subsequently used to clarify the questions for the empirical study proper, to test the rigour of the initial questionnaire and themes for focus groups, and build up a data base of potential teachers / institutions to target for the survey questionnaire (Booth *et al.* 2003). The pilot study was deemed fit for purpose, and was successfully executed and the assignment passed.

Only one aspect had to be modified for the actual study: my original intention had been to wait and see what qualitative data responses came back within the HEI survey questionnaires, from which to formulate the topics for the focus groups. Given the technological problems and delays (see below), however, this was slightly modified in that I had to build the focus group themes actually on some of the same questions or themes used in the survey questionnaire design. This did not prove to be a problem as the responses to

the HEI survey were very much as anticipated, and therefore supported the qualitative data from the focus group interviews.

The methods in the empirical study

The first version of the HEI survey was designed for electronic distribution, with *Adobe LifeCycle Designer* version 8. It was sent to 55 teachers, identified through a process of scrutinising HEI websites for those offering any sexual health course, acknowledged either by their voluntary inclusion on the educational provision page of the Genito Urinary Nurses Association (GUNA) website, or through a manual trawl of all HEIs listed in both the Nursing and Midwifery Admissions Service (NMAS) and Universities and Colleges Admissions Service (UCAS) websites (Appendix 6).

The survey was designed in accordance with the pilot version and modified in line with comments from the pilot study respondents. It was then sent electronically, in the first place, and then in a paper version, to the 55 identified sexual health teachers / HEIs, with accompanying cover letter and research information sheet (Appendix 7). This number (55) equates to 100% of those teachers identified at 39 HEIs offering any course on the (sub-) specialities of sexual health. The rationale underpinning voluntary participation of respondents in this survey acknowledged that a non-response was equivalent to the withholding of consent to participate: a free decision and unquestionable right (RCN 2005).

What was not anticipated beforehand, especially with the preliminary investigation, was that the vast majority of intended respondents work at HEIs with electronic spam systems which block all attachments with the word "sex" in them: the electronic survey was doomed from the start! The response rate was 5 out of 55 (9%). Two weeks after initially sending the e-survey, I followed it up with a prompting e-mail, in accordance with recommended survey design practice (Oppenheim 2005; de Vaus 2001), upon which a number of people replied saying they had never received the original e-mail.

It became necessary to send prompting e-mails / letters with both the electronic and printed versions of the survey. Unlike advice in Cohen *et al.* (2000), however, I sent only one *per* method, and preferred to put greater encouragement for participation in the introductory letter, rather than bombarding people with two or three chasing letters afterwards. Expressing my thanks for voluntary participation and their time (estimated at about 45 minutes to completion) was important. It was the only incentive I could offer (plus the potential good (beneficence) which may come from completion of this study, with hopeful dissemination of findings through publication to influence future policy). I did not go down the gimmicky route of free pens or condoms, but appealed to the participants' sense of professional altruism.

Back to the drawing board

Over and above the issue of cyber policing for e-mails and attachments with a "sex" word content, the e-survey had been designed with the latest version

of *Adobe LifeCycle Designer*, which apparently can create other electronic problems when viewed with older operating systems and earlier versions of *Adobe Acrobat Reader*. The failure of the e-survey meant I had to redesign and reconfigure the questionnaire into printed format: for example, visibly displaying all options from the previously partially hidden 'drop down' menus. Fifty three such forms were then sent out with adapted cover letters, explanations for what had happened earlier, and with stamped addressed envelopes (to be returned to me, at the School of Education and Training Office). The response rate - now, for a postal survey - was far more appropriate (*n* = 24 / 45% or 52% (*n* = 29) after adjustment for 5 'return to sender' envelopes for teachers / courses no longer available at specific HEIs). According to Oppenheim (2005), a 45% response rate is acceptable in the standards of social science survey research.

Figure 3: 3   English regional distribution of 24 completed and returned HEI Survey questionnaires
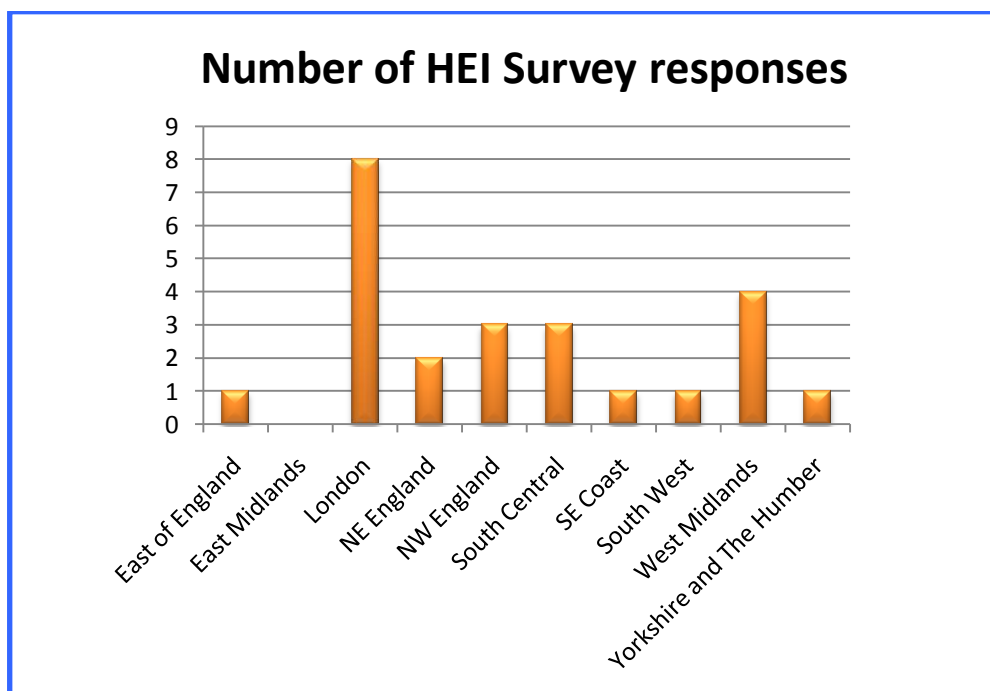
The research study and related ethical procedures were explained in covering letters sent with the electronic and postal surveys. Two recipients of the original e-survey e-mailed me directly to highlight their own ethical concerns. One non-respondent said that her HEI's Ethics Committee required me (an outsider) to go through *her* UREC for approval, prior to contacting her or any other member of their staff, even though their personal contact details are in the public domain. A second non-respondent wrote and informed me that I should not have sent the introductory letters and questionnaires directly, but designed a 'flyer' to advertise my study and then invite participation, only then sending out the full materials. These issues were discussed with the EdD programme leader, who reassured me that my proposed method and University of Greenwich UREC permission were both appropriate and typical for sound educational research practice. I thanked the two individuals and subsequently omitted them from the postal survey (hence, 53 questionnaires sent out = 100%).

The focus and questionnaire groups

The final methods to operationalise this study were carried out between July 2007 and August 2008. As on-going manager of the RCN <u>Sexual Health Skills</u> distance learning course, it was my duty to ensure that the two compulsory experiential learning 'Away Days', were adequately facilitated across the UK. This was done with the collaboration of expert, senior nurses / educators in sexual health. I would participate in the final Away Days sometimes as sole or co-facilitator, and sometimes as evaluator.

For this EdD study, however, and cognisant of good ethical, educational research practice, I wrote to all Away Day facilitators and students beforehand, outlining my research proposals, and clearly highlighting the fact that participation in this doctoral study was: voluntary; unlinked to the RCN course, and outcome of the academic assignments; completely anonymous, with no responses linked to individual participant's names; conducted after the end of the day's programme, but within its time constraints, and finally, when conducted by me (the focus groups), a clear demarcation was drawn between my role as manager of the course and now as an educational researcher and fellow student.

These issues were all clearly addressed in the research ethics application, to which I adhered completely. UREC also stipulated that, contrary to my wishes for 'consent to participate' to be implied by those remaining for this hour-long session, as opposed to those absenting themselves at this point, the main facilitator for the day (or a student, if that person was me) had to distribute individual consent forms for signing and individual participant identification numbers (instead of their own names). The facilitator also had to complete a register, to correlate individual participant identification numbers with their consent form number (Appendix 8). These registers, along with the consent forms, were then sent by the Away Day facilitator (or student), in a stamped addressed envelope provided by me, to the Administrator in the School of Education and Training Office for safe keeping.

For the majority of these groups (Figure 3: 4), in which research participants ranged from 4 – 18 in number, I conducted the sessions as digitally recorded

focus groups, with free discussion of themes presented as six key topics on *PowerPoint* slides (Appendix 9). The transcribed focus group materials add up to over 108,000 words in total. A small number of these Away Days clashed because they were on the same day, but in different parts of England. These were the occasions when I would personally facilitate a focus group for one of them, but enrol the assistance of the cohort facilitator to administer the questionnaires, based on the exact same six themes, to volunteer participants of the groups I could not attend (Figure 3: 5).

Figure 3: 4   Demographics of the recorded Focus Groups
(researcher facilitated)

Focus Group Number	Venue	Date	Number of Participants	Duration
01	London	23 Jul 2007	11	51:35
02	London	24 Jul 2007	12	01:03:57
03	London	25 Jul 2007	10	57:31
04	Nottingham	26 Jul 2007	10	38:07
05	London - A	29 Jul 2007	13	38:07
06	London - B	29 Jul 2007	09	40:34
07	London	23 Aug 2007	04	52:04
08	Peterborough	01 Mar 2008	06	01:03:35
09	London	16 Mar 2008	06	28:21
10	Manchester	01 May 2008	05	46:47
11	Birmingham	02 May 2008	11	45:51
12	Birmingham	07 May 2008	06	48:50
13	London	24 Jun 2008	08	23:58
14	Birmingham	27 Jun 08	07	50:09
15	London	10 Jul 2008	06	40:15
16	Birmingham	11 Jul 2008	12	47:14
Totals			**136**	**c. 13 hrs**

Figure 3: 5   Demographics of the Questionnaire Groups
(administered by Away Day facilitators)

Questionnaire Group Number	Venue	Date	Number of Respondents
01	Birmingham	07 May 2008	1[5]
02	London	29 July 2007	1
03	Leeds	27 July 2007	11
04	Norwich	28 July 2007	8
Total respondents			21

Reasons for choosing the method of focus groups

Based on an exploration of the research literature, of the *pros* and *cons* of various research methods, and in order to evaluate the merits of compatibility for focus group techniques, I performed a SWOB analysis (Strengths, Weaknesses, Opportunities and Barriers), with the following results (Figure 3: 6).

(*overleaf*)

Figure 3: 6   A 'SWOB' analysis: rationale for choosing to undertake focus groups

> *(Figure 3: 6 is divided into two parts:*
> *Strengths and Weaknesses shown overleaf;*
> *Opportunities and Barriers on the following page)*

---

[5] One respondent each from a Birmingham and London Focus Group could not stay for the session, but wanted to contribute. They volunteered to take a Self Completion Questionnaire with them and posted them back to me at a later date.

Figure 3: 6   A 'SWOB' analysis: rationale for choosing to undertake focus groups

Strengths and weaknesses

Strengths

- methodologically rigorous, especially for this sort of specialist subject matter
- encourages group support and triggers memories for similar / shared professional experiences, with minimal researcher prompts
- easy to run for time and space e.g. travelling to various sites across England
- clearly helps participants explore personal /sexual health learning trajectory
- safety in shared / sharing experiences
- prior skill and careful leadership / management, to ensure the focus group would not be taken over by vociferous / experienced minority
- 'insider-researcher' role clarification: this had clear spelling out in writing and during the sessions, and proved not to be a problem.

Weaknesses

- shortage of time, if the main programme ran late
- not wishing to probe into the explicitly personal, therefore, potentially having less intensity of data compared to one-to-one personal interviews
- juggling probes to bring out knowledge without putting words in their mouths / suggesting ideas they hadn't thought of (this was the researcher's personal contract with subjects, of not forcing anyone to say anything if they chose not to, whilst gently supporting and encouraging 'silent' members - *a strength*)
- no power to do anything about little or no response by quiet individuals.

Figure 3: 6   A 'SWOB' analysis: rationale for choosing to undertake focus groups

Opportunities and Barriers

Opportunities

- enthusiastic 'captive' audience, in that they were already *in situ* with me, (researcher), present at the venue in another capacity (course manager)
- ideal respondent group, in that they personally chose to do something positive about their sexual health learning, after realising there was a gap between what they knew and the demands of current clinical practice
- opportunity for respondents to 'have a voice' and contribute to the wider debate of sexual health learning for current and future professional colleagues
- opportunity for them to 'tell their stories', some personally revelationary, some were cathartic, and one of the first or only opportunities (ever, for some of them) to share such personal reflections and insights publically
- opportunity to positively assist fellow students e.g. by allowing the re-telling of their stories in this thesis, and placing their stories within the wider discourses and publications of nursing education and policy.

Barriers

- time shortage; some groups were only about 40 minutes due to late running of the Away Day programme and my written promise to finish at a set time
- intrapersonal barriers to speaking publically about sexual health / learning, even in a safe educational forum and 'quiet people' not wishing to speak out
- interpersonal difficulties negotiating equal, individual time for voicing
- cultural perceptions of what are appropriate sexual health topics to consider with patients (most participants still did not 'push the boat out' and to talk of 'non-clinical' issues such as masturbation and other elements of the *ars erotica*
- complaints of lack of organisational time with patients: sometimes this might be an excuse not to address issues or leave it to clients to bring up first.

Despite the research literature extolling the benefits of individual face-to-face in-depth interviews, I chose not to go down that route. My reasons for this decision were fourfold: firstly, because the process would have been impossible to do with so many respondents, especially over such diverse venues across England. Secondly, it would also have been too time and resource expensive. Thirdly, with prior knowledge from conducting individual qualitative data interviews for my Master of Philosophy degree, I concluded

that there was no real need for individual interviews because the proposed questions in this study were not intended to be overly personal. Finally, individual interviews would also lack peer encouragement and support, a benefit which the focus groups clearly offered in this study.

Conclusion

The three themes of the Methods chapter have laid the foundations for the Sexualities & Gender Epistemologies (S&GE) that underscore the whole of this study. They include the ethical standpoint regarding my role, as researcher, right through to the specific choice of methodologies and methods. The Sexualities and Gender Epistemologies 'crystallise' relevant theories, through a Foucauldian lens, so to speak, that enables the practice of this research to discursively engage with the power / knowledge of sexual health 'silences', those often socially and clinically invisibilised needs of clients in relation to the provision of nurse education.

Chapters 4 and 5 will present a selection of the data from the three elements of the empirical study. I will do this by means of an analysis of discourses influenced by pertinent sexualities and gender epistemologies, as outlined hitherto in this work, using methods broadly associated with a Foucauldian methodology. Chapter 4, in particular, will contextualise the respondents' discourses in a detailed exposé of Foucauldian terms as used through the remainder of this thesis.

Chapter 4

<u>DATA ANALYSIS AND DISCUSSION</u> (1)

Listening with Foucault

to the participants' 'voices'

DATA ANALYSIS AND DISCUSSION (1)

Listening with Foucault to the participants' 'Voices'

Chapter 4 thematic outline

- ➢ Applying Foucauldian concepts to contextualise the respondents' discourses: The History of Sexuality
- ➢ Foucault's 'tool box':
- ➢ Discourse analysis
- ➢ Power / Knowledge and governmentality
- ➢ Genealogy, stigma and Foucault's 'triple edict'
- ➢ Conclusion

Introduction

Rather than a traditional presentation of research results followed by analytical interpretation and discussion, chapters 4 and 5 will be a combination, a mixing and matching of each of these elements to the study. Chapter 4 starts with a clarification of Foucauldian concepts and shows how the data are interpreted in light of them. Chapter 5 starts the other way around: with the data – from the six discussion points of the Focus Groups – and then interprets the responses in light of the theories. Chapter 4 is fundamentally an in-depth exposé of Foucauldian methods as utilised throughout this thesis. It forms a framework for the substantive analysis and discussion of data collected throughout the empirical elements of this study, grounding the respondents' discourses in pertinent aspects of Foucauldian theory. Chapter 5 then continues with a further analysis and discussion of data, but takes, as its starting point, personal responses of the study's participants and explains them in light of Foucault.

The interrelationship between the data gathered for this work and the Foucauldian theories and 'tools' employed here highlights numerous tautological nuances - similar and dissimilar - for understanding Foucault's meanings. These nuances can vary between Foucauldian authors as well as within the philosopher himself (O'Farrell 2005). Indeed, Hayter (2007: 361) views this as

> "one of the challenges of conducting a Foucauldian discourse analysis [in that] Foucault never clearly articulates how to proceed with an analysis of data generated from empirical studies [but provides] the broader and more abstract explanatory frameworks".

Building a glossary

On the explicit recommendations of my supervisors, I started to develop a glossary of Foucauldian terms; the biggest difficulty was keeping it brief. As I constructed the extended glossary after I had carried out the empirical studies, the pages evolved more like a larger exposé of theoretical terms which appeared to clarify and conceptualise what I read out of the various data: it all seemed to make sense. To assist analysis and category clarification, I built up a colour-coded framework of the concepts and tools used and applied this to the individual data sets. The colours are not significant in themselves. It is important to state that it was often impossible to code the data within just one concept or methodological tool. Most of the data relate to at least two concepts or tools, for example between 'power / knowledge' and governmentality, or genealogy and discontinuity; the use of these terms will become clear below.

Sometimes Foucauldian authors represent the same or similar words for the same, modified, or even different concepts. Prime examples include the shifts in thinking from 'archaeology' to 'genealogy'; the difference being from neutral theory in the former to the inclusion of "power and real practical struggles" (O'Farrell 2005: 64) in the latter. Another shift is 'episteme' to *'dispositif'* (translated as 'apparatus'). *Dispositif* developed out of episteme to include wider social influences and powers, including structures constructed by ethico-moral, legal, built environment and philosophical 'regimes of truth'. One example of this is found in the confusion experienced by some healthcare staff with transgender people attending GU clinics. The options of the service may be exclusively either 'male' or 'female' for clinic sessions as well as gender-specific waiting areas, instruments, and even male or female coloured note sets. For the sake of clarity, it is beneficial, therefore, to explore the terms used throughout this thesis and present them in a discursive, relational, way with the data gathered for this project. It is also desirable to situate the concepts into the wider arena of sexual health learning. The aims of the process in this chapter are therefore to:

1) analyse the data for sexual health learning and professional education with relevant Foucauldian concepts

2) engage with specific authors, using their works to illuminate the theory in relation to sexual health professional education and practice (a request from my supervisors)

3) synthesise the implications of the discourses and analysis, specifically to complete the overall aims of this research project, and

4) make full use of the literature I have reviewed, by or on Michel Foucault, in relation to the analysis, discussion, and implications for professional educational practice interpreted out of this thesis' findings.

<u>Foucault's History of Sexuality</u>

In volume 1 of the <u>History of Sexuality</u> Michel Foucault (1984) provides a number of key concepts relevant to this thesis. They include terms that Foucault developed, adapted, and sometimes changed over his life time. The main ones used in this thesis relate together well with the subject matter of professional sexual health education for nurses. Using the colours I employed to ease manual coding, they include: **discourse analysis** (DA); **episteme**; **genealogy**; *ars erotica* and *scientia sexualis*; **power / knowledge**; **governmentality** and stigma in the guise of the **"triple edict of taboo, non-existence and silence"**. I will demonstrate throughout this chapter, as I have in chapter 1 for the terms *ars erotica* and *scientia sexualis*, the ways in which the concepts will be customised, synthesised, and / or inter-related within this work, according to Foucault's own desires that his works be used as a "tool box" of skills for greater understanding of life (Danaher *et al.* 2000). Although I colour coded the entire transcribed data sets, I will only display a limited example in colour here, to alert the reader to how I reached these interpretive decisions. The remainder is clarified in the associated textual discussions.

Here is an example of how I analysed the cross-over in the data between some of these concepts and tools. The following discursive *vignette* shows 1)

evidence of all three aspects of the *triple edict:* taboo, non-existence and silence; 2) various power / knowledge 'games' played out, including resistance; 3) the construction of an orthodoxy of truth and practice with counter-practice, and 4) the pollution and contagion *dispositif* so 'beloved' (*sic*) in early HIV client care (Sontag 1991; Hodgson 2003).

Conceptual coding key   ***for this section***
Triple edict taboo / non-existence / silence and / or stigma
Discourse analysis
Power / Knowledge
Governmentality

FG08 / P04 The other thing in midwifery [... 1994] was the first time I'd seen people um … who had um … HIV and AIDS who were giving birth and stuff, um … and um … I remember a lady who had herpes and was going to have a Caesarean. So an actual sexually transmitted disease which was affecting um … births of children.

Me: Yeah? And how was that dealt with, with your colleagues?

FG08 / P04 Well the lady who um … who had herpes that was just … that seemed to be you know, that was just par for the course, but the um … the hospital that I worked in, there was quite um … a high um … population of people from sort of Central Africa and Southern Africa so there was … it was not uncommon um … to have people who were pregnant and who had HIV. But they were always nursed in a side room, and always had um … barrier nursing in a side room which um … I suppose now would probably be wrong.

[Although I have changed the categorisation in the dialogue above to reflect the imposition of a professional power / knowledge of healthcare staff in relation to the process of isolating and excluding this woman, the coding could equally have remained as the triple edict for its stigmatising 'hiddenness' (enforced concealability) of the individual, taboo of the condition and non-existence of the hidden-away patient. With her situation

'swept under the carpet', she is subsequently shrouded in silence]. The vignette continues:

Me: And can you remember the rationale for that?

FG08 / P04 Because they were infectious! [Okay?] That's really how they were treated, and I remember that um … nurses not spending any time in with them at all and it was relatives who came to sit with them. But people didn't really spend time with them.

Me: And again, any talk amongst the staff, you know, were people trying to learn about it?

FG08 / P04 No! No! It was just … *that's what she's got* ... it wasn't up to me. I wanted to learn a bit more about it, find out a bit more about it [Yeah?] but it de-humanised her completely!

Me: And what sort of attitude? Was it that people were segregated or putting people into isolation wards: were they doing that because of Infection Control procedures or could there have been something else going on as well?

FG08 / P04 I think similar to your experience there is *more* than infection control! It was like, well that's um … although it was a sexually transmitted disease it wasn't treated as an *infectious* disease and … it was quite sad really. Badly handled!

Me: Right. The thing I'm trying to get to then: is there something underlying that as well, could there be sort of moral judgments going on?

FG08 / P04 I would say so! Looking at it from the point of view as an innocent student nurse, I would have said there was a bit of a moral judgment there. Just thinking back, I mean, you know with hindsight it's very different, but thinking back just some of the comments that came out at the time. Yeah. It's judgmental and very unhelpful towards her as a patient; very cutting of the trained staff.

[There are a number of occasions when the 'ethos of governance' includes not just an active surveillance and policing of others – which can then be internalised by the individual – but a punitive regime, too; a regulation, for example, of their freedom and equal treatment in healthcare, based on the moral or negative (pre-)judgements of their presenting clinical condition. The histories of people living with AIDS, in the very early days of the 1980s, are full of similar stories].

Me: And what sort of impact did that have on you as a learner at that time?

FG08 / P04 I think it's quite powerful because you try not to get drawn into that but it's very difficult when you're in a learning environment that you know … Its very different now, I think, when you are training, to what it was when I was training. You couldn't have too much of an opinion; if you were too opinionated it didn't do you any favours! [Uh huh] But I like to think that I *did* spend quite a bit of time with her, treated her as a person, gave her the respect and dignity that she deserved *and expected* really.

These scenarios are evocative of Lawler's (1991: 15) quest to understand "the nature of the nurse-patient relationship and the 'manner' of the nurse [which is] central to the management of the body and its various functions, embarrassment, and the patient's sense of vulnerability". This is particularly apt in the categorisation of the final sentence above. Through the *in situ* probing and analysis of the discourses, and a constant questioning, the result demonstrates a discourse of 'good' i.e. ethically beneficent nursing practice.

Embarrassed perturbations

Two other comments worth highlighting about the data in general include, firstly, the number of perturbations and hesitations in speech. Perturbations are represented in the text variously as: "urm ... ummm ... urrrr ..." or just micro-second delays, represented by "...". Hesitations and 'stammering' or floundering in disjointed sentences are reported *verbatim*. Both of these phenomena are perceptible, throughout, as respondents 'build up to' saying something difficult, embarrassing or uncomfortable. Psychological counsellors have long attested to these traits of speech. As Peräkylä and Silverman (1991) and Silverman (1994) remarked in relation to sex or

discrediting illness talk in HIV counselling, for example, these perturbations and hesitations are classic identifiers of people being cautious not to offend a 'professional' and often require skilled learning of professionals to handle in a sensitive, therapeutic, manner. Perturbations might equally represent a searching for language which the individual may not routinely use in 'polite' circles; or they might point to something which the individual otherwise finds difficult in expressing to others. This difficult speech is akin to Lawler (1991: 89) ascribing certain words, topics or bodily functions as "vulgar". Perturbations and hesitations can provide significant psychological insights into wider discursive transactions, too; these might include nervous or embarrassed body language. However, such analysis falls outside the scope and practice of this current methodology.

Real people

The second point relates to the extract from **FG08 / P04** when she said:

> Because they [HIV+ pregnant women on a maternity ward] were infectious!

Notice how the respondent categorises the difference between nursing staff (professionals) and a patient's significant others ('lay' people):

> That's really how they were treated [infectious], and I remember that um … nurses not spending any time in with them at all and it was relatives who came to sit with them. But people didn't really spend time with them.

It appears she is bemoaning the fact that the professionals, the nurses, who should understand the modes of transmission of various pathogens and subsequently how to prevent spread through accurate infection control policies, such as Universal Precautions, do not spend time with these

patients. Significantly, this is attributed to fears of contagion. Therefore, only the relatives (non-healthcare professionals / 'lay' people) spend time with them. It sounds as though the respondent is saying that only nurses are 'real' people and that the relatives do not count as such. This is wholly contrary to the acceptance and empathy Hodgson (2006: 287) found in carers who opt to work with HIV+ individuals, and who work almost exclusively with HIV+ people, when he noticed how

> "there is a strong suggestion that carers identify with those infected with HIV: there is no quantitative space between their own behaviour, and those of their clients."

Using Foucault's toolbox: starting with Discourse Analysis

Foucauldian Discourse Analysis (DA) is the most significant concept used in this thesis to examine the discourses on sexual health learning, both from the literature reviewed in chapter 2 and throughout, and in the various empirical data gathered. Mills (2002) and Stevenson (2004) outline particular understandings for the term *discourse analysis*, with Danaher *et al.* (2000: 31) conveniently defining discourse itself as "language in action". The following *vignettes* are a brief exploration into DA from the perspective of 'language in action':

> **FG15 / P18**: My clinical environment is pædiatrics obviously, yeah? And 20% of my client group are adolescents, but sexual health is not mentioned at all in relation to that. When I spoke to the psychologist about it she said "I have never been asked about this before!" but within a few days she was back to me saying she had thought a lot about what I had said and she discussed it with her colleagues and they are now investigating a research programme on the sexual health of young people and their needs!

My essay paper, you see, is on sexuality and cranio-facial anomalies, and there is very little research out there, so that's where she's going to focus, you know, on children who have difficulties facing life for these different reasons. It'll be interesting to see what comes out of this!

Me: Yeah? And when you said "cranio-facial anomalies", urm that captures what [Participant] Number 10 mentions about stigma, for example, thinking of any disabilities ... thinking of anything which causes disfigurement and something visible on the face - automatically people will look there - and that can be a stigmatising condition in itself.

An analysis within the text of Participant 18 (**FG15**) clearly elaborates a number of discourses and concepts, all interrelating simultaneously. These include power / knowledge in the development of her learning and its application through multi-professional practice. There are also socio-sexual discourses on the transitional nature of child-to-adulthood through the period of adolescence and the *angst* that typically attends teenage identity-in-the-making. This is compounded, within the example, by the stigmatising visibility of cranio-facial disfigurement (Mason *et al.,* 2001) and the contrary invisibility of awareness of these issues by a professional discipline (child psychologists), akin to Lawler's (1990: 166) description of "minifisms", i.e. the process by which professionals minimise the significance of that which they find embarrassing. Finally, there is the "language in action-*ness*" by which this nurse gets something done through raising this issue, not simply for her own learning development but for her clients' improved care: she has 'woken up' another professional group that one might (mistakenly, here) have assumed would be 'on the ball' about this sort of stigma and its ramifications on a teenage girl.

There is clear evidence in this *vignette* of "taboo, non-existence and silence" in the various professional discourses around adolescents as sexual persons and the well-being of stigmatised individuals similar to that which frequently accompanies disabled people (Sherry 2004). This could equally demonstrate a "policing of desires" (a term used in the title of a book by Watney 1993) under the generalised powers and procedures of governmentality.

Returning to the general practice of DA, it originated with a micro-level exploration of particular types of texts by semiologist Ferdinand de Saussure (1877 - 1913). Mills (2002), Stevenson (2004) and others such as Graham (2005), O'Farrell (2005), Starks and Trinidad (2007), explore the method from a later, more post-structuralist perspective. They generally portray a convergence of heterogeneous methodological concepts into two main categories: those of *radical social constructionist discourse* and the other, *critical Foucauldian*. The 'critical' element "is geared towards a counter-reading of historical and social conditions and offers possibilities for social critique and renewal" (McHoul and Grace 1995: 27), as evidenced in the *vignette* (**FG15 / P18**) above. As Mills (2002: 15) claims, "[d]iscourses structure both sense of reality and our notion of our own identity". A further extract from Participant 18 demonstrates this well:

> **FG15 / P18** [...] going back to pædiatrics: I think that no one has really thought about sexuality and adolescence. I can see where they're coming from, but I would have thought that psychologists would have dealt with it or thought about it, at least *try* to. I was actually asking them about pædiatric training and it is only in the next group that they are introducing HIV in pædiatrics! They have never brought it up before! *You know what I mean?* These are conditions that children have and have even been born with; we are even looking after HIV patients!

Me: And they've never done anything on it?

FG15 / P18 They've never done any formal learning!

Me: And when you think of pædiatric nurses and psychologists, and looking at the stages of life and growth and development, you would have thought that sexual health would have come in at some point?!

DA: "our sense of reality and our notion of our own identity"

In many cultures and societies identity and reality are epitomised in the discourses of dominant regimes which win at being heard and accepted as orthodoxy. This relationship of winners and losers sees the subjugated and their discourses consequently categorised as heretics and heresy, respectively (Lee *et al.* 2008). Orthodoxy can only exist as such in relation to challenges that claim its reality as otherwise. Take, for example, the ways in which 'orthodoxy' around HIV infection clearly accepts it as the causative organism for the development of AIDS. Contrary discourses are trivialised and dismissed as being unscientific and ill-informed; their proponents are derogatively labelled "AIDS dissidents" (Youde 2005). This is especially so by elements in the 'powerful' pharmaceutical industries, which produce the lucrative anti-retroviral (ARV) medications upon which the HIV → AIDS link is imperative (Butler 2005).

Applying Foucault's DA to nursing research

Stevenson (2004) contends that nursing research which perceives Foucauldian DA as irrelevant, by treating it as overly fixated on the symbolic understanding of that which is 'spoken, written or acted' more than on the bodily experiences involved in nursing care, is misconceived. Indeed, Lawler (1991: 61) explains how Foucault argued that "the body is the point of

reference for processes of social control". Stevenson (2004) clearly views Foucauldian DA as beneficial, in that it explores various genealogies and constitutive power / knowledge regimes around the very subject of the body. Such regimes include (self-) surveillance and confession (Pryce 2000) as contributory elements of a wider 'ethos' of governmentality (Van Loon 2008: 49). Crowe (2005) agrees with its benefits to nursing research, and subsequently encourages DA's wider use. Just as sexual health and the body are intimately entwined, I demonstrate within this thesis a clear role for the theoretical approach used, acknowledging what Foucault said in interview that

> "sexuality, through becoming an object of analysis and concern, surveillance and control, engenders at the same time an intensification of each individual's desire, for, in and over his *[sic]* body."
>
> (Gordon 1980: 56-57)

"Discourse analysis is an interpretive process [which] acknowledges the multiple interpretations that can emerge from the text" (Crowe 2005: 61). In Foucauldian terms, however, a key understanding of discourse goes further than this, and views it as a 'body of knowledge'. This is akin to an academic discipline such as medicine and epidemiology, i.e. a medical discourse; sexology and sexual health would, in effect, be subsidiary discursive disciplines. Each discourse, discipline, or body of knowledge is constructed in a dynamic power relation with society, cultures, history and the power / knowledge that constitute the discourse's *disciplinary practices.* The latter are "forms of social control and social possibility" (McHoul and Grace 1995: 26), which give rise to the understanding of self and ways in which this

understanding is both enabled and constrained to challenge that which can be said. Stevenson (2004) explains that as the methods of discourse analysis are fluid and eclectic, there is no reason why specific areas of being relevant to nursing - like Lawler's (1991) "nosology" for the body, or a person's mental life or spiritual life etc. - should not form a discursive domain of inquiry. This thesis clearly addresses issues concerning the corporeality or physicality of the body, as well as the full meanings in the post-Foucauldian notions of the performativity of sex. By way of example, the following data discourse accentuates the *triple edict* around older people and sex, with evidence of the *ars erotica* transposed through to *scientia sexualis* (on erectile dysfunction), and power / knowledge or governmentality *policing desire* (condoms) to support an institutionalised 'apparatus for control'.

Conceptual coding key   *for this section*
Triple edict taboo / non-existence / silence and / or stigma
Ars erotica / *scientia sexualis*
Power / Knowledge
Governmentality

FG01 / P20 Urm, I think probably for me the one thing that hasn't changed [after successfully completing this RCN course] is that I will still probably find it difficult to talk to elderly people about their sexual health, sexuality and sexual activity, because ... I don't know why? It's just ... I don't know ... I don't know [group laugh].

FG03 / P30 I have always been a district nurse, I've always been adult trained and I haven't had the experience of having to talk to the elderly when it comes to sexual relationships because they will never talk about it. It's an issue that was always swept under the carpet and suddenly I have started working with children who are sort of now becoming very sexually active and very street wise.

FG06 / P27 I think it's a travesty in this country that there seems to be an emphasis only on young people and sex and urm there's no emphasis on sexual health and older people. You know, there's sexuality issues that could be addressed, but there's so much embarrassment that people don't like to discuss it, and nobody asks the questions!

FG06 / P22 I have already people who get erectile dysfunction because of their medications and they don't like to talk about their sexual problems because the way they get them, they don't like to speak about them.

FG06 / P19 Also we see more and more people who are divorced or separated and actually they think there is no need for contraception, you know, because someone has been with her husband several years and no need for contraception at all and now, but with new relationships and things like sexual infections!

FG05 / P05 Yet something I do particularly watch is urm postmenopausal women, because I do a lot of cytology screening. Postmenopausal women find it quite uncomfortable and they also find that sexual relations with a partner would be uncomfortable. So I broach the subject with them, and you can almost hear the actual relief that somebody's mentioned this to them! "Somebody is asking me about it!" they think. It isn't up to them and there are things that can be done about this.

Me: Why do you think they don't like to talk about it?

FG05 / P05 Urm, because the women who are menopausal women, when they urm, in their upbringing sexual health was never talked about openly and urm they just assume that it's part of growing old and, you know, they shouldn't really be having sex when they're this age anyway,

Me: and this taps into exactly what number 10 was saying, about ...

FG05 / P05 yes ... urm, so it is usually their embarrassment rather than being uncomfortable.

FG08 / P10 There is an issue on financing in that we have older ladies who were in their fifties coming in who didn't need [condoms] for contraception but needed them for infection. And there was a big dispute within the department because the manager said we weren't able to give them condoms because they weren't needed for contraception! And yet we were supposed to be a contraception *and* sexual health clinic!

148

And so in fact what tends to happen is that we would give them out to any age, we just don't tell anyone we are doing it. But that was a very definite no, we only have a certain amount of condoms and they have to be for young people not older people.

FG08 / P10 Well we thought they were quite sensible, they came in … and as kind of two or three would come in and then other friends would come in, we had quite a group of ladies who were that little bit older, in their fifties, wanting to protect themselves and the management said no.

Participant 10 in Focus Group 08 was not the only one to express concerns over condom availability for the prevention of sexual infections. In Focus Group 16, **P03** gave evidence of the aspects of Foucault's *triple edict* as well as a policing of desire in the form of an ethos of governance:

FG16 / P03 As we've kind of mentioned before the big issue that we have is that … is the um … is that we're not allowed to distribute condoms. Um … and yet … and yet we are affiliated to a GP who does surgeries three times a week and therefore he prescribes the contraceptive … or the oral contraceptive and if needed we have emergency contraception, and yet we are not allowed to distribute condoms um … to our clients. And I mean I think it's … um … I think it's because of the ostrich approach, I think they bury their head in the sand because they think it's not happening. There's um … some poor arguments that are put up which is that they think that if we were in a position where we did offer condoms we would have them queuing at the door to collect them which I think anybody knows is not going to be the case, you know? If they are brave enough to come to us to ask for condoms, you know, we are not going to have them queuing up in their hundreds collecting them! But that's probably our biggest failure at the moment we have.

What others say

In a discursive analysis of narratives, Chambers and Narayanasamy (2007) uncovered how their study's nursing respondents "construct[ed] health and enact[ed] their health education practices". This is an important point in this current thesis, for professional education, the way that nurses – as part of the

149

'lay' world – bring such lay beliefs, social representations and judgements into the domain of health promotion strategies and clinical practice. Chambers and Narayanasamy (2007) highlight a crucial point with the role of 'risk theory' in contemporary health promotion discourses. The point is significant in lay perceptions of sexual health. This is especially true concerning the HIV pandemic and is associated with personal agency and a cognitive ability to 'choose' between healthy and 'ill-healthy' behaviours, with the subsequent imposition of guilt on the latter. However, such lay - and even professional - belief systems often disregard the "hegemonic assumptions" (Poole 1999) initially constructing and maintaining these beliefs. These belief systems frequently operate in binary oppositions: "licit and illicit, permitted and forbidden" (Foucault 1984: 83), but it is such dyadic polarisation that Foucault's methods strenuously challenge. Related to sexual health, many of these dyads to be challenged include, significantly:

Normal: *versus*   **Abnormal**:

normalising and normalised   deviant; pathological

= *good / socially acceptable*   = *personally culpable*

                                         or blameworthy.

One need only think of the UK Government's HIV television campaign of the early 1990s (referred to in chapter 1), with its slogan "AIDS: you know the risks - the decision is yours!" (Wellings and Field 1996: 93). Such messages are emblematic, Chambers and Narayanasamy (2007: 157) argue, of medical discourses which "present illness as the organic pathology of individual patients". Resonating with the techniques used in this thesis, Chambers and Narayanasamy (2007: 158) examined the respondents' scripts for "regularity and variability of patterns, use of rhetoric, adoption of

subject positions, resistance and acceptance of dominant discourses" with contradictory discourses represented as the "variability". It is argued that the greatest variability on responses in this thesis are in the exceptionally small number of participants who could actually identify any formal education on matters pertaining to sexual health in the curriculum, in contrast with the overwhelming majority who expressed none of note or importance. Chambers and Narayanasamy's (2007) respondents were 12 newly qualified nurses, all of whom projected a professional health promotion *persona* to their clients and colleagues but underneath maintained an earlier lay belief system equally socially constructed. For example, one respondent said "if something is proving to be bad for you, unless you are prepared to face the consequences, then I believe you should not do it. It's as simple as that!" (Chambers and Narayanasamy 2007: 158). This response is similar to that of the medical students recounted by Jayasuriya and Dennick (2011: 101) that "some students felt that they should discourage activity that they believed was 'inappropriate'". Such personal and 'professional' attitudes penetrate current discourses on the self-governance of personal risk, and as Pryce (2001: 161) affirms, are emblematic of "[t]hese neo-liberal consumerist pressures [which] reinforce the message that the individual must engage in educated calculations that direct and control their sexual health and responsibilities".

Extending the remit of care

A contrary, more inclusive / approving example, was demonstrated by one participant who considered the difficult situation of not only dealing with problems faced by her clients but on their former partners, too.

151

FG16 / P04 Um … one of the things that … the fact that there seems to be quite a bit of support now thankfully for people who do want to come out as gay / bisexual / lesbian but there is no support for if they have been in a heterosexual relationship up to that point; there is no support whatsoever for the person that they leave behind, their straight spouse. Um … and … that then pushes that person into a closet whether they want to or not, they then … face the same issues that um … their gay partner has had to face with coming out. They are facing the same issues and I think that's something that's completely ignored by the healthcare service and social services as well.

Me: Yeah? And in your practice do you find that that comes out in particular ways?

FG16 / P04 Well um … it's just something that I'm tentatively trying out at the moment, but I have had people um … uh … we have a needle exchange client at the moment who has started drinking again and it turns out that his drinking has been exacerbated recently by the fact that his ex-girlfriend has just moved in with another woman. And um … so yeah I think there is an issue there, it certainly is an issue, there are people there but they're too frightened … too embarrassed to actually approach anybody because it's something not discussed, not really accepted.

The limits of language

The *vignette* above epitomises the key aspects of a personal construction, awareness and belief system which bring meaning, the ability (or not) to 'be' in the world and to relate to others. In fact, "discourse analysis assumes that language constructs how we think about and experience ourselves and our relationships with others" (Crowe 2005: 56). In many ways, DA is epitomised by the title of Anthony Grey's (1993) classic monograph <u>Speaking of sex – the limits of language</u>, with Foucault's methods clearly adept at analysing such limits. As Crowe elaborates, discourses, like speaking of sex - and the limits of its language - are instrumental in the construction of how subjects 'are' in their world, their ontology or being. Equally, discourses clarify how subjects 'relate to others', and finally how subjects 'make meaning of their

world', with their knowledge and associated power, understanding and belief systems. It is thus that discourse analysis provides the numerous contextual meanings of language (Crowe 2005).

Subsidiary terms and concepts within Discourse Analysis

Discursive formations

Discursive formations, or an equivalent term, 'systems of thought' (McHoul and Grace 1995: 11), refers to the multiple influences that configure a specific discourse or discipline. A prime example is the conflicting discourses on 'teenage pregnancy' between the United Kingdom and other resource-rich and western countries compared with 'developing' and resource-poor nations. In many of the former countries, teenage pregnancy is problematised when people are not getting married in the same numbers as they did in a certain past, often treated as a mythical 'golden age' e.g. of family life and morals. Teenage pregnancy is also problematised where marriage is viewed as something for slightly older people, in those who have already 'achieved' some of their 'ambitions' in life. Conversely, in many developing countries and cultures, most people get married in their teenage years and the woman's role in life is essentially dependent on the 'procreation and education' of children. This is despite some recent trends against this – such as for the alleviation of young girls' suffering from early pregnancies and the perpetuation of familial poverty (DCSF 2007). Early teenage marriage and pregnancy are also more endemic in hegemonic communities, the world over, with their higher incidence of traditional hyper-masculinised and patriarchal systems of domination, which tend to be

culturally and religiously conservative and resource-poor in all senses including in the schooling and education of females (Her Majesty's Government 2009). There were no significant data, from the empirical research, correlating to this example.

A "Vergegnung" – a "miss-meeting"[1] : failing to reconcile cases with courses

Under the aegis of such 'systems of thought' or discursive formations, i.e. the constructed ways in which we think about things, this is an appropriate place in which to explore some of the empirical data collected from the postal surveys to teachers of sexual health in some of England's HEIs.

Answers to numerous questions on the availability of courses provided by the respondents are juxtaposed on to regional maps of England. The maps show the corresponding nurse educational courses dealing with particular epidemiological reports of teenage pregnancy (Figure 4: 1a, b), sexual infections (Figure 4: 2a, b) and HIV infection (Figure 4: 3a, b).

---

[1] The German noun *Vergegnung* and its clumsy English translation as "miss-meeting" was coined by the existentialist Martin Buber (1878 – 1965). I first explored its use in my Bachelor degree dissertation in theology (University of Kent at Canterbury: 1985). It seems appropriate to reapply its meaning here. *This is another example of how the author can bring years of collective professional experience, across a number of disciplines, to bear on the gravitas of this current professional project.*

Figure 4: 1a Teenage conceptions *per* **1,000** [2],[3]
rated numerically from highest to lowest

Map publically available at www.cppe.man.ac.uk, adapted by DTE
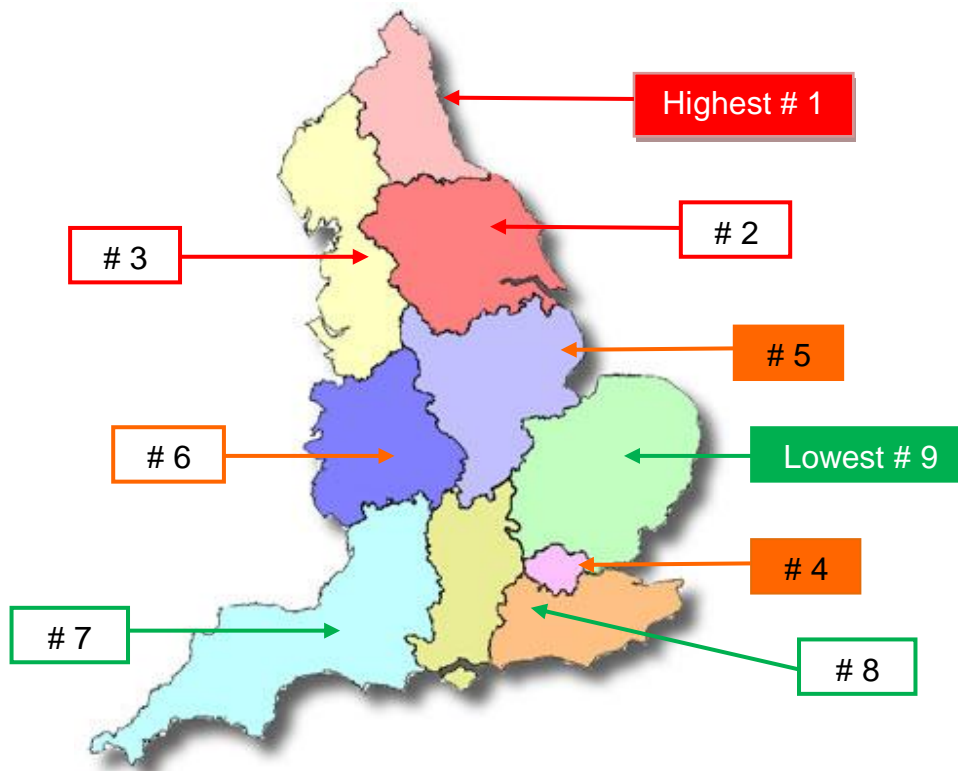
As the data were not 100% of all courses provided across England, for example, due to the return response rate of the questionnaires, the maps can be supplemented further with courses advertised on the Genito Urinary Nurses' Association website (Appendix 6). Figure 4: 4 shows additional miscellaneous courses listed by some HEI-Survey Respondents, whilst 4: 5 completes the presentation of this data with a table of the HEI Respondents reporting "full academic awards" in sexual health. It is worth emphasising once again, that a significant number of respondents in this study mention particularly poor or detrimental learning experiences around abortion care, usually whilst working (as students) on gynæcology wards. Figure 4: 1b is

---

[2] Data kindly supplied to me by Alison Hadley OBE, Manager, Teenage Pregnancy Unit, Department for Education, December 2010.
[3] The TPU uses a different categorisation for regions to the 10 StHAs shown here, in that there is no "South Central" or "South East Coast" regions. Statistics for these are distributed predominantly in those for the "South East".

witness to the fact that almost one in two teenage conceptions, and around 2:3 in London, end in legally permitted abortion. None of the HEI courses listed below (or on GUNA: Appendix 6) are devoted to abortion care whatsoever. Courses marked with * are Contraception and Sexual Health (C&SH) and therefore, potentially, double up for Figure 4: 2b.

Figure 4: 1b Teenage conceptions *per* 1,000 females correlated with relevant courses, listed by HEI-S Respondent

Region for teenage conceptions	Conceptions rate *per* 1,000	Abortion percent	Relevant HEI courses
North East	49.0	45	1 Foundation in S&RSH 2 Practical aspects of S&RH
Yorkshire & The Humber	47.3	44	*No courses listed*
North West	45.8	49	1 Uni Cert foundation in contraception 2 Family Planning Update
{London	44.6	*61*	1 C&RSH 2 Adv Dip in Contraception & Women's Screening 3 Contraception 4 Foundations in FP & RSH 5 Discussing sexual health & contraception 6 C&RH 7 Delivering SH & contraceptive care **8 Theories of C&SH***
{West Midlands	44.6	*48*	1 Uni Cert Foundation in FP 2 Uni Adv Cert Developing skills in R&SH care (Clinical competencies attached) 3 Contraception Care 4 Foundations in RH 5 Contraception 6 Practice of contraceptive care **7 Developing theory in C&SH*** **8 C&SH *** **9 Clinical practice in C&SH ***
East Midlands	39.6	46	*No courses listed*
South West	34.9	51	1 Practice of contraceptive & sexual health

South East (& Central)	33	51	1 Developing Skills in C&RSH Care 2 C&RH

East of England	31.4	49	1 Some non clinical courses
			    (eg FP Appreciation)
			    open to social workers
			2 Issues in C&RSH
			3 Practice in C&RSH
			4 FP Appreciation
			5 Update days in SH & FP
			6 Re-skilling in contraception

Figure 4: 2a Sexual infections (excluding HIV) recorded by the Health Protection Agency, 2009

rated numerically from highest to lowest
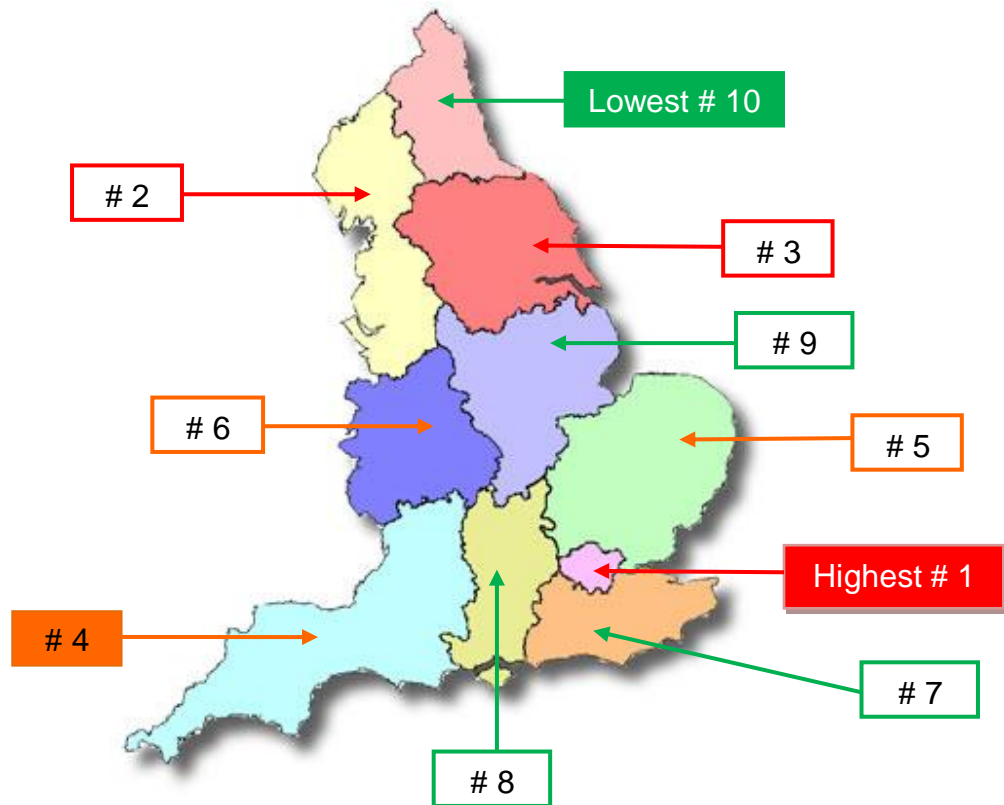
Figure 4: 2b Sexual infections (excluding HIV) recorded by the Health Protection Agency, 2009, correlated with appropriate courses, listed by HEI-S respondents for the individual universities

Highest to lowest Region	Sexual infections (SHA of residence) 2009	Relevant HEI courses
London	12,469	1 STI module 2 Sexual infections 3 Introduction to STIs 4 Exploring STIs
North West	11,691	1 Sexual Health and STIs
Yorkshire & The Humber	7,012	*No courses listed*
South West	6,908	*No courses listed*
East of England	6,762	
West Midlands	6,495	1 Skills for SH care 2 University Advanced Certificate Developing Skills in the treatment and management of STIs (with clinical competencies attached 3 Sexual Health 4 Into to HIV & STIs 5 Practice of sexual health care 6 The management of sexual disease in society 7 STIs
South East Coast	5,950	Developing the clinical expertise of nurses in sexual health
South Central	5,465	*No courses listed*
East Midlands	5,441	*No courses listed*
North East	4,446	1 Sexual Health module 2 Focus on Sexual Health

Data from the Health Protection Agency, at www.hpa.org.uk cited on 31.01.11: **Number of quarterly GUMCAD clinical submissions ... by clinic SHA, 2009**

Figure 4: 3a Regional distribution of people living with HIV by SHAs (2009)

rated numerically from highest to lowest, HPA statistics
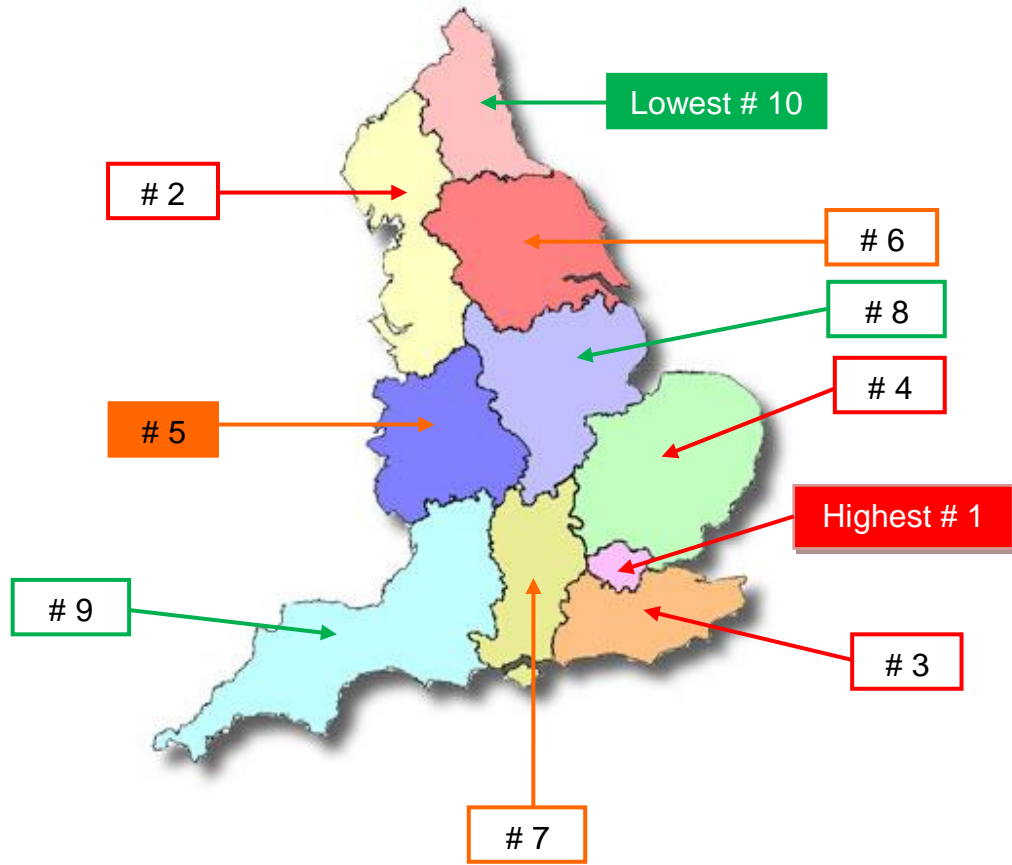
Figure 4: 3b Regional distribution of people living with HIV in SHAs (2009) correlated with appropriate courses, listed by HEI-S respondents for the individual universities

Highest to lowest Region	HIV infections (SHA of residence) 2009	Relevant HEI courses
London	28,285	1 HIV Module 2 HIV 3 Current issues in HIV 4 Introduction to care & management of individuals with HIV disease 5 Care of people with HIV and AIDS
North West	5,957	*No courses listed*
South East Coast	4,207	1 Care and management of people with HIV disease

East of England	4,192	*No courses listed*
West Midlands	4,141	1 Principles of care for people with HIV 2 Care/management of persons with HIV/AIDS 3 HIV/AIDS implications & strategies for care
Yorkshire & The Humber	3,284	*No courses listed*
South Central	3,233	*No courses listed*
East Midlands	2,940	*No courses listed*
South West	2,804	*No courses listed*
North East	1,195	*No courses listed*

Data from the Health Protection Agency, at www.hpa.org.uk cited on 31.01.11: **Diagnosed HIV-infected individuals resident in SHAs**

Figure 4: 4   Table showing miscellaneous courses, over and above C&RSH, STIs or HIV

Regions number & title	Names of courses
(3) London	1 Cervical cytology and breast awareness 2 Cervical screening short course 3 Exploring teenage sexuality and sexual health 4 Health promotion & screening 5 Promoting sexual health 6 Women's screening
(4) NE England	1 Dissertation in sexual health issues
(5) NW England	1 University Certificate Health Advising for Sexual Health 2 Teenagers and sexual health 3 University Certificate in cervical cytology 4 Emergency Hormonal Contraception supplied by nurses
(7) SE Coast	1 Developing the role of the health advisor
(9) West Midlands	1 Cervical screening 2 Promoting sexual health 3 Psychosexual health 4 Domestic violence and women's health

Figure 4: 5 Table showing the regional distribution of full academic awards in sexual health as report by 42% of HEI-S Respondents (*n* = 10)

Region number and title	Title of Full academic award	Comment
(3) London	1 BSc Nursing (sexual health) 2 MSc sexual health (Work Based Learning)	
(3) London	1 BSc (Hons) professional practice - sexual health route	*2 respondents / same HEI*
(3) London	1 BA (Hons) sexual health	*"We only have one student to finish this programme and then it was made obsolete due to poor uptake"*
(5) NW England	1 DipHE S&RH 2 BSc(Hons) S&RH 3 University certificate in SH 4 Advanced Certificate in SH	
(5) NW England	1 Cert in C&SH care 2 DipHE in C&SH care	
(5) NW England	1 DipHE in S&RH 2 BSc(Hons) S&RH	
(9) W Midlands	PG Certificate in SH PG Diploma in SH	
(9) W Midlands	1 BSc(Hons) in C&SH 2 PGDiploma in C&SH	
(9) W Midlands	PG Certificate in S&RH	

Abortion: an absent presence in nurse education

Figure 4: 1b shows the percentage of teenage conceptions (2009) that ended in abortion, whilst Figure 4: 7 below shows recent data for legal abortions performed in the English Regions / Strategic Health Authorities (StHAs). What is notable in comparison with the HEI survey of courses is that not one

respondent mentioned any formal learning provision or course specifically on abortion or care of women undergoing the procedure. This absence of formal learning is despite a 2007 House of Commons Science Committee recommendation for "[.] the need to prepare nurses rigorously (for example, in performing risk assessments) and ensuring policies are in place to deal with adverse incidents" (Lipp 2008: 1235) including domestic violence and post-abortion psychological trauma.

Figure 4: 6   Legal abortions in England, 2008

Adapted from the Department of Health statisitics
cited on 03.08.10 at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_099285

Abortions: English Regions / StHAs	Total 2008
East Midlands	12,409
East of England	16,460
London	48,679
North East England	7,482
North West England	25,019
South Central	11,934
South East Coast	13,248
South West	13,812
West Midlands	20,476
Yorkshire and the Humber	16,699
All of England total	186,218

Lipp (2008) highlights the various needs of education for nurses, such as for those working directly in abortion services or gynæcology, as well as a wider abortion awareness remit for referral nurses such as school and practice

nurses and those working in young people's outreach. Hoggart and Philips (2010) even recommend that abortion care nurses themselves should be qualified as contraception nurses to effectively promote protected sex for females and males and thus help reduce the numbers of repeat abortions, especially common in the under 20 year olds.

The role of the partner of a female undergoing termination of pregnancy, especially for young people, is also highlighted, usually in the context of being almost completely neglected. In this regard, the 'voice' of men is characteristically silenced (see Figure 4: 7). The issues for nurse education, both for the woman undergoing abortion and for possible male partners and significant others, could arguably form a topic for learning that researchers show is currently absent (Astbury-Ward 2010). Research identifying this absence of training, on how to deal with - and include - the effects of abortion on males, is highlighted with young men in general by Lipp (2008: 1234) and the "common anxieties of the male partner [which] included powerlessness, difficulties in influencing the decision and anxiety about their own maturity." This is supported by French's (2009) doctoral research, in relation to young black males in London. Astbury-Ward (2008), in a literature review article based on her now successful doctoral thesis, likewise bemoans the lack of research into the emotional and psychological impact of abortion on women which is lamentably so for males too. Excluding male partners from a presence in abortion care, whilst totally necessary and / or understandable in some situations, misses two key opportunities in others. The two opportunities are 1) to deal with the psychological impact of the termination

163

on the male and his relationship with his partner, and 2) of including him in
discussions for the practice of safer sex and contraception to decrease the
likelihood of future / further unplanned and unwanted conceptions (Hoggart
and Philips 2010) and infections.

(*overleaf*)

Figure 4: 7   "Abortion: are we failing men?"

Poster assignment by Vicky Papworth, University of Greenwich,
Contemporary Issues in Sexual Health course, 2009. *Used with permission.*

164

'I got the feeling that I should not be there'

ABORTION

Are we failing men?

Pregnancies, planned or unplanned, cannot occur without the essential role of men. Yet, the role of men in abortion clinics is too often at worst non-existent, and at best solely to support women. Sadly, the importance of including men in the management of unwanted pregnancies is not adequately recognised within health-care.

The literature that addresses the topic of 'men and abortion' is insufficient. When recommendations are made in the literature for the inclusion of men, many of these are on the basis of their benefits towards women. Such benefits are indisputably valuable; however, what about helping men in their own right? Research supports that men often endure negative emotional consequences following abortion, but this emotional need is rarely addressed in abortion services. Moreover, men are not routinely invited to appointments for discussion of pregnancy options and abortion. Research suggests that common feelings of sadness and disappointment result from the exclusion of men in abortion services and their sense of powerlessness. Further difficulties arise when a man disagrees with the decision to abort a pregnancy. Research shows that men want to be involved, want to take part in decision making, and many want emotional support, either in the form of counselling or support from nurses.

Nature has chosen woman as the child bearer, and as such, and in line with British Law, it should always be the woman's decision to continue with a pregnancy or have an abortion. This is not to say that men should not be part of the decision making process, and ideally men should always be consulted. As nurses we can all do our bit to increase the visibility of men in abortion provision.

Recommendations for Nursing Practice

♂ Nurses can create a welcoming environment for men

♂ Nurses should include men in consultations, when appropriate

♂ Nurses should include men in the explanation of the abortion pathway

♂ Nurses should acknowledge the grief a man may experience

♂ Counselling services should be opened up to include men

♂ Men can be invited to the post-abortion follow up, but women should be given the additional option of being seen alone

♂ Nurses can contribute to academic research to gain a greater understanding of men's needs in abortion provision and how these needs can best be met

Vicky Papworth RGN BN (Hons)
Sexual Health Nurse
vickypapworth@yahoo.co.uk

Abortions on the gynæ ward: a cap on learning potential

In the following three extracts, from different Focus Groups, it is possible to analyse layers of discourses which clearly overlap elements of governmentality with stigma as taboo, non-existence, silence, i.e. the 'triple edict', and includes here, most notably, an active silencing.

> **FG15 / P18** At least half of women on the ward were in for terminations, and errrm it was actually very difficult because a lot of them, half of the women there couldn't have a child and the other half were there because they were having a termination, [yeh?] for sexual health ... I don't think we really covered ... it wasn't discussed, to be honest.

> **Me:** ... so for you as a student: what were your experiences around that?

> **FG07 / P18** I didn't think it was appropriate, actually. They should have had some sort of policy where this shouldn't happen [yeah?] and urmm I know they said to me - I am an Irish Catholic and everything - but err I remember them saying to me that they were very surprised because a lot of the nurses - I was on–nights - and a lot of the nurses were not treating them very well because they were in for terminations and I said I was there to give nursing care regardless. It's not up to me to decide what you do with your life really!

> **Me:** So you managed to discuss it with some of the others then?

> **FG07 / P18** Well, that was with the patients, yes. It is the ones who were in for terminations who kind of said to me, you know, that I wasn't condemning them, you know, I was treating them all the same basically, just commenting on it. I wasn't aware of it myself, just commenting on it.

> **Me:** Did you manage to discuss this with anyone, say for example, in the School of Nursing? Did you have any support around that all?

> **FG07 / P18** I don't remember any at all [right, right] and I don't think I brought it up either.

In the discursive extract above, notions of governmentality are exemplified most noticeably as an *apparatus of control*:

- over the young student nurse's interactions with the patients undergoing abortion

- in the *closedness* of potential for discussing her learning needs, and

- in the punitive way in which patients were generally regarded by other nurses, with her as an acknowledged (variable) exception.

What is also significant in this extract is the perception by others of this student. They were surprised by her approach to abortion patients given that she was of an ethnic and religious background known for its usual disdain of abortion. The following two respondents demonstrate particular moral discourses in light of an unhappy union between gestation and termination in a ward environment, especially when the abortion is judged on grounds of *unwantedness*. The cap on learning potential remains clear in both.

> **FG08 / P04** I think it was more um…with a lot of terminations going on, women trying to keep babies or have babies alongside women that were terminating, it's those kinds of issues and … so I suppose it was more the after effects really of … you know sexual … activity. But it was a bit of a moral issue as well I think.

> **FG08 / P04** Not at all! They came down on me like a ton of bricks!

> **Me:** Why?

> **FG08 / P04** Because I made a comment, I passed a comment um … that I felt it was a little bit unfair for women that were trying desperately to have children to be put alongside those that were obviously trying to terminate children at the same time, or babies whatever. Um … and I thought nothing else of the comment, until the tutors descended on me and tried to talk to me, and I wasn't refusing to nurse anyone, nor have I ever since. But it was just a passing comment I had made so there was nothing to prepare us and there was nothing afterwards said about it either, it was just that comment.

> **Me:** So it stayed with you for quite a while?

> **FG08 / P04** Yes. Yeah. Yeah.

PG12 / P04 I deal with ladies who are having a termination of pregnancy, and they're not teenagers anyway, urm so obviously they have an unwanted pregnancy, urm, domestic abuse, we see a lot of women with domestic abuse ... urm, you just don't ever know what someone is coming in with! You know, somebody starts talking to you about all sorts of issues when they come in.

Discontinuity

Discontinuity refers to changes which lead to discursive – or even epistemic – transformations. "Foucault is therefore concerned with charting these moments of this continuity when discursive structures undergo radical change" (Mills 2002: 27) i.e. discontinuity. The changes may take place in small ways and usually without any great appeal to historical moments. These discontinuities facilitate a transformation which in some ways is akin to, but wider than, the popularised Kuhnian scientific term: "paradigm shift" (Little 2009). As discourses relate to Foucault's ideas of an episteme, so, too, discontinuities and discursive transformations are interrelated with the wider notions of epistemic shifts. Foucault claimed in The Order of Things (Foucault 2007: 56) "within the space of a few years a culture sometimes ceases to think as it had been thinking up till then and begins to think other things in a new way". An example of this shift now follows in relation to more awareness of transgender people. At the same time, however, there is still a simultaneous, age-old, misunderstanding of them and how to work with them.

FG17 / P06 My [greatest difficulties with sexual health] is with transgender individuals: if they are registering for condoms we also include in that discussing about testicular examination and breast examination. And then it's hard to know if they are pre- op and it was more I didn't want to offend them by asking them! But I think it is all right to ask them to make sure that they are getting the right information now. But at the time, the first person that I did I felt quite embarrassed and very uncomfortable that I wasn't doing them a good service.

Me: How do you think you overcame that?

FG17 / P06 I think just with discussing um … discussing it with the rest of the team, and how they would approach it, and then there's also a helpline as well that we can get information from and refer them there as well. And I think it's just with … that person's since come in a few more times and I feel a lot more comfortable in dealing with them now.

Foucault's methods attempt the not-so-easy task of identifying discontinuities; they happen in different ways and in different times in relation to the power / knowledge of the various subjects in societies and cultures. Although discontinuities happen, for example the British treatment of 'madness' to 'mental health' over the past three centuries, there are still common themes that run throughout, which 'overlap and intersect', as exemplified in the *vignette* from **FG17 / P06**, above, in relation to the learning development from personally working with transgender people and their clinical needs. In Foucault's theory, discourse and the transformative powers that effect discontinuities are inseparable. Over and above the myriad changes for transgender people in the UK, there are a number of other prime examples from the spectrum of sexual health care and professional education where these discontinuities have happened, thus creating both discursive and epistemic shifts. These include:

- the social construction of sexualities and genders, epitomised in the naming of '*the* homosexual' (Foucault 1984)
- historical practices of 'back street abortion' to legally permitted therapeutic abortion, in light of the 1967 <u>Abortion Act</u>
- the discrediting status of the 'barren' and infertile woman (Goffman 1990; Blythe and Moore 2001) to the rights of access for *in vitro fertilisation*; likewise of 'impotent' men to anti-erectile dysfunction (ED) medications after the advent of *Viagra* (Tiefer 2006)

- the secretive and discredited venereal diseases of the <u>Venereal Diseases Act</u> (1917)-generation, to the somewhat more openly discussed promotion of 'sexual health', and finally

- the current national focus on teenage conceptions, pregnancy and parenthood. Some of these teenage parenthood discourses were categorised as "illegitimate" in the statistics for 'birth out of wedlock' in 1926, the year of Foucault's birth. In more recent times, there is a whole industry encircling the problematisation and support of teenage pregnancy and parenthood (Bonell 2004).

Mapping discontinuities

Foucault's processes of mapping discontinuities and shifts can so easily be applied to discourses on abortion. In the time span of so-called 'Victorian family values' to date, the discourses have shifted from illegal status and "back street" abortions to the legally permitted procedure enshrined in UK law. However, unlike discourses and policies towards "teenage pregnancy", there is still a vociferous and undercurrent *sotto voce*, or even *sub judice* 'dislike' (an underlying prejudice) regarding abortion in both public and healthcare psyche and its social representation (Baird and Rosenbaum 2001).

In clinical healthcare practice, this reluctant acceptance of legally permitted abortion can result in patients who seek early, medical, termination being delayed to such an extent that they are denied the possibility of medical compounds (i.e. only available prior to nine weeks gestation) and consigned to the later surgical procedures - sometimes in the hope that the woman will change her mind and "keep the baby" (Astbury-Ward 2010). Abortion care points to another difficulty expressed by some of the respondents, in the

170

terminology for a foetus to be aborted. Some, uncomfortably, used terms such as "baby" and "child" which, in abortion services, are considered technically inaccurate and also, frequently, emotively laden.

What discourses on teenage pregnancy and legally permitted abortion highlight are the discontinuities which ultimately lead to complete epistemic shifts and transformations. Foucault's methods are not interested in the shifts from a chronological point of view. Rather, his genealogical approach is more interested in the power / knowledge influences that accentuate some of these voices, side-line others and (re-)formulate yet others, in light of majoritarian discourses in a given society and culture. One then needs to ask: what is it that enables or permits certain discourses to achieve this majoritarian status; equally: what power / knowledge maintains it thus and equally constrains the voices of resistance?

Epistemic transformations

A clear example of an epistemic transformation revolves around our present-day discourses on teenage pregnancy. In the space of four or five generations, the discourses have shifted exponentially from illegitimacy and its discrediting 'bastard' status to the 'problematisation' of teenage conceptions as a socio-economic and even an educational issue. 'Teenage pregnancy' is now attended by its own Government Strategy and Departmental Unit; it also includes an industry of support workers and Teenage Pregnancy Coordinators.

Contemporary discourses intimately relate teenage pregnancy with poor educational achievement and high social care cost (Bonell 2004). The majority of conceptions taking place in Wales now occur 'out of wedlock' (www.statistics.gov.uk). To some young people, especially from more socio-economically deprived environs, there are actual perceived 'benefits' from becoming pregnant and being a lone or single parent at an early age. As Lessa (2006: 284) explains

> "As central figures in a category of entitlement based on contributions to society other than employment, single mothers were a key target for the reforms of the 1990s. Their motherhood status changed, over the course of the century, from an important role in the socialization of children into a barrier to employment and their entitlement to benefits restricted by the age and schooling of the youngest child."

A range of other discourses in the UK, spanning Victorian times to the 21st century, are witness to major discontinuities and transformations. Discourses in a near geographic neighbour, the Republic of Ireland (RoI), perpetuated many of these Victorian themes until the collapse of the *Magdalene* workhouses or laundries in 1997 (Inglis 2002). This discontinuity was spurred on by wholly different discourses than those in the UK, with the RoI's discourses formulated in juxtaposition to the systematic (sexual) abuse of minors by the clergy and members of various Religious Orders. This situated the discourses more firmly within the power dynamics of the Church and its moral (*sic*) authority.

Episteme / dispositif

An episteme may be described as a wide open space of a philosophical framework, where discourses, discontinuities and power relations all intersect. As Danaher *et al.* (2000: xi and 17) explain, they are "the product of certain organising principles which relate things to one another [.] the grounds on which we base everything, so we more or less take them for granted", or "periods of history organised around, and explicable in terms off, specific worldviews and discourses". A relevant example for sexual health could be related to aspects of the so-called Victorian family values system as applied to key epistemies within current sexual health. These 'family values' can be discerned in relation to the discursive formations pertaining to the already mentioned teenage pregnancy and abortion, plus masturbation, sexual orientations and venereal diseases (now renamed sexual infections, or the wider term 'sexual health'). An episteme includes the various channels through which knowledge develops, for example through the media, in a culture, in society or its politics (Petersen and Wilkinson 2008). This makes it possible to think about things in a given way. A discourse, therefore, which evolves out of the numerous practices and social structures facilitates and constructs communication of this epistemic knowledge.

Some examples of epistemies from the data, i.e. 'wide open philosophical spaces' where discourses, discontinuities and power relations intersect, are clearly identified in the following respondent's quote regarding changes personally witnessed in sexual health in care.

> **FG16 / P10** ... just basically reiterate what the others have said, because I have come across men who have erectile dysfunction with

> diabetes or for other reasons. You know, it doesn't really seem to be something that is greatly addressed, it seems to be something that everyone is a little bit embarrassed about and 'bringing it up', if you like [group laugh] and like the older generations ... you know! I don't know why people feel the need to speak to *me* but they do tend to open up, you know they will, perhaps, say that they are suffering with erectile dysfunction or something like that, and they feel embarrassed about it and you know, it's something that they have been quite embarrassed about and it's having quite profound effect on their relationships and their partners are getting a sense of rejection, then it's all the psychology of relationships and all.

The discourses on erectile dysfunction (ED) are relatively modern, and are a break (discontinuity) with the hither-to invisibilised "highly stigmatising" impotence discourses of the pre-*Viagra* days (Lawler 1991). They also contradict the age-old masculinist *persona* and the penis-power of men (Ward 2005). Affected men are increasingly more willing to 'admit' (governmentality: *confess*) something is wrong with their 'manhood'. By making the first move in raising this discourse they are also engaging proactively with the traditional power / knowledge dynamics of 'who mentions delicate things first: qualified professional or patient?'. This practice breaks a taboo highlighted by Lawler (1991: 89) on the 'similar space shared by sexuality and the body' which is normally "secreted away and talked of in terms which are either sanitised or regarded as vulgar".

Power / Knowledge and Governmentality

Foucault said that he wished he could claim authorship for the popular term "knowledge is power"; instead, he promoted the concept of "Power / Knowledge" (Foucault 1980). His various sub-categories of power applicable to sexual health, such as bio-power (or bio-techno-power) and bio-politics,

are inextricably linked to his concept of governmentality. Bio-power is variously described as "a subtle, constant and ubiquitous power over life" (Gastaldo 2006:115) and "the technology which appeared in the late 18th century for managing populations" (O'Farrell 2005: 130). Over and above this, governmentality includes various practices of (self-) surveillance and confession, forms of internalised disciplinary power by which to produce "docile bodies" (McHoul and Grace 1995: 74; Perron *et al.* 2005), or, conversely, Pryce's (2000) "active patient".

Again, most of these concepts can be seen to converge in the discourses of sexual and reproductive health, such as in the technological ways in which bio-power analyses, controls, regulates and defines the human body and its behaviour (Danaher *et al.* 2000: 64). To promote bio-power, the role of the modern state is omnipresent, 'increasing concern' from disease prevention through defining and monitoring the *status quo*, to ensuring that it provides what it considers necessary for its citizens to maintain their health and biological well-being (Shawver 2006). For bio-power to work effectively, Perron *et al.* (2005) argue that nurses are pivotal in the crucial interface between the bio-power of the state and the anatomico-political 'subject' of the patient.

Foucault proposed that power was relational, "a more-or-less organised, hierarchical, co-ordinated cluster of relations" (Gordon 1980: 198). This is more akin to the classical Greek concept of *dunamis* (δυναμις), from which we derive the English terms 'dynamism' and 'dynamic'. Power is formulated

as much by transgression and resistance to it, as any imposition, and it is constitutive of "particular kinds of knowledge" (O'Farrell 2005: 45). These kinds of knowledge lead to the construction of "forms of subjectivity" which produce "hegemony [as] people's compliance in their own oppression" (Mills 2002: 30); as the following *vignette* exemplifies:

> **FG01 / P27** It's also about stigma, and the number of people who can't access services because they will be judged or looked down on. It's not just young people, it's older people who have entered new relationships, will suddenly feel ashamed that they don't know enough, or don't know where to go for help or how to access it! Also stigma around HIV and HIV testing, and having a sexually transmitted infection. And this goes right across the board; and discrimination against things like people with disabilities. People with disability can't have sex: that's a view! These are much wider issues!

The 'apparatus for control'

The various apparatus for control can be seen through every stage of the patient encounter in relation to sexual health matters. A prime example is in using the *ars erotica* to reformulate feelings of embarrassment. With a case in point, from gynæcological situations, Meerabeau (1999) suggests that greater patient embarrassment can inadvertently emanate from friendlier staff – especially opposite sex – and those showing less formality and being more personal with the patient. Pryce (2001), conversely, describes this as a "profound paradox" which has the potential for harnessing or capitalising on the personal - the very intimate nature of the *ars erotica* – the results of which contain the reasons why the person is attending a sexual health clinic, into a transformative process as the 'active patient'. This process is a clear by-product of the power (δυναμις) of the 'disciplinary gaze' of the *scientia*

sexualis. The following respondent focuses on this patient / client need, by identifying her own lack of education to address it:

> **FG15 / P07** I'm a practice nurse. Looking back at my student years urm I didn't have much on sexual health it was just a slight overview on sexual health, so now that I've gone into practice nursing I find it *SO* important to learn, at least getting it right, to get the basics because when you're dealing with the sexual health of a person I've discovered it is so important to these people. They want to know things and I felt I wasn't equipped to deal with it. So if people want to know, I didn't feel I was equipped enough to deal with it, so attending this course has really helped. I found how important it is to have sexual health learning and urm to help to help me to provide that service because we, as health care professionals, must provide holistic care. I've learned that incorporating sexual health needs to be part of the learning curriculum and it should be identified, definitely. I hope and believe I can expand my learning and get more courses done and pass that on to my patients so I will be able to answer their questions.

Even the degree of confidentiality assured to individuals under the various Venereal Diseases Acts and their periodic updating VD Regulations can have a counter-side. This, at once, identifies a given population, for example through the practice of epidemiology and the reporting of statistics in the KC60 statutory reporting system. At the same time, however, it denies them an active patient voice so desired in the National Strategy for Sexual Health and HIV (DH 2002) because of the advanced processes of confidentiality. These simultaneously tap into exceptionalised notions of secrecy and stigma, therefore (re-) producing stigma, silencing and isolation (Sontag 1991), or back again to Foucault's (1984: 5) "triple edict of taboo, non-existence and silence". Two examples of patient silencing and the "medicalisation of life [.] through the pathologization of normality" (Skolbekken 2008: 17) clearly demonstrate this point:

FG07 / P14 Specifically for me, we carry out terminations as we are supposed to do. We're supposed to have their consent forms sorted before they get to us, but very rarely is that happening. And I found - because I didn't know enough about anything - I felt that I was almost bullying them into doing something and I felt I needed more information. It was for them to choose or consent, and not them doing whatever it is 'I' convinced them to do, as soon as they have walked in through the door.

Coupled with *disciplinary power* and the subsequent making of 'docile bodies':

FG08 / P07 I think, you know it's about the knowledge thing but sometimes I think it's about trying to make it normal. As I said about stigma before, I think if you normalise the questions that you ask since then the people aren't just thinking "what is she saying that for?" Then hopefully the rest will follow. But obviously this goes hand in hand with having the knowledge to either refer them or, you know, what to do with them? [yes] ... and that type of thing. But I find that I ... urm ... money is a big part of this thing. It's like opening a big can of worms on that scenario.

Me: So from the point of view of money, would it be for supplying resources, say, for example, if you are talking of erectile dysfunction then someone has to pay the bill for *Viagra*, or is it to buy extra time, even?

FG08 / P07 Both, really, and the example most recently is hepatitis B ... urm ... you know, I found out that people who have been in prison or sex workers, should have a course of Hep B. I've picked up several actually over the last few months who haven't had it, or haven't had the complete course of hepatitis B vaccine. But then they [healthcare professionals] are reluctant to do so because it's a bit of a grey area who's going to pay for it. It's all to do with funding really.

The apparatus for control are also evident by contrasting the noticeable public and medical discourses on HIV infection compared with the personal concealability of something, which is commonly perceived by infected and affected individuals, as being a discrediting illness (Carlisle 2001). Again, compare the almost daily contributions to public and media discourses on

teenage pregnancy, with the taboos and stigmas associated with abortion. As with theories of stigma and spoiled identity (Goffman 1990) and the way they are managed by being hidden (concealability) or 'outed', and the course of both positions (Evans 2001), Foucault's work on the role of *confession*, in regard to such spoiled identities, is integral across all aspects of professional sexual health care and education. The personal felt effects of the various stigmas around sexual health and illness at some time encourage individuals to monitor and silence themselves (self-surveillance), at other times they are encouraged to confess or 'out' themselves in some of the most personal and intimate ways (Perron, Fluet and Holmes 2005).

> **FG16 / P16** That comes mainly from working with staff in GUM who have got really bad attitudes and assumptions to certain groups of people: bisexuals, homosexuals, and I think that should be addressed at a very early stage … at the beginning of nurse training.

These personal felt effects are akin to "a greater regulation of emotional and physical expression" (Meerabeau 1999: 1507) which can be counter-productive in promoting health and early access to treatment and care. Meerabeau (1999: 1508) asserts that "[s]hame usually refers to self-blame or self-disgust, whilst embarrassment stems from concern with one's public image", all key concepts in sexual health, the 'spoiled identity', and the professional balancing act to manage the therapeutic encounter positively.

Governmentality

Governmentality is "an *ethos* [.] of governance" (Van Loon 2008: 49), which includes "rituals of truth" (Shawver 2006) such as the evolving iconography of sexual disease (Pryce 2001). These produce 1) systems of surveillance,

which are typical in the discourses surrounding the epidemiology of sexual infections, HIV and teenage conceptions, and 2) self-surveillance, for example, through the practice of 'confession' (Foucault 1980). As cited above, this can be witnessed in "a greater [self-]regulation of emotional and physical expression" (Meerabeau 1999: 1507) which Lawler (1998: 244) postulates is "richly indicative of 'the problem of the body' and privatised body functions [... which] highlights the silence of the body in discourse generally."

> **FG06 / P18** I think again on sexual health assessments and how you were to ask the student nurse to address the issues, is: "if the lady had a hysterectomy, her sexuality would be an issue for her?" So it will be discussed, perhaps very briefly, but just getting used to doing an assessment of those urm needs. There needs to be more attention paid to that: identifying these needs, and on top of that also a general overview of the methods of contraception and sexually transmitted diseases which I personally had nothing of that my training.

Governmentality is intricately related to power / knowledge and also incorporates Foucault's notions of bio-power and a sub-division of this: disciplinary power. In relation to sexual health, *bio-power* is exemplified by 'confession' of the hidden (presumed 'wrong doing'), thereby gaining 'liberation' from the concealed self. *Disciplinary power*, on the other hand, is more the internalising of surveillance which results in personalised 'policing' for the sexual confession and the subsequent making of 'docile bodies' (Shawver 2006). In essence, this is the "medicalization of life [.] through the pathologization of normality" (Skolbekken 2008: 17) which, in clinical practice, Meerabeau (1999) demonstrates as being exemplified more often in the female sexual body than the male. With the male body, as outlined by Lawler (1991: 206), it frequently encompasses the practice of masturbation and forms of sexual harassment usually dealt with unproblematically by many

nurses, given the profession's predilection as not only a "highly sex-typed occupation, but a highly sexualised one, too."

> **FG12 / P16** The only thing in the [Sexual Health Skills] course I thought was difficult - I don't really know why but I know it just provoked strong attitudes from other people - was the idea of being able to masturbate in hospital and being given - you know – *privacy*! Yeah previously there was no privacy. I couldn't imagine it in our setting and I know what reactions would be, you know, if a patient is masturbating in the morning when staff go to them! They are really horrified about it! It is just one of those issues really, you know, it's just ...?

> **FG12 / P19** I don't know why it's an issue, really, because everyone does it! Everyone thinks it's personal, it's a personal thing, but in hospital you are in a public place. You wouldn't go out on the street and, well .... [group laugh] *most* people wouldn't go out on the street to masturbate; is that possibly why people have got a problem with it? ["yeah, yeah" - from all others].

> **FG12 / P16** Sorry, I was going to say ... it is also, you might think it is more acceptable if it is a young lad doing it and they are all doing it together, and as a young nurse there. But it tends to be like the bloke who might be, I don't know - he might be *70* - what did he feel like masturbating for? Yes, that's the attitude!

Supplementary themes: Let's (not) talk about sex!

In the following extracts the respondents are acting out what they believe are traditional notions for not talking of sex with patients, on the grounds of potential increased personal vulnerability for the clients. This constructs an *ethos of governance* which clearly demonstrates certain 'rituals of truth' confirming an 'iconography of disease', i.e. sick people don't want sex, so best not talk about it!

> **FG07 / P10** I think it was normal *not* to talk about it, see!

> **FG07 / P08** And if they are sick people they haven't got the energy for sex anyway! [Loud, embarrassed, laughter from group, as a possible sign

181

of discomfort at the thought of this]. They don't, do they? They get quite frustrated if they can't have sex [yeah, yeah] [still more laughter]. It's all swept under the carpet!

FG07 / P10 ... especially the people with cancers, it's just so irrelevant! Because that may cause greater distress in a person's life than anything ...... even more than cancer itself ... you know, the relationship with their partner.

Complementing this discourse, another respondent in the same group discloses her ethnic / cultural reasons for not talking of sex. The following *vignette* displays additional practices or systems of (self-) surveillance and confession, with particular forms of internalised disciplinary power producing "docile bodies" arguably in the nurse and client.

FG07 / P07 Because I'm from a south Asian background often I find that when I have patients from the same background come in, you know with a sexual health issue, they're quite reluctant and embarrassed to discuss it and I find it a real challenge to discuss because we were brought up to think we are not allowed to talk about sex or even think about sex that openly, so it is difficult for me, from childhood, to discuss about it. But often when I say in a professional capacity that I have to talk about this, I have to work slightly a bit more harder to be incorporated, especially when people are from the same background. And that is quite challenging for me! I think I find it a bit more hard work than someone who might be a Caucasian professional - they are much more willing to do it and talk about it. I think actually it is challenging for me and hard to reverse that.

Me: That is wonderful what you have just said, that you are actually doing it ...

FG07 / P07 Yes, I am doing it!

Me: ... because there are so many people who are shut-off about this, and they won't talk about it.

FG07 / P07 That's right, that's right! I have to say ... I have to open up actually, and work hard at it and say something to someone else, you know, within my own culture, to reflect on that even more and try not to be judgemental. I think that's really hard in my culture. [Thanks]

182

"Flick it with a pencil!"

Van Loon (2008) argues that the results of the process of governmentality clearly contribute to the development of a society's notions of 'risk', with the whole emphasis – for example, in relation to sex – transformed through regulation and control into the realms of Foucault's *scientia sexualis* rather than the *ars erotica* (see chapter 1)*.* Turner (2006: xix) claims this leads to regulation and control "especially in the area of sexual etiquette, to become self-regulating and self-forming". From such a starting point, it is not sex which comes first, but risk, and socially constructed notions of risk at that. As Skolbekken (2008: 20) states, "[i]t is in the transformation of physiological factors into risk factors that the pathologization of normality occurs". Van Loon (2008) associates governmentality, in this instance, with increased personal vulnerability to risk, for example, when he presented evidence from an analysis that showed how the UK's Teenage Pregnancy Strategy (SEU 1999) would fall short of its projected targets for 2010. New conceptions have not gone down enough to match the desired decrease for the target date. Pregnancy statistics may be coming down slightly but incidence of sexual infections, in the same demographic populations, are rising exponentially. This possibly results in part from a certain 'contraceptive mentality' (Evans 2005c and 2006) that emphasises the narrowness of contra-conception instead of the wider practices of protected, 'safer sex', which include contra-infection. In identifying uses of the term 'risk' in relation to safer sex, it can therefore be seen to be imprecise and sometimes contradictory. Risk also includes opposing facilitating and restraining forces, or incentives and disincentives to its practice, e.g. protection from unplanned

consequences of sex *versus* a lack of intimacy and apparent trust. Finally, risk in safer sex can vary in understanding: in health promotion / prevention methodologies, as well as between individuals and their societies, cultural life-ways and other personal demographics. This respondent situates risk in relation to fears of increased personal knowledge of school children:

> **FG16 / P19** Um … again I think it's because they have a rigid outline of what they can and can't or will and won't teach and um … there is a risk that if we come in [to deliver SRE in the school] sessions might start devolving from the main subject and children might decide that they can ask us things that they wouldn't normally ask other people and therefore it all gets a bit uh … a bit kind of you know … edgy! Parents … they go home and say to their parents, "well, we talked about this" and then you get the parents on the phone complaining about it. So … I mean it's a risk, I would never stand at the front of a class and go "sorry I'm not going to answer that!" because I am just not, you know. But um … its hard work, there is a lot of politics involved and actually the fundamentals of PHSE teaching are that you have to be prepared to answer a question whatever it is don't you? Whatever it is!

Two humorous warnings about particular risks for young female nurses caring for young male clients are told by the following respondents from the same group; they are evocative of the myriad similar admonitions recorded in Lawler (1991):

> **QG03 / P22** [1983] One note of caution we were given by the tutor (female, very strict and 'old school') was to be cautious when removing the bed clothes when bed bathing male patients "as you never know what you might find!" *I've never forgotten that one.*

> **QG03 / P27** [1980] Absolutely no learning or discussion [of] sexual health within pre reg nurse training, other than clinical tutor telling us, in our 6 week induction: if a man had an erection when we washed him we had to flick 'it' with our pencil!

Genealogy

Crowe (2005: 57) explains how genealogy has "particular relevance to nursing [.] in that it investigates complex and shifting networks of relations between power, knowledge and the body which produce historically-specific forms of subjectivity." Lawler (1991: 7) likewise "wanted to know how nurses construct a view of the body [... which] involves transgressing taken-for-granted rules [...]". The relevance of genealogy is undoubtedly clear in the case of sexual health nursing, notwithstanding the assertion by Meadmore *et al.* (2000: 464) that its under use in nursing research is frequently due to a two-fold misunderstanding a) that it lacks a clear 'how-to-do' format, coupled with b) "the awkward questions about tense, i.e. [it is] a 'history of the present'." Meadmore *et al.* (2000) present the methods of genealogy as an epistemological quest that begins with what 'we' know and believe and hold true today, through an exploration of how various 'games of truth' are played, and, by "tracing the lines of decent", explore the multifaceted ways in which this knowledge, belief and 'truth' came to be so. A case of school-based homophobia outlines this process well, clearly demonstrating the inter-relationship between power, knowledge and the body forming a particular form of subjectivity.

> **FG16 / P19** I think also in the area that we work in um … homosexuality is something that is hugely ignored and um … and treated with copious amounts of embarrassment and shame. And its … and its sad because you know we do have … we do have clients who are clearly homosexual, even that are quite young, but the problem is that because its not addressed they won't come and talk to us about it. We did have leaflets and things delivered to us to put out but we're not allowed to put them out. Um … neither are we allowed to put out anything about um … contraceptives in case people see them! [Laughter]
>
> [...] [Homosexuality] exists but we prefer to think it doesn't here. And … and there's a kind of big divide in the client base because some of

them completely accept it and just think well that's the way you are. But the larger amount of it, of the clients tends to … they won't be in the same room, and they won't be you know seen in conversation with these people, and they won't … just in case they're tainted by association.

Me: So homophobia is a big problem then?

FG16 / P19 Yes it is. I think it is. Yeah.

Me: And how big is your client base, how many people are you talking about?

FG16 / P19 We have 1800 pupils in the school.

Me: And when you think the most conservative statistics on gay and lesbian people say that around about 5% of the population … so even if you had a 1000 pupils that could be around about 50!

This *vignette* identifies "historically-specific forms of subjectivity" (Crowe 2005: 57) and the significance the process genealogy plays for sexual health and associated educational research. The process of genealogy is important for giving clear attention to the 'local' voices, i.e. ways in which they make sense of, and struggle with or against, the current state of 'truth' and knowledge and belief. These latter processes are referred to as the *regimes of truth* (Gordon 1980). It is through these *regimes of truth* that the Foucauldian concept of genealogy can claim, especially in the <u>History of Sexuality</u> (volume 1) that the body "is the inscribed surface of events" (Foucault 1984: 83).

In similar ways to Queer Theorists aiming to 'queer all (hetero-) sexualised spaces' the Sumara and Davis (1999) understanding of genealogy takes a fresh look at what 'we' know and believe and examines how that can be so. It is a transgressive process for crossing the lines or boundaries that are typically given or taken to define 'us'. In interviews with Colin Gordon (1980),

Foucault reaffirmed that the knowledge which is produced from the genealogical process is no more or less true than institutional 'truth'. The difference is it includes the non-traditional or non-majoritarian (read: non-orthodox) voices, i.e. the "dissenting beliefs", plus localised knowledge and the resisting power struggles that transgress both of these with such mainstream beliefs and histories, as clearly exemplified in **FG16 / P19** immediately above.

According to O'Farrell (2005: 69 & 91), "genealogy is about the 'constraints' that limit the orders of knowledge", with culture "form[ing] its identity in relation to what it rejects". It is from this "range of practices" (Mills 2002: 24) that knowledge - 'truth' beliefs - and the body are supported and built up. At the same time, these *regimes of truth* exclude all that, and all those, they perceive as contrary. In sexual health terms, the institutionalised disciplining of sexuality and the regulation of fertility and reproduction is visible through key instruments of State in relation to the <u>National Strategy for Sexual Health and HIV</u> (DH 2001). One example of this includes the naming and categorisation of subjects for epidemiological purposes. Notice from the Health Protection Agency's formal sexual and gender categories, the complete invisibility of lesbians from our national statistics. This lack of naming or categorising has a knock-on effect in the absence of provision of services, from primary prevention through to treatment and care (Marrazzo and Stine 2004).

Another pertinent example of the power of categorisation relates to influences of recent <u>Sexual Offences Acts</u> of 2000 and 2003. A child can be held criminally responsible from age 10 in England, Wales and Northern Ireland (8 in Scotland), but they cannot legally consent to sex (even with someone of the same age) until 16. A problematic 'grey area' existed in that under 13, sex can never be consented to by the child; it is therefore illegal and criminal. Consensual sex between 13-16, however, is not criminal. This posed serious professional and ethical issues across sexual health, contraceptive and young people's services, when many nurses, youth workers and teachers feared they would be seen as aiding and abetting 'criminal' activity if they gave safer sex and contraceptive advice to young people under 16. The situation required government Departmental (DCSF) clarification and advice before the various professions were content to proceed. However, such discourses are now moving outside the scope of this thesis, in that they are related to the UK's social and media constructions of child sexual abusers as "pædophiles", no doubt a library of theses in its own right.

Here is an example of a participant resisting power struggles, transgressing the boundaries which are typically given to define the appropriate learning of student nurses:

> **FG15 / P10** What I found out for myself was on placement. [...] I made a point of, because I was on placement on the gynæcology ward, so I made a point of finding out as much as I could then, and also spending some time at the GUM clinic, attached to our hospital so, I wouldn't have found out otherwise.

Me: Right, right. So presumably most of your colleagues wouldn't have had that learning?

FG15 / P10 No!

There is evidence of this student investigating complex and shifting networks of relations between power, knowledge and the body which produce historically-specific forms of subjectivity. There are also discontinuities evidenced in the following text, too (highlighted here by sentences within the symbols < and >)

FG16 / P08 I started my first student training in 1972, and although we had the basic biology and ... urm, sex was not a part of it. It was still erm, under the carpet. It was not readily discussed, and it was frowned upon by the older generations. Urm, it was just a "no-no" and although urm around that period they got you to sort of focus on talk about *holistic* care, they still didn't bring sex in, you know, it wasn't encompassed into it [yeah, yeah] as part of treating that being.

Me: So do you think you were conscious of that at the time?

FG16 / P08 No, no!

Me: When did that come then? When did you realise that - even what you've just said there about holistic care - that there was something missing? When did you realise that?

FG16 / P08 Urm, quite a lot later, probably when <it must have been about four or five years later > and we began operating GU services from an acute hospital setting, and they needed to find people for those who required some sort of sexual health service. [Yeah?] So, you know, it is just that extra bit, you know, you are just adding to, that person's care [yeah] and how important it was. < I think it's taken quite a long time to dispel the *myths*, this is just as important as surgery... >

Me: Right. Can you think of any myths in particular?

FG16 / P08 [pause] urm [pause] <It's the cultural, it's a religious thing and it's ... it's ... I've questioned it, why has it sort of arisen? And I think it's to do with the evolution, you know and acceptance and ease of

talking about it ... sex ... urm and you know that you're just considering it, just normalising it! >

Me: Okay, okay, thanks!

<u>Stigma and Foucault's 'triple edict'</u>

Multiple stigmas around aspects of sex, sexualities and sexual health have been acknowledged and examined at various points throughout this thesis. Foucault's concepts of the "triple edict" have been used to analyse data in this study from the perspective of something which is discrediting for an individual. Many of the respondents would discuss issues they considered were clearly labelled as stigma. Other times, relevant matters were 'evidenced' by their invisibility – their 'non-existence' – which was then enveloped in a specific form of silence, a negative or condemnatory silence, and ultimately indicative of their nature as taboo.

> **FG15 / P14** I started my training in 2003. I don't think there was ever anything as specific as sexual health, we did women's health and men's health but there was never anything specifically *sexual* health in my training and I worked in a gynæ ward and the whole thing is covered up! The whole thing is something we don't deal with a well - or not specifically - maybe we'd do it, but not specific. You don't say something is specifically sexual health!

> **Me:** So when people say they are caring for clients holistically?

> **FG15 / P14** We're not!

> **Me:** You don't think so? No? Okay!

> **FG15 / P14** I hadn't really thought about it before this course, but urm, our ward is a gynæcology ward but we also deal with mastectomy patients too. Urm and it's not something we really addressed you know, how their body image is or their sexual health post leaving us really, and they could have just had surgery. Other women are having hysterectomies - and how they feel about themselves. It's not really

190

addressed in the short term when they're with us, but I don't think it's addressed anywhere else either.

Me: So it's being missed altogether?

FG15 / P14 Yeah, yes somehow ... maybe the breast patients, because they get to see a breast specialist nurse, but the women for hysterectomies just come in for surgery and go and nobody really follows them up.

This next respondent also makes reference to aspects of sexual being which are more evocative of Foucault's *ars erotica.* It is followed by two other extracts from participants from the same Focus Group that oscillate between elements of *ars erotica* and the *scientia sexualis.*

FG15 / P08 I'm agreeing strongly with Number 17 urm, in terms of body image and urm post surgery and how this is an area which is I think is quite considerably overlooked. At the other end of the scale it's interesting how much we actually want to enhance our sexual health urm feelings or body image in terms of piercings or false nails or plastic surgery, erm, or all the - you know - liposuction: they are all things sort of that enhance our sexual presentation to whoever! And they are all things that really matter at the end of the day, aren't they, to that individual?

Me: Yeah, really good point! Thanks.

FG15 / P07 Urm ... from this course I have identified some other issues, but before, as I said, then I had limited awareness about sexual health. It's looking at chronic diseases like diabetes and erectile dysfunction and a lot of other issues, *that's* sexual health! And it's just finding ways with a patient to let them know they can come to me and ask about these issues. So it's not just about teenage pregnancies: sexual health can be wide ranging, so we're not just focused on this [teenage pregnancies] but like in the work of today, I have identified people with arthritis for example could have problems with sexual health and come to discuss them. How can they satisfy their partners, for example, so sexual pleasure and needs can come from all different aspects of health. So it's not just about teenage pregnancies or sexually acquired infections it's about all other issues that we need to look at.

> I've also realised certain drugs, urm like hypertension drugs [right] can have an impact that I didn't know about before. So I'm going to explore these - medicines and how that can have an impact on sexual health - and sexuality; so it's looking at the wide spectrum of issues on sexual health is not just focusing on teenage pregnancy and STIs but other issues that need addressing.

In a related way, **P16** recounts a theoretical conundrum for a male patient:

> **FG08 / P16** I do remember doing ethics and law and, urm, one of the assignments we had been given was considering, urm, a chap who got remarried and he had ... he basically had to have his prostate removed and it was his reluctance to have the prostate removed because it might make him impotent and with his new wife and the issues of that.

Lawler (1991) highlights how studies on male sexuality have characteristically focused not just on the penis and its ability to respond appropriately in life and relations, that is, in the *ars erotica* and sexual performativity, but also on attributes of masculine identity (including power) and the pre-eminent role given to the erection and orgasm. Indeed, she cites Wilhelm Reich's 1922 radical assertion that "regular orgasm was absolutely fundamental to good health" and that Kinsey was in fact not so much a sexologist as an orgasmologist (Lawler 1991: 92-3). That the patient in the *vignette* above was concerned about losing his erectile and orgasmic potential was therefore wholly consistent with typical masculinity concerns.

<u>Conclusion</u>

The analysis of data in this chapter has been according to my understanding of particular Foucauldian theories and techniques. This approach is taken primarily to present a glossary of terms, as used in this thesis, supported by clear examples of how they relate to an analysis of the data. At points, the

respondents' voices show a clear disquiet about the lack of any formal sexual health learning to prepare them for the needs of their - then and now - clinical encounters. Not only that, but many of the nurses cited here highlight elements of experiential learning – 'on the job', in their clinical placements – only to have this learning capped or thwarted by senior clinical and educational staff, unable and / or unwilling to explore the full learning potential through reflection and analysis of practice.

In reflecting on the data on numerous occasions, such as when I collected, processed, transcribed and later re-read them, a clear theme coming through from so many respondents concerns the critical incidents and learning potential in their gynæcology placements. This area of practice, possibly more than any other, is coming through with key themes that underlie much of the respondents' later learning in clinical practice.

This chapter uses as its starting point the various Foucauldian concepts employed in this work as a whole. These include discourse analysis, concepts of the *ars erotica* and *scientia sexualis*, power / knowledge, governmentality and the 'triple edict'. It then situates relevant *vignettes* of data, 'enfleshing' the theory with real life examples. Chapter 5 presents more of the data, but this time clearly set within the themes explored in the various Focus and Questionnaire Groups across England.
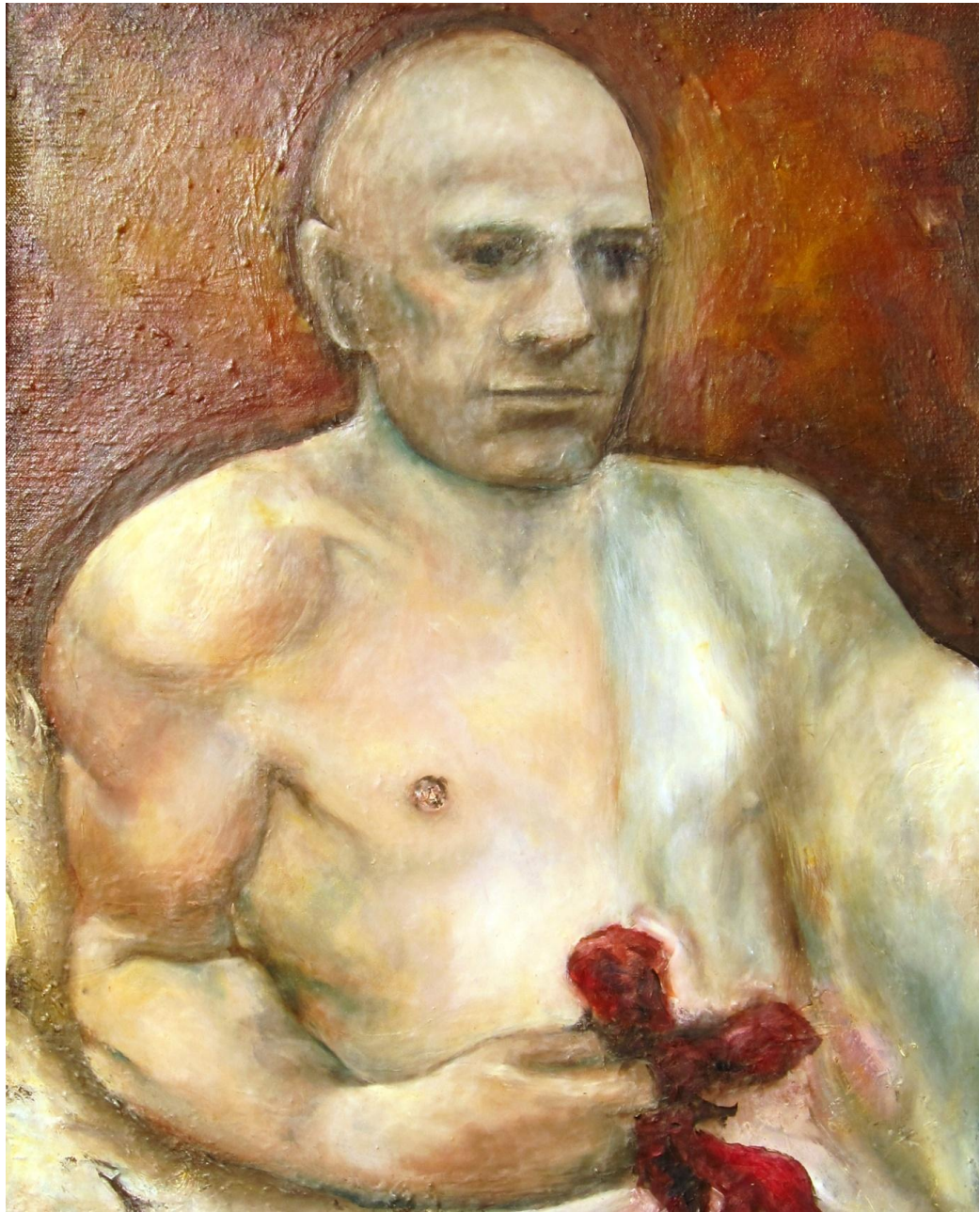
Foucault after Caravaggio (II)

Foucault after Caravaggio (II)

After struggling for so long
to comprehend Michel Foucault,
I came across <u>Understanding Foucault</u>
by Danaher, Shirato and Webb (2000),
a book that opened my eyes!

The cover of Danaher's book had a drawing entitled
Foucault after Caravaggio
by the artist Marina Pozzi.

Via the internet, I managed to track Marina down
where she lives, in Australia,
and commissioned her to paint this work for me, in 2005.

Chapter 5

DATA ANALYSIS AND DISCUSSION (2)

Listen to the nurses!

Chapter 5

DATA ANALYSIS AND DISCUSSION (2)

Listen to the nurses!

Introduction

This chapter takes as its starting point more of the responses provided by participants of this study. It situates their discourses and subsequent analysis within the epistemological framework outlined in chapter 3 and as explored with the exposé of Foucauldian concepts and tools in chapter 4. Chapters 2, 4 and 5 demonstrate clear evidence of gaps in the provision of sexual health education for nurses in England both through analysing the discourses in the literature and the empirical data, then comparing them with obvious gaps in educational service provision e.g. as identified through the respondents' experiences and relevant national statistics. It is argued that the gaps in educational discourses pertain especially to a lack of holistic sexual health education as well as insufficient HEI courses to address healthcare client / patient needs in England. The situation appears to be no different to when Hayter (1996) wrote on whether non-judgemental care is possible in the context of nurses' attitudes to patients' sexuality. Serrant-Green (2005: 515) echoes Hayter (1996), when she says:

"research suggests that nurses themselves find it hard to overcome their personal aversions to particular sexual practices or aspects of sexuality and receive little or no education in how to manage this, and this has a knock-on effect on the care they provide and their willingness to conduct research in this area."

Gaps in the curricular triptych

Exemplifying Hayter's (1996) findings, **Participant 23** of Questionnaire Group (**QG**) **04** was not alone in commenting how she found "homosexual issues" – presumably male, as she makes no reference to female - the most difficult, personally, to deal with. She added that she had "very limited knowledge" on the subject but attributed this to

> "very few men present at FP clinic for condoms".

It is easy to name the most noticeable gaps for educational provision in relation to the 'triptych' explored earlier in this work. The first gap centres on all aspects of sexual health within the pre-registration curriculum, despite the voices that proclaim nursing as a holistically focused profession (Evans 2003), where holism is treated as its "ideological cornerstone" (Lawler 1991: 24). The five quotes following are examples of others obtained across the data. The first two quotes demonstrate Foucault's "triple edict":

> **FG05 / P22** I did the old nurse training in 1979. I don't remember any urm sexual health training at all, urm, we just didn't do it [...] We weren't allowed to go on the gynæ ward because there were abortions on there.

> **FG05 / P18** I did my training in 1982. I actually don't remember any sexual health training, not even when I went to the spinal unit, you know, and found the difficulties there.

> **Me:** What sort of difficulties did you find?

Notice a shift to a discourse of Power / Knowledge, where personal needs around the *ars erotica* are silenced, symbolically, by having a cap "rammed" on the organ of male sexual desire and performativity:

> **FG05 / P18** Errrm, I remember young men being paralysed from the neck down and discussing - and wanting to discuss - about their girlfriends, their wives, and to be honest all I ever remember is the healthcare assistant going around and it looked like he was ramming a condom on, to put it on a *convene* ... but I don't member anyone talking about their sexual problems or any relationships. [Okay. Thanks]

The following example emphasises an 'ethos of governance' of the *scientia sexualis* whereby even required clinical learning is curtailed, officially, unless individual practitioners take it upon themselves to do something about it:

> **FG02 / P14** I did my midwifery but it was a long time ago and then I sort of went into health visiting and um … you just need … you need to keep yourself up to date. People ask you questions about contraception and again even on my health visiting course we didn't touch on sexual health: how to treat it, or relationships, or anything at all! So um … you have to, you just have to sort of broaden your knowledge base and you have to do it yourself.

Finally, a return back to the taboo, non-existence and silence of the "triple edict" (Foucault 1984), where even the often stigmatised intravenous drug users (IVDU) are easier to talk about than people's sexual practices:

> **FG02 / P22** [...] at the time that I was qualifying [1992] HIV was really sort of coming to the forefront um … I did a placement on the HIV ward which was half of the medical ward and um ... obviously there were some patients there who had got HIV through sex. But the whole time that I was there that was never discussed! And the only sort of reference to how anyone got their HIV was usually the IVDUs um … and it was like a really horrible nasty *nasty* working environment with lots of blame and lots of nurses refusing to work on that side of the ward. And you know, double gloving, and like really *really* bad poor practice and from a student nurse's point of view we got absolutely no support or education at all.

The lack of formal education was highlighted by almost all of the study's respondents, with the exception of three participants. The three exceptions were nurses who trained in Africa, where their early induction into community nursing brought them in direct and frequent contact with patients who had various needs around contraception, gynæcology and sexual infections. Of critical note is a lack of any mention, from two of them, of HIV infection and disease. This is despite them training during the early days of wide-spread devastation caused by the AIDS pandemic, which disproportionately affected their continent then and now.

> **FG03 / P22** I trained in Africa and we did some lessons which covered every speciality. We did go out to the community and doing what you call … practice nursing. You joined them to see what they do, so most of the cases that would come in when you went to the community, sexual health problems, and sexual health infections, so you were given time to do the assessment, ask the person … write down what sort of treatment that you are going to give. In Africa we didn't have like the laboratory facility to do tests; we did it by signs and symptoms. You try to come up with a clinical diagnosis and give the drugs according to that. [...] Then after my training I did a module on family planning. But so we also covered things in the well-woman clinic: how to do smears and to give contraception, to do full physical examinations.

> **FG03 / P18** I also come from the same area as number 22 [Africa] and uh … I did my … I did my training … I actually remember on my placement in 1979 when I did my sexual health component. I was attached to an industrial clinic, mainly attended by men which um … which actually identified the confidentiality issues as well as assessing sexual health assistance, or sexual health care from the same GP area, who is their family doctor. So each time these men were at work in that area they would come to the sexual health clinic at work and there were so many conditions that they were exposed to … from sexually transmitted infections to sexual dysfunction. So when I was on my placement I was able to be exposed to all these issues and get the input at the School of Nursing and then while you're out there you are actually going to be asked "Okay, so which conditions are you looking for?" "I am looking for gonorrhoea, I am looking for syphilis, I am looking for warts." You get them and see if you know them there, and the

> attendance was very good. And then when I did my midwifery component as well it didn't start off from the antenatal section, they put us back to the gynæ wards with the women who had been exposed to infections and then eventually to the normal midwifery. So it really *really* was quite um …

The second obvious gap in education, reported by the respondents, involves associated implications of sexual health for people with certain health conditions or in particular settings where it could and should be addressed. These conditions and settings include people with diabetes, mental health problems, cardio-vascular disease, and in school nursing and midwifery services. There is evidence that sexual health learning on specialist courses, which can be customised and related to the clinical conditions of clients, is also typically absent. It is important to note that this list of specialities, where elements of sexual health could be addressed but isn't, is not exhaustive.

Finally, all elements of the study corroborate evidence of a nation-wide lack of provision of specialist sexual health courses. This lack of specialist sexual health courses highlights the gap between educational provision by HEIs and clinical (patient) requirements across the English regions (refer to Figures 2, 3 & 4, chapter 4)[1].

To a large extent the gaps in learning provision were anticipated by the author and serve to confirm my original hypotheses on the state of formal sexual health education in England. The respondents' discourses emphasise a relationship between the gaps in learning provision and, therefore, related

---

[1] See Appendix 11 Position statement of the Nursing and Midwifery Council on sexual health education, 2011.

clinical practice, with key epistemological questions evident behind so many of their responses. These questions are 'why? what? and how?' Firstly, *why* do these gaps in learning exist? Secondly, *what* are they and what are the implications of the gaps in relation to professional practice and its associated learning? Thirdly, *how* are these gaps constructed, 'policed' and maintained? These questions are so evident in the data *vignettes* analysed in this chapter; whilst the concluding chapter moves forward to propose concrete recommendations for the development of professional learning and education.

The six themes of the focus and questionnaire groups, outlined in Figure 5: 1 below, take the respondents on a journey over time related to their sexual health learning experiences and opportunities. This time-span starts from their early days as students, progresses through their clinical careers to date and then asks them to project their learning into recommendations for the future.

Figure 5: 1   The six themes of the focus and questionnaire groups

The quality and quantity of sexual health learning in the formal curriculum or clinical-based experience, gained during pre-registration education
Gaps identified *now* - between initial pre-qualifying learning and present-day demands on clinical / professional expertise - which motivated respondents to undertake the Sexual Health Skills course
Over and above sexual health in terms of teenage pregnancies and sexual infections, other issues confronting the respondents in clinical practice
Sexual health issues or conditions the respondents consider are not fully or even adequately addressed in their area of practice or speciality, and why they think this is so
Sexual health issues the respondents, personally, find most difficult to address thoroughly. *Reasons why?*
Based on current level of learning or clinical experiences of various client needs to date, and in relation to sexual health and illness: recommendations the respondents would make to education providers as being *key* areas of sexual health for the curriculum, and why

A journey: learning for life

This journey over time through the six themes starts with the participants' own formal curricular and experiential learning during their student training (Theme 1). It moves through what they perceive as the learning associated with clinical needs, which they would now encourage practice and HEI-based educators to take on board for learners of today (Theme 6). In between these two points, they were also asked to explore what they perceived as the gaps between their initial learning compared to clinical situations they are faced with from clients / patients today (Theme 2), as well as to identify the whole range of sexual health issues they are confronted with in clinical practice (Theme 3). Theme 4 probes sexual health matters that they consider their service avoids, potentially invisibilises, or otherwise does not

fully address. This can be compared with question 4e of the HEI Survey (Figure 5: 2 below), which asked the teachers (*n=*24): "Do you (personally) consider that the provision of sexual health learning and education, at your institute, is appropriate for pre / post registration students?" **HEI-S / Respondent 17** commented how the lack of pre-registration curricular attention is only corrected by individual enthusiastic teachers. This response was not atypical and others commented on a range of reasons. The reasons included a lack of staff or teaching time right through to other overriding demands on the curriculum. Such overriding demands were perceived as conformity with requirements that 'down grade' the relevance of sexual health, especially within the dynamics of holistic care.

Figure 5: 2   Assessment of pre and post registration sexual health input, on formal curricula, by HEI-S Respondents

Vertical axis represents number of respondents
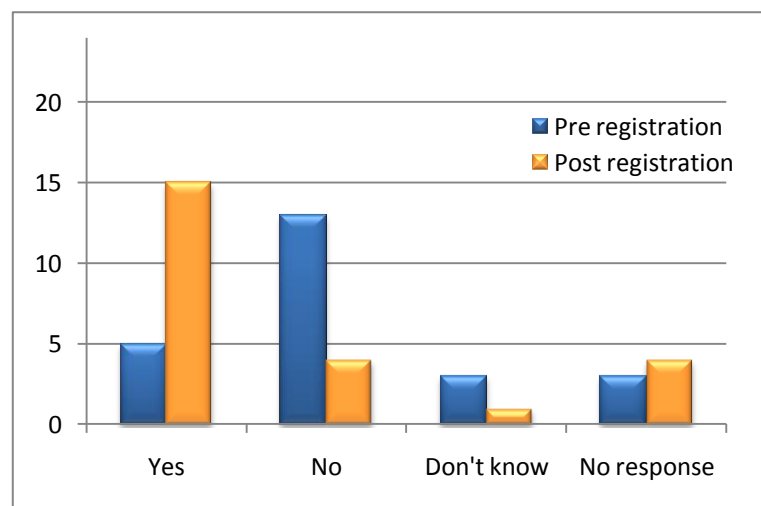
Theme 5 of the Focus / Questionnaire Groups is the one and only really personal question, in which I asked the respondents if there were any sexual

health issues which they - individually - found difficult to address, and if so, why? Finally, based on what they have said about their own formal education, experiential learning and current clinical practice needs, theme 6 offers them an opportunity to 'tell' HEI teachers and practice educators what *they* consider important for nurse education today. This element gives the respondents a voice in this thesis and intended disseminations.

How long have you been nursing?

At the beginning of each Focus Group, I asked respondents to state when they started their initial nurse training, to try to get an impression of whether matters had noticeably improved - from the point of view of sexual health input - from earlier times to current training. Sadly, and crucially for this study: this proved not to be the case. *Whether someone qualified twenty-five years ago or within the last three months, the quality and quantity of formal sexual health learning across the curricular triptych model remains negligible and incommensurate with clinical demands on professional nursing care.*

The oldest participant (**QG04 / P28)** was close to 65 years old; she commenced nurse training in 1963. The youngest (**FG02 / P20** age 21) qualified just three months before undertaking the RCN Sexual Health Skills course and this focus group. On top of data already used in chapter 4, more are summarised here to give prime examples of key discourses*.*

The Six Themes for the Focus & Questionnaire Groups

Theme 1

"Freely discuss the quality and quantity of sexual health learning out of the formal curriculum or clinical-based experience that you gained during your pre-registration education programmes."

In analysing the transcripts for this first theme, seven discourses clearly emerged:

1) for the majority of respondents: there is a clear absence of any formal education on matters sexual

2) for a tiny number of contrary cases: a small amount of curricular learning was provided

3) working on gynæcology wards brought unprepared-for and conflicting learning, especially on abortion patient care

4) confronting HIV patient care was as though by accident

5) there is demonstrable evidence of the *scientia sexualis* and the pathologisation of life with corresponding invisibilisation of the *ars erotica*

6) there are a number of parallel / associated or indirect discourses 'tagged on to' sexual health

7) summarising important outcomes for learning and professional education.

Discourse 1: We had nothing at all!

Just a few of the responses are shown here, but these examples encapsulate the sentiments of almost all of the others.

FG01 / P22 I trained in **1980** to 83 and I can't remember sex being mentioned *A-T A-L-L* !

FG01 / P20 I trained in the **70s**, re-trained again and just finished last year [**2006**] with the degree. We had t-w-o hours on the degree!

Me: And what was that on?

FG01 / P20 ... a public health module. One of the tutors: it's her subject, and she had a handout and discussion in two hours.

FG15 / P10 I started in **2000** and basically we didn't get that much to be honest. It was an overview on sexual health and sexually transmitted infections and HIV and stuff, but we never really went into it in any great detail. [...]

FG08 / P11 [no date] All I can remember from my nurse training was, urm, going through Activities of Daily Living, as we did with every patient and the box that said "sexuality" was just "male" or "female". And that's what you were taught! We had to put down whether they were male or female and other than that nobody ever put anything down, *we didn't explore anything.*

This last respondent was in the overwhelming majority who referred to sexuality solely as male / female. Only those who had ever worked with transgender people were aware of their specific needs and their presence in healthcare services and simultaneous absence on formal documentation.

FG01 / P01 I did my training in **1979** and I can't remember having anything to do with sexual health. Also done subsequent courses, and the diploma course, and I cannot remember anything at all until I started doing this [SHS] course. And then I became pregnant a year ago; that was the first time that I actually started thinking about urm, issues in sexual health. When patients started coming into the clinic with different issues, that's when I felt I had to come on this course because I just did not know anything. So this is my first encounter with sexual health, and I'm still struggling having to deal with some of the issues myself, really.

It is worth noting that a number of respondents across all elements of the study had a personal interest in sexual health, which appears to have led them to work in the speciality. For others, as with **FG01 / P01**, it is as though they went in to sexual health by default. This is most noticeable in those working in gynæcology and HIV client care. Nurses in the latter case just happened to be working in an environment, such as a medical ward,

infectious diseases or an intensive care unit (ICU), where HIV+ patients were admitted.

FG02 / P22 refers to sexual health as a "taboo subject":

> I qualified ages ago! – **1981** [...] It was always a very taboo subject.

Given what this thesis states on Foucault's "triple edict", then it is clear that many of the *vignettes* recorded here are emblematic of the whole subject area being treated as taboo, with enforced silence or invisibilisation resulting in a contested existence through apparent non-existence. This 'non-existence', however, is not so absent for the participants who are confronted with particular issues in clinical practice. What is then noticeable is the way that the clinical or experiential learning is equally enforced into a status of silence, be this through the domain of Power / Knowledge or under the control of various aspects of governmentality. Gestaldo (2006: 124) claims that in Foucauldian terms this is akin to the "anatomico-politics [which] involves the docilisaton [*sic*] of individual bodies". Witness, for example, the following response, which is evocative of an *episteme* in that there is evidence of how discourses, discontinuities and power relations intersect (see page 171):

> **FG07 / P10** We had two days in our final year, they looked at sexual health and infections; that was probably in the morning, then in the afternoon, a cross-section. [Discourse]
>
> The second time was a local HIV specialist nurse came in, in the morning, [...] Then my final semester we were allowed to do an elective placement anywhere we liked so I chose sexual health nursing and I spent time in the GU and contraceptive clinics and in HIV infections. [Discontinuity]

> The university told me "no!" So I was quite concerned, quite angry. I asked why and they said "it is not related to nursing" - they don't see sexual health as related to a nursing course! [Power relations].

I made the following statement to Focus Group 02, but it could equally have been made to all of the groups and I am sure the response would have been the same:

> **Me:** [...] lots of you are saying the good part of your learning was from clinical practice rather than what you were taught from the curriculum? *There was general agreement, and overwhelming "yes" from all FG02 participants.*

The HEI respondents echoed all other responses, with nothing new or of note to add. These two clearly encapsulate the rest.

> **HEI-S / R06** RGN 1982 very limited SH training. RM in 1986, more sexual health training as contraceptive advice is part of role, but not enough. Later went on to BSc(Hons) in sexual and reproductive health.

> **HEI-S / R14** Session on "VD". 1980s. "Dark Ages".

Discourse 2: Contrary cases: we had a little

These respondents were in the tiny minority of those clearly identifying some sexual health teaching in pre-qualifying studies.

> **FG08 / P17** I did my nurse training [...] not that long ago actually, and yes we did have sexual health training, um … we found out about things in the classroom environment. We discussed things like HIV, sexually transmitted infections, um … we didn't have essays to write on it or anything, but we definitely had a few tutorials and things like that.

> **Me:** Excellent! Okay, and can you remember roughly how much time was spent on that? Was it like less than a day, and could it have been split over three years / different sessions?

> **FG08 / P17** We revisited it two or three times during our um … nurse training. We did it in the foundation and then again um … as you took your branch, we did it again.

FG03 / P12 *I can't remember getting any formal stuff during my SRN training but on the wards I think a lot of that; we did have a particularly good nurse tutor who was hands on. And the only experiences that I can remember about being on wards were the guys who had prostate surgery: sexuality and difficulty with erections and that kind of thing was discussed. And also on other surgical wards where people had colostomies and also breast surgery, where there was attention to their own sort of body image. There was quite a lot of stuff around body image, and the effect of that on their life but that was...that's all I can remember.*

Evidence from the data reveals that formal learning took place only for a minority of respondents, who are therefore categorised as 'contrary cases' to the majority or norm. Lawler (1991: 52) states:

> "It is important to make a distinction between 'formal' (classroom) education and 'informal' (that which is learned on the job) in nursing. While nurses are instructed in those matters which are contained in textbooks, there is sometimes considerable dislocation between that knowledge and what is learned in clinical practice."

Respondent after respondent in this study confirm this statement, made by Jocalyn Lawler (1991). Given the advances in clinical care over this same time frame, for example through improved medications, operating procedures, computing and life-saving technology and the like, it is lamentable that this area of care still appears to be hidden in the shadows, or as Lawler's study proclaims "behind the screens".

Discourse 3: Abortion

The theme of abortion has been introduced in chapter 4; here are a few further brief points of note. Firstly, the discourses around abortion outlined here are not what many consider typical in mainstream UK society. For

example, abortion is traditionally considered to be a procedure relating predominantly to teenagers or younger women. Secondly, it is possible to guarantee from the data that none of the respondents mentioned anything about male partners of the females undergoing termination.

> **FG02 / P11** [Asian respondent, trained "back home"]
> I qualified eleven years ago um [...] I went to the gynæ ward, mainly dealing with abortions, <u>illegal</u> abortions. They would come in presenting as if they had just had a miscarriage but they had gone back street.

Not only do all the respondents highlight how they had no formal learning on the procedure of termination of pregnancy in their curriculum training, but they often-times mention related learning and skills they required, such as counselling skills and greater awareness of associated problems like rape, sexual violence and domestic abuse.

> **FG12 / P05** I deal with ladies who are having termination of pregnancy, and they're not teenagers anyway, urm so obviously they have an unwanted pregnancy, urm, domestic abuse, we see a lot of women with domestic abuse ... urm, you just don't ever know what someone is coming in with, you know somebody starts talking to you about all sorts of issues when they come in.

In 1994, Hayter commented how experiential learning, especially around clinical and professional issues, such as ethical dilemmas and matters which attract 'judgementalism', can benefit from a robust approach to critical reflection and informed practice-based supervision. This current study, some fifteen years later, shows little evidence of any major change in this process of learning particularly around abject matters such as abortion.

Discourse 4: HIV client care - in the workplace

> **FG03 / P09** [...]   The first I remember is um ... is when I did my midwifery in the **early eighties** [...] going to a sexual health clinic and seeing someone with warts and it was just at the start of HIV and I remember the adverts saying 'it's coming and it's going to infect everybody'! That was the first I think. [...] I think that's why it was sort of a panic really.

> **FG08 / P07** I did my training um ... in London in the **mid 80s** in a hospital that set up the first HIV clinic and we didn't actually get anything formal in our training as such but just generally working clinically at that time there was a lot of um ... we came across HIV a lot and AIDS a lot in ITU with people with pneumonia, and in every area we worked in because of where ... the hospital I worked in. But I can't actually remember having been sat down and given any formal training as such at that time.

For most of the respondents, the theme of HIV is reported in relation to clinical reaction.   None of them showed evidence of being proactively prepared, educationally, to address the complex issues of HIV patient care – clinical, psycho-social and emotional, sexual and stigma-related - other than to react to emergencies or unanticipated clinical cases confronting them. This equates to Hodgson's (2003: 27) classification of staff as "the HIV naïve", which, he says, is not a pejorative term, although sometimes it does indicate people with a negative moral predisposition towards those whom they consider to be somehow culpable for their own condition.

Upon reflection on the various data responses in this research, a most personal insight that struck me was in reaction to a statement made by **Participant 14** / **FG01**:

> It's a long time ago; it's hard to remember!

My personal reflection

To this participant, who lived through those early days as an adult and as a nurse, the events have faded in her memory. My own position then, however, was, and continues to be, very different. In 1981 when the HIV pandemic / AIDS panic was first declared (5 June), I was two years out of 5 years nursing, and studying to become a Roman Catholic priest. Maybe because of the initial "gaying of AIDS" (King 1993), with stories of 'gay plague' and 'gay cancer' (Sontag 1991), my own memories and experiences of frenzied media *reportage* were of the social representations of gay men dying; of homo- and race hatred campaigns; and of US and UK government responses (*sic*) to the illness and deaths. These early images are personally ingrained on my brain as I thought at the time "these are my brothers – people like me – dying!" **P14 / FG01's** statement is more understandable when one considers the moral framework, so-to-speak, of the wider world in which we live. As Knox (2006: 3) states:

> "Often the heterosexist discourse in such settings states that people should be treated equally and, therefore, the *same*. What this translates into is that everyone should be viewed and treated as *heterosexual*. Therefore, according to the language of heterosexist hegemony, equal means heterosexual and queer people are rendered invisible" [*emphasis original*].

The above statement, it may be argued, is also transferable to the field of HIV, where peoples and communities most affected are often those for whom it remains most significant; for the 'general population' – everyone the same as the rest - HIV is irrelevant. To compound this situation of apparent irrelevance, there is support in the data that respondents who trained well

after the initial years of the HIV and AIDS 'panic' appear to give the impression that HIV is no longer an issue for their clinical practice or their education.

Discourse 5: Scientia sexualis and the pathologisation of life

FG02 / P13 I trained in London between **1980** and 1983 [...] I think they did talk about sexuality, if someone had a colostomy or if they had had a heart attack.

FG05 / P01 I'm a nurse in GUM and I did my training in **2004** so I'm quite new, urm, I don't remember there being any specific lectures on sexual health. [...] There was definitely, urm, related stuff in other areas I worked in. In dialysis, we covered HIV along with other blood-borne viruses. Then we did some more when we did midwifery. We covered Chlamydia and things like that, and in gynæ as well. As students we were allowed to go to GUM and the abortion clinics, if they wanted to, but there wasn't anything directly specific to sexual health.

Me: And when you were on the dialysis unit, when they urm discussed things on HIV: did they tell you anything about the sexual transmission of HIV or was it purely from the point of view of blood products on the unit?

FG05 / P01 They would have told us the ways it can be transmitted, but because the unit mainly had to do with blood matters, we would have concentrated on that and it was more to do with the virus itself than the transmission. But they did go in to that, but not in any great detail.

Me: What did they talk about, if one of the patients was HIV positive: what about the personal sex life, kind of thing?
FG05 / P01 No! [Okay, thanks].

FG06 / P27 [...] Sometimes people got stories to tell about things when things went wrong etc. [...] I was a sick children's nurse at the time and I used to see babies born with problems [e.g. *ophthalmia neonatorum*] but we never discussed sexual health with their parents.

FG06 / P05 [...] when I was working on male surgical ward, I do remember that people who had prostatectomy were told that they would

be impotent afterwards and that's the only thing I remember, and I don't remember anything really about how these men would deal with that problem after surgery.

Me: So were they just told that fact, was there no discussion?

FG06 / P05 Yes, just that. I don't know what was spoken of behind closed doors with a male doctor, but the nurses weren't involved in there. [Fine, thanks].

FG11 / P11 I suppose when I think about it, as a student nurse again, doing my stint on urm coronary care just listening to the nurses giving advice, you know post-MI ... urm and they did address the issue of sex but the message was [she laughs, embarrassed giggles] ... **"Don't do it"** [another participant exclaims!] No, no, [laughs] they would say "just do what you normally do"! And the patients used to say "what do you mean?" And they used to say "don't try any new positions! Don't have a new partner! Nothing you think which is likely to excite you; just do what is *normal* for you!" It just made me think about this now!

Analysing the following two quotes, there is evidence of how discourses also relate to medical power / knowledge, with elements of governmentality and the 'surgical' *policing of desire,* ways "in which technologies of domination articulate with technologies of the self" (Fox 2006: 42). This process is with apparent hegemonic relegation of the *ars erotica,* transposing it into more of a *scientia sexualis.* By way of example, **Participant 19** recalls a most extreme, but sadly, not isolated case in point of medicalised disregard for a person as a sexual being.

FG12 / P19 [...] I nursed women who had hysterectomies, and, urm, I don't remember anyone ever talking to them afterwards about how it might affect their sex lives or anything like that. Urm, I can actually remember in those days, urm, a client actually had a vulvectomy, she had got cancer of the vulva, and I can actually remember the consultant with a team of medical students coming around urm, examining the lady, and explaining what was going to be excised and saying "of course, we'll be taking the clitoris as well! ... Some people say that plays some part in sexual pleasure" and this poor woman was lying on the bed, listening to this happening. That is something that has stayed with me!

214

Me: Were you able to talk about that sort of stuff back in the School of Nursing, for example? Did anything about ever come up?

FG12 / P19 No, we didn't really have time to talk about things like that. We used to have a midwife - because we used to have women who were having a termination and early miscarriages - and then a midwife would come over from the maternity block to talk about contraception afterwards with them. [With both groups of women?] Yes. [okay, okay thanks]

FG12 / P11 And you [P19] saying about the lady with the vulvectomy? I can remember being in theatre, you know, as a student. I can remember a surgeon doing a mastectomy and whether I remember this correctly or not, but it is the memory that stayed with me and has been hidden. As he sort of took the last excision, so he put the breast in his hand – it was a large breast - and *throwing* it into a bucket on the floor. And me thinking, "it's too big to fill the bucket!" because it collapsed down, and I remember thinking the way he threw it in there! It was almost something about disregarding it, like "*THAT* can go!"

Finally, on the "medicalization of life [.] through the pathologization of normality" (Skolbekken 2008: 17): Lawler (1991: 126) poignantly asserts that this happens to be part of being a nurse, i.e. "being expected to learn such emotional control and to learn it as they developed their nursing skills, and as they coped with a daily working life that was often difficult and disturbing".

FG11 / P03 We haven't got time anyway! There's another three clients waiting outside!

Me: [Regarding the role of professional power / knowledge, I asked:] With the emphasis these days on all of us being reflective practitioners, then on some of these harrowing events, reflection and learning how to deal with them to move on to the future: is there the opportunity for that?

FG11 / P03 Yes, yes, and I think it can be cathartic, it is a lack of appreciation from management that we have to deal with some terrible things or situations [yes, yes]. We *do* cope ... because that's what we do! Most of us deal with it, because that is your job, but sometimes the recognition of the fact that this has been particularly harrowing by this

team of people, and we recognize that this is the norm as opposed to, well, "what's the problem? You can talk to me if you want to", that sort of culture.

Discourse 6: Parallel discourses to sexual health

These parallel discourses range from the practicalities and performativity of sex to sexual traumas for particular clients as well as harrowing (lack of) support issues for the staff, as referred to in the quote from Lawler (1991) immediately above.

> **FG02 / P12** The only thing I do remember was when we were learning about marijuana and it could reduce sperm count - and one of the male students sort of went pasty white ... [group laughter].

The following participant was the most recently registered / qualified of all the respondents for this study:

> **FG02 / P20** I qualified in February [**2007**] and I don't remember sexual health being taught to us *at all* apart from a reference to if a man urm … is catheterised, and needs to stay catheterised, to still have sex it can be bent around and a condom put over the top because some men were found to be pulling them out and that was the reason why, because nobody had talked to them about how to still have sex.

> **Me:** Did they mention anything about sex and women with indwelling catheters?

> **FG02 / P20** No.

> **FG11 / P12** My clients, say 99.9% of them, have been sexually abused.
> **Me:** And your client group ... it is?

> **FG11 / P12** They are female sex workers, commercial female sex workers. Urm, and they have all had some sort of sexual abuse in the past. So, urm, they are very damaged from that.

> **Me:** And do they tend to talk about it?

> **FG11 / P12** No! No they find it very very difficult to talk about it. They are also concurrent drug users as well and that is to dampen everything down really, to put the abuse out of the way. We have got

facilities for counselling when they are ready, but some of them are never ready, it is too gargantuan for them to face really.

Me: And what sort of psychosexual counselling experience or learning would you have had?

FG11 / P12 I don't do that psychosexual counselling myself, urm, we have got specialised counsellors who actually come into the centre, who will do the counselling. I don't think they are primarily *psychosexual* counsellors, they are just general councillors, urm, and if they feel they need something more specific they would refer on. But it is quite difficult to get them to access counselling.

Me: But do you find working in your role as a nurse, you are using counselling skills with them?

FG11 / P12 Definitely! Just by having a caring, motherly attitude ... they have had a terrible upbringing and they will often disclose things and we have had to involve social services several times where abuse that we know is going on with smaller siblings that are left behind in the family. [...] Also, quite a few of our clients do get raped in their field of work as well [...] Police aren't always sympathetic. We have got quite a good team at the moment, but some [clients] do feel reluctant to talk because they feel that they deserved it because of the type of work they are doing.

FG11 / P05 When I took over we had a 13-year-old rape come in to us for termination of pregnancy, and the police were involved there. [We also] have issues around another problem, of foetal disposal, which is a sensitive issue but we have to address it, and obviously in this case we have to keep the foetus as evidence for the police. You know, that is really harrowing.

Me: Yes, of course, and what sort of support is available to you, as staff?

FG11 / P05 Urm, not a lot other than talk amongst yourselves. But I think because like you [Participant 12] we are a small team, we all flow together, you just do! [...] When I worked in midwifery we had issues of stillbirth, you know, unfortunately it never seems to happen in ones, there is always a run of a least the couple, there is *never* any support. I don't think we do well generally as nurses in the support stakes. If you look at the police, if a dramatic issue happens to the police they send them away for a fortnight counselling, you know! I am not saying that

> we should do that all the time but it's a case of "Right! Do you want to talk about it? See you in work tomorrow!" And on you go. [yeah, yeah]. As opposed to, I think, sometimes we're hardened to the fact that so many of these things can have an adverse effect on you. *It's not normal to be dealing with a dead baby, you know!* If you see one in your midwifery life, that is awful, but we don't: we see more than one, you know! It is not normal to be cutting locks of hair off dead babies and doing hand prints and footprints. That is really harrowing! But because you are *supposed* to do it, it is just assumed to be normal. Taking dead babies to the mortuary. You know? How much support are we getting? What sort of nursing network? "Are you okay? Do you want to talk about it?"

This discourse is more evocative of an episteme of nursing and midwifery skills, especially around how nurses / midwives cope with support and lack of support. There are clear discontinuities in what is accepted as the "normal" – *life is for living* - and how nurses and midwives have to deal with other than that, and still carry on working! The power dynamics in the fuller *vignette* appear to intersect each time there is apparent concern expressed by managers, but such concern is perceived more as lip-service that does not subsequently materialise into concrete support, compared to the police, for example.

Discourse 7: Summarising issues for learning and education

In this discourse, only specific points will be highlighted for education as they are dealt with more fully later (Theme 6). Personal motivation to work in a sphere of sexual health was a common topic in all groups; this is despite any noticeable role models or practice-related placements during student training. A theme I did not investigate, but in hindsight – or maybe for another project – would be "why?" Why do nurses with little or no knowledge or experience of sexual health clinical practice and related education choose to enter that area of care? What motivates them, especially when a number of the

discourses revealed in this work are harrowing, shrouded in stigma and taboo, and often treated with far less due regard and professional esteem than other areas of clinical care?

Some of the respondents mentioned how the only sexual health or sexuality education they had in the classroom was related to the *Activities of Daily Living*. However, not one mentioned anything more than the inappropriate way in which this was dealt with, even if, as such, it was the bare minimum of reference to it. Support around moral and ethical issues (such as abortion) as well as lack of time and emphasis on associated skills, such as therapeutic listening, were also absent. As **FG11 / P12** said above, in times of stress and trauma: "Just by having a caring, motherly attitude ...". However commendable, this cannot necessarily be translated as appropriate, therapeutic, listening and counselling skills for the psychosexual issues facing these professional carers. If counselling skills for nurses and midwives are absent in the curriculum, there is presumably no evidence that a "motherly attitude" is taught to replace them.

> **FG03 / P14** From my nurse training um … we had the ADL form of assessment and through that there was … you had to assess the sexuality section. We had, I think, one day on sexuality and teaching, and that wasn't I felt explored in enough depth, um … but to me I was quite interested in that area because I was always quite unsure what to say when assessing clients. And so I did other projects and some of my assessments were related to assessment with the sexuality theme. So … I didn't feel the input from the university was good but it allowed me to go off and do it in more depth if I wanted to.

Theme 2

"What gaps can you identify *now* - between your initial learning, which we have been talking about – between that learning and the

present-day demands on your clinical / professional expertise which motivated you to undertake this particular course?"

Analysing the data for this section revealed five key themes that were evident, especially in relation to the Foucauldian concepts used throughout this work. These themes include:

1) gaps in practice effected by taboo, non-existence and silence
2) perpetuating the gaps through 'regimes of truth'
3) resisting power struggles of the *scientia sexualis*
4) *scientia sexualis* doesn't tally with *ars erotica*
5) the odd ones out.

Discourse 1: 'Triple edict' and gaps in clinical practice

FG08 / P06 I am actually now working as a practice nurse induction trainer, so new practice nurses ... training them in the basics. And um … one thing that I have really picked up from doing this course is that there was nothing at all on sexual health in the basic rolling programme for them [...] but we're actually looking now at changing that and adding something in there [...] The fact that practice nurses deal with the sexual health issues so much now, but there still isn't anything included!

FG15 / P06 I've noticed throughout my training and through my job as a practice nurse that there was a stigma in regards to sexual health in clinical care and even now although it is becoming less urm ... I kind of sort of noticed that there were huge gaps between all of the services. And so I was trying to look how to build bridges between the services so we could not take on the service of the GUM clinic but actually offer some appropriate sexual health to different client groups and ... urm ... and try not to increase the stigma any further.

Me: When you talk about stigma, can you identify anything in particular that you would stick the *stigma* label to?

FG15 / P06 Well basically you know people used to be quite reluctant to go to a screening for a sexual health disease, as it would be perceived that they were seen as promiscuous or whatever so it is kind of about ... one may be just normalising things really and making them see that it's just another aspect of the overall body: it's not a bad thing.

The statement by this practice nurse reveals a double problem of stigma and sexual health. She is not alone in identifying concerns that some patients have in going to general services about sexual health matters; this includes worries that they will be negatively judged, not least as being 'promiscuous' (Evans & Stapley 2010). At the same time, Pryce (2001: 160) elaborates similar worries of people physically attending a service known or designated as something to do with the 'sexual' domain of life and prejudged as indicative of "low status and *otherness*".

> **FG01 / P01** Yes, it was gaps that I realised that I was forced into the situation I am in. It was sexual issues they come in with - infections "down below" - and they came in and I thought "where do I go from here?" I didn't know what they were, and this course is self funded because my surgery won't take an interest in sexual health, but I felt I wanted to be the best! You know, I must give the best care to my clients, so that is why I had to put myself on this course to learn more.

> **FG01 / P27** [...] the thing that motivated me to look at this course urm is to look at thinking outside of the box. So you have got a client who is coming in and discussing things like ... you need to be aware that sexuality may be different for individuals. People come from different religious backgrounds - look at the belief they bring with them - so it is looking outside the box and for me that has been the really good valuable bit of it.

Despite religions, ethnicities and cultures sometimes playing a significant role in people's perceptions and practice of sex and sexuality, these terms or their associated belief systems and life-ways were rarely mentioned throughout the empirical study. This low profile of religious, ethnic or cultural regard was particularly evident in relation to the often contentious ethical issues around abortion client care and people with non-heterosexual sexual identities. Other aspects of the 'triple edict' are witnessed in the following *vignettes*:

FG01 / P02 I work in oncology, there are so many issues urm, sexual issues, sexuality, sexual health problems and related issues coming up all the time and clearly some related to surgery - depending on their diagnosis and treatment - and what I have found on the documentation [...] ridiculous comments that were made. I've seen loads of those in the box on the documentation.

Me: Can you give me some examples?

FG01 / P02 Well, urm, something like 'living with a partner', I mean, really, you know! ... definitely tells you the person's sexuality, their sexual relationships: it doesn't at all!

FG01 / P07 [...] we do a lot of screening on HIV, all pregnant women, and checking for syphilis, HIV and hepatitis, but also when we talk to them about vaginal discharges. Urm, prior to urm looking into urm sexual health in midwifery training, the implications and the differences of vaginal discharges were not made very clear to me, so there was a huge gap in my knowledge around sexual health.

FG01 / P08 I found when I was training there was a lot of time spent in general on holistic care, psychological impact, but we were never actually taught anything *useful* and so we have patients sitting in front of us asking all these questions that we are not equipped to answer! [...] I actually wrote my essay on, urm, herpes because I have so many patients that just sit there and they want the answers, and obviously I've got some ideas, but, urm, I don't have enough knowledge and that's not just in GU that's across-the-board. We are not actually *taught* about the medical information to prepare us to hand onto the patients! It's all about ... last module in my training was about 'style of leadership': it was absolutely useless at the time! [Everyone laughs].

The following respondent clearly highlights a desire for breaking through the silence with a quest for more knowledge, which, in turn, will result in more personal (individual) power around their own sexual health and well-being.

FG03 / P16   [...] the gap is that people just seem so much more anxious now, they want to know more information, and they want to know all the 'what if's'. Um … and they just seem to be more aware, I suppose, of their sexual well-being and there is just a lot of anxiety, there's a lot of anxiety about everything, um … but I can focus in on the anxiety about the sexual health.

Discourse 2: 'Regimes of truth' perpetuating the gaps

FG01 / P20 I am keenly aware that as a gynæ nurse [...] there is very little discussion with regard post surgery. People are pushed through so quickly now that we just had a concern that they have no infection and we wave 'goodbye'. I felt if I had done the course it'd give me more confidence to actually sit down and say to them, "well you know, do you want to talk about anything?" So I have a few people really open up to me and I have the courage to question them, urm, which I don't think you would be able to do if you haven't done this course.

FG01 / P02 I actually do sex education at school and think it is woefully inadequate in schools. There is nothing! There is little contraception, very little sexual health, no self-esteem, none of those things - it's *woefully* inadequate. It just doesn't happen, and I want to develop an in-depth programme, therefore I need the knowledge and the certificate, so if I get the kickback from parents I have got the research to prove that this is the right way to go [...] They only do the biology: they have one lady who comes in once in year seven - it's an all girls school 11 to 18 - in that time they get a one-hour lecture which is basically scary photographs really, and then there is no follow up with that person so they have nobody to continue their sexual knowledge with, so I wanted to deal with that and to develop it.

There were some very limited examples of respondents promoting the *ars erotica* in the face of triple edict intransigence, such as:

FG01 / P22 I think it's a combination of fear. A lot of people are scared to talk about sex and are ignorant. I think people are scared, especially when we are talking to young people [...] they are scared, if I talk about urm oral sex, telling them how to use a condom, talk about anal sex: are the parents then going to be beating on the door saying "you shouldn't be saying that!"? So I think some people are just very overcautious. I think people are fearful of a reaction, and fear, ignorance and embarrassment are because they don't like to talk about intimate physical things and then have to bump into the same people in the corridor. So they find it easier to ignore it completely.

This following quote is reminiscent of the judgmentalism outlined by Chambers and Narayanasamy (2007: 158), as explored in chapter 4.

FG06 / P09   I think there should be more taught, and I think on attitudes rather than just behaviours.

Me: Like what: what other attitudes?

FG06 / P09   Well, urm, I think urm people are quite - you know, unless they come across with something to do with sexual health first hand - they could have quite negative attitudes towards it, including nurses as well, who could have not seen it as an area of health that is preventable and "it's *your* fault if you get something"! But actually there isn't enough education out there, I think, to help nurses see the wider picture about sexual health.

Me: So you think that nurses could be part of this sort-of blaming culture?

FG06 / P09   I'd like not to think so [yeah] but I think anybody, if they are not equipped with the right amount of knowledge, it's easy to make assumptions about things and I think when you're a nurse you get so much in School - information given to you about lots of other things - and you learn all about development and disease, and you know, epidemiology of disease, and that should be the same in sexual health! Just to make sure there is no stigma in health services, and it's not just left to professional specialists, but *everyone* has a decent bit of knowledge.

As an example of many of the concepts used here which cross-over and inter-relate, the literature and discourses of the various respondents witness to how attitudes are still shrouded in the element of Foucault's (1984) "triple edict". These attitudes may relate to the physicality of sex or sexual identities, to sexual and reproductive health, and include modes of transmission of HIV infection. Sometimes these attitude are manifest through taboo, non-existence or silence, or, more often than not, in a dynamic inter-relationship between all three of these.

The following *vignette* is another one difficult to categorise; maybe it bridges the divide between discourses 2 and 3 of *regimes of 'truth' perpetuating the*

gaps and *resisting power struggles of the scientia sexualis.* It is so atypical of almost all other responses and yet clearly establishes its role within the dynamics of Power / Knowledge in the formulation of alternative truths and conflict between the *ars erotica* and *scientia sexualis.*

> **FG12 / [Inaudible number]** Something interesting came up the other day, and this is how statistical information is accepted by central government, because you know I manage the Chlamydia programme and we have to have the exact formatted data which is returned on a quarterly basis. Well, we returned the specimen that - a set of data - that said it was "male vulvo-vaginal swab". It has been rejected as quality data! It was sent back to us, and we were told we must check our data for inconsistencies before we send it out lah-de-dah-de-dah! They will not allow it to count at national level for the LDP because it is "male", and it's been recorded as a "vulvo-vaginal swab". I was told to go back and contact the client to ascertain what specimen it was. I turned round and I said "no!" and they said "why not? Obviously it is a mistake made!" Obviously, it's not! I went: "what if it is an individual undergoing transgender reassignment that is living as a male at the moment, perceive themselves as a male, but has still got a vagina?" Someone has taken a vulvo-vaginal swab. And they went, "don't be so stupid!" And it had been rejected from the Department of Health because it doesn't tick the right boxes. They won't accept that! Why do they want to know people's sexual practices in gender if they don't want to know about people undergoing that sort of procedure?

Discourse 3: Resisting power struggles of the scientia sexualis

Jolly (2001: 246) reported of her respondents that "a majority of the nurses (87%) had not received any specific training on how to nurse teenagers with sexual health problems" She continued, "65% considered that the quality of sexual health service offered to teenagers was poor." Jolly also highlighted that despite 65% of her respondents having worked in gynæcology for more than five years, they did not consider their learning and education was adequate to address their client needs or the tasks at hand. Only 33% ($n =$ 16) of Jolly's respondents claimed proficiency at taking thorough sexual

histories (p. 249). A similar deficit in learning is evident through the respondents of this study, with two commenting on professional silencing around the issues:

> **FG03 / P14** I did gynæcology and it was more that area where the women were dropping hints and to my horror they just weren't being picked up by the nurses. They'd just had their miscarriages, or they'd just had their vaginal hysterectomies and I didn't ever hear anybody giving any sexual health promotion, just to check they were maybe concerned about when they could start having sex again. And I think I even approached it with one of the nurses and she sort of brushed it off and said "oh the doctors talk to them about that!" You know that really shocked me and I think that's also what motivated me to keep … to try and do something about it and so … yeah.

Discourse 4: Scientia sexualis doesn't tally with ars erotica

As Dattilo and Brewer (2005: 210) poignantly observe: "[.] the majority of practising professional nurses do not typically assess the sexual health and concerns of their clients." Quotes from the following respondents clearly identify a perceived clinical role that is required to address the human actions of their presenting clients. The difficulties many respondents recount are in keeping up-to-date not only with the clinical issues of sex, such as pathogenic modes of transmission, but discussing risk activities, appropriately and effectively promoting sexual health and well-being, as **FG05/P23** clearly demonstrates below.

> **FG03 / P18** [...] the sexual health field has changed quite a lot and you find that there are new trends that you may want to follow but you find that you really need … you need to be exposed in a setting where all this information can be given. Why? Because even the clientele themselves they have changed, some of them are well versed with all the information, but of course they still need somebody to polish up that information when they come to a setting. They may still find [Participant] Number 18 who trained in 1979 with that '79 information, and this is the year 2007: it doesn't sort of really tally!

FG03 / P10 [...] because I started in the critical care background then I went to um … HIV and I think because of the way I was trained I was always clinically focussed, and I think working in HIV I have realised that there is a bigger picture to sexual health. And I have got away from the kind of symptomatic kind of critical care thinking and look at the kind of bigger picture.

FG05 / P23 Urm sometimes with teenagers, it's the problems they have, like: should they have sex? how should they be protected? or they have had sex: what should they do afterwards? You know: what should they be screened for? Where things have gone wrong and they're worried, and urm ... with like ... sometimes we see people with diabetes, and you get told they've got erectile dysfunction and it could be part of a disease or their medication and they know there's treatment out there that they would like, the medication, they would like it. And sometimes we get women who are post-menopause, or peri-menopausal [...] you come along with one problem and it's like opening up all these new things of a sexual nature.

Discourse 5:   The odd ones out

The following two examples speak for themselves and are noticeable for their individual reasons.   There were many other idiosyncratic data which were unique in their one-off nature.

FG06 / P05 I started working in a new practice. The doctor who was the lead GP was very interested in sexual health and contraception. She is from Holland herself, and was appalled at the lack of knowledge in this country.   She did some training and practice development for services and wanted - *and needed* - some of the nurses to be trained as well. She wanted a practice nurse to do this course. [...] I find some of the knowledge I have now got extremely useful and am introducing things into the practice that you know I wouldn't have thought of before!

FG03 / P09 I got sent on this course because I have the best sickness record in the unit!

Me: Because you've got the best…?

FG03 / P09 Sickness record! We have a terrible sickness problem and I was the only person that hadn't had any days off sick! [Laughter]

227

Me: So they rewarded you by sending you…

FG03 / P09 So they rewarded me! I wasn't quite sure in the end whether it was a reward or a punishment! [Laughter] That's why I came … and I guess part of it was [...] keeping myself current. [Yeah]

Theme 3

"Sexual health is frequently spoken of in terms of teenage pregnancies and sexual infections, but over and above these, what other issues confront you in clinical practice?"

The respondents highlighted a considerable number of wider sexual health matters that were a) omitted from their pre-registration training, but b) confronted them in their various fields of practice. Many of the respondents show evidence of consolidating learning, especially by transferring skills. Over and above the majority of typical issues identified, which one might expect to hear related to sexual health, the following matters accentuate some of the more unusual ones. These issues in practice sometimes led the respondent to identify gaps in their learning which they were not always certain how to address. There were two key discourses appearing in the data concerning these specific issues in sexual health:

1) language in action, and

2) managing the *ars erotica* in practice

Discourse 1: Language in action

There was clear evidence of a number of the nurses actually making the first move in addressing both generic (holistic) and particular sexual health matters with clients, i.e. not waiting for the patient to mention problems first.

The practice areas or topics of consultations were wide and varied, with just a few key examples shown here.

FG02 / P22 … Travel clinics, well-woman consultations: you might get a middle aged woman talking about vaginal dryness or something like that, um … erectile dysfunction in men, when someone comes up with a chronic disease issue such as diabetes.

FG02 / P17 Eating disorders, um…and uh…sort of self esteem and life skills, and drugs, and alcohol, and [...] problems with food. And then they seem to also be the vulnerable girls who are um … *sketing.* I can't think of a way of saying it. They are giving out the numbers and if boys want favours, sexual favours, they text or call these particular girls who will then go and do the job. So … it's like a whole culture of related issues and then maybe in return they will get some … weed, or … so it's like a cycle of things that go on. They are girls that seem to be involved in lots of different things. [...] So a boy will say "she's a *sket*".

FG02 / P12 Sexual assault: I have got one of each at the moment [male and female], but it has been mainly female. It's usually behavioural issues, and I sit down and start chatting to them and it turns out, "well actually I was raped when I was seven and mum and dad covered it up" and stuff like that.

FG02 / P16 [...] body image, people have said a lot about surgery and mastectomies and MIs and things like that, just about how they affect their day-to-day living and their sexual health.

FG03 / P14 Patients with high cervical spinal injuries and how they can have sex / have babies [...] and how they are going to deal with the fact that they've changed from … now needing a wheelchair, maybe they were in relationship when it happened, then that's been a problem. One of our patients was struggling with his relationship and decided to leave his girlfriend because he didn't think that she would want to be with him in a wheelchair. [...] not knowing _how_ they can have sex [...] So … yeah, that's a big issue.

FG03 / P09 Well I suppose working women and working men … [commercial sex workers]. It's the porn industry: coming in for certificates, [HIV and] sexual health screens.

FG05 / P19 Actually finding a partner [...] Young people want to know how to make relationships work, or even actually meet people.

> When is the right time [for sex], and urm it's just about those two things and how they can get them wrong.

Given the concerns about lack of appropriate education of a number of the respondents, for nurses to raise the issues first sometimes took considerable courage. Evidence from the data shows how some of the respondents lack confidence around particular topics, especially when they felt their knowledge or skills-base was poor. **FG02 / Participant 22** is characteristic of a number of others.

> Initially when I first started out I didn't particularly mention it, they mentioned it to me! Now I am actually probing a little bit more because I … I realised if I probe it in a sort of subtle way, the options, people *do* actually respond and talk about it. It surprised me actually!

The problems of sexuality for ... ginger people

Language in action clearly resonates with the ways in which, from a Foucauldian perspective, discourses are ultimately productive of meaning of that which or whom they signify (O'Farrell 2005). During the data transcription phase, I struggled time-after-time to hear and make sense of one particular quietly spoken respondent who sounded as though she was talking about the psychological problems of sexuality for *ginger* people.

> **FG01 / P24** In practice, urm, I think it's urm, it's [inaudible ... ginger ... inaudible] sexuality problem, because we have got a psychologist who comes to visit who I could refer to, but I think that is the hardest part for me to broach, it's knowing who to refer and I don't think, I think it's a taboo subject with some of the staff, especially if they are older and have been there are quite a long time. ... which is wrong.

This recording / *vignette* needed clear reflection on my part to try to ascertain what problems of sexuality "ginger people" might actually have. In fact, in all my years of teaching and studying sexual health, no specific problems came

to mind from experience or from literature I have studied. After at least a dozen times of re-playing this section and listening carefully, I suddenly realised the respondent was saying "I think it's urm, it's a gender and sexuality problem".

My personal reflection

On one level, this experience made me laugh to think how one might have further investigated a hypothesis on a mistaken or misunderstood claim made by a practitioner. Most significantly, it reiterated to me, as researcher, the ethical requirement to listen attentively to the meanings of data respondents, to ensure authenticity of the discourse and message. This 'listening attentively to' such discourses is frequently problematic when, relating to so many sexual aspects of life, they are already consigned to the elements of Foucault's 'triple edict' of taboo, non-existence and silence, or elided from the pleasures and joys of sex, the *ars erotica*, into a pathologised essence in the *scientia sexualis* as demonstrated in Discourse 2, below. One final point on misunderstanding the meanings of gender (not to mention sexualities), in relation to Theme 5 of the Focus Groups – issues they would personally find difficult to deal with – one participant clarified her confusion when she said:

> **FG01 / P24** Gender issues! I would find that difficult because I don't come across many, urm ...

> **Me:** So, by 'gender issues' you mean ...?

> **FG01 / P24** People who are not sure; not if they are gay or lesbian, but if they feel they are different ...

> **Me:** Don't you mean *transgender* issues?

FG01 / P24 Yeah, yeah!

Me: Okay: so for people who want to go through gender transformation and that type of stuff?

FG01 / P24 Yes, that it!

Me: Any ideas why you might find that difficult?

FG01 / P24 Just because I haven't come across it very much, I think, although one of our old consultants has now changed from a man to a woman so maybe I should approach her about it! [Group laugh].

Discourse 2: managing the ars erotica

Positive feelings and self-regard are often treated, in published texts and popular psyche, as being indispensible for enjoying the pleasures of sex and relationships: simply recall the supremacy of self-actualisation in Maslow's iconic *'Hierarchy of Need'* (Naidoo and Wills 2000: 320). Sometimes, there is evidence in the data of an absence of a healthy love of self, with which the respondents have to work with in clinical practice, oftentimes to help their patients or clients 'pick up the pieces'.

> **FG03 / P12** Teenagers, particularly girls being sexually active, but when you ask, finding that they are not actually enjoying sex, and that sort of thing.

> **Me:** What's that about? Is it to do with pleasure of sex, they're not physically enjoying it, or sometimes … like when you read some of the literature and it says 'girls are often looking for relationships / boys want sex', and therefore … if 'boy meets girl' and the boy moves on fairly quickly the girl might think "well, I am sorry I did it now!" So there is a lot of regret amongst young girls because they were expecting more of a relationship. So is *that* what you mean by not enjoying it, or not physically enjoying the act of sex?

> **FG03 / P12** I think a bit of both; it might also be emotional stuff because they may have been abused in some way and … just um … just

a bit of a minefield because there is loads of stuff like pregnancies and sexual infections but they are quite surprised when you actually ask them about whether they've *enjoyed* it and what their experience has been because then you think 'well, why are you doing it if you are not enjoying it?' 'What's in it for you?' [...] I think a lot of it is just pressure and the environment they're in. You hear about girls giving blow jobs to get a joint of marijuana, you know that kind of thing. And it's just a very strange sort of society going on, you're not really quite sure of it yourself because you're not there. But … um … I think there is a lot of things that we would see that should happen, or I might feel should happen in a relationship that are … there is **no respect** for themselves or sexual acts are seen as sort of separate to a relationship. I'm not really quite sure, I don't really…

Me: … but even when you say "there is no respect for themselves", like when you mentioned earlier … Number 22 … when you mentioned about people self harming and all that um … What sort of impact is that having on a person's sexual health and well being, how they *feel* about themselves?

FG03 / P22 They say that they are *worthless*. I see people having more sex when they are feeling like that because they want to build their self esteem, and maybe they value themselves less so … I have seen people with different things, quite often if they are harming, cutting, they will be having more sexual partners with little regard for themselves.

The personal expectations of some clients, in relation to sex and relationships, also forms part of the extraneous learning from discourses on various acts or the wider performativity of sex.

FG06 / P10 I was working on a ward when a patient had just gone through a total hip replacement. But even before this he wanted to know when he could start having sexual relations again! So I went off to find out as much information that I could, but I came across brick walls all over again!

Me: And what was this brick wall?

FG06 / P10 The Charge Nurse said "don't worry about that, we shouldn't have to talk about that. Just ignore it!" [Embarrassed laughs from group] I think I went off to another ward somewhere and found information related to similar situations after surgery, but the nurses at

work - they are funny - you'd think they were being ageist, but I just thought it was important to get that information.

FG06 / P05 I think it's urm society's views of sexual health. Bizarrely, in setting up services for young people, there's a lot of people like who don't want to let them know what's available, in case it encourages "promiscuity", so I think it's attitudes and education.

FG06 / P01 Urm, my observation has been that it seems like there isn't that much attention that is really given to mental health patients as far as their sexual health needs are concerned[2]. You can actually see this sometimes in people labelling different types of behaviour: chaotic behaviour, a psychotic person ... but if you ask them, if you ask the staff, they say that they feel embarrassed to talk of sex. Sometimes, urm, the staff they don't know how to respond to the different sexual activities that they consider inappropriate.

Me: When you say that some of the staff see some of the sexual activities as inappropriate, what, like what?

FG06 / P01 Sometimes it is because some men see women doing things [masturbating in their own rooms] and these other patients will be looking. They look in from outside the doors. And when you look for the patients, you will find them looking through the doors! The service user will be watching outside the door, and the staff come up and they see them and they are all embarrassed. The staff call others, and the three of them are outside looking in! They tell him off but they always give bad advice.

These *vignettes* are a clear example of how the *ars erotica* fits uncomfortably in the world of the science of sex. In the final example above, a case of a female masturbating in the 'privacy' of her own room, it is not so much how the male patients looking on are dealt with, rather, it is more indicative of the internal 'discomfort' of the staff in dealing with the whole scenario, like

---

[2] In relation to sexual health and mental health, and with some of the insight gained from this current study, between 2009-2010 I have been fortunate enough to be a significant co-author of an e-learning course, hosted by the **Social Care Institute for Excellence**. Sexual and Reproductive Health and Safety – for mental health practitioners, www.scie.org.uk (in print) with Drs Kathryn Abel (consultant psychiatrist, University of Manchester) and Roxanne Agnew-Davis (Director, Domestic Violence Training).

dealing with badly behaved children: masturbating girls with 'peeping toms' looking on. There are various layers of governmentality evident, as recounted by **FG06 / P01**. Not only is there an element of (inappropriate but understandable) erotic surveillance of one patient by another, but the response of the staff is to produce a self-surveillance and control over the individual reprimanded in a way which is totally ill-at-ease with the naturalness of the initial act being performed (in 'private') and observed. Turner (2006: xix) states that there has been a creation of

> "a political climate within which intervention and control are seen to be both necessary and benign. Individuals need, especially in the area of sexual etiquette, to become self-regulating and self-forming".

In the *vignette* of **P01**, a difficulty is highlighted both in relation to the mental health status of the clients and, as Foucault demonstrated across his career life-span, in something which is emblematic of the observation and regulation (governmentality) across the whole field of psychiatry.

The data from a number of groups had other unique stories, too; for example on viewing pornography in a care home to the sexual silence of growing old.

> **FG06 / P33** I work in a care home and yes we see things. Sometimes we have this man and he is in his room and when we have to take medication and things he's watching porn pictures and things, with videos. We are embarrassed to go into his room. I don't really know what to do, I am embarrassed ...
>
> **Me:** When you have to go in to his room, do you all knock the door?
>
> **FG06 / P33** Yes, yes, and then he stops what he is doing and then you get very embarrassed about it.

FG08 / P06 When we are doing smears obviously that's part of the sexual health and um … post menopausal women with problems that they can't have sex because it's so uncomfortable, things like that, which um … we often pick up in … when we are doing the smears and that's sort of part of the chat that we have generally with them. Um … and it's something that they won't tend to bring up themselves because they think it's just part of getting old and there's nothing they can do about it.

Me: So who tends to mention this first them or you?

FG08 / P06 Well I have certainly found it tends to be me as a nurse that brings it up.

Me: Yeah? OK and what sort of response do you get?

FG08 / P06 Relief really! It's something that they haven't wanted to bring up but once you bring it up they are quite happy to talk about it and quite often quite amazed that there are things that can be done to help them!

Me: Yeah. Okay. And what type of thing might your practice offer?

FG08 / P06 We usually offer that they can use some of the creams and pessaries, um … and I think they just genuinely don't realise that there are things that could be done.

Me: And from some of the practice areas where you're working in would there be any leaflets or posters about this sort of thing, would there be anything encouraging people to talk about it?

FG08 / P06 No!

Me: No? So it's down to you as individuals: if you mention it, it will get discussed, if you don't it won't?

Participant 05 of GQ04 highlighted a three-pronged process in relation to managing the *ars erotica*, basically associated with changes in personal demographics of client cohorts and how these relate to existing (traditional) service provision. She commented on:

236

- Changes in patterns of sexual relationships – far more casual partners within the heterosexual communities: "fuck buddies" and "linking", [i.e.] meeting with friends, very casual, just for sex.

- Changes in ethnicity of local population: large increase in BME community and associated increase in HIV.

- Lack of co-ordinated sexual health provision: disjointed services; lack of "one-stop shops"; lack of communication between sexual health providers.

The final word presented here in relation to 'managing the *ars erotica*', typifies a transgressive process for crossing the lines or boundaries that are given or taken to define 'us'. Like the *vignettes* above, the following includes the non-traditional or non-majoritarian (read: non-orthodox) voices coupled with evidence of resisting power struggles.

> **FG05 / P08** One of the issues I've come across in sexual health is children with autism or other learning disabilities, because sometimes they have the same feelings but they use it inappropriately, and it's teaching them how to do it in an appropriate way, and that they still have the right to do it. So that's quite difficult.
>
> **Me:** And when you say 'teaching them', is that is part of your role?
>
> **FG05 / P08** The school that I'm talking about is actually very good and very very strong on that, giving them the space, letting them know it is okay to do it especially as they go into adolescent years. Just because they are 15 or something, they can do it inappropriately
>
> **Me:** Yeah? Right.
>
> **FG05 / P08** Yeah, like this one lad has got a foot fetish. If he saw you in an open toe sandal he would want to masturbate, so if you are in the classroom on a nice summer day ... you know!!! It is teaching him that it's okay feeling about wanting to do it, but not in the classroom

After having analysed these data, reflecting on implications of the *ars erotica* in health care services, it was fortuitous to be able to test and develop the

ideas further, in a different forum, presenting a workshop at the University's Sexual Health Research and Practice Development Conference, November 2010[3].

Theme 4

"Which sexual health issues or conditions do you consider are not fully or even adequately addressed in your area of practice or speciality, and why do you think this is so?"

Various issues and conditions the participants considered inadequately addressed are highlighted in data throughout these chapters. The reasons for this neglect, according to the respondents, relate to:

- embarrassment
- a clear lack of commensurate education and skills (on their part)
- a lack of clinical time and priority
- no authority to go against senior colleagues
- lack of appropriate materials and resources to provide to clients, e.g. for health promotion, advice and / or service provision e.g. condoms.

On the topic of embarrassment, Lawler (1991: 142) advises that "if nurses are not embarrassed, it gives permission also for the patient to feel no embarrassment, but nurses must first learn to manage their own embarrassment and to convey the impression that they are not feeling uncomfortable". A need for learning could equally apply to the cultural and institutional *erotophobia* (Evans 2001 & 2004f) perpetuated by services and manifested through the absence of necessary and holistic sexual health

---

[3] Pleasure: Naughty but nice? Using the *ars erotica* to promote sexual health and well-being, see Appendix 12.

attention and care. All of these issues are closely allied to the "problems nurses reported in delivering an effective sexual health service" by Jolly (2001: 250). Jolly categorised the problems under the headings of "resources", "organisation" and "training needs", elements of which are detectable throughout the data for this study.

Resources:
FG01 / 08 Urm, I used to work in gynæ and we didn't used to cover [any sexual health issues], but that was mainly because we didn't have the time, it was a heavy workload, anyway, and it was just, we would be sweating blood on a daily basis and we just didn't have time to cover that.

Organisation:
FG17 / P19 I think also in the area that we work in um … homosexuality is something that is hugely ignored and um … and treated with copious amounts of embarrassment and shame. And its … and its sad because you know we do have … we do have clients who are clearly homosexual, even that are quite young, but the problem is that because it's not addressed they won't come and talk to us about it! We did have leaflets and things delivered to us to put out but we're not allowed to put them out. Um … neither are we allowed to put out anything about um … contraceptives in case people see them! [Group laughter]

Training needs:
FG02 / P12 Quickly ... on the assault thing, our social workers are really bogged down, I can refer things on to the child protection guy at the school, then there is a waiting-list of a hundred and twenty kids with the social worker before mine can be seen. Um…which is often a problem.

In the following *vignette*, two contrary discourses are detected, one on the enthusiasm of individual staff and the other on the apparent disregard for holistic care, witnessed through a genealogical discourse of hegemonic gender relations.

FG01 / P20 Urm ... in the acute sector I think it's easier for nurses to just worry more about if [the patient has] got an infection or if the wound is healing properly, or something else, like if they've *wee'd*

properly. So they can actually ignore this part of it [sexual health] and pretend to give them holistic care. I think also a lot of the nurses have been there for a long time, and it's just something that they are not discussing. What WILL be interesting is we have a new gynæcology consultant who has one of his interests as psychosexual problems [right] so, urm, hopefully he will get people to move on [Group laugh]. [...] We sometimes see women who have had several miscarriages and they have been advised just to get checked that they haven't got an infection, but we don't actually um … screen them for streptococcus B, which is a reason why people can miscarry regularly or frequently. And the nurses consider that's because our consultant is not interested in women. And we had another woman, well she is about twenty-one and she is a commercial sex worker, she comes in monthly for her screens but she was having lower abdominal pain and we wanted to do a cervical smear on her, which was clinically indicated and he said "no". Now, because I was still quite new to the clinic at that time I went along with him, being the one that controls all the budgets and everything, that's his decision; whereas clinically if I had been perhaps a bit more confident in myself I would have just done the test anyway because we do think now that she has got some sort of cervical cancer problem.

On Power / Knowledge and governmentality:

FG07 / P10 I work on an infectious diseases ward where we have mostly HIV-positive patients, and when I started five months ago I was amazed that out of 12 or more nurses only one, the sister, had any training or education in HIV. None of the carers have any real knowledge about it!

Me: So there is no in-house training, or anything?

FG07 / P10 No, no in-house training, like you know the consultant who looks after all HIV patients comes onto the ward every day and he specialised in sexual health, sexual health and HIV, and we have good relations with the HIV Nurse Specialist who comes onto the ward, but there is no training. I am still totally amazed! Because I am still new I am the most junior nurse and I can't really find out why, why there is no training.

This *vignette* appears to cross a number of Foucauldian boundaries. Notice the multiple levels of power relations criss-crossing or intersecting each other at various points, which still result in this junior nurse feeling trapped in a

situation of wanting to know more but being unable to get others to help on the learning journey. The result is an interplay of various "rituals of truth" (Shawver 2006)[4] in the 'making' of a 'typical' junior nurses as 'seen but not heard', i.e. as the respondent perceived this: not to 'rock the boat'. This 'rocking the boat' would be a challenge to nursing and medical 'superiors', with their years of experience and their presumed greater knowledge which clearly enhances their power. This respondent is trying to cross these various boundaries; he is transgressing the way the staff traditionally know about knowledge and their role-expectations. Increased knowledge isn't seen to be part of what they need to be about. They are required or expected to be 'docile', in a passive receptive-manner, as used with the meaning of Foucauldian *docile bodies* (Perron *et al.* 2005), not docile in intellectual ability. Such docility inculcates a culture of stagnant learning, i.e. the assumed sufficiency of one-off learning, provided by initial professional training, and is contrary to the demands of learning for life (Dattilo and Brewer 2005; NMC 2010).

> **FG16 / P14** Like you said before: I think it's lack of knowledge, you know it's only since being on this course that I have actually started to think of sexual health as somebody as a whole with sexual health as opposed to just sex and contraception. It's about body image and feeling good enough about yourself in order to get that far. So I think it's knowledge, it's our knowledge in the first place.

From within an *ethos of governance*, the *vignettes* below refer to the frustration expressed by a number of respondents especially about the short-comings of what is presumed to be holistic care. The frustration is even more evident when policies such as the Activities of Daily Living (ADL) are in

---

[4] "Rituals of truth" are explained under Governmentality, in chapter 4 p. 179.

place, as such policies are intended to make sure that sexual health is formally addressed and not simply relegated to an *iconography of sexual disease* (Pryce 2001). Dattilo and Brewer (2005: 209) attribute the "reasons most often cited for omitting this area of care included inhibitory factors such as personal discomfort, lack of inclusion in nursing curricula, and lack of a practice behaviour of their nursing colleagues."

> **FG07 / P27** I think nursing is too quick to label. If you work in orthopædics you care for bones, if you work in pædiatrics, it's children, or you work with young people or you work with the elderly ... We don't see *people* in the holistic sense at all. That's was wrong with all of this! Simply mentioning the Activities of Daily Living and doing an assessment of clients' needs, and sexuality *is* there, but it's clearly that we've missed it terribly. We miss an awful lot of issues which could try and help clients feel more comfortable about their sexual life.

Notice, here, the move to internalisation and the formation of 'docile bodies':

> **FG15 / P07** I think there are two issues here. It could be the patient feels embarrassed to talk about it, or on the other hand, it could be the health professional themselves who could get embarrassed to start the conversation if they don't have adequate knowledge to talk about it. Secondly: in my experience - I know it's not an excuse - but it's to do with the timing we have to explore other areas.

> **Me:** When you say then about the embarrassment, that the client may be embarrassed and healthcare professional might be embarrassed ...?

> **FG15 / P07** Yes, it could be both ways, absolutely it could be related to the professional's culture, background, experience that may prevent that professional to open up, I mean, they may not be able to deal with it because they are too embarrassed, they are not adequately skilled to deal with this. So...?

> **Me:** So whose job do you think that should all be? Supposing you have got that situation now: you have a person in front of you that you *know* will have a sexual health condition, like erectile dysfunction: whose job should that be? Should the patient mention it to you first? Or should you mention of the patient? ...

> **FG15 / P08** I think urm when you say something like 'erectile dysfunction', it should be a two-way thing. It should be that every health professional is good enough to draw that out of the patient, and the patient feeling relaxed enough ... urm ... you know, that you've got their best interests at heart, so you will pull that information out of them. It's about having that perception to do so, and even then when you've got it, urm, can you adequately deal with this as [Participant] Number 7 says: it's not just about embarrassment. It is so often about politics, resources, what primary care trusts are going to pay for and what they are not going to pay for and whether the patient has got to travel miles and wait months for adequate referral!

Theme 5

"Which, if any sexual health issues, do you personally find most difficult to address thoroughly, and why?"

The issues respondents found most difficult to address can be viewed within a number of Foucauldian categories. As highlighted throughout this thesis, the difficulties are frequently and primarily related to one or more elements of the *"triple edict",* especially present as stigma.   There are three other concepts which clearly emerge from the data; they include episteme, Power / Knowledge and governmentality.   A prime example of these concepts is demonstrated in ways that show sexual health sometimes refusing to be confined within the straitjacket of pathologisation. It would appear such a phenomenon makes it difficult for many clinical professionals to deal with.

> **FG01 / P01** One of the issues I have problems with, and find difficult to work around, is urm throat infection probably caused by, urm, sex, urm you know, oral sex. One of the GPs did mention it that one of the practice nurses could pick it up on the screen and he thought it was so funny! I was doing this course then, and I heard what happened, so I said "what is it?" And he said "look at this: sexual infection in the throat!" And I said "you can get Chlamydia and you can get gonorrhoea", so he did ask the right questions, but she [the patient] said "can you? I didn't know!"

Me: So do you feel that even though you find that difficult to talk about, it's getting easier now that you know more about it?

FG01 / P01 It is getting much easier, because you know what happened? I can actually, urm, focus on the issue now if I have the patient coming in. I aim to be very more empowering when I am doing cervical smears so I ask the ladies the questions for "down below there" and do tests. That's the way I ask the ladies, urm, and then hand them a leaflet as they're going out, to read about this. And they can come back and we can discuss it. Because time is always the issue, you know, and you know, it's good giving them something to read and then they can come back, you know, and also I mean I am able to send them on to the GUM clinic. But all this information I did not know until I started this course!

Evocative of an episteme of sexual health, **Participant 07** speaks for a number of other respondents who show that transformative knowledge is power: power to improve practice. In some small way, through education, traditional discourses within sexual health practice change for the better.

FG01 / P07 I think if you had asked me this question at the beginning of the course I would have said almost everything, anything sexual health or sexual ill-health related, urm the list of diseases, urm, because I thought that everybody else knew all about those things and that I must have just missed that day in my training! But now having completed the course I would be like my colleague here and I completely agree that I feel quite comfortable that even if I can't fully discuss it, to be able to refer people on to exactly where they go, or where they need to go.

Some respondents showed possible evidence of passivity as *docile bodies* requiring help in resisting power, including power present in the dynamics of stigma relations.

FG05 / P19 [School nurse] I think, I think I find it difficult myself with the limitations placed on us by the educational establishments because I'm more than willing to talk about anything but we have to work within the guidelines of the education department so that restricts me, and it's a real restriction on children.

FG05 / P10 Trying to change the stigma and the negative attitudes towards sexual health that the nurses have. Over the last couple of days

on the ward I have heard some negative comments, and some of these have come from religion, but we are professionals and we should treat everyone equally. We can't have these that lead to prejudice.

Me: So what are the stigmas you're talking about? How does that show, how do you identify it?

FG05 / P10 Urm, ... just looking at the negative attitudes towards people with HIV, that "they are all homosexuals" or "they're IV drug users" or "they'll sleep with anybody", and everybody again is at risk!

Me: And if there is this stigma, then, assuming all HIV-positive people *are* homosexual or IV drug users ... what is this stigma doing now, what is this saying? Is it is labelling people, like "Oh! that person is homosexual or an injecting drug user" or is there any more to do with that label? What I mean is: *so what*? Someone is gay, or someone is an injecting drug user, *so what?* But are you implying that there is <u>more</u> than that?

FG05 / P10 I'm not sure?

Me: Go back ... when you said then that some of the other nurses might look at the patient and think, "oh, he is homosexual", or they might think "you are all HIV-positive because you are *gay* or you are *injecting drug users*", so that they are making a value judgement on that. But so what? Is there something *more* to do with: "Ah! BECAUSE you are gay, is why you are HIV positive!" Are they making some actual link?

FG05 / P10 Yes, I'm just trying to analyse this trying to get it clear in my mind.

FG05 / P27 Challenging stereotypes, changing labelling as well, not all the time but there is a culture.

Stigma theories of individuals with the typical characteristics of a stigmatising person (see Figure 2: 8, chapter 2), frequently mention how once a stigmatising person actually knows someone with a discrediting mark, they are confronted by it and have an opportunity to change (Mason *et al.* 2001). The next respondent highlights this:

FG05 / P05 [...] I think urm stigma comes from your entire family, husband, friends everybody .... it's much wider. Just a personal example, my husband is in the military and because of that, urm, you know, I think you have to go along with the crowd. I don't think my husband believes a lot of it, but you have to go along with it. That's what is

expected, that is what is talked about. It's a macho thing! Whether we are in the Air Force or in the Navy, we don't talk about *that* at all! And that's how my husband went along for years, and then urm my sister urm explained that urm she had a lesbian partner, and the fact that she chose .... she kept it hidden, she kept it closeted for years, for such a long time, by fear of being rejected, urm, and I think although the stigma is there, it can be really really deep and I think because people just go along with the flow, urm, everybody else is saying it so they go along with it really. And I think that is a tragedy that we have to live with really.

FG14 / P14 [...] what I have found from doing the course, is my views on learning disabilities and sexual health. I found that I was quite – maybe, overprotective is not the right word - and it's not something that I think very well about, you know what I mean? As a person I am being overly protective, and that as a person it's not something I come up against very often, but it is something I have identified within myself, but it's not something I do very well!

Me: Any idea why you might feel like that?

FG14 / P14 Erm? I think maybe because years ago I worked with severe learning disabilities and I suppose that's where I am seeing it from and maybe not the minor disabilities, and so yes, it's possibly that.

ME: And any particular learning experiences around people with *severe* learning disabilities that stick in your mind?

FG14 / P14 Not as far sexual health is aware but you know, it was a locked ward with severe mental health issues and learning disabilities and social problems, it wasn't really a huge issue. Just not something that wasn't dealt with.

ME: [Summarising **FG14** on this theme] So, what some of you are saying about attitudes and all: that's the type of stuff that it will be lovely if that could be explored in the classroom, so that people can thrash these things out. But what some of you are saying, if you look how things are "swept under the carpet" so they are *not* discussed. That's where people haven't got the opportunity even to think of it out loud!

A final note in this section relating to the *ars erotica* in issues the respondents personally found difficult about sexual health reminds nurses that we, too, are sexual beings.

FG01 / P22 I have yet to meet a celibate nurse, so nurses are sexually active themselves therefore the education can be directed towards them as well as education to pass on. So it shouldn't just be "you are the nurse, and this is what you need to pass on" *you are human*! And with that you can easily weave it in the self-esteem and you can say "no". If you help one group of people, be it student nurses, to be more self

confidence in the way to say no, as well of the choices of contraception and prevention of sexually transmitted diseases etc, then not only are they empowered with their knowledge to pass that on to others, it empowers themselves, and would hope they would be better role models!

FG05 / P30 We were talking about the curriculum, weren't we? And, urm, apart from yes I agree that it should be normal, for example about normal adolescences and relationships and what to expect etc. And look at things like *lust*, you know. What is the **physicalness** of lust and arousal and things like that? This is actually ... when you look into it ... what fits into people's lives! You've got X problem because you are *this far* on the line, and things like, and things like partner notification: we are from a public health perspective we do need partner notification courses!

FG08 / P03 And to show … also to show people that sexual health is not just sexual ill health, that it is good sexual health as well, um … that people should be taught not just about um … you know about … sexual diseases, you know health and disease, but also about good *sexual* health, and about how that should just come into people when they're promoting health. That should just be part of promoting health, and good sexual health comes under the umbrella of all health: that's just another part and it should be included in sort of … in health promotion as promoting people to look after their own sexual health and to be aware of their sexual health.

<u>Recommendations for educational development</u>

What the respondents said

Giving the respondents of this study a voice in recommending what could and should be done provides an opportunity to 'spring-board' off from the findings of this work into recommendations for professional practice and educational development. The data responses are truncated to avoid repetition, but are representative of the main themes. The recommendations are hypothetically addressed to teachers of sexual health at HEIs across England. Before examining key discourses in detail, however, excerpts from the unofficial e-mail communication to me outlining the current position of the NMC on sexual health can be summarised under a few key points which are crucial – if they are acted upon fully – for the development of professional

practice in sexual health education for nurses across the curricular triptych for care.

> "The standards that we set are generally broad and overarching. These should be sufficient to provide a regulatory framework around which programmes can be developed at local level in partnership with stakeholders that meet local and national need whilst safeguarding the public. In this way programmes remain dynamic, evidence based and responsive to change.
>
> It is for providers to determine the more detailed content of the curriculum at local level drawing on contemporary evidence based practice. *It would however be anticipated that areas of practice such as sexual health would be **well represented** in all pre-registration programmes.*"

<div align="right">

From Appendix 11
emphasis added

</div>

This statement can be supported within the broader framework of some more recent, important, UK Government and NMC documents. The documents can be used to argue in favour of increasing the amount of sexual health education right across the curricula 'triptych' as proposed in this thesis. Sadly, however, despite these recommendations being adaptable to support sexual health, with all but one exception below, they are neither specific nor necessarily supported with funding for Continuing Personal and Professional Development (CPPD). Over 50% of the nurses attending the Sexual Health Skills course, and therefore participants in this study, have paid for themselves to undertake the training with no financial or other support from their employers or alternative sources. The relevant background statements to promote sexual health learning include three key aims extrapolated from

the NMC (2010) <u>Standards for Pre-Registration Nurse Education</u>, to assure "the public can be confident [in] all new nurses", that they will:

- practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively
- act on their understanding of how people's lifestyles, environments and the location of care delivery influence their health and wellbeing
- seek out every opportunity to promote health and prevent illness.

These aims are further supported in the Chief Nursing Officer's <u>Modernising Nursing Careers</u> document (DH 2006: 15), which requires "a flexible principle-based curriculum that is built around patient pathways, with a strong academic foundation and interdisciplinary learning". Despite a lack of funding identified in <u>Liberating the NHS: Developing the Healthcare Workforce</u> (DH 2010), the chief Nursing Officer's <u>Modernising Nursing Careers – Setting the Direction</u> (DH 2006) requires that "pre- and post-registration learning needs should therefore be planned and funded to take account of *patient needs* and the changes identified in this report" (*emphasis added*). The statement is further supported by the desire for "promoting high quality education and training that is responsive to the changing needs of patients and local communities" (DH 2010: 44). The one and only sexual health-specific aim comes from the cross-departmental mental health strategy (HMGovernment 2011), with a stated aim to "[improve] outcomes for lesbian, gay and bisexual people with mental health problems".

The respondents' own recommendations for future education

Of the 24 HEI-Survey (HEI-S) Respondents, only 17% taught solely at pre-registration level, with 46% at post registration and 33% between both. Fifty percent of HEI-S Respondents were aware of the GUNA Educational Database (which is therefore an indication that 50% or more are not advertising their own courses this way) and 79% (*n* = 19) were aware of the nationally available RCN Sexual Health Skills distance learning course. Interestingly, in response to question 4e,

> "Do you (personally) consider that the provision of sexual health learning and education, <u>at your institute</u>, is appropriate ... ?"

only five respondents (20%) judged affirmatively on the provision to pre-registration students. Fifty four percent (*n* = 13) said "no", with a further 3 "don't know" and 3 missing. These statistics were somewhat reversed for post-registration, with 62% (*n* = 15) agreeing it was appropriate, and only 4 (16%) disagreeing. Question 5j of the HEI-Survey probed these matters further. The respondents were asked to make a personal judgement on the sexual health education provided by their HEI, this time in relation to local needs (Figure 5: 3).

Figure 5: 3   Question 5j from the HEI Survey

In light of the provision of sexual health learning identified within this study, the responses would benefit from further investigation, in that they were relatively affirmative, with between 50-54% agreeing "yes" to all questions, and the remainder almost equally shared between "no" or nor response; but as **HEI-S / Respondent 17** commented:

> Pre-reg ask us to teach if there's an enthusiastic / pro-sexual health teacher running their courses, otherwise it's all left to post-registration specialist courses.

with **HEI-S / R23** adding:

> More staff needed if more work to be done; can't do it all alone.

Theme 6

> **"Based on your current level of learning or clinical experiences of various client needs to date, and in relation to sexual health and illness, what would you recommend to education providers as being *key* areas of sexual health for the curriculum, and why?"**

This final question of the Focus and Questionnaire Groups really helped to consolidate the deficits and negativities, as perceived by the respondents, leading up to this point and gave them an active voice in trying to redress the balance. Three over-riding themes emerged:

1) holistic education to combat against the *triple edict* in care
2) holistic care is influenced by Power / Knowledge
3) holistic education is needed to combat specific stigmas.

Discourse 1: holistic education to combat against the triple edict in care

As a reminder, Foucault's (1984: 15) *triple edict* refers to "taboo, non-existence and silence".

Starting with non-existence, **HEI-S / R23** says:

[Sexual health] is just not seen as central enough to be on the radar!

With evidence of silence and further non-existence:

FG15 / P18 Obviously in the hospital we are so busy with medical and surgical needs that urm, sexual health is the last thing on our minds, so urm, education ... it should be there in ALL nurse training, it should be touched on in a just about every course because somewhere along the way it relates to it in all what you're doing. **And to the person: you can't treat someone holistically - you're _not_ treating them holistically - if you leave out the sexual health aspects.**

<div align="right">(emphasis added)</div>

All three elements of the triple edict are reported by the following respondent:

FG01 / P20   Right from a start, when you do your anatomy and physiology [A&P] lectures actually, mention something about sex and the impact it can have; ejaculation problems; erectile dysfunction ... you can have, you know, problems of menopause; dry vaginas, but nothing is mentioned about it all! It's as if that area of your life is never affected by any illness.

Me: And that would be an easy way to get it in, when you talk about "anatomy and physiology"?

There is further evidence of silence and taboo, followed by more silence coupled with non-existence in the following responses:

FG01 / P20   But it's not even in that [i.e. it is not even mentioned in relation to A&P]! So what hope have you got to get it anywhere else?

FG01 / P22 Even just to look at sexuality, and at the person as a whole being; looking at all aspects, to know that this can happen to a person - even if they [the teachers] don't want to teach STIs, just something about it, _we need something_!

FG09 / P06 I think its um … really that it should be brought in as a basic part and a big part of nurse training, and that um … it should be sort of drummed in as it were from the very beginning that it is part of holistic nursing care and it needs to be addressed in most issues that we

> are going to come across in nursing practice, and to try and make it so
> every day that people aren't … or the nurse certainly aren't
> uncomfortable in bringing it up in the first place.

The vast amount of data gathered on this final theme is too voluminous to address any more fully here, but a few of the more unique or critical suggestions for educational provision, some of which relate to taboos, non-existence or silences, include: Contact tracing and partner notification; this is particularly relevant for practice nurses and their expanding role into this area; BBV (Blood Borne Viruses), especially for nurses working with injecting drug users and people having sex whilst travelling (e.g. hepatitis B vaccination; with hepatitis A vaccination for those vulnerable to the virus from oro-anal sex); plus matters of child protection; specific counselling skills, such as for use with victims of domestic violence, abuse and rape.

Numerous respondents mentioned national problems receiving periodic media attention. These include issues of sex abuse, the "Jade Goody" effect on cervical screening and HPV awareness campaigns, and sex for the over 40 year old age groups. The latter was particularly so for those entering new sexual relationships whom some respondents perceived as disempowered in the language and skills of safer sex knowledge. There were also a number of references to people coming into the UK from different cultures (Kean 2006; Tiefer 2006; Grant and Ragsdale 2008; RCN 2009b). The latter point, immigration, including barriers around people's differing ethnicities, cultures, languages and practices, received more attention in certain Focus and Questionnaire Groups than other. Norwich, for example, made more reference to immigration issues; Birmingham referred to multi-ethnic

populations. As Serrant-Green (2005: 17) recommended, "nurses' involvement in ethnicity and sexual health research may be advanced by adopting a more inclusive approach to sexual health in nurse education." Some other recommendations highlighted for education included:

> **FG06 / P05** Increased role of nurse in view of nurse led clinic / PGDs. How to discuss difficult personal issues without sounding stupid.

> **FG06 / P05** Inability by some people to move away from own personal values / feelings.

To this list can be added issues that many people in society – including nurses - do not talk about openly, as **FG03 / P18** said of training in 1979, above. **QG04 / P05** stated:

> [There are] changes in patterns of sexual relationships – far more casual partners within the heterosexuals. "Fuck buddies" and "linking". Meeting with friends, very casual, just for sex!

Discourse 2: holistic care is influenced by Power / Knowledge

On Power / Knowledge, especially relating to the *scientia sexualis,* **Focus Group 08** made the following exploration relating to sexual health's holistic role as foundational to care.

> **FG08 / P04** Spending more time really I suppose on the counter effects. It's okay to treat people with diabetes and high blood pressure etc, what we don't always advise them on is the counter effects of the tablets, knowing full well that sometimes they will develop sexual dysfunction, pre warning them.

> **FG08 / P06** But do you think that's because it's not … it's not part of the basic nurse training? So it's still something, even … even in *this* age ... it's still something that is seen as something you really don't discuss! It's embarrassing, and if that was actually … if you go right back down to the basics, if that formed part of - a good part of - the basic nurse training, then it would have that knock-on effect where you are going to be. Those new nurses coming through are going to be looking at it, they are going to be promoting it so hopefully then it should have um … a far

254

higher … be far higher up on the agenda of everything because it *does* affect most things.

QG03/ P17 even claims this will "encourage nurses to consider taking this area up after training"; an essential point to be made, especially given the comments in this thesis about the lack of opportunities to work in, or even visit, sexual health services during pre-registration training.

> **FG06 / P05** [Student] placement in sexual health clinic [is important]. I understand about confidentiality, but sometimes I think this increases the stigma. Like sex is *so* confidential student nurses couldn't deal with it! We have to deal with it in a ward environment, but are never really properly prepared for it! After all, it is one of the most important parts of people's lives. People are defined and define themselves by their sexuality, but you're never taught how to talk about it you just have to work it out yourself.

The following messages to nurse educators are witness to Power / Knowledge cutting through the triple edict to the *ars erotica.*

> **FG11 / P06** The number one area to address is simply: **address it!** More people need to talk about it! *I-n-c-l-u-d-e i-t!* [group laugh] Include it at *any* opportunity; explore areas, that why, as nurses, we *don't* talk about it, you know, a bit further, which we have explored in this course. I don't just mean through a lack of knowledge but the fact that you are not comfortable with it yourself! And exploring back, until somebody *is* comfortable to talk about it. And don't make it into the back door: it should be a proper module on its own. It's society's change really ... [group agreement] you know, if you could practically educate those who are working with midwives, or nurses dealing with diabetes ... they look at the issues specific to the diabetic patient.

Jayasuriya and Dennick (2011: 101) have echoed this advice, for medical colleagues, when they claim "these studies support the view that learners are not 'blank slates' – they come with previous experience, knowledge, preconceptions and prejudices."

> **FG11 /** Inaudible Number Basically, there's not one area that it doesn't apply to, so every module you should have it really, shouldn't it?

If you take it out of the nursing setting, and you ask somebody about their life, it's part of everybody's life in effect! So why is it such a huge issue addressing it in any of the role?

Me: One of the things we were saying earlier around that: if a person is ill, why would you think about sex if you're ill? If you are ill, sex is one of the last things on your mind! *But it may not be!?*

FG11 / Inaudible Number Especially if you don't know how long you have got to live and you want to spend as much time enjoying your partner, you know! Unless you are throwing up or something like that ... most people want sex. And what is the thing most people are talking about? Look at the jokes about sex and money; they affect so many, if not the one thing then the other. It crops up everywhere; why is that? Because everyone is doing it! Everyone's doing it, but we still haven't moved on really have we? We still, as a nation, struggle with sex and sexuality.

Me: So it's not just a nursing issue, is it?

FG11 / Inaudible Number No, it's life! I mean: my clients find it difficult to talk about it, you know ... they are working in the sex industry, and they can talk about their abuse and other issues, but they still find it difficult to talk about sex.

A QG respondent raised awareness of wider influences of power which result in insufficient financial and human resources to address certain clinical needs.

QG03 / P21 Resources: one person carries psychosexual issues for two PCTs, same for dysfunction – this in a population of 200,000 and pathways are not well established. Practitioners do not routinely make the kind of brief interventions that would optimise sexual health

Discourse 3: holistic education is needed to combat specific stigma

FG15 / P10   I was thinking it needs to be addressed holistically rather than touched on in little areas, in, you know, urm, there may be body image things, or there may be teenage pregnancy, may be ... whatever. It needs to be addressed, the whole subject in a holistic way as such, not just sort of limited, rather than the odd few scattered lectures and through the university nurse training. There is just a whole lot more

negativity, and as you say, even with the stigma attached to it years ago, even though it's [stigma] still going on, it's still there and people say they think and feel it, and it goes to their head whatever when they've got STIs - and we need to tell people 'it's just not the case'. You know! I meet people every day and teenage pregnancy, they are not all going to turn out the same, some of them may end successfully. You can't just write them off, you know? It's just always so negative.

Additionally, the following extracts show a clear preference for addressing sexual health across the triptych model of the curriculum, as explored throughout this thesis. Despite the status of guidance for sexual health in the pre-registration nursing curriculum (*sic*), the messages following show a practical desire for its incorporation as a broad and foundational element to care and associated learning. The respondents' 'wish list' for educators, with just a few of the many practical suggestions in the data shown here, clearly demonstrate a need for aspects of sexual health and related knowledge and skills to be integral both to nurse education and in clinical practice, and across the full spectrum of care.

In nursing education in general:

FG15 / P08 I think it's particularly important that urm, we encompass it in nurse training, because it has been frowned upon and swept under the carpet, or not talked about, or the older generation basically not interested in it. I think particular focus should be made of it in terms of urm practice ... you know, to go through surgery and it in any way alters their urm, relationships, physically and mentally. You know they are both as important in their mind as well of their body image. So I think to bring this back more into the forefront of nurse training is urm, could be really really beneficial.

FG15 / P07 I agree with Number 8. I think that as nurses and professional healthcare providers we should be equipped with sexual health knowledge, especially as sexual health is part of holistic care and needs. I think we might not be doing well and it should be part of our curriculum like it is with this RCN course because then it covers a

holistic healthcare and we ... I'm thinking of some of the post registration courses as well, in particular ... particular courses that we might be doing, urm, anything on it for them.

In specific courses related to health conditions affected by sexual health:

FG15 / P08   I am doing the diabetes course, so I think we could do sexual health, sexual health and diabetes, so I'm looking forward to that, that specialist learning, so I'm looking forward to that!

On the need for reflection, personal awareness and openness:

FG03 / P12   I think just linking in [...] um … about exploring our own personal sexual health feelings, our own blockages or whatever, so that we're aware of where we're at and how comfortable we are with our own sexuality because I think it's very difficult if you're uncomfortable to be able to then listen to somebody who might have a completely opposite end of the spectrum experience and be coming to you to listen to them and give advice or support. So I think probably my starting point would be for, "right: at the very beginning of nurse training, and throughout nurse training, that you looked at your own hindrances, your own judgments, and feeling about sexuality, your own bodies" and work from there.

Me: Excellent! Thanks! Thanks for the tip.

FG03 / P20   Can I just say … I think one of the key areas for me having done this course was reflection: and I hate it! I hate all of the navel gazing but actually um … a course similar to what we've covered, covers not in any great deal on anything but it gives a good working knowledge of sexually transmitted infections. It prompts exploring contraception but also reflects on your own personal experiences because every nurse … any nurse out there is not devoid of having experience of sexuality … of sex, full stop ... be it in an abusive or a good relationship, whatever. So I think um … reflection, being able to be guided through reflection as part of that would be very beneficial because then like you say you can be aware of what is stopping communication, what is aiding and just addressing some of our own sexual health issues at the same time.

FG03 / P18   So if the education providers are going to educate people they might as well start from A rather than jumping to sort of like C.

[referring to the *ABC of sexual health learning*, in the <u>Sexual Health Skills</u> course materials: Attitudes → Behaviours → Clinical practice].

Learning in practice not just the classroom:

FG08 / P10 I think it should be included in the clinical areas they visit. It's not seen traditionally as … it's sometimes seen as an option that they can go to. I think it should be one of the areas like you do surgical and medical; you ought to go to one of the sexual health arenas.

Me: And do you think there would be enough sexual health clinical placements to take the numbers of students?

FG08 / P10 Well I think if you could see sexual health in different arenas, whether it be working with midwives, it could be working with the erectile dysfunction nurse, or it could be family planning or a young person's clinic, or PSHE. These are areas where it forms quite a lot of the agenda for that health professional. They don't all need to go to the same one it could be … all of those areas.

The examples of thwarted experiential learning, not only 'in the classroom' but by professional colleagues and educational mentors in practice, highlights the need for appropriate elements of sexual health to be integrated into the various teaching programmes of health professional educators and mentors alike.

Good communication skills – across the spectrum of care

Many of the following recommendations are evocative of the skills deficits highlighted in medical training by Jayasuriya and Dennick (2011), and act as a remedy to counteract the short comings. According to DH (2010: 5.12), this should be of importance

> "for effective workforce planning, healthcare providers will need to have a skills and development strategy that identifies their skills gaps based on workforce data about the workforce they currently employ

and the workforce they plan to employ. This strategy should then inform the investment needed in education and training".

FG01 / P27 I think underpinning it all with communication from, you know, try to communicate with people and how to tackle prejudice, urm, because without that as basic skills, as building blocks relating specifically to sexual health, it's covering the issues of how to talk to people about sexually transmitted infections or sexuality or sex in, urm, urm, different age groups and talking the boys, talking to girls, actually looking at all of those and the building blocks of communication skills, and with sexual health it is specific within that communication skills.

FG03 / P22 I think … what I got from this course, what the tutors need to know is that every course that you do, whether its pæds, geriatrics ... there has *got* to be an aspect of that that's related to sexuality because I think we compartmentalise it - *we do!* - and I think every time … whatever course is being taught um … there has to be an aspect of sexuality and sexual health.

FG03 / P16 There has to be some experiential work on communicating, um … and how nurses communicate about sex and fear and anxiety that they feel when someone brings up something like that. I think *that's* what stops a lot of nurses from talking about sex; it's that immediate feeling "I don't know what I'm doing!" like "I don't know what you're going to say, but I don't want to hear it because I can't cope with it". And I think there needs to be some work around that definitely!

Me: Where do you think that comes from?

FG03 / P16 Um … I think it's a fear, um … I think it's a fear of nurses are so in control, they are so used to problem solving, um … and this is a situation where they may not be able to solve a problem, and they have got a limited amount of time, probably about 5/10 minutes normally the patient has got their hand on the door, they're about to leave, and they throw it into the conversation. So really I think it's about all those things.

What **Participant 16 / FG03** states here at the end, "they're about to leave, and they throw it in to the conversation" is a well-known and characteristic strategy used by many clients of counselling professionals when dealing with

difficult or embarrassing matters of disclosure, especially for the first time. Their motives may be varied and range from sheer embarrassment and prior concealability, through to a desire to 'expose' a delicate issue, but possibly nervous of having to spend time on it there and then in the here and now: bringing it from 'out there' to 'in here'. By alerting a professional to such issues as a session is formally ending can require considerable skills on behalf of the nurse, skills that need to be learned and practised, on how to assess, manage and respond to these issues.

> **FG03 / P18** I find that um … I have got my sort of life skill in communicating about sexual health from when I did my HIV/AIDS counselling, it was um … where I got my training … I was in a certain setting where there was also sort of like a cultural influence, where sex really wasn't just sort of like talked about. So … when I was now tasked in doing this … I would have found myself having a barrier, but after the counselling course it made me really realise that I *could* talk about it. So [...] there is a need for giving the providers themselves the learning to have that area addressed somehow.

> **FG06 / P05** I would underline all of that, what that lady had just said, and, urm, how to take sexual histories. I have learned a lot during this course by watching other people doing it undoubtedly very helpful and I have been doing, urm taking sexual histories before I observed the peoples on this course, and I'm definitely better at it now! And so to take sexual histories is something they need to feel confident in. If you don't feel confident then the client won't feel confident either. In the area I it work, the message about safer sex, most people know about it, but how to put it across is what I would like to have more input in, because the culture where I work [school nursing], urm, condoms aren't really used and if you do use them you are a big sissy! It is quite difficult to put across that message when there is a subculture there that's old, and ...

Motivation

> **FG03 / P17** [...] um…all these things should be added for key areas for education but one thing that we need is **motivation** to actually go out and approach those difficult questions and I think that's what's important is if the educators explain to us what the consequences are if

we *don't* approach sexual health. I find that worked quite well for me when I had to approach the subject of organ donation, as I understood completely from the course what the consequences are if I *don't* request that and I think nurses really want to help people and understand the consequences if they don't discuss this, or miss it, think it will be fine, that might motivate them to actually realise they are there to help, which is what we're really here to do to help …

FG06 / P23 But I think it's why England has such high teenage pregnancy rates etc, and other problems as well, because they *know* it's a problem yet they won't proactively talk about it! Nobody wants to take responsibility for proactively talking about it.

Me: So if you were telling nurse educators <u>now</u>, about this issue, what would you say to them that they should do?

FG06 / P23 While I think that the problem is in society, the problems, it could be deeper, it could be a bit political but urm I think the problem is with education and I think nurses *should* be educated in order to educate others.

Tapping in to local expertise

FG01 / P07 I would say, just because you are nurse educator you are not necessarily expert in every field of education. Tap in to your local resources! Use your GUM service, and get them to come in and talk to your student nurses and student midwives, and promote the services that are within your local area, so that people have more knowledge of what is going on, rather than as well as, especially in post registration courses, as well as the pathogens of what things are.

FG06 / P19 I think what they should be doing is looking at the needs of the population, because, we have already highlighted within this course what we know to be lacking, and there are these people and the general population demanding knowledge from us, and if they're not going to get it, then we're not going to meet their needs! We've got to address sexual health areas within nursing, and not leave it to the individual to do!

FG07 / P18 This course had given us a whole load of ideas on how best to do it, this is how to do it! Because urm I am still frightened to ask people about certain things, I know what I want to ask them not to sure how to do it. I find myself asking questions: I'm on a roll and it's quite easy. I'm just beginning to ask them, sometimes it is difficult. I

think we become a bit more skilled in watching other people doing it, I think maybe doing role play and things, to get people used to asking those sort of questions, you know and if somebody had that experience perhaps from a GUM clinic, urm, instead of by themselves if they didn't feel they had the experience or are confident enough to do it, then maybe using someone else with knowledge to come in to share them ideas reverse.

Conclusion

Chapter 5 started with an analysis and discussion of critical discourses from many of the study's respondents. These discourses have been contextualised within the theoretical framework used throughout this thesis. Through the use of relevant Foucauldian 'tools' and concepts, applied through the specific light motif of crystallisation (chapter 3), the theory has clearly underpinned the interpretation of discourses. These tools and concepts have proved suitable for their deployment in the understanding of sexual health learning research, which, after all, is the substance of this thesis. Out of all that has been written by and on Michel Foucault, certain concepts and methods appear to lend themselves well to this current work. They do this by supporting an epistemological framework for the analysis and understanding of data gathered through both the literature reviewed and the various empirical discourses of the study's respondents. That way, some sense has been made: firstly, of what the respondents said – giving them an active voice and, as researcher and author, listening attentively to it and sharing it with you, the reader, and with others through professional disseminations. Secondly, as with the references throughout this work to that which is "invisibilised", it has permitted an understanding of the knowledge / power constraints which privilege some learning (sadly, very little, as far as

holistic and particular sexual health goes) whilst simultaneously constraining even more.

'Listening to the nurses' in the six main themes presented in this chapter has revealed a wealth of information about the state of sexual health learning, for professional practice, in England today. This has given the last word, so to speak, to the clinicians themselves, speaking of what they consider to be the sexual health needs of their clients or patients.

The final chapter will not only conclude this work and thesis as a whole, but it will move on from the analysis of discourses in the data to examine the strengths and limitations of such a study, out of which to formulate concrete recommendations for the advancement of sexual health learning and education practice. Most particularly, the conclusion will only be the close of this current thesis, but will in no way be an end to the debates related to sexual health learning for practice. So much data gathered for this study has had to be summarised in brief, or not used at all – as with much of the quantitative data from the HEI survey. That is primarily because of the constraints of wordage for this particular project. However, inherent in the nature of professional doctorates, such as the EdD, is the explicit intention to share findings with much wider audiences, affording the academic professional / author new opportunities for informing and influencing practice through sound research endeavours.

Chapter 6

CONCLUSION AND RECOMMENDATIONS

FOR PROFESSIONAL

EDUCATIONAL PRACTICE

Sexual Health Matters!

Learning for Life

Chapter 6

CONCLUSION AND RECOMMENDATIONS
FOR PROFESSIONAL EDUCATIONAL PRACTICE

Sexual Health Matters!

Learning for Life

Chapter 6 thematic outline

- ➢ Sexual health matters! Learning for life
- ➢ Sexual health in England
- ➢ What the thesis has covered: chapter by chapter
- ➢ Recommendations for professional development in education
- ➢ Limitations of the study
- ➢ Contribution to learning and the professional development of the art and science of sexual health education
- ➢ Conclusion

Introduction

> **HEI-S / R13** I think it is important for all health care professionals to receive training around sexual health care. We need to push for sexual health to be seen as part of holistic care. I often get students to think about where sexual health care will impact in their practice areas and getting them to think about the man who has had a heart attack, who is going to discuss with him when he can resume sexual relations?

The opening chapter of this thesis began with a play on an ancient Royal toast, "sexual health is dead: long live sexual health"; so it ends with the title of this thesis, two *double entendres*: "Sexual health matters! *Learning for life*". 'Sexual Health Matters!' has been the title of training courses I have facilitated, over a number of years, in my freelance professional teaching. The current thesis has most definitely concerned itself with particular discourses of sexual health matters. Equally, it has promoted the idea that holistic, related and specific sexual health subject areas actually *matter* for

the professional education of nurses in England. 'Learning for life' is from the logo I use for the branding of my freelance educational consultancy.   The research informing this thesis is witness to how the subject matter of sexual health is integral to the holistic well-being of individuals throughout the whole of life. The learning on this subject matter is therefore something that has to continue throughout professional life, too, and not just be one-off event. Indeed, as **FG03 / P18** was reported as saying, in chapter 5:

> [...] even the clientele themselves they have changed, some of them are well versed with all the information [...]   They may still find [me, Participant] Number 18 who trained in 1979 with that '79 information, and this is the year 2007: it doesn't sort of really tally!

Both interpretations of the *double entendres* clearly underpin the discourses examined throughout this research, those from the literature (chapter 2) as well as those in the analysed data (chapters 4 and 5).   By using a Foucauldian lens to identify pertinent discourses and a method of epistemological crystallisation to explore them further (chapters 3 and 4), this has helped me to map client need with professional sexual health education for nurses in England.   In so doing, this thesis has achieved its aim of exploring the central research and empirical questions, respectively:

> *"In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?"*

> *"In which ways could professional education have adequately prepared nurses for meeting the sexual health needs of their clients?"*

Applying the illumination motif of crystallisation through various epistemological concepts and tools of Michel Foucault (1926 – 1984), most particularly the History of Sexuality volume 1 (1984) and his ideas on the *triple edict*, light has been shed on the various sexual health learning matters, including those identified as 'invisibilised' at the beginning of this thesis. The invisibilised issues, though highlighted here, still remain relatively hidden; they include, but are not limited to:

- a proactive use of the *ars erotica* in sexual health promotion and care
- a utilisation of the benefits to health and well-being of non-procreative sex, especially masturbation, and
- the identification of sexual identities hidden from official epidemiology and care, e.g. lesbian females.

This chapter concludes the research analysed for this study and makes some clear recommendations, based on the findings, for future professional practice in the *ars et scientia* of sexual health education for nurses. These recommendations are grounded in suggestions made by the various respondents of this study – and sometimes on what they did not say, the 'invisibilised' material – as well as through synthesising the implications for nurse education out of a number of contemporary key policy documents. These recommendations aim to address client need and professional education across all three areas of the curricular *triptych* model envisaged and outlined earlier in this thesis. BASHH (2010b: 3) recommends that

> "the workforce is appropriately skilled and trained ... [because]
> the cost of failing to improve sexual health will be much greater

than the cost of investing in appropriate sexual health services and prevention work".

Although exploring the 'invisibilised' was an important concern at the commencement of this research process, the concern remains somewhat unfulfilled a) as the respondents have only alluded to various invisibilisations and b) they are far wider than the scope of which a doctoral research project permits. The respondents demonstrate how nothing of significance has been done, practically or realistically, to over-turn the invisibilisations. A similar problem exists for the NMC (2010) review of pre-registration nurse education, in that there is an in-built flexibility in programmes, to be customised, to include specific matters of local priority. If certain matters or persons remain invisibilised, however, then there is no way they are identified to thus be included in the curricula. It is postulated here that this process of invisibilisation by professionals may be indicative of a cultural and nosocomial erotophobia which continues to shroud aspects of sexual health care and associated learning and formal education.

Sexual health in England: a new age!

In chapter 1, a subsection heading posed the question: "Sexual health in England: a new age?" Now, emphatically, in this section, an answer is given. This study has been conducted in the final half of the decade which operated under England's first ever governmental strategies for teenage pregnancy (SEU 1999), sexual health and HIV (DH 2001, 2002). Sadly, despite these, the Government's most recent health White Paper (HM Government 2010: 2)

still proclaims that "we have among the worst rates of sexually transmitted infections recorded".

The earlier strategies have run their course; their two Independent Advisory Groups (for Sexual Health / Teenage Pregnancy) have also ceased to exist. Over this decade, whilst there have been pockets of development for post registration nurse education (see Appendix 6), there is still no evidence that matters will improve significantly or demonstrably under the impetus of the Government or Nursing and Midwifery Council for pre-registration nurse education (see below and Appendix 11). There is also clear evidence that without any significant professional leadership for the education and accreditation of CPPD learning for nurses across England (and the UK), such as through a dedicated faculty of sexual health nursing, various sexual health medical organisations will continue to expand their remit and associate membership to train nurses in specific skills and competencies required by clinical or client need.

> Education "for the development of skills and competence to deliver STI services at all levels should be multidisciplinary and standardised in content across the professions where appropriate".
>
> (MedFASH 2010 2.1.5)

The above statement is not disputed here; in fact, multi-professional learning is clearly essential for 21st century healthcare (DH 2010). The wider holistic domains of a person's life, however, as initially outlined in chapter 1, include more than the requirements of tasks for skills-based learning. These domains include the physical, psycho-social, mental health and well-being,

relational and spiritual. As the respondents have demonstrated in chapters 4 and 5, these life-domains also include a number of associated moral, ethical and legal aspects related to sexual health, too. Examples were given of ethical dilemmas whilst caring for women having abortions on gynæcology wards; or transgender people confronting dilemmas of male / female-only GU services; or school nurses prevented from discussing certain sexual topics or providing condoms and contraceptives, and various specialities treating women who have been genitally mutilated (FGM). Achieving clinical competencies is vital for career progression up through the professional trajectory from "novice to expert" (DH 2006; RCN 2009). Equally important – as emphasised time and again by respondents in this study - is the incorporation of wider holistic dimensions pertinent to sexual health care. As though summarising the comments of numerous respondents, these two poignantly remarked

> **FG11 / P28** In all aspects of our lives, sexual health plays a huge part in it. I think it is remiss of us for this part to be less important than other parts. In order to holistically care for patients, we need to be aware of every aspect of a person's life and the things that are affecting it. Otherwise how can we give the patient a full package of care? It is important to normalise these issues so they can be broached without embarrassment.

> **QG04 / P05** Outside of sexual health services, nurses appear to still be uncomfortable dealing with sexuality / sexual health and often lack confidence / knowledge to deal with issues or refer on appropriately.

The above reflections are clearly evocative of the warnings based on medical educational research by Jayasuriya and Dennick (2011: 99):

> "the training that does exist tends to emphasise the factual, 'clinical' aspects of sexual health, with far less emphasis on sexuality, sexual dysfunction or attitudes to sexual health."

The wider holistic approaches to sexual health and well-being, arguably required in the nursing curricula, might facilitate a personal, professional and social resistance to the "ethos of governance" (Van Loon 2008: 49) endemic in the reductionism of the knowledge and powers surrounding the *scientia sexualis*. One of the many examples of governmentality and resistances to it, highlighted throughout this work, concerns young people, sex and the discourses surrounding their desires. It is worth noting that the respondents of this study had nothing to say on current media representations of child sex abuse, 'pædophilia' and increasing access to Internet 'porn'.

Institutionally and discursively, the science of sex has taken precedence over the *ars erotica* in ways that ultimately formulate a number of acquiescent or docile bodies. The docile bodies may be identifiable across the strata of society and emanate, in many ways, from the culture of the Teenage Pregnancy Strategy (SEU 1999). Such discursive formations are then embodied in the various subjects under scrutiny, i.e. teenagers in general or pregnant teenagers in particular, and the ethos of control ultimately internalised within them. As demonstrated throughout this study, the effect is to create a new personage or mode of being, as Foucault (1984) highlighted in the 'creation' of *the homosexual*. The result is that we now have the creation of 'the sexualised teenager' and 'teenage mums', as though our society has had neither before this current state of preoccupation. These latter beings ('teenage mums') have their own governmental strategy, their own statistics, their own teenage pregnancy coordinators, welfare support, midwives and educational programmes. This 'ethos of governance' even

stretches to constructed notions of risk with concomitant guilt or blame and inadequacy for those who are deemed to fail.

What is apparently missing from most of these discourses is notable resistance to these organising principles, other than those which deal with 'risk takers' as the rule-breakers. Sexual desire, including in the young, in non-procreative, unprotected and non-heterosexual sex, continues to be institutionally hidden from young people in the vain hope of perpetuating notions of a cocooned childhood innocence and juvenile virginity. This one-sided application of the knowledge and powers of governmentality has clearly failed young people on at least two accounts: 1) there has been a less-than-desired reduction in teenage conceptions; and 2) this social "contraceptive mentality" (Evans 2005) has inadvertently contributed to increasing rates of sexual infections. In Queer Theories such as Warner's (1999) The Trouble with Normal, there is a clear methodology of resistance, enabled through deconstructing various science-of-sex discourses which 'produce' categories of individuals, who are then encouraged to 'police' themselves and their desires, with the ultimate effect of re-producing them as docile bodies. The transformative effect of this deconstruction can facilitate a change or resistance - to queer the predominant knowledge / power governance currently in vogue – which (arguably) is not working well and at least to suggest some wider, holistic, alternative approaches which take the person as the focal point of care and not the targets and rules endemic in strategic formations.

The chapters of the thesis

Chapter 1 introduced various complexities around defining 'sexual health' as a distinct area of nursing care and explored discourses relevant to its role in healthcare provision, related education, and the deficits or gaps in both. The chapter also began a defence for the decision to use concepts and tools of the French philosopher Michel Foucault. It continued with an exploration of how Foucault's analysis of the *ars erotica* and *scientia sexualis* in the <u>History of Sexuality</u> (1984) can be adapted to gain an understanding of some traditional approaches to sex and sexual health in nursing education and the foundations as to why so many remain 'invisibilised'. Out of his <u>History of Sexuality</u> (1984: 5), it was proposed that the concept of the "triple edict" of "taboo, non-existence and silence" is akin to stigmatisation of sexual health, a major theme continued throughout this work. In chapter 1, I also developed a model: an educational triptych for sexual health in nursing curricula. The triptych highlighted how current client need and service provision could profitably be addressed

1) holistically: for example, in foundational nursing care for all, through pre-registration and CPPD education

2) distinctively: for example, customised for the elements of sexual health which are effected as secondary to some other health conditions, such as *diabetes mellitus* in a male, a causative factor on erectile dysfunctions or body image impairment after mastectomy for breast cancer in a female

3) specifically: relating to the essential core specialities of sexual health, as identified through epidemiological classification of sexual ill-health, teenage and unplanned conceptions and

274

stigmas relating to all (DH 2001; 2002 and chapter 2 of this thesis).

Chapter 2

Chapter 2 analysed generic and specific discourses in the literature, and clarified difficulties inherent in a traditional "top down" literature review for this subject matter. The chapter also explained how the various searches were incremental, over time, to support the demands on the author's professional role and expertise.   The literature review explored problems of conceptualising the vast array of definitions under the umbrella term of 'sexual health' and related invisibilisations. It also showed how a 'grass roots' approach, that is educational needs inductively read out from clinical sources, was more appropriate. This grass roots approach also enabled a more Foucauldian genealogical analysis of discourses – a "history of the present" (Foucault in Rabinow 1991: 118) - highlighting ways in which these particular subject areas are often akin to the proverbial 'elephant in the room', present by their apparent (official) absence. Taking such an approach further enabled an understanding of the various forms of stigmas often associated with sex, sexualities and / or sexual health and illnesses, and situated the tackling of such stigmas within the curricula for learning and education.

Chapter 3

The methods chapter outlined how a mixed *genre* approach, essentially, though not exclusively, Foucauldian, was suited for constructing a research paradigm of sexualities and gender epistemologies.   The epistemologies supported the three key elements of the empirical operationalisation of this

study: a survey of sexual health teachers at universities across England (HEI-S), supported by focus and questionnaire groups (FG / QG) of nurses attending the then RCN Sexual Health Skills course, across England. Responses from the HEI Survey, on the provision of various sexual health courses, were set against the formal epidemiology of sexual ill-health and teenage conceptions in the same regions as the universities, across England. The focus and questionnaire groups' respondents were taken on a career journey of their sexual health learning, with findings not dissimilar to elements of Lawler's (1991) *somology,* her term for a study of the body and embodiment in nursing. This journey started with the respondents' pre-registration training, through current demands and difficulties on their clinical roles leading them to undertake this specific course. It ended by giving them a 'voice' in recommending to teachers of today what they consider 'should' be done to improve sexual health across the curricula *triptych* of nurse education. The methodological image of a crystal was chosen to show how, as light is taken in and then refracted outwards, dynamically illuminating areas it shines on, so the 'truths' of sexual health are not one and singular, but multiple and ever-changing.

Chapters 4 and 5

Although it is somewhat unusual to have two data chapters, due to the large amount of data gathered for this study (108,000 words transcribed plus the HEI-S questionnaires), these two chapters present, analyse and discuss the responses from all three elements of the empirical study, contextualising them in the works and findings of others. Throughout this thesis, key

elements of Foucauldian thought, most notably from his History of Sexuality volume 1, have been applied to the subject matter and data. The key concepts and tools used have included Foucault's ideas on the *ars erotica* and *scientia sexualis;* discourse analysis; genealogy; Power / Knowledge; governmentality, and stigma in the guise of Foucault's *triple edict* of taboo, non-existence and silence.

As my supervisors had asked me to clarify the Foucauldian concepts and tools being used, chapter 4 is essentially an exposé of these terms with examples of how their meanings are applied to sexual health education through the data provided by the study's various respondents. Therefore, the starting point for each section or methodological tool in chapter 4 is with Foucault, situating the data – by way of example - appropriately within the conceptual framework. Chapter 5 analyses and discusses more of the data, this time set within the framework of the six key themes, the journey of learning, of the focus and questionnaire groups. As each set of data are presented and discussed, their analysis refers back, again, to the main Foucauldian concepts used in this work. Out of the six themes, it was possible to detect a number of significant discourses which leant themselves to a more rigorous Foucauldian analysis, with the results clearly indicating that respondents consider that not enough has been done for sexual health education in the past, especially in relation to the demands on their current roles in the present. Out of these data responses and analysis, the respondents did not appear to be too hopeful for any great improvement for

the future of sexual health learning and education, despite the fact that they had a great personal desire for this to be so.

Recommendations for educational development

Nurses' influence in the wider environment of care

Respondents in the study confirmed earlier work by McFadyen (2004), highlighting the fact that it is not just nursing and healthcare that needs to be more open and honest about sexual health: it is society at large. McFadyen (2004: 119) said specifically of sex education for the generations of the future:

> "A statutory sexual and reproductive health programme with agreed standards should be the right of every school pupil in Scotland and not delivered at the discretion of individual head teachers in a piecemeal fashion".

This debate is similar to the current one in England (ESG 2008). If the compulsory nature of SRE did happen, as ESG (2008) recommends, then the obligations to widen the professional education of all public health nurses - school nurses in particular - would increase to ensure that all school nurses were 'fit for purpose' for the effective delivery of holistic sexual and relationship education.

> ➤ Recommendation: school and public health nurses need to be educated to be 'fit for practice' in relation to growing sexual health demands on their roles.

HM Government's (2010) <u>White Paper</u> on health instigates a number of related documents across the spectrum of care, such as in mental health (HM Government 2011, launched on 2 Feb 2011), sexual health and teenage

pregnancy (spring 2011) and also other critically related areas. Many of these areas of care relate to the effects of poor socio-economic indices that go hand-in-hand with sexual ill-health, such as – but not limited to – alcohol and substance abuse. Likewise, the proactive health promotion initiatives to improve these poor statistics, especially for disadvantaged people with certain "protected characteristics" in the Equality Act (2010), will be expressly funded by *Public Health England* (HM Government 2010: 59). Nurses working with clients across all these spectra of care would benefit from customised education to promote sexual health in the holistic, related and specific areas of care as outlined in the *triptych* model proposed throughout this work.

> ➢ Recommendation: the profile of sexual health education requires greater awareness and integration into holistic models of care, especially in foundational studies such as in pre-qualifying formation. This awareness includes encouraging sexual health placements and appropriately trained HEI teachers and clinical mentors / practice educators to assist pre- and post qualifying learners.

> ➢ Recommendation: secondary or associated implications of other healthcare conditions on sex, sexualities and sexual health, needs greater attention for primary prevention, treatment and care. This requires wider training of non-sexual health educators, both in initial teacher training courses for healthcare professionals and learning opportunities for those currently in post.

> ➢ Recommendation: educational provision on specific sexual health courses requires funding for greater access, to match suitably qualified professionals with local sexual ill-health needs.

Responses in the data from HEI educators and clinical colleagues alike recommend that mentors, practice educators, university faculty and academics all have a crucial role to play in broadening the remit of holistic and specific sexual health education. This thesis has included numerous examples of missed opportunities, most poignantly retold by the number of respondents working (often as students or newly qualified staff) in gynæcology, and their stories of women and abortion care. Not only were the students often lacking particular clinical knowledge and skills, there was a clear hindrance in the advancement of their learning in associated matters such as psychological care, ethico-legal queries and personal support through periods of critical *angst*.

> ➤ Recommendation: the profile of customised sexual health learning for nurses working in areas of care which have related issues of sexual health (in its broadest terms), particularly gynæcology, needs to be raised as a matter of urgency.

Contemporary political and (multi-)professional guidelines

Despite ten years of the two major Governmental Strategies and millions of pounds of spending, the White Paper states that sexual and reproductive health in England is still unacceptably poor, necessitating it being in the top three priorities for improvement (HM Government 2010). In this regard, many of the responses throughout the data, as highlighted on page 139, bear witness to sexual health clinical care and associated learning often being thwarted by an *"ethos of governance"* (Van Loon 2008: 49). This governmentality is exercised as a policing of desire (on the *ars erotica*) that ultimately aims to re-define and impose an orthodoxy of 'acceptable' regimes

of truth, to the exclusion – *invisibilisation* – of others. Despite best efforts to see how respondents would deal with a number of invisibilisations, most notably for sexuality (in references to lesbian women) and for sexual practices (*ars erotica*: notably as masturbation), the data references have been too limited to draw out any substantive conclusions other than their continued existence shrouded under Foucault's (1984) *triple edict* and managed through forms of Power / Knowledge and governmentality. There are, however, a number of current or proposed UK Government and professional organisations' guidelines to help argue in favour of being more inclusive with sexual health learning for life and for practice. This is undisputedly the case for practical / clinical skills and competencies, although, without a mandated faculty of sexual health nursing (or similar), current professional accreditation for nurses is problematic and in disarray. Sometimes the strategies or guidelines may be generic and offer recommendations only, as in the NMC (2010) <u>Standards for Pre-Registration Nurse Education</u> and unofficial correspondence (Appendix 11); other times – as with various clinical competencies - they are more prescriptive. What will remain a problem, however, is effective ways to proactively address the various invisibilised clients and their holistic and specific sexual health needs.

As **HEI-S / R17** commented

> "Pre-reg ask us to teach if there's an enthusiastic / pro-sexual health teacher running their courses".

Sadly, this may continue for some of the invisibilised people and issues, unless enough effort is made to see how all the best practice guidelines, ancillary documents and legislation (such as the *Gender Duty* of the <u>Equality Act</u> 2010) are brought to bear on the matter.

The skill for the intentional promotion of greater inclusivity of sexual health learning to be provided by HEIs, and in clinical practice, will happen most successfully if elements of various and diverse guidelines and recommendations are drawn together and acted upon (implemented). The final part of this chapter will therefore synthesise a few recommendations (certainly not all), by way of example for a positive way ahead for professional educational development. Based on the sexual health elements of the health White Paper (HM Government 2010); its pre-emptive 'commentary' by BASHH (2010b); the Mental Health Strategy (HM Government 2011), the TP-IAG Final Report (TPIAG 2010); the guidelines and competencies outlined by RCN (2009a) and MedFASHH (2010), a list of priorities for nurses and their education can be envisaged as demonstrated in Figure 6: 1 below.

(*overleaf*)

Figure 6: 1   Documented priorities for sexual health in nurse education

Public Health / Promotion

- a proactive raising of the profile of sexual, reproductive health and HIV with a health promotion and awareness remit desired of the new public health orientation for all professionals. This is especially so for combining C&SH education and services, e.g. to cross-train professionals and help those working with young people develop such / new services including in schools (TPIAH 2010; HM Government 2011)

Young People's Services (including school nursing)

- to redress the "inexcusable failure" "to make SRE part of the national curriculum" and adequately prepare School and Practice Nurses, Midwives, Health Visitors and the Family Nurse Partnership to efficiently and competently manage new developments (TPIAG 2010: 3)

Mental Health

- more focus on links between mental health and sexual health, from child sexual abuse, gender and sexuality based violence (which can affect around 50% of in-patient MH service users, HM Government 2011: 6: 31)
- 'join up the dots' between associated poor indices of health, including mental health, alcohol and substance abuse, obesity, anti-gender and sexuality violence and bullying
- to improve outcomes for lesbian, gay and bisexual people (HM Government 2011: 61)
- to raise awareness of transgender people, their equality and healthcare rights (HM Government 2011: 6: 34)

Competencies, 'in-house' training opportunities, reflective practice

- implement in-house training opportunities. *Based on research and data in this study: there needs to be a foundational build-up to **C**linical skills training with appropriate regard paid to underlying **A**ttitudes and **B**ehaviours of staff, who may have personal, moral or belief system incongruence with the presenting client and their needs (**A-B-C** of sexual health education, referred to above)*
- standardised, multi-professional competencies and skills training and assessment, with appropriately trained clinical assessors (MedFASH 2.1.2)
- reflective practice especially through mentorship and clinical supervision (which means sexual health training of these professionals, too, as well as educators in general – e.g. old people's courses teachers RCN 2009b); this includes clinical, psycho-social and mental health issues, additionally, personal attitudes and beliefs and the covert ways in which nurses disengage from patients they dislike or find distasteful or the subject matters, as demonstrated throughout this thesis in relation to abortion, non-heterosexual orientations and masturbation

Integrated holisitc services to include attention for abortion care

- work towards an integrated model of service delivery (including abortion services; despite no mention of abortion whatsoever in the Mental Health Strategy) (HM Government 2010: 3.43)
- to equip nurses to deal with patient consequences of abortion, which account for almost 1:2 of all under 18 year old conceptions in England (TPIAG 2010: 1)

Limitations of this study

As with most studies, there are certain areas which pose challenges of limitations. Some of these limitations are already proving to be opportunities for the author, with future development through post completion research and publications.

From the empirical study, probably the greatest limitation was from the relatively few responses from teachers at HEIs identified as offering sexual health courses. Although the response rate was judged acceptable for a postal survey, by not achieving close to one hundred percent it missed the opportunity to be a full update to replace the 2007 GUNA Database of Educational Courses. A second limitation was from the Questionnaire Groups. Their self-completion forms asked identical questions to the Focus Groups, however the quality and quantity of data responses were in no way comparable between the two.

An epistemological and practical limitation concerns the 'invisibilised' issues of sexual health, as identified throughout the thesis and epitomised in this work for sexuality in reference to lesbian females, and for *ars erotica*, as masturbation. An opportunity to redress the balance for lesbian females has now been afforded to me by being appointed to a research team undertaking a systematic review of resilience in young lesbian, gay bisexual and transgender individuals (May – August 2011).

The final limitation to identify is through hindsight knowledge, from the study, which might prove profitable for further research both to develop uptake of sexual health educational programmes and recruitment and retention within sexual health service areas. Given how many respondents recounted a lack of opportunity, coupled with an active resistance, to them working in sexual health service areas during their student days: why do so many sexual health service 'naïve' people actually choose to move into and work in these clinical areas? What motivates them a) when they are deprived of positive encouragement and role models, and b) in the face of clear discouragement?

Contribution to learning

After reviewing the literature and exploring the Index of British and Irish Theses, I am satisfied that the theme of this study, and, most particularly the unique epistemological approach developed to explore it, definitely contributes to professional learning in this field. The study has brought out into the open, in a way that in the literature is found wanting, discourses that testify to the gaps in professional education related to patient / client needs and associated clinical practice.

The specific application of Foucauldian tools and concepts to the subject matter has enabled a unique analysis of the discourses which would traditionally be side-lined and invisibilised. It has demonstrated the relevance to client / patient needs in as much as those needs are perceived by nurses who care for them and in the nurses' educational providers. My specific contribution to learning has also:

285

- **highlighted new ways of looking at old questions**. These new ways include relating 'official' forms of knowledge, such as the *science of sex* and epidemiology, with the frequently silenced voices of others, across the triptych model of the curriculum developed earlier in this work

- **gathered and interrelated unique sets of data** from across England, from sexual health teachers at HEIs and nurses in clinical practice

- **adapted Foucauldian methods and developed metaphors of crystallisation** to demonstrate the relevance for customising the epistemological approach used to analyse and interpret the literature and data

- **transformed my earlier (RCN 2001) model of a 'sexual health umbrella'** (p. 52) into a coordinated awareness of sexual health across three domains of life and professional practice, otherwise demonstrably absent in the literature reviewed here and the professional curricula of the majority of respondents. These three domains relate to the holistic foundations of personhood in nursing care; secondary aspects of sexual health matters associated with underlying health conditions, and in the specific classification of sexual ill-health

- **conceptualised a model of sexual health matters 'learning for life' across a curricula** *triptych* embracing the holistic, related and specific sexual health matters confronting client care (immediately above)

- **clarified various power dynamics which keep particular discourses hidden (invisibilised) and neglected** in traditional 'orthodox' medico-scientific 'regimes of truth', and

- **given a voice to particular nurses** for highlighting their concerns at various client / patient needs which they consider are sub-optimally addressed across the professional educational curricula.

Contribution to professional educational development

The contribution to professional development is summarised in Figure 6: 2 series, below. The contribution outlined covers the period of time over which the empirical study and writing up of this thesis was conducted. It is also the author's intention to publish elements of this thesis in relevant journals, with the specific aim of promoting sexual health learning and education across the curricular *triptych*.

Figure 6: 2a The *art and science* of sexual health nursing education:
My professional contributions over of duration of this
study – publications and the development of learning*

Publications

- Evans, D. T. and L. Stapley "Sexual health issues in men - part 1." Practice Nurse
- Evans, D. T. and L. Stapley "Sexual health issues in men - part 2." Practice Nurse
- Roberts, C and D. T. Evans, Chapter 11: 'Male Health', Nurse Practitioner Manual of Clinical Skills
- 'Opinion: What should be done to stem the rise in STIs?' Independent Nurse
- 'Inspiring Sexual Health', RCN Magazine
- 'Promoting sexual health to young people to reduce STIs', Nursing Times
- 'Life is sexually transmitted! Live with it', Practice Nursing
- '"Clever dicks do it in a condom"– developing positive ways to actively promote effective and consistent condom usage, as an element of safer sex, among young people', Practice Nurse
- 'Sex, drugs and HIV prevention: a case for PEPSE (Post Exposure Prophylaxis – Sexual Exposure)' Nursing in Practice
- 'Sex education is still fundamental: Antiviral therapy is useful for those exposed to HIV but, says David Evans, it should not replace safer sex', Independent Nurse

Development of learning
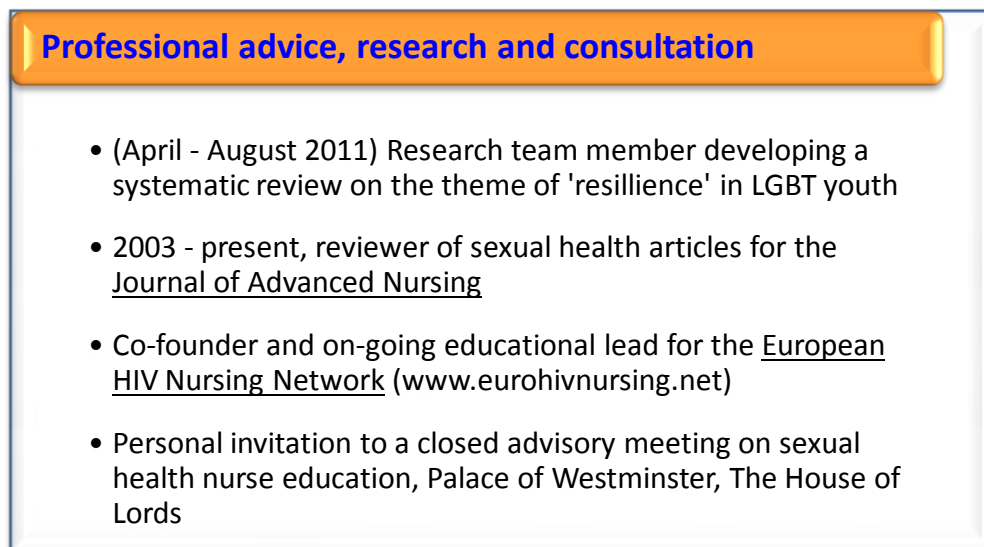
- **Sexual, Reproductive Health and Safety** *e-learning modules for mental health and social care professionals*, Social Care Institute for Excellence (www.scie.org.uk); co-authored with Dr Kathryn Abel & Dr Roxanne Davis.
- **Contemporary issues in Sexual Health**, core course (e-learning) of the University of greenwich MA in professional practice - sexual health route
- Griffiths, V with D.T. Evans, **RCN Chlamydia learning initiative** www.rcn.org.uk/publications/pdf/Chlamydia.pdf

Figure 6: 2b The *art and science* of sexual health nursing education:
My professional contributions over of duration of this
study – conference presentations

Conference presentations

- **Royal College of General Practitioners, Manchester** *From boys to men: engaging and working with half of the population's sexual health in primary care*

- **RCN Practice Nurses' Association, Annual Conference, Cardiff** Plenary session: *Sexual Health Issues for gay males and lesbian females*

- **1st European HIV Nursing Network Conference, Warsaw, Poland** Plenary session: *HIV Care Issues across Europe: perspectives from the western region*

- **17th Derbyshire Practice Nurses Conference** Plenary session: *Sexual health matters! for practice nurses*

- **RCN Travel Health Annual Conference, London** Plenary session: *The sexual health of travellers*

- **RCN Sexual Health Forum Annual Conference** (RCP, London) Plenary session: ***After three glorious years … the RCN Sexual Health Skills course***

- **Royal College of Nursing Congress, Harrogate** Fringe event: ***HIV antibody testing: giving a positive result*** (co-presenter)
- Fringe event: ***Sexual Health Nursing in the new health age*** (co-presenter)

- **Practice Nurse Conference, St Albans** Plenary presentation: ***Life is sexually transmitted! Sexual health issues for Practice Nurses***

- **Westminster Briefing Conference, London** Plenary presentation: **Sexual Health and Young People:** ***Are Teenage Pregnancy Strategies and Advice Services Working?***

- **DH Achieving Excellence in Sexual Health Training** (around England) Plenary presentation and Workshop: *RCN Sexual Health Skills course*

- **Director Nursing Services (Royal Air Force) Conference**, RAF Coningsby Opening Presentation: Royal Air Force Nursing and Sexual Health

- **Nursing in Practice Conference, Manchester** Presentation: *Sexual Health and Teenage Pregnancy*

- **International Council of Nurses Congress, Taipei, Taiwan** Workshop presentation: Anti-(HIV)Stigma campaign: strategies to combat stigma and create stigma-free health services
- Research Network presentation: HIV in a "man's world": male sexual health and nursing research

Figure 6: 2c The *art and science* of sexual health nursing education:
**   *My professional contributions over of duration of this*
**   *study – advice, research and consultation*

> ### Professional advice, research and consultation
>
> • (April - August 2011) Research team member developing a systematic review on the theme of 'resillience' in LGBT youth
>
> • 2003 - present, reviewer of sexual health articles for the <u>Journal of Advanced Nursing</u>
>
> • Co-founder and on-going educational lead for the <u>European HIV Nursing Network</u> (www.eurohivnursing.net)
>
> • Personal invitation to a closed advisory meeting on sexual health nurse education, Palace of Westminster, The House of Lords

Conclusion

This thesis is based on research which set out to answer two key questions:

> *"In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?"*

> *"In which ways could professional education have adequately prepared nurses for meeting the sexual health needs of their clients?"*

Over the course of the studies and the gathering of empirical data, it became important to contextualise the materials soundly within the epistemological framework chosen, namely, various concepts of Michel Foucault. This has enabled me to identify a number of key discourses pertaining to sexual health and illness and 'listen attentively' to the respondents' voices as they explored

their knowledge (or frequently, the lack, thereof) and experiences of sexual health learning within their professional careers as nurses. The discourses show how many respondents react to sexual ill-health, in a manner typical of the traditional discourses and voices pertaining to matters sexual within England and the rest of the UK. The respondents were also witness to the fact that the various gaps between client need and professional education are often 'policed' through 'regimes of truth' that accentuate some issues but concurrently invisibilise others. What contemporary healthcare practice and recommendations are calling on them to do is be more *proactive* rather than reactive: this has profound implications on the provision of education and learning.

That the study has drawn attention to the on-going disregard of sexual health matters across all three domains of the curricular *triptych* model developed here, lends weight to the process of analytical crystallisation used in this work. Through this unique analysis, it is possible to understand how some voices and discourses are heard out loud, whilst others remain perpetually hidden and invisibilised. Regrettably, a conclusion I reached from the data in chapter 5 must be restated here: *whether someone qualified twenty-five years ago or within the last three months, the quality and quantity of formal sexual health learning across the curricular triptych model remains negligible and incommensurate with clinical demands on professional nursing care.*

On a positive note, this work has enabled me, as researcher and author of this thesis, to have a clear understanding of the issues contemplated and firm

ideas of what needs to be done, by way of publications, disseminations and professional consultation / advice to advance the *ars et scientia* of sexual health learning and education.   A plan of action has evolved by way of advocating on behalf of the silenced voices, through their professional carers who have demonstrated a passion for the subject matter and the subsequent delivery of expert care.   This plan of action has already started, by me, as clearly demonstrated in my contribution to professional educational practice outlined in Figures 6.2a-c above.

Finally, despite any shortcomings in the facilitation of learning and provision of education, the respondents in this study showed a clear desire for more to be done in regards to formal sexual health learning through the curriculum and in practice.   To that end, I dedicate this work to them and their patients, and – as a requirement of such professional doctorates – will endeavour to tell their stories to professional and academic colleagues with the sole intention of improving the *art and science* of sexual health nursing education.

> **FG17 / P07** Um…having done the course now I can't believe that I have gone through years of nursing and missed so many opportunities to be able to help people just from doing this sort of course. I think they should be instigating this sort of awareness of sexual health because it affects us all whatever age, gender, and I think they should bring that into nurse training.

> **FG11 / P06** The number one area to address is simply: **address it!** More people need to talk about it! *I-n-c-l-u-d-e i-t!* [group laugh].

Post Script

Researcher identity: So what? Where am I in this study?

One of the *viva voce* examiners commented how I, as the Subject / Author, appeared on every page of this study, for example through my use of language, first person singular and style of writing. Equally, it was noted how I was not always so apparent. I anticipated this point of objective distancing early on and drew attention to it in various sections throughout the thesis. There are two reasons for this: firstly, like Foucault, I, as the Subject / Author, grappled with the notions of being heard but not seen, so to speak. He considered the reader of the text and the meaning they make of it as taking precedence over authorship. Secondly, I possibly erred on the side of caution in the methodological tension between research objectivity and fear of 'contaminating' the work with too much personal subjectivity. This doctoral journey has been a balancing act between what I, as an 'expert' in my field of educational practice already knew, compared with what I was discovering and consolidating through new reading, through listening attentively to the voices of the various respondents, and through the outcome of constant reflective analysis upon these two elements in relation to my research questions. After studying feminism / gender and masculinities studies as part of a PhD foundation programme at The LSE Gender Institute (1999-2001), the greatest challenges to my personal belief systems during this current research came from Foucault and the post structuralist Queer Theories I read. Frequently these studies would challenge my prior notions of essentialism, which contribute to the 'immutable' status of sexual orientation, identity politics and associated human rights. This enabled me to positively challenge majoritarian, essentialising, notions in others too, both in the respondents for this study and students I subsequently teach.

So what?

This study has taken much longer to complete than I kept on anticipating. In part this has been because of trying to fit it in with the challenges of freelance working contracts. Also, the delays have come through 'agonising' over the *minutiae* of precise meanings (like "the problems of sexuality for *ginger* people" in chapter 5). This is to make sure that the best meanings were always given and that everyone's voice was adequately heard. Clear examples of this precision to detail include the way I have possibly incorporated too many of the 108,000 words of respondents' transcribed data (and subsequently removed some, as a requirement of the examination process), and how, with critical reflection – for example, in relation to challenges by my supervisors – how I eventually argue my case for using a given word or phrase. This was demonstrated during examination when I referred to my use of the word "performativity" in the text, over "performance", for example in relation to sexual acts. In the early days of AIDS awareness,

many gay males were being told to give up sex; to many of them, this was a recurring moral injunction heard over times, places, religions and cultures. As an act of defiance, contrary to this complete 'abstinence model' of health promotion, which masquerades as safer sex messages, some gay men continued to *fuck* not just as a physical / biological act, but as something which brought the full symbolism (performativity) of resisting the powerful dynamics of cultural, 'moral' and institutional governmentality.

The opportunities for personal reflection during this study have given me insights into my subject area from new and challenging perspectives. Foucault has been a tough read! I was determined to try to 'get to grips' with some of his ways of thinking, explicitly to challenge myself to think outside of my usual box. Also, there have been moments of disappointment and frustration when I have thought that the respondents 'should' know better, or at least know more. This was not just in an academic sense of increased knowledge or skills, but in human feeling and personal insight and reflection. From over four decades of being consciously and profoundly aware of my own, sometimes marginalised, sexuality and sexual experiences in life (including ten years of celibacy whilst with the Catholic priesthood and of caring for many people dying with HIV disease), of experiencing some of Serrant-Green's (2011) "screaming silences", or being enveloped in Foucault's (1984) "triple edict of taboo, non-existence and silence", I feel that my practice of reflection on these sensitive issues is quite acute and highly developed.

Where am I in this study?
Without going around in circles again: as author, I am everywhere in this work. Through reflecting on the epistemologies and adapting and applying them through the voices of the various respondents, it is ultimately *my* interpretation of these findings that are outlined in the pages of this thesis. As stated in chapter 6, my hope is that this work will make a clear and significant contribution to the development of the *art and science* of sexual health learning for clinical practice.

References

References

Acts of Parliament and other legislation

Defence of The Realm Act 1917, *George V*, Her Majesty's Stationary Office.

European Convention on Human Rights 1953, Council of Europe.

Human Rights Act 1998, *Elizabeth II*, London, Her Majesty's Stationary Office.

References

Adler, M. W., Ed. (1988). Diseases in the Homosexual Male. The Bloomsbury Series in Clinical Science. London and Berlin, Springer-Verlag.

Adler, M. W. (2001). ABC of AIDS. London, Wiley-Blackwell.

Adler, M. W. (2003). "Sexual health Report finds sexual health service to be a shambles (editorial)." British Medical Journal (2003)(327): 62-63.

AIDS-action (2001). Recommendations - stigma and HIV prevention. Washington DC, AIDS Action, cited at www.aidsaction.org cited on 13.07.05.

Allan, H. (1993). "Feminism: a concept analysis." Journal of Advanced Nursing 1993(18): 1547-1553.

Allen, D. (2004). Fishing for Foucault. Nursing Standard 18(38): 20-21.

Alonzo, A. A. and N. R. Reynolds (1995). "Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory." Social Science Medicine 41(3): 303-345.

Anderson, J. M. and K. McCann (2002). "Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship." Nurse Researcher - the international journal of research methodology in nursing and health care 9(3): 7-27.

Anderson, P. B., A. Fakhfakh, M.A. Kondylis, (1999). "Attitudes toward the media's portrayals of gays and lesbians." Electronic Journal of Human Sexuality 2(July 1999).

Annan, K. A. (2006). The Secretary-General - Message on the Occasion of World AIDS Day 1 December 2006, UNAIDS, cited at www.unaids.org cited on 08.08.07.

Arnold, M. (1997). The story of lesbians with AIDS. The Lesbian Health Book - caring for ourselves. J. White and M.C. Martinez, Seattle, Seale Press: 148-159.

Astbury-Ward, E. (2008). "Emotional and psychological impact of abortion: a critique of the literature." <u>Journal of Family Planning and Reproductive Health Care</u> 34(3): 181-184.

Astbury-Ward, E. (2009). "Provision of contraception and its influence on abortion." <u>Nursing in Practice</u> 2009(March/April): 56-58.

Astbury-Ward, E. (2010). <u>A qualitative study of abortion care perceptions of patients and staff</u>, Wrexham, University of Wales. PhD (unpublished).

Baird, R. M. and S. E. Rosenbaum (2001). <u>The Ethics of Abortion: Pro-Life vs. Pro-Choice</u>. New York, Promethius Books.

Barrett, P. S. and L. C. Barrett (2003). "Research as a kaleidoscope on practice." <u>Construction Management and Economics</u> October 2003(21): 755–766.

Beard, M. and J. Henderson (1997). "With this body I thee worship: sacred prostitution in antiquity." <u>Gender and History</u> 9(3): 480-503.

Beauchamp, T. L. and J. F. Childress (1994). <u>The Principals of Biomedical Ethics</u>. New York, Oxford University Press.

Berridge, V. (1996). <u>AIDS in the UK - the making of policy, 1981-1994</u>. Oxford, Oxford University Press.

Bhabha, H. (1994). <u>The Location of Culture</u>. Abington and New York, Routledge.

Blake, S. and G. Frances (2001). <u>Just Say No! to Abstinence Education</u>. Lessons learnt from a sex education study tour of the United States. London, National Children's Bureau / Sex Education Forum (.pdf summary sheet available at www.dfes/teenagepregnancy).

Blythe, E. and R. Moore (2001). Involuntary childlessness and stigma. <u>Stigma and Social Exclusion in Healthcare</u>. T. Mason, C. Carlisle, C. Watkins and E. Whitehead. London, Routledge: 217-226.

Bonell, C. (2004). "Research Review: Why is teenage pregnancy conceptualized as a social problem? A review of quantitative research from the USA and UK." <u>Culture, Health and Sexuality</u> 6(3): 255–272.

Booth, W. C., G. G. Colomb, J. M. Williams, (2003). <u>The Craft of Research</u>. Chicago and London, The University of Chicago Press.

Brookey, R. A. and D. H. Miller (2001). "Changing Signs: The Political Pragmatism of Poststructuralism." <u>International Journal of Sexuality and Gender Studies</u> 6(1/2): 139-153.

Brown, S. (2001). "What Makes Men Talk About Health?" <u>Journal of Gender Studies</u> 10(2): 187-195.

Bryar, R. (2000). "An examination of case study research." <u>Nurse Researcher - the international journal of research methodology in nursing and health care</u> 7(2): 61-78.

Buhi, E. R. and P. Goodson (2007). "Predictors of Adolescent Sexual Behavior and Intention: A Theory-Guided Systematic Review." <u>Journal of Adolescent Health</u> 40: 4-21.

Burgess, H., S. Sieminski, L. Arthur, (2006). <u>Achieving your doctorate in education</u>. London, Sage Publications Ltd.

Burman, E. (1995). 'What is It?' Masculinity and femininity in cultural representations of childhood. <u>Feminism and Discourse - psychological perspectives</u>. S. Wilkinson and C. Kitzinger. London, Sage Publications: 49-67.

Butler, A. (2005). "South Africa's HIV/AIDS policy, 1994–2004: How can it be explained? ." <u>African Affairs</u> **104**(417): 591-614.

Butler, J. (2004). <u>Undoing Gender</u>. New York and London, Routledge.

Cameron, E. and J. Bernardes (1998). "Gender and disadvantage in health: men's health for a change." <u>Sociology of Health & Illness</u> 20(5): 673-693.

Campbell, T. (2006). "She's feeling lustless." <u>Healthcare Counselling and Psychotherapy Journal</u> 6(4): (on line).

Carlisle, C. (2001). HIV and AIDS. <u>Stigma and Social Exclusion in Health Care</u>. T. Mason, C. Carlisle, C. Watkins and E. Whitehead. London and New York, Routledge: 117-126.

Carter, M. (2007). IAS: HPV diversity suggests value of HIV-positive gay men receiving Gardasil. <u>Aidsmap news</u>, cited at www.aidsmap.org.uk/en/news/ cited on 16.08.07.

CDC (1993). 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, <u>MMWR</u> 41(RR-17); Publication date: 18/12/1992. Atlanta, Georgia, and cited at http://wonder.cdc.gov/wonder/help/AIDS/MMWR-12-18-1992.html last accessed on 09.05.09, Centres for Disease Control and Prevention.

Challinor, S. (2006). Sexual health assessment in a general practice travel clinic. <u>Nursing Times</u> 102(32): (on line).

Challinor, S. (2008). Let's talk about sex! <u>Nursing in Practice </u>March / April(41): 70-73.

Chambers, R., G. Wakley, and S. Chambers (2001). <u>Tackling Teenage Pregnancy: sex, culture and needs</u>. Oxford, Radcliffe Medical Press.

Clarke, C. (2004). "The structure of educational research." <u>British Educational Research Journal</u> 31(3): 289–308.

Cleaver, K. and A. Rich (2005). "Sexual health promotion: the barriers school nurses face." Community Practitioner 78(12): 429-432.

Clegg, S. (1999). "Professional education, reflective practice and feminism." International Journal of Inclusive Education 3(2): 167-179.

Cohen, L., L. Manion and K. Morrison (2000). Research Methods in Education. London, RoutledgeFalmer.

Cohen, D. A. and T. A. Farley (2004). "Social marketing of condoms is great, but we need more free condoms." The Lancet, cited at: www.thelancet.com cited on: 20.01.05 Volume 364(9428): 13.

Cole, M. (2006). The Role of Confession in Reflective Practice: Monitored Continuing Professional Development (CPD) in Health Care and the Paradox. Theorizing Surveillance: The Panopticon and beyond. D. Lyon (Ed). Cullompton Willan Publishing.

Coleman, E., Ed. (2002). Masturbation as a means of achieving sexual health. Masturbation as a Means of Achieving Sexual Health. New York, London, Oxford, The Haworth Press, Inc. (co-published simultaneously as *Journal of Psychology and Human Sexuality*, vol. 14, Nos 2/3, 2002).

Coleman, L. and S. Cater (2006). 'Planned' Teenage Pregnancy: Perspectives of Young Women from Disadvantaged Backgrounds in England. Journal of Youth Studies 9(5): 593-614.

Cook, H. (2007). The Long Sexual Revolution - English women, sex and contraception 1800-1975. Oxford, Oxford University Press.

Corfield, P. J. (2000). Power and the Professions in Britain 1700-1850. London, Routledge.

Coyle, J. and B. Williams (2000). "An exploration of the epistemological intricacies of using qualitative data to develop a quantitative measure of user views of health care." Journal of Advanced Nursing 31(5): 1235-1243.

Creswell, J. W. (1998). Qualitative Enquiry and Research Design - choosing among five traditions. London, Sage Publications.

Crosbie, E. J. and H. C. Kitchener (2007). Vaccination against cervical cancer. Royal College of Obstetricians and Gynaecologists - Scientific Advisory Committee Opinion Paper 9 February 2007: 1-5.

Creswell, J. W. (1998). Qualitative Enquiry and Research Design - choosing among five traditions. London, Sage Publications.

Crowe, M. (2005). "Discourse analysis: towards an understanding of its place in nursing." Journal of Advanced Nursing 51(1): 55-63.

Daly, J., I. McDonald, E. Willis, Eds. (1994). Researching Health Care: designs, dilemmas, disciplines. London and New York, Tavistock / Routledge.

Danaher, G., T. Schirato, and J. Webb (2000). Understanding Foucault. London, Sage Publications.

Dattilo, J. and M. K. Brewer (2005). "Assessing Clients' Sexual Health as a Component of Holistic Nursing Practice: Senior Nursing Students Share Their Experiences." Journal of Holistic Nursing 23(2): 208-219.

Davenport-Hines, R. (1991). Sex, Death and Punishment: attitudes to sex and sexuality in Britain since the Renaissance. London, Fontana Press.

DCSF (2007). Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts. London, Department for Children, Schools and Families & Department of Health.

DCSF (2008). Government Response to the 4th Annual Report of the Teenage Pregnancy Independent Advisory Group. London, Department for Children, Schools and Families.

de Vaus, D. A. (2001). Surveys in Social Research. London, Routledge.

Denzin, N. K. and Y. S. Lincoln, Eds. (2003a). The Landscape of Qualitative Research: theories and issues. London, Sage Publications, Inc.

DfEE (2000). Sex and Relationship Education Guidance. London, Department for Education and Employment.

DH (2001). The National Strategy for Sexual Health and HIV. London, Department of Health.

DH (2002). The National Strategy for Sexual Health and HIV - implementation action plan. London, Department of Health.

DH (2006). Modernising Nursing Careers – Setting the Direction. London, Department of Health: Chief Nursing Officer's Directorate.

DH (2009). New Horizons: Towards a shared vision for mental health - Consultation. London, Department of Health.

DH (2010). Liberating the NHS: Developing the Healthcare Workforce. A consultation on proposals. London, Department of Health.

DHSSPSNI (2003). Consultation Document - A Five Year Sexual Health promotion Strategy and Action Plan. Belfast, Department of Health, Social Services and Public Protection, Northern Ireland.

Diamond, I. and L. Quinby, Eds. (1998). Feminism and Foucault - reflections on resistance. Boston, Norteastern University Press.

Dingwall, R. (1994). 'Don't mind him - he's from Barcelona' - qualitative methods in health studies. Researching Health Care: designs, dilemmas, disciplines. J. Daly, I. McDonald and E. Willis. London and New York, Tavistock / Routledge: 161-175.

Dodds, C. (2006). "HIV-Related Stigma in England: Experiences of Gay Men and Heterosexual African Migrants Living with HIV." <u>Journal of Community & Applied Social Psychology</u> 2006(16): 472–480.

Dodds, C., P. Keogh, O. Chime, T. Haruperi, B. Nabulya, W. Sseruma, P. Weatherburn, (2005). <u>Outsider status: Stigma and discrimination experienced by Gay men and African people with HIV</u> - Research Report. London, Sigma Research / National AIDS Trust.

Dunleavy, P. (2003). <u>Authoring a PhD - how to plan, draft, write and finish a doctoral thesis or dissertation</u>. New York, Palgrave MacMillan.

Durkin, A. (2003). "Comfort levels of nursing faculty regarding student assignment to a patient with AIDS." <u>Nurse Education in Practice</u> 2003(3): 124-132.

Eadie, J. (2004a). Abject. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold: 1.

Eadie, J., Ed. (2004b). <u>Sexuality - the essential glossary</u>. London, Arnold.

Earle, S. (2001). "Disability, facilitated sex and the role of the nurse." <u>Journal of Advanced Nursing</u> 36(3): 433-440.

Enson, S. (2009). "Barriers to accessing sexual health services." <u>British Journal of School Nursing</u> 4(10): 449-502.

<u>Equality Act</u> (2006), Her Majesty's Government, London, The Stationary Office.

ESG (2008). <u>Review of Sex and Relationship (SRE) Education in Schools</u>: A report by the External Steering Group. London, Department for Children, Schools and Families.

Evans, D. T. (1997). <u>The Psychic Shadows of HIV and AIDS</u> - and the role of social representations in post registration nurse education. University of Wales College of Cardiff (unpublished MPhil thesis).

Evans, D. T. (2000a). "From nits to crabs? School nurses and sexual health." <u>British Journal of Nursing</u> 9(18): 2022-2029.

Evans, D. T. (2000b). "Speaking of Sex: the need to dispel myths and overcome fears." <u>British Journal of Nursing</u> 9(10): 1162-1169.

Evans, D. T. (2001). The stigma of sexuality: concealability and course. <u>Stigma and Social Exclusion in Health Care</u>. T. Mason, C. Carlisle, C. Watkins and E. Whitehead. London, Routledge: 104-116.

Evans, D. T. (2003). "Sexual health matters to all practitioners." <u>British Journal of Nursing</u> 12(11): 649.

Evans, D. T. (2004a). Professionalisation in sexual health nursing: sexual and gender theoretical perspectives. From the "world's 'oldest' profession"

to the professionalisation of 'Cinderella'. University of Greenwich (unpublished doctoral assignment: <u>ACAD 1070</u>).

Evans, D. T. (2004b). Scientia sexualis. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 188-189.

Evans, D. T. (2004c). Behind the headlines: sexual health implications for nursing ethics and practice. <u>Primary Health Care Journal</u> 14(8): pp. 40-49.

Evans, D. T. (2004d). "The trouble with men is ... Raising the profile of men's sexual health." <u>Nursing in Practice Journal</u> 2004(17): 36-38.

Evans, D. T. (2004e). Normalisation. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 142-143.

Evans, D. T. (2004f). Stigma. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 221-222.

Evans, D. T. (2004f). Erotophobia. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 61.

Evans, D. T. (2004g). Sexual orientation. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 207-208.

Evans, D. T. (2004h). Sexual preference. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 209-210.

Evans, D. T. (2004i). Situational homosexuality. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 212-213.

Evans, D. T. (2005a). Sex, Drugs and HIV prevention: a case for PEPSE. <u>Nursing in Practice</u> (March / April 2005): 54 - 57.

Evans, D. T. (2005b). Experiences in searching historical sources - "Bad girls and naughty boys! From 'Venereal Diseases' to 'sexual health': the transformation of epistemies, stigma and (in)visibilisation". University of Greenwich (unpublished doctoral assignment, <u>ACAD 1061</u>).

Evans, D. T. (2005c). Clever dicks do it in a condom. <u>Practice Nurse</u> 14 October 2005: 27-34.

Evans, D. T. (2005d). <u>Anti-stigma campaign: strategies to combat (HIV and AIDS) stigma and create stigma-free health services (UG EdD dissemination No. 2; ACAD 1064)</u>. International Council for Nurses Congress, Taipei, Taiwan.

Evans, D. T. (2006). "Life is sexually transmitted: live with it!" <u>Practice Nursing</u> 17(8): 401-405.

Evans, D. T. and C. J. McKenzie (2004). SM. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Arnold Publishers: 214-216.

Evans, D. T. and L. Stapley (2010a). "Sexual health issues in men - part 1." Practice Nurse 2010(17 September): 30-34.

Evans, D. T. and L. Stapley (2010b). "Sexual health issues in men - part 2." Practice Nurse **2010**(8 October): 33-36.

Fallon, D. (2003). "Adolescent access to emergency contraception in A and E departments: reviewing the literature from a feminist perspective." Journal of Advanced Nursing 2003(12): 4-11.

Farrell, L. (1996). Seven Deadly Sin: Lust. British Medical Journal 1996(313): 1592

Fee, E. (2000). "The wages of sin." The Lancet 354: SIV61.

Fenton, K., J. Giesecke, F.F. Hamers (2001). Europe-wide surveillance for sexually transmitted infections: a timely and appropriate intervention. EuroSurveillance - European Communicable Diseases Bulletin 6(5): 69-92.

Few, C. (1997). The politics of sex research and constructions of female sexuality: what relevance to sexual health work with young women? Journal of Advanced Nursing 25(3): 615-625.

Forrest, S. (2003). Difficult loves: learning about sexuality and homophobia in schools. Education, Equality and Human Rights. M. Cole. London and New York, Routledge Falmer: 99-117.

Foucault, M. (1980). Power/Knowledge: selected interviews and other writings 1972-1977. C. Gordon. Pantheon Books, New York.

Foucault, M. (1984). The History of Sexuality: an introduction. London, Penguin Books.

Foucault, M. (1985). The History of Sexuality: the use of pleasure. London, Penguin Books.

Foucault, M. (1986). The History of Sexuality: the care of the self. London, Penguin Books.

Foucault, M. (2007). The Order of Things - An archeology of the human sciences. London, Routledge.

Fox, N. J. (2006). Is there life after Foucault? Texts, frames and *differends*. Foucault, Health and Medicine. A. Petersen and R. Bunton. London, Routledge: 31-52.

Franklin, K. (1998). Unassuming Motivations: contextualizing the narratives of antigay assailants. Stigma and Sexual Orientation: understanding prejudice against lesbians, gay men and bisexuals. G. M. Herek. Thousand Oaks (Ca) and London, Sage Publications. 4: 1-23.

French, K., Ed. (2009a). Sexual Health. Oxford, Wiley-Blackwell.

French, K. (2009b). <u>The invisibility of young black heterosexual men in sexual health discourses</u>. London, City University. PhD (unpublished).

French Adami, M. and A. Kiger (2005). "The use of triangulation for completeness of purpose." <u>Nurse Researcher - the international journal of research methodology in nursing and health care</u> 12(4): 19-29.

Gamson, J. (2003). Sexualities, Queer Theory, and Qualitative Research. <u>The Landscape of Qualitative Research - theories and issues</u>. N. K. Denzin and Y. S. Lincoln. London, Sage Publications: 540-568.

Garcia, C. M. (2005). "Commentary on "Assessing Clients' Sexual Health as a Component of Holistic Nursing Practice"." <u>Journal of Holistic Nursing</u> 23(2): 220-223.

Gilbert, N., Ed. (1995). <u>Researching Social Life</u>. London, Sage Publications.

Goffman, E. (1990). <u>Stigma: notes on the management of spoiled identity</u>. London, Penguin.

Gastaldo, D. (2006). Is health education good for you? Re-thinking health education through the concept of bio-power <u>Foucault, Health and Medicine</u>. A. Petersen and R. Bunton. London and New York, Routledge: 113-133.

Giddens, A. (1997). <u>The Transformation of Intimacy: sex, love and eroticism in modern societies</u>. Oxford, polity Press.

Giles, G.G., G. Severi, D.R. English, M.R.E. McCredie, R. Borland, P. Boyle, J.L. Hopper (2003). Sexual factors and prostate cancer. <u>British Journal of Urology International</u> 9(3): 211-216.

Gill, R. (2003). Participation and access of women to the media, and information and communication technologies and their impact on and use as an instrument for the advancement and empowerment of women. <u>United Nations Commission on the Status of Women</u>, Forty-seventh session, New York, 3 - 14 March 2003.

Goffman, E. (1990). <u>Stigma: notes on the management of spoiled identity</u>. London, Penguin.

Gordon, C., Ed. (1980). <u>Power / Knowledge: selected interviews and other writings 1972-1977 by Michel Foucault</u>. New York, Pantheon Books.

Graham, L. J. (2005). <u>Discourse analysis and the critical use of Foucault</u>. Australian Association for Research in Education, Sydney.

Grant, K. and K. Ragsdale (2008). "Sex and the 'recently single': perceptions of sexuality and HIV risk among mature women and primary care physicians." <u>Culture, Health & Sexuality: An International Journal for Research, Intervention and Care</u> 10(5): 495-511.

Graziottin, A. (2001). Editorial. Female sexual function and dysfunction: can the Cinderella of medicine turn into a princess? <u>Climacteric</u> 2001(4): 4-6.

Grbich, C. (1999). Qualitative Research in Health: an introduction. London, Sage Publications.

Green, G. and S. Platt (1997). "Fear and loathing in health care settings reported by people with HIV." Sociology of Health & Illness 19(1): 70-92.

Grey, A. (1993). Speaking of Sex: the limits of language. London, Cassell.

Grmek, M. (1990). History of AIDS - emergence and origin of a modern pandemic. Princeton New Jersey, Princeton University Press.

Gruenbaum, E. (2005). "Socio-cultural dynamics of female genital cutting: Research findings, gaps, and directions." Culture, Health & Sexuality 7(5): 429-441.

Gutting, G. (2005). Foucault: a very short introduction. Oxford, Oxford University Press.

Haddock, G. and M. P. Zanna (1998). Authoritarianism, values, and the favorability and structure of antigay attitudes. Stigma and Sexual Orientation - understanding prejudice against lesbians, gay men, and bisexuals. G. Herek. London, Sage Publications: 82-107.

Hadley, A., Ed. (1999). Tough Choices - young women talk about pregnancy. London, Live Wire from The Women's Press.

Hadley, A. (2007). Teenage Pregnancy: accelerating the Strategy to 2010 ... how nurses can help. Webcast conference presentation and accompanying Power Point slides, Nursing in Practice Conference, Manchester, 20 May 2007. Available at www.nursinginpractice.com/ cited on 16.05.11.

Halperin, D. M. (1997). Saint Foucault - towards a gay hagiography. New York and Oxford, Oxford University Press.

Hart, C. (2003). Doing a Literature Review. London, Sage Publications.

Hassouneh-Phillips, D. and E. McNeff (2005). ""I Thought I was Less Worthy": Low Sexual and Body Esteem and Increased Vulnerability to Intimate Partner Abuse in Women with Physical Disabilities." Sexuality and Disability 23(4): 227-240.

Hayter, M. (1996). "Is non-judgemental care possible in the context of nurses' attitudes to patients' sexuality?" Journal of Advanced Nursing 24: 662-666.

Hayter, M. (2007). "Nurses' discourse in contraceptive prescribing: an analysis using Foucault's 'procedures of exclusion'." Journal of Advanced Nursing 58(4): 358-367.

Hayter, M., H. Piercy, M-T. Massey, T. Gregory (2007). "School nurses and sex education: surveillance and disciplinary practices in primary schools." Journal of Advanced Nursing 61(3): 273-281.

HCHC (2003). House of Commons Health Committee: <u>Sexual Health</u>. London, The Stationary Office Limited.

Hearn, J. and D. H. J. Morgan (1990). <u>Men, Masculinities and Social Theory (Critical studies on men & masculinities)</u> London, Routledge.

Herdt, G. (1997). <u>Same Sex Different Cultures - exploring gay and lesbian lives</u>. Oxford and Colorado, Westview Press.

Hicks, S. and K. Watson (2003). "Desire Lines: 'Queering' Health and Social Welfare." <u>Sociological Research Online</u> 8(1): (on-line) http://www.socresonline.org.uk/8/1/hicks.html cited on 16.05.11.

Higgins, A., P. Barker, C. M. Begley, (2006). "Sexual health education for people with mental health problems: what can we learn from the literature? ." <u>Journal of Psychiatric and Mental Health Nursing</u> 2006(13): 687–697.

Higgins, A., B. Barker, C. M. Begley, (2009). "Sexuality and mental health nursing in Ireland: Weaving the veil of socialised inhibition " <u>Nurse Education Today</u> (29): 357-364.

Hite, M. and B. Whitkey (1998). Do heterosexual women and men differ in their attitude toward homosexuality? A conceptual and methodological analysis. <u>Stigma and Sexual Orientation - understanding prejudice against lesbians, gay men and bisexuals</u>. G. Herek. Thousand Oaks and London, Sage Publications: 39-61.

Hilton, G. L. S. (2007). "Listening to the boys again: an exploration of what boys want to learn in sex education classes and how they want to be taught." <u>Sex Education</u> 7(2): 161–174.

HM Government (2010). <u>Healthy Lives, Healthy People: our strategy for public health in England</u>. Department of Health. London, The Stationary Office, also cited at: www.dh.gov.uk.

HM Government (2011). <u>No Health Without Mental Health</u>: A cross-government mental health outcomes strategy for people of all ages. Department of Health. London, The Stationary Office.

Hodges, D. B., A. Kuper and S. Reeves (2008). "Qualitative research: Discourse analysis." <u>British Medical Journal</u> 2008(337): 570-572.

Hodgson, I. J. (1997). "Attitudes towards people with HIV/AIDS: entropy and health care ethics." <u>Journal of Advanced Nursing</u> 1997(26): 283–288.

Hodgson, I. J. (2003). <u>An ethnographic investigation into the culture of health care workers involved in the care of people with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)</u>. Division of Nursing, School of Health Studies. Bradford, University of Bradford, PhD (unpublished).

Hoggart, L. and J. Philips (2010). <u>Young People in London: Abortion and Repeat Abortion</u> - research report. London, Government Office for London / Department for Children, Schools and Families.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe, R. Thomson (1996). '"Don't die of ignorance." I nearly died of embarrassment' - condoms in context. <u>Feminism and Sexuality - a reader</u>. S. Jackson and S. Scott. Edinburgh, Edinburgh University Press: 117-129.

Holloway, I. and J. Walker (2000). <u>Getting a PhD in Health and Social Care</u>. Oxford, Blackwell Science.

Holmes, D. and D. Warner (2005). "The anatomy of a forbidden desire: men, penetration and semen exchange." <u>Nursing Inquiry</u> 12(1): 10-20.

Holroyd, G., D. Richardson, J. Webb, (2008). Recasting masculinity: mapping out challenges and opportunities for public health. <u>The Sexual Health of Men</u>. L. Serrant-Green and J. McLuskey. Oxford and New York, Radcliffe Publishing: 13-26.

HPA (2007a). <u>Testing Times - HIV and other Sexually Transmitted Infections in the United Kingdom: 2007</u>. London, Health Protection Agency, also available at: <u>www.hpa.org.uk</u>.

HPA (2007b). <u>Annual Report and Finances 2007: Protecting People's Health</u>. London, Health Protection Agency.

Howe, J. (1995). "A Natural Remedy: giving patients permission to masturbate." <u>Nursing Standard</u> 9(29): 46-47.

Huntingdon, A. D. and J. A. Gilmour (2001). "Re-thinking representations, re-writing nursing texts: possibilities through feminist and Foucauldian thought." <u>Journal of Advanced Nursing</u> 35(6): 902.

IAG-SH (2007). Independent Advisory Group on Sexual Health - Annual Report 2005-2006. London, Department of Health.

ICN (2003). <u>Nurses: fighting AIDS stigma, caring for all</u>. Geneva, International Council of Nurses.

Ihekweazu, C., N. Maxwell, S. Organ, I. Oliver (2007). "Is STI surveillance in England meeting the requirements of the 21st century? An evaluation of data from the South West Region." <u>European Surveillance</u> 12(5): Cited at: <u>www.eurosurveillance.org/em/v12n05/1205-225.asp</u> Cited on 15.06.08.

Inglis, T. (2002). "Sexual Transgression and Scapegoats: A Case Study from Modern Ireland." <u>Sexualities</u> 5(1): 5-24.

Ingram, J. and D. Salmon (2007). "'No worries!' Young people's experiences of nurse-led drop-in sexual health services in South West England." <u>Journal of Research in Nursing</u> 12(4): 305-316.

Irwin, L. (2007). "Homophobia and heterosexism: implications for nursing and nursing practice." Australian Journal of Advanced Nursing 25(1): 70-76.

Irwin, R. (1997). "Sexual health promotion and nursing." Journal of Advanced Nursing 1997(25): 170-177.

Itzin, C. (2006). Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse. London, Department of Health.

IPPF (2008). Drive to curb teen pregnancy rate. International Planned Parenthood Federation - News www.ippf.org/ cited on 21.04.08.

Jacono, J. and B. Jacono (2001). Teenage pregnancy, stigma and differential provision of healthcare. Stigma and Social Exclusion in Health Care. T. Mason, C. Carlisle, C. Watkins and E. Whitehead. London, Routledge: 226 -233.

Jackson-Hayward, C. and H. Mullen (2006). Children, Schools and Families - Residential Child Care Sex Education, Relationships and Sexual Health Policy. Hertfordshire, and cited at: www.ncb.org.uk/ cited on 20.04.08, Hertfordshire Council, Children, Schools and Families Department.

Janesick, V. J. (2003). The choreography of qualitative research design: minuets, improvisations, and crystallization. Strategies of Qualitative Inquiry. N. K. Denzin and Y. S. Lincoln. London, Sage Publications: 46-80.

Jayasuriya, A. N. and R. Dennick (2011). "Sexual history-taking: using educational interventions to overcome barriers to learning." Sex Education 11(1): 99-112.

Jinks, A. M. and E. Bradley (2004). "Angel, handmaiden, battleaxe or whore? A study which examines changes in newly recruited student nurses' attitudes to gender and nursing stereotypes." Nurse Education Today 2004(24): 121-127.

Johnston, C. and E. A. Mohide (2009). "Addressing diversity in clinical nursing education: Support for preceptors." Nurse Education in Practice (2009)(9): 340-347.

Johnston, J. H. (2009). "The preparation of child health nurses in sexual health education: An exploratory study." Nurse Education Today 2009 (29): 845-849.

Jolley, S. (2001). "Promoting teenage sexual health: an investigation into the knowledge, activities and perceptions of gynaecology nurses." Journal of Advanced Nursing 36(2): 246-255.

Jones, E., A. Farina, A. H. Hastorf, H.Marcus, D. T. Miller, R. A. Scott, R. de French, Eds. (1984). Social Stigma: the psychology of marked relationships. New York, W H Freeman.

Kendall, G. and G. Wickham (1999). Using Foucault's Methods. London, Sage Publications.

Knox, S. (2006). "Exploring Heterosexual Hegemony in Health and Social Services: Critical Que(e)ries." Variegations 3: 1-8.

Koll, G. and J. Gutierrez (2010). "Stigma and homophobia: Addressing homophobia and HIV stigma is critical to decreasing the spread of HIV in communities of color." Achieve: A Quarterly Journal on HIV Prevention, Treatment and Politics Spring 2010: 5-7.

Kontula, O. and E. Haavio-Mannila (2002). Masturbation in a general perspective. Masturbation as a means of achieving sexual health. W. O. Bockting and E. Coleman. New York, London and Oxford, The Howarth Press, Inc.: 49-84.

Kean, R. (2006). "Understanding the lives of older gay people." Nursing Older People 18(8): 31-36.

Kelly, D. (2009). "Changed men: the embodied impact of prostate cancer." Qualitative Health Research 19(2): 151-163.

Kelly, J. (2003). Gender and equality: one hand tied behind us. Education, Equality and Human Rights. K. Cole. London and New York, Routledge Falmer: 6-20.

Kendall, G. and G. Wickham (1999). Using Foucault's Methods. London, Sage Publications.

Keogh, P., P. Weatherburn, L. Henderson, D. Reid, C. Dodds, F. Hickson, (2004). Doctoring gay men: exploring the contribution to general practice - research report. London, Sigma Research.

Kidger, J. (2006). "Measuring effectiveness in school sex education — methodological dilemmas in researching an intervention involving young

Kim, L., M.R. Johnson, B. Barton, M.R. Nelson, G. Sontag, J.R. Smith, F.M. Gotch, J.W. Gilmour (1999). Evaluation of sperm washing as a potential method of reducing HIV transmission in HIV-discordant couples wishing to have children. AIDS - official journal of the International AIDS Society 13: 645–651.

King, E. (1993). Safety in Numbers: safer sex and gay men. London, Cassell.

Koedt, A. (1998). The myth of the vaginal orgasm. Feminism and Sexuality - a reader. S. Jackson and S. Scott. Edinburgh, Edinburgh University Press: 111-116.

Lawler, J. (1991). Behind the Screens: nursing, somology and the problems of the body. Edinburgh, Churchill Livingstone.

Lawler, J. (1999). Body care and learning to do for others. Understanding Health and Social Care - an introductory reader. M. Allott and M. Robb. London, Sage Publications: 236-245.

Leitzmann, M. F., E.A. Platz, M.J. Stampfer, W.C. Willett, E. Giovannucci, (2004). Ejaculation frequency and subsequent risk of prostate cancer. Journal of the American Medical Association 291(13): 1578-1586.

Lee, H., M. Learmonth, N. Harding (2008). "Queer(y)ing public administration." Public Administration 86(1): 149-167.

Lees, J. and R. Crouch (2003). "Sexual health in the emergency department – what do we need to know?" Accident and Emergency Nursing 11(214-220).

Lessa, I. (2006). "Discursive Struggles Within Social Welfare: Restaging Teen Motherhood." British Journal of Social Work 2006(36): 283–298.

Lichtenstein, B., E. W. Hook III, A. K. Sharma, (2005). "Public tolerance, private pain: stigma and sexually transmitted infections in the American Deep South." Culture, Health and Sexuality 7(1): 43-57.

Lincoln, Y. S. and E. G. Guba (2003). Paradigmatic controversies, contradictions, and emerging confluences. The Landscape of Qualitative Research. N. K. Denzin and Y. S. Lincoln. London, Sage Publications: 253-291.

Linné, R. (2003). "Alternative textualities: media culture and the proto-queer." Qualitative Studies in Education 16(5): 669-689.

Lipp, A. (2008). "Supporting the significant other in women undergoing abortion." British Journal of Nursing 17(19): 1232-1236.

Little, D. (2009) Kuhn's Paradigm Shift. Understanding Society - Innovative thinking about social agency and structure in a global world, http://understandingsociety.blogspot.com/2009/10/kuhns-paradigm-shift.html Cited on 26.04.11

Llewellyn-Jones, D. (1974). Sex and V.D. London, Faber and Faber.

López-Sosa, C. and R. R. Tévar (2005). "The Human Sexual System in the Context of the Health Sciences." Sexuality and Disability 23(3): 145-154.

Lupton, D. (2000). Foucault and the medicalisation critique. Foucault, Health and Medicine. A. Petersen and R. Bunton. New York, Routledge: 94-112.

Lynch, M. and S. Woolgar, Eds. (1990). Representations in Scientific Practice. Cambridge Ma. and London, The MIT Press.

Magnusson, C., G. Finnerty and R. Pope (2005). "Methodological triangulation in midwifery education research." Nurse Researcher - the international journal of research methodology in nursing and health care 12(4): 30-39.

Manzo, J. F. (2004). "On the sociology and social organization of stigma: some ethnomethodological insights." Human Studies(27): 401-416.

Martin, J. (2003). Gender, education and the new millennium. <u>Education, Equality and Human Rights</u>. M. Cole. London and New York, Routledge Falmer: 21-38.

Mason, T., C. Carlisle, C. Watkins, E. Whitehead, Eds. (2001). <u>Stigma and Social Exclusion in Health Care</u>. London, Routledge.

Maurice, W. L. (2003). "Leading comment: Sexual medicine, mental illness, and mental health professionals." <u>Sexual and Relationship Therapy</u> 18(1): 7-12.

MedFASH (2005). <u>Recommended Standards for Sexual Health Services</u>. London, Medical Foundation for Sexual Health and HIV (Department of Health approved).

Meerabeau, E. (1999). "The management of embarrassment and sexuality in health care." <u>Journal of Advanced Nursing</u> 29(6): 1507-1513.

Marchetti, V. and A. Salomoni, Eds. (2003). <u>Michel Foucault - Abnormal - Lectures at the Collège de France 1974-1975</u>. New York, Picador.

Marrazzo, J. M. and K. Stine (2004). "Reproductive health history of lesbians: Implications for care." <u>American Journal of Obstetrics and Gynecology</u> 2004(190): 1298-1304.

Martin, B. (1988). Feminism, criticism and Foucault. <u>Feminism and Foucault - reflections on resistance</u>. I. Diamond and L. Quinby. Boston, Northeastern University Press: 3-20.

Martino, W. (1999). "'Cool Boys', 'Party Animals', 'Squids' and 'Poofters': interrogating the dynamics and politics of adolescent masculinities in school." <u>British Journal of Sociology of Education</u> 20(2): 239-263.

McAlister, S. and G. Neill (2009). ""The L Pack": Addressing the Sexual Health Needs of Young Lesbians." <u>Child Care in Practice</u> 15(3): 209-226.

McFadyen, J. (2004). "Teaching sex education: are Scottish school nurses prepared for the challenge?" <u>Nurse Education Today</u> (2004)(24): 113-120.

McHoul, A. and W. Grace (1995). <u>A Foucault Primer - discourse, power and the subject</u>. London, UCL Press.

McLeod, A. (2001). Changing patterns of teenage pregnancy: population based study of small areas. <u>British Medical Journal</u> 2001(323): 199-203.

Meadmore, M., C. Hatcher, E. McWilliam, (2000). "Getting tense about genealogy." <u>International Journal of Qualitative Studies in Education</u> 13(5): 463 - 476.

Meerabeau, L. (1999). The management of embarrassment and sexuality in health care. <u>Journal of Advanced Nursing</u> 29(6): 1507-1513.

Miller, J. (1993). <u>The Passion of Michel Foucault</u>. Cambridge, MA., Harvard University Press.

Miles, K. and R. French (2008). "One-stop shops for sexual health." <u>Primary Health Care Journal</u> 18(9): 37-39.

Mills, S. (2002). <u>Discourse</u>. London and New York, Routledge.

Mills, S. (2003). <u>Michel Foucault</u>. London and New York, Routledge.

Mooney, S. (2004a). Performance. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Hodder Headline Group**:** 155-156.

Mooney, S. (2004b). Performativity. <u>Sexuality - the essential glossary</u>. J. Eadie. London, Hodder Headline Group**:** 156-157.

Morland, I. and A. Willox, Eds. (2005). <u>Queer Theory - readers in cultural criticism</u>. New York, Pallgrave MacMillan.

Murphy, D. A., K. J. Roberts, D. Hoffman, (2002). "Stigma and ostracism associated with HIV/AIDS: children carrying the secret of their mothers' HIV+ status." <u>Journal of Child and Family Studies</u> 11(2): 191-202.

Murray, R. (2003). <u>How to Write a Thesis</u>. Maidenhead and Philadelphia, Open University Press.

Myers, G. (1990). Every picture tells a story: Illustrations in E.O. Wilson's 'Sociobiology'. <u>Representations in Scientific Practice</u>. M. Lynch and S. Woolgar. Cambridge MA and London, The MIT Press: 231-266.

Naidoo, J. and J. Wills (2000). <u>Health Promotion - foundations for practice</u>. London, Baillière Tindall / RCN.

Nakayama, T. K. (1998). Communication of Heterosexism. <u>Communicating Prejudice</u>. M. L. Hecht. London, Sage Publishers: 112-121.

NAW/CCC (2000). <u>A Strategic Framework for Promoting Sexual Health in Wales</u> / <u>Fframwaith strategol ar gyfer hybu iechyd rhywiol yng Nghymru</u>. Cardiff, National Assembly for Wales / Cynulliad Cenedlaethol Cymru.

Neville, S. and M. Henrickson (2006). "Perceptions of lesbian, gay and bisexual people of primary healthcare services." <u>Journal of Advanced Nursing</u> 55(4): 407-15.

NHIVNA (2007). <u>National HIV Nursing Competencies</u>. London, National HIV Nursing Association.

NMC (2010). <u>Standards for Pre-Registration Nurse Education</u>. London, Nursing and Midwifery Council also available at www.nmc-uk.org.

Norris Lance, M. and A. Tanesini (2005). Identity Judgements, Queer Politics. <u>Queer Theory - readers in cultural criticism</u>. I. Morland and A. Willox. New York, Pallgrave MacMillan: 171-186.

Novick, A. (1997a). "Balancing Stigma." Journal of the Gay and Lesbian Medical Association 1(1): 123-128.

Novick, A. (1997b). "Stigma and AIDS: three layers of damage." Journal of the Gay and Lesbian Medical Association 1(1): 53-60.

OPSI (2001). The Nursing and Midwifery Order 2001, United Kingdom Statutory Instrument 2002 No. 253. London, Office of Public Sector information.

Oppenheim, A. N. (2005). Questionnaire Design, Interviewing and Attitude Measurement. London, Continuum.

O'Farrell, C. (2005). Michel Foucault. London, Sage Publications.

O'Rourke, A. (1998). "An Introduction to Evidence-Based Practice." Retrieved 19.04.00, 1998, from http://www.shef.ac.uk/uni/projects/wrp/sem3.html.

Paechter, C. (2003). "Power, Bodies and Identity: how different forms of physical education construct varying masculinities and femininities in secondary schools." Sex Education 3(1): 47-59.

Paglia, C. (1990). Sexual Personae: art and decadence from Nefertiti to Emily Dickinson. London and New Haven, Yale University Press.

Parker, R. (2009). "Sexuality, culture and society: shifting paradigms in sexuality research." Culture, Health & Sexuality 11(3): 251-266.

Parker, R. and P. Aggleton (2003). "HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action." Social Science and Medicine 57(2003): 13-24.

Pellowe, C. M. (2004). The educational preparation of midwives to undertake HIV antenatal screening. Does it meet the needs of women? London, Institute of Education. EdD.

Peräkylä, A. and D. Silverman (1991). "Reinterpreting speech-exchange systems: communication formats in AIDS counselling." Sociology **25**(4): 627-651.

Perron, A., C. Fluet, D. Holmes (2005). "Agents of care and agents of the state: bio-power and nursing practice." Journal of Advanced Nursing 50(5): 536-544.

Petersen, A. and I. Wilkinson, Eds. (2008). Health, Risk and Vulnerability. London, Routledge.

Phillips, E. and D. Pugh (1996). How to Get a PhD - a handbook for students and their supervisors. Buckingham, Open University Press.

Pillow, W. (2002). "When a man does feminism should he dress in

drag?" Qualitative Studies in Education 15(5): 545-554.

Plato (1974). The Republic. London, Penguin Books.

Plummer, K. J. (1973). Deviance, sexuality and the interactionist perspective: the case of male homosexuality. London, London School of Economics. PhD.

Plummer, K. (2003). "Queers, Bodies and Postmodern Sexualities: A Note on Revisiting the "Sexual" in Symbolic Interactionism." Qualitative Sociology 26(4).

Poole, R. (1999). Discourse of Power. The New Fontana Dictionary of Modern Thought. A. Bullock and S. Trombley. London, HarperCollins: 230-231.

Povey, H. (2000). "Critical Epistemologies and Gender Issues in Initial Teacher Education." Pedagogy, Culture and Society 8(219-231).

Pratt, R. J. (1995). HIV & AIDS: a strategy for nursing care. London, Edward Arnold.

Pratt, R. J. (2000). Sexual health and disease: an international perspective. Sexual Health: foundations for practice. H. Wilson and S. McAndrew. London, Baillière Tindall / RCN: 1-6.

Pratt, R. J., C. M. Pellowe, S.K. Juvekar, N.S. Potdar, A.J. Weston, A. Joykutty, N. Robinson, H.P. Loveday (2001). "Kaleidoscope: a 5-year action research project to develop nursing confidence in caring for patients with HIV disease in west India." International Nursing Review 2001(48): 164–173.

Procter, M. (1995). Measuring attitudes. Researching Social Life. N. Gilbert. London, Sage Publications: 116-134.

Pryce, A. (2000). Frequent observation: sexualities, self-surveillance, confession and the construction of the active patient. Nursing Inquiry 2000(7): 103-111.

Pryce, A. (2001). Governmentality, the iconography of sexual disease and 'duties' of the STI clinic. Nursing Inquiry 8(3): 151-161.

Quattrocchi, A. (2010). The Pope Is Not Gay! London and New York, Verso.

Rabinow, P., Ed. (1991). The Foucault Reader: an introduction to Foucault's thought. London, Penguin Books.

Ramazanoglu, C., Ed. (1993). Up Against Foucault - explorations of some tensions between Foucault and feminism. London, Routledge.

Ramprogus, V. (2005). "Triangulation." Nurse Researcher - the international journal of research methodology in nursing and health care 12(4): 4-6.

RCN (2001). Royal College of Nursing Sexual Health Strategy - guidance for nursing staff. London, Royal College of Nursing: 28.

RCN (2004). Sexual Health Skills - a distance learning course for the development of practice and life-long learning. London, Royal College of Nursing.

RCN (2005). Informed consent in health and social care research - RCN guidance for nurses. London and cited at: www.rcn.org.uk/publications cited on 21.04.06, Royal College of Nursing.

RCN (2006). Female genital mutilation: An RCN educational resource for nursing and midwifery staff. London, Royal College of Nursing.

RCN (2009a). Older People in Care Homes: Sex, Sexuality and Intimate Relationships: An RCN discussion and guidance document for the nursing workforce, London, Royal College of Nursing. *(Note: this document is being re-published in 2011; I was one of the formal reviewers advisors).*

RCN (2009b). Sexual Health Competencies: an integrated career and competency framework for sexual and reproductive health nursing. London, Royal College of Nursing.

Reidpath, D. D. and K. Y. Chan (2005). "A method for the quantitative analysis of the layering of HIV-related stigma." AIDS Care 17(4): 425-432.

Rice, B., A. Nardone, N. Gill, V. Delpech, (2008). Continuing high levels of HIV diagnoses in men who have sex with men in the United Kingdom. EuroSurveillance 13(14): www.eurosurveillance.org/edition/v13n14/080403_2.asp

Richardson, L. (2003). Writing: a method of inquiry. Collecting and Interpreting Qualitative Materials. N. K. Denzin and Y. S. Lincoln. London, Sage Publications: 499-542.

Richmond, J. and H. McKenna (1998). "Homophobia: an evolutionary analysis of the concept as applied to nursing." Journal of Advanced Nursing 28(2): 362-369.

Roberts, C. and D. T. Evans (2007). Male Health. Nurse Practitioner Manual of Clinical Skills. S. Cross and M. Rimmer. Edinburgh & London, Elsevier Publications: 253-270.

Robson, C. (1994). Real World Research - a resource for social scientists and practitioner-researchers. Oxford, Blackwell.

Rodgers, B. (1989). "Concepts, analysis and the development of nursing knowledge: the evolutionary cycle." Journal of Advanced Nursing 1989(14): 330-335.

Roberts, C. and D. T. Evans (2007). Male Health. <u>Nurse Practitioner Manual of Clinical Skills</u>. S. Cross and M. Rimmer. Edinburgh & London, Elsevier Publications: 253-270.

Sachs, G. S. and C. Chan. (2000). "Medication-Induced Sexual Dysfunction." <u>MedScapeCME</u> Retrieved 24.02.10.

Santos, E. M. (2010). Cervical cancer-causing virus linked to other cancers and diseases. On-line. Last accessed 01.12.10, University of the Philippines Manila, www.hpv.com.ph.

Scott, D. (1996). Methods and data in educational research. <u>Understanding Educational Research</u>. D. Scott and R. Usher. London and New York, Routledge: 52-73.

Scottish-Executive (2003). Enhancing Sexual Wellbeing in Scotland: a sexual health and relationship strategy - proposal to the Scottish Executive. Edinburgh, The Scottish Executive.

Seale, A. (2004). Breaking the vicious cycle that threatens the global response to AIDS. <u>Impact 9: HIV-related stigma and discrimination</u>. London, National AIDS Trust: 15-18.

Seidman, S., Ed. (1996). <u>Queer Theory / Sociology</u>. Twentieth-Century Social Theory. Oxford, Blackwell Publishers.

Selwyn, N. and E. Powell (2007). "Sex and relationships education in schools: the views and experiences of young people." <u>Health Education</u> 107(2): 219-231.

Serrant-Green, L. (2005). "Breaking traditions: sexual health and ethnicity in nursing research: a literature review." <u>Journal of Advanced Nursing</u> 51(5): 511-519.

Serrant-Green, L. and J. McLuskey, Eds. (2008). <u>The Sexual Health of Men</u>. Oxford, Radcliffe Publishing.

SEU (1999). <u>Teenage Pregnancy</u>. London, Social Exclusion Unit: 139.

Shawver, L. (2006). Dictionary for the Study of the Works of Michel Foucault <u>Post Modern Therapy News</u>. World Wide Web, www.postmoderntherapy.com cited at http://users.sfo.com/~rathbone/foucau10.htm cited on 01.05.09.

Sherry, M. (2004). "Overlaps and contradictions between queer theory and disability studies." <u>Disability & Society</u> 19(7): 769-783.

Shilts, R. (1988). <u>And The Band Played On - politics, people and the AIDS epidemic</u>. New York, Penguin Books.

Silverman, D. (1994). Applying the qualitative method to clinical care. <u>Researching Health Care: designs, dilemmas, disciplines</u>. J. Daly, I.

McDonald and E. Willis. London and New York, Tavistock / Routledge: 176-188.

Skolbekken, J.-A. (2008). Unlimited medicalization? Risk and the pathologization of normality. Health, Risk and Vulnerability. A. Petersen and I. Wilkinson. London, Routledge: 16-29.

Smart, B. (2004). Michel Foucault - revised edition. London and New York, Routledge.

Sontag, S. (1991). Illness as Metaphor: AIDS and Its Metaphors. London, Penguin Books.

Spargo, T. (1999). Foucault and Queer Theory (Postmodern Encounters). Cambridge, Icon Books.

Sprague, J. (2005). Feminist methodologies for critical researchers - bridging differences. Oxford, AltaMira Press.

Squires, J. (1999). Gender in Political Theory. Malden, MA, Polity Press.

Starks, H. and S. B. Trinidad (2007). "Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory." Qualitative Health Research 2007(17): 1372-1380.

Stenvoll, D. (2002). "From Russia with love? Newspaper coverage of cross-border prostitution in northern Norway, 1990-2001." The European Journal of Women's Studies 9(2): 143-162.

Stevenson, C. (2004). "Theoretical and methodological approaches in discourse analysis." Nurse Researcher - the international journal of research methodology in nursing and health care 12(2): 17-29.

Stine, K. (2002). "Discrimination's Impact on Public Health Practice." Journal of the Gay and Lesbian Medical Association 6(2): 79-83.

Strauss, A. and J. Corbin (1990). Basics of Qualitative Research - grounded theory procedures and techniques. London, Sage Publications.

Sullivan, N. (2003). A Critical introduction to Queer Theory. Edinburgh, Edinburgh University Press.

Sullivan, N. (2003). A Critical introduction to Queer Theory. Edinburgh, Edinburgh University Press.

Sumara, D. and B. Davis (1999). "Interrupting heteronormativity: toward a queer curriculum theory." Curriculum Inquiry 29(2): 191-208.

Tanesini, A. (1999). An Introduction to Feminist Epistemologies. Oxford, Blackwell Publishers.

Taylor, B. (2001). "HIV, stigma and health: integration of theoretical concepts and the lived experiences of individuals." Journal of Advanced Nursing 35(5): 792-798.

Taylor, Y. (2005). "Inclusion, Exclusion, Exclusive? Sexual citizenship and the repeal of Section 28." Sexualities 8(3): 375-380.

Téllez, C., M. Ramos, B. Umland, T. Palley, B. Skipper (1999). "Attitudes of Physicians in New Mexico Toward Gay Men and Lesbians." Journal of the Gay and Lesbian Medical Association 3(3): 83-89.

Thaczuk, M. (2006). Anal HPV more prevalent than cervical HPV in HIV-positive women, AIDSmap News, cited at www.aidsmap.org.uk cited on 09.08.07.

TheBody (2009). "Sexual Minorities More Likely to Seek Mental Health Services [study report - news item]." http://www.thebody.com/content/whatis/art53243.html?ic=700100 August 14, 2009.

Tiefer, V. (2006). The Viagra Phenomenon. Sexualities 9(3): 273–294.

Tremain, S. (2000). "Queering Disabled Sexuality Studies." Sexuality and Disability 18(4): 291-299.

Turner, B. (2006). From governmentality to risk: some reflections on Foucault's contribution to medical sociology. Foucault, Health and Medicine. A. Petersen and R. Bunton. London and New York, Routledge: ix-xxi.

Turner, D. (2007). Diagnosis and treatment of patients with prostate cancer: the nurse's role. Nursing Standard 21(39): 48-56.

UNAIDS. (2001). "Statement of the Joint United Nations Programme on HIV/AIDS (UNAIDS) at the 4th WTO Ministerial Conference, Doha, Qatar, 9-13 November 2001." 15.11.01, from http://www.unaids.org/publications/documents/health/access/WTOstatement 2001.html.

UNAIDS (2004). Position Statement on Condoms and HIV Prevention, July 2004. Geneva, World Health Organisation.

Usher, R. (2002a). A critique of the neglected epistemological assumptions of educational research'. Understanding Educational Research. D. Scott and R. Usher. London and New York, Routledge: 9-32.

Usher, R. (2002b). Textuality and reflexivity in educational research. Understanding Educational Research. D. Scott and R. Usher. London, Routledge: 33-51.

Van Loon, J. (2008). Governmentality and the subpolitics of teenage sexual risk behaviour. Health, Risk and Vulnerability. A. Petersen and I. Wilkinson. London, Routledge: 48-65.

Voss, B. L. (2000). "Feminisms, queer theories, and the archaeological study of past sexualities." <u>World Archaeology</u> 32(2): 180–192.

Walker, L. O. and K. C. Avant (1995). <u>Strategies for Theory Construction in Nursing</u>. Norwalk, CT, Appleton and Lange.

Ward, E. G. (2005). "Homophobia, hypermasculinity and the US black church." <u>Culture, health and Sexuality</u> 7(5): 493-504.
Warren, C. A. B. (2003). "Sex and gender in the 1970s." <u>Qualitative Sociology</u> 26(4): 499-513.

Wellings, K. and B. Field (1996). <u>Stopping AIDS: AIDS/HIV public health and the mass media in Europe</u>. London and New York, Longman.

West, J. (1999). "(Not) talking about sex: youth, identity and sexuality." <u>The Sociological Review</u> 47(3): 525-547.

Westwood, J. and B. Mullan (2009). "Teachers' and pupils' perceptions of the school nurse in relation to sexual health education." <u>Sex Education</u> 9(3): 293 - 306.

Weston, A. (1994). <u>Sapphic Sickness: a study of the health care experiences of women patients who disclose their sexual identity as lesbian</u>. (unpublished MSc in Medical Anthropology). London, Brunel University.

White, J. and M. C. Martinez, Eds. (1997). <u>The Lesbian Health Book - caring for ourselves</u>. Seattle, Seale Press.

WHO (2001). <u>Female Genital Mutilation: The Prevention and the Management of the Health Complications</u>. Policy Guidelines for nurses and midwives. Geneva, Department of Gender and Women's Health, Department of Reproductive Health and Research, Family and Community Health, World Health Organization.

WHO (2004). Sexual health - a new focus for WHO. <u>Progress in Reproductive Health Research</u> (67): 1-4.

WHO (2006). Trends in sexually transmitted infections and HIV in the European Region, 1980−2005; <u>Technical briefing document</u> 01B/06 Copenhagen, World Health Organisation / Regional Office for Europe.

WHO (2008). Eliminating Female genital mutilation. An interagency statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva, World Health Organisation.

Wilchins, R. (2004). <u>Queer Theory, Gender Theory - an instant primer</u>. Los Angeles, Alyson.

Williamson, G. R. (2005). "Illustrating triangulation in mixed-methods nursing research." <u>Nurse Researcher - the international journal of research methodology in nursing and health care</u> 12(4): 7-17.

Wintemute, R. (1995). <u>Sexual Orientation and Human Rights: the United States Constitution, the European Convention, and the Canadian Charter</u>. Oxford, Clarendon Press.

Wilson, H. and S. McAndrew, Eds. (2000). <u>Sexual Health: Foundations for Practice</u>. London, Baillière Tindall / RCN.

Wuest, J. (1994). "A feminist approach to concept analysis." <u>Western Journal of Nursing Research</u> 16(5): 577-586.

Youde, J. (2005). "The Development of a Counter-Epistemic Community: AIDS, South Africa, and International Regimes." <u>International Relations</u> 19(4): 421–439.

Appendix 1

ENB core curricula

sexual health modules

(pre-2002)

Appendix 1 Pre-2002 ENB core curricula sexual health modules

Contraception and reproductive health

- **N74**   Family Planning Appreciation
- **ENB103**   The Practice of Family Planning and Reproductive Sexual Health Care
- **S103**   Clinical Specialist in Family Planning and Reproductive Sexual Health Care
- **ENB901**   Foundation in Family Planning and Reproductive Sexual Health Care designed for health care professionals and others who are, or will be required to provide general and opportunistic contraceptive and sexual health advice
- **A08**   Advanced Family Planning Nursing
- **R71**   Developing Skills in Contraception and Reproductive Sexual Health Care

Genito-Urinary Nursing

- **N07**   Foundation Studies in Sexually Transmitted Infections Practice
- **A07**   Clinical Care in Genito-Urinary / Sexually Transmitted Infections
- **ENB276**   Caring for Persons with Genito-Urinary Infections and Related Problems

HIV Nursing

- **ENB934**   Care and Management of People with Acquired Immune Deficiency Syndrome (AIDS) and Human Immuno-Deficiency Viruses (HIV) - related Conditions
- **ENB280**   Care Provision for People with Human Immuno-deficiency Virus (HIV) Infection and Acquired Immune Deficiency Syndrome (AIDS) (3 modules: clinical, management, education)
- **N57**   Caring for Families & Children Affected by HIV/AIDS
- **N58**   Community Care for People Affected by HIV/AIDS

Sexual Health (other)

- **ENB985**   Principles of Psychosexual Counselling
- **N65**   The Physical, Sexual and Psychological Abuse of Adults with Learning disabilities
- **N87**   Sexual Function and Dysfunction
- **N90**   Sexual Health for Nurses, Midwives and Health Visitors

Appendix 2

PowerPoint Slides of

Anti-Stigma Campaign:

Strategies to combat stigma
and create stigma-free health services
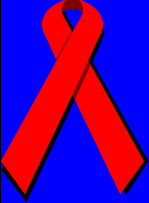
Slide 1

This presentation was part of a whole-session workshop on Stigma, to about 110 nurses from across the globe. The first part of the workshop, by Dr Ian Hodgson, RN, explored the origins and nature of stigma. This second part focused on strategies to combat stigma. It was interactive and comprised of two short PowerPoint presentations (slides 1 - 12 and 13 - 27), interspersed with small group discussions between participants, completion of a one-sided A4 questionnaire, and feedback to whole group.

Many of the slides used graphic images, and were shown for effect and the message they can portray. The graphics on each slide appeared on the screen in a timed fashion, as I made my verbal presentation. It was the images I wished to leave with the participants, not so much the text, as this was available to them in printed and electronic formats to study at their leisure.

Slide 2

Intended Learning Outcomes
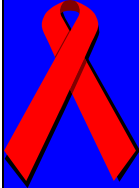
■ to highlight nursing experiences in tackling stigma

■ to discuss best practices and strategies to create stigma-free health services

Royal College of Nursing

Slide 3

I started the presentation by showing a traditional sign for "no smoking", but asked "if we want to say 'no stigma', or to advertise 'stigma free' services, how might we go about it, what symbols could be used?" I emphasised how the diverse nature of stigmas, even the same stigma but at different times and places, can mean different things to different people(s). Therefore, it is not always easy to identify stigma (as Dr Hodgson had explored) let alone label it and do something constructive about it.

"all that will stop HIV prejudice
is speaking openly
about the facts"

ICN (2003)
Nurses: Fighting AIDS Stigma – Caring for All

Royal College of Nursing

At first glance, this quote, from *the* ICN document on HIV stigma, appears exceptionally utopian and simplistic. Not to dismiss it as a facile attempt to deal with complex issues, I decided to explore the actual stigmatising barriers which prevent verbalising the various HIV prejudices.

Slide 5

This slide emphasises some through-time and regional / global images of HIV awareness and prejudice.

The first to appear was the pink triangle on black background, "Silence = Death". This was an early US image, made famous by ACT-UP (AIDS Coalition To Unleash Power) in the 1980s.

Second, printed as red ribbon, the international sign for HIV and AIDS awareness. This animated .gif image shows four separate UN AIDS posters of women, all young, but of different ethnic origin and nation. Here was text accompanying each image, with a main headline on each:

    No sex. No home.
    No respect. No hope.
    No sex. No school.
    No rights. No life.

Then, a large poster, appearing before the red ribbon, with the rhetorical question: Have you heard me today?

Slide 6

```
┌─────────────────────────────────────┐
│                                     │
│                                     │
│                                     │
│                                     │
│          [intentionally blank]      │
│                                     │
│                                     │
│                                     │
│                                     │
└─────────────────────────────────────┘
```
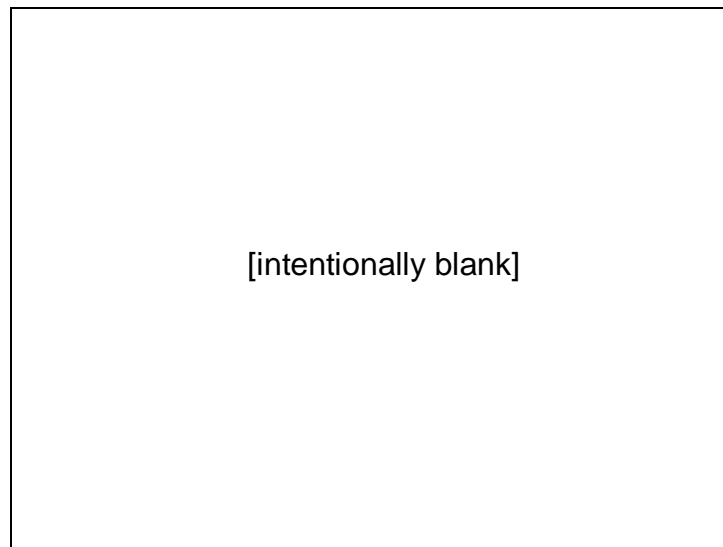
Another UNAIDS animated .gif slide appeared at the bottom of the screen. With images of different men, this slide said:
    Don't you touch my sister.
    You are not my son anymore.
    You have just experienced
          some of the most painful symbols
          of HIV and AIDS.
    Help us fight fear, shame, ignorance and injustice worldwide.
    Live and let live.

Both the UN AIDS presentations were developed in 2000CE and for following years.

Slide 7

The aim of this part of the workshop can conveniently be focused into giving voice to silence.

Slide 8
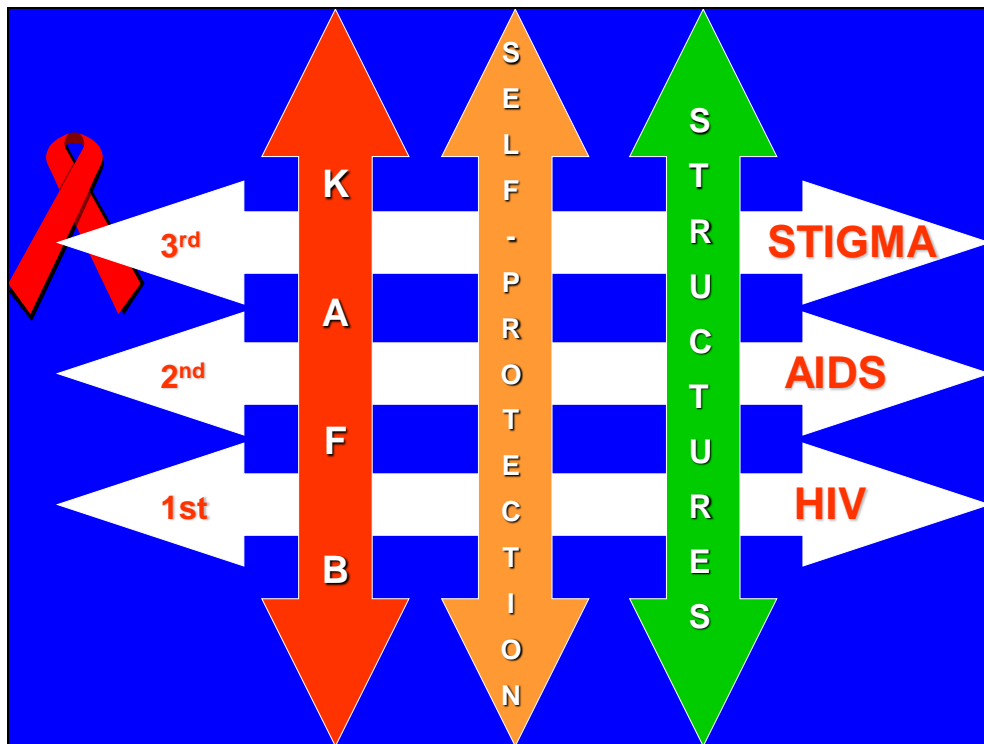
(These arrows appeared as 1st, 2nd and 3rd, followed by KAFB, Self protection, Structures).
Quoting Jonathan Mann (UNAIDS 2003), in his speech to the United Nations, said that there were "three AIDS epidemics". The 1st / HIV one, I overlaid with the text: "pollution, contagion, plague" (not visible in this printout). The 2nd / AIDS, I overlaid with "blame, sickness, isolation". The 3rd / stigma, with "stereotypes, discriminates, denies".

Following the lead of certain social psychologists, nurses have tended to promote health through individualistic models, such as KABP: provide Knowledge, improve Attitudes, positively enhance Feelings, change Behaviours. This is a top-down model, from healthcare providers.

A bottom-up approach has been through various strategies of Self Protection, such as empowerment, raising self-esteem, counselling. Again, nurses have traditionally been party to these strategies. What nurses have not been consistently proactive dealing with, on a personal level, as well as *en masse* through the weight of the profession and national / international nursing associations, are some of the structural influences in cultures and societies, that promote stigma, prejudice and discrimination.

Reference: UNAIDS (2003). A Report of a Theological Workshop Focusing on HIV- and AIDS-related Stigma (English Edition, 2005). Windhoek, Namibia, UNAIDS.

The structural 'pillars' of

s o c i e t y

**Power and
the reproduction
of social difference**

The structures, or 'pillars of society', I suggest have an influence on sexual stigmas are those perceived of with traditional power; it is this dynamic (in the original Greek sense of 'dynamism') that creates and perpetuates social difference including stigma and discrimination.

Slide 10

The eight pillars appear, each surmounted by a societal dynamic or force:
-Religion, especially in its role of proscribing acceptable / unacceptable sexual practice and relations
-Law and the judiciary, in many cultures intimately entwined with religious origins
-Politics, like law and the judiciary, emanating from religious forms of government and perpetuating a specific social order
-Marriage and family; both institutions, in most cultures, rigorously defined, regulated and protected by religion, law and government
-Health care systems, often dealing with past influences of religion in their ancient understanding of illness (viz.: plagues), as well as the vocational nature of caring whether as nursing or medicine. Medicine has a large role to play in the control of fertility, contraception, abortion and the definitions of 'normal' versus pathological. Psychiatry has played an enormous, often times, negative role in the understanding, construction and treatment of sexualities and sexual problems.
-Education: whether in compulsory education or professional and higher, the promotion of certain sexual life-ways and practices as 'normal', right and proper, and the invisibilisation and demonisation of all that is other.
-Military and law enforcement (police, prison services); these are traditionally male-dominated, highly sex typed (hyper-macho masculine identity), sexist, heterosexist and homophobic
    (continued overleaf)

Slide 11

```
[intentionally blank]
```
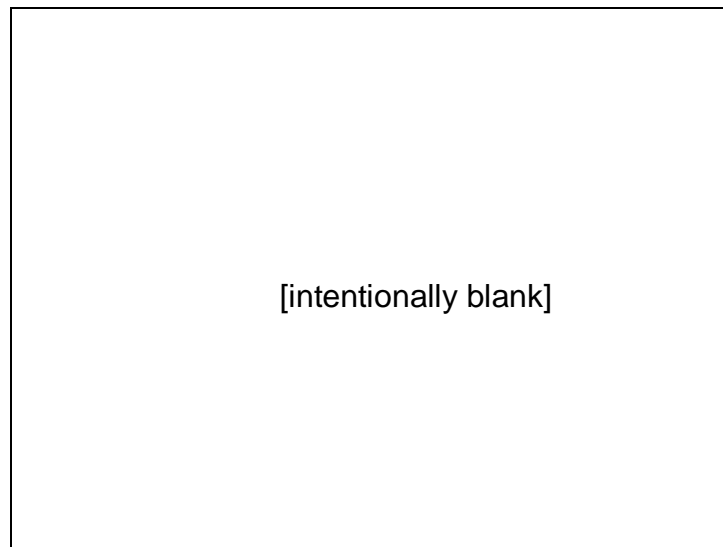
(Notes from eight 'pillars' of society, continued)

-Media: characteristically, the popular media perpetuates the model of society promulgated by these 'pillars' and concomitantly denies or derides all that is contrary.

The 'devil's fork' image here symbolises how these institutional pillars decide and define what is good and evil for their societies. The outcome of these definitions variously stigmatise those who do not conform to their definition of what is good; discriminates against them in all matters, from legal rights through to care and the equitable provision of education and customary public services; and invisibilises their needs as well as their very essence.

Slide 12

The animation of this slide focused one at a time on the three central bullet points, after each one, one of the red boxes at the bottom appeared (L-R); so for 'stigmatising others for their difference' the attributes of 'misinformation and stereotyping' followed. After all three bullet points and red boxes had appeared, the call-outs for 'being bullied', 'anger', 'low self-esteem', 'guilt and self-blame', 'depression' and 'internalised oppression' appeared. Many of these personal feelings can contribute towards intense self-loathing, leading to suicidal ideation and attempts. The last call-out to appear, ''dynamism' for equality and freedom' was presented as a positive way to capitalise on the disempowering effects of the central bullet points, their outcomes (red boxes) and the various negative feelings.

Special note: some of these printed slides appear somewhat over-crowded, but the on-screen effect of gradual appearance builds up, as each aspect is described, revealing the magnitude of an over-all effect.
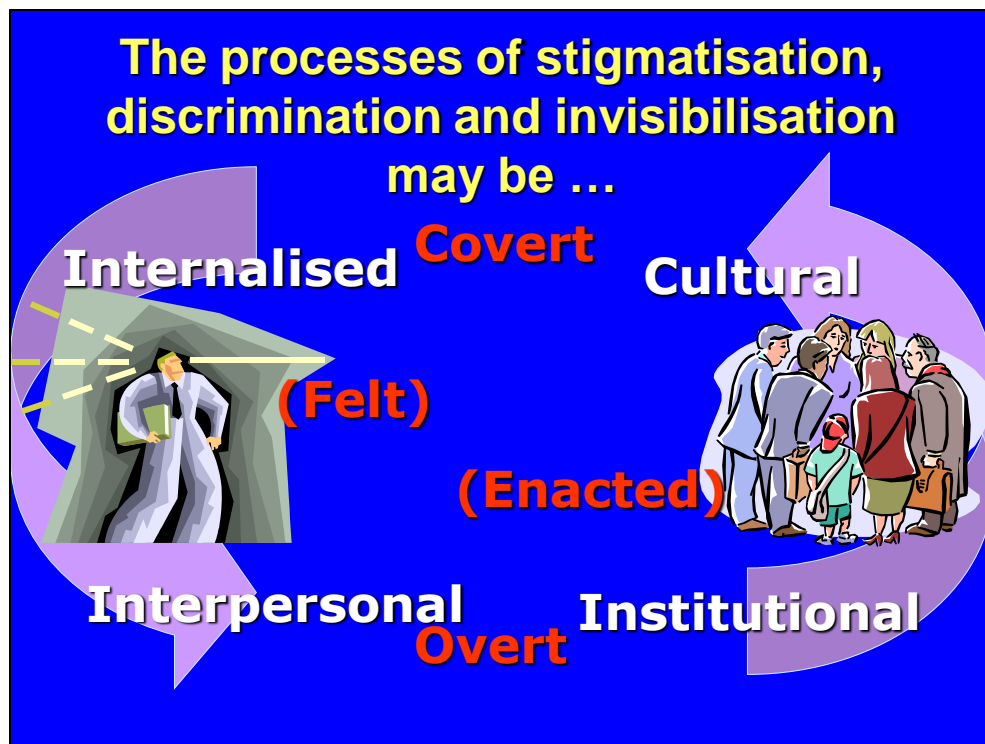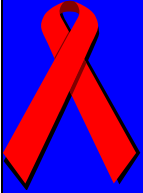
Based on research and various theories of stigma, the process shown here highlights the inter- and intra-personal nature of stigma, discrimination and invisibilisation (see EdD 'literature review' assignment, ACAD 1064, August 2005).

Following Goffman (1963), ICN (2003) explains the personal perception of these discriminators to be 'felt', and their application by others, including society, 'enacted'.

In keeping with the invisibilisation of stigmatised people and their needs, the covert nature of oppression is evidenced as much by omission as commission: not just doing nasty things to people, but not doing positive or nice things to them: non-existence.

References: Goffman, E (1963 reprinted 1990) Stigma notes on the management of spoiled identity, London, Penguin
ICN (2003). Nurses: fighting AIDS stigma, caring for all. Geneva, International Council of Nurses.
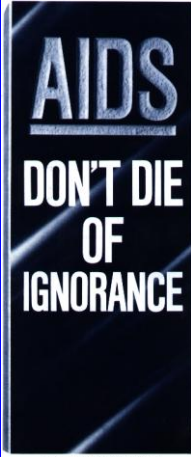
The participants were given a brief A4 questionnaire on their arrival. At this point, they were asked to complete section B, and then discuss their thoughts with their neighbours. Finally, each group fed back to the whole audience.

**Evidence-based strategies
for combating stigma
/ creating stigma-free
health care services**

After the feedback from the groups, two sets of strategies were presented to them, which dove-tailed with their experiences of stigma and need to over come it. These strategies are proposed by UN AIDS and the International Council of Nurses. The following slides were passed through relatively quickly, as the participants had handouts of the actual strategies. The main point was the graphic image, used for creating high visual impact. Brief examples and explanations were given where appropriate, especially drawing on elements of the feedback given by the group.
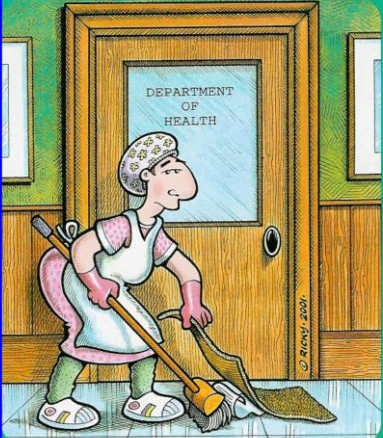
Slide 16

This is of particular relevance to education in nursing, where many participants experienced these themes as "too little, too late". The participants recommended incorporating effective HIV education in pre-registration education programmes, as well as post-registration continuing education.

Slide 17

10 Strategies to counter discrimination
UNAIDS - 2002

■ Encouraging people infected with HIV to tell their story

DEPARTMENT OF HEALTH

OUT ABOUT HIV
HIV+ FOR 20 YEARS

Between the Sheets
+ve January 2002 Issue 25

UNAIDS

The societal silencing of HIV+ve people, especially people of fame, has the added effect of continuing to marginalize them and their needs, as well as maintaining the false dichotomy of 'them' and 'us', the 'good' / 'normal' versus the 'bad' / 'not normal'.

Slide 18

The normalisation of HIV received unprecedented awareness by the words and actions of Her Late Royal Highness, Diana, (The) Princess of Wales, here shown hugging a young child with HIV on a tour to South America. The mother and child motif is carried over in the bottom slide, where 'goodness' and 'naturalness' of motherhood are universally challenged when HIV enters the reproductive equation. Typically, "maternal transmission" of HIV places the emphasis on the mother's role, without acknowledging that the majority of HIV+ve mothers who conceive are also infected by the same man they are pregnant by: "parental transmission".

Nursing documentation can be an effective tool in challenging stigmatising and discriminating acts or omissions in care of HIV+ve people. The 'space suit' mentality, especially in the early days of the HIV pandemic, are nothing new, as witnessed by the image of a 1720CE French doctor, dealing with contagion and plague; contrast this with the bottom right image of ambulance staff with a person with AIDS, in Hong Kong, 1980s (source: Harvey V Fineberg 'The Social Dimensions of AIDS' in: The Science of AIDS, readings from Scientific America, (1988) W H Freeman and Co. New York.

Tackling societal and health care professional stigmas around HIV and sexual health also mean tackling institutional erotophobia, the fear of sexual matters, especially in advertising and promoting sexual health.

Slide 21

These images challenging the powers of silence. The bridal motif clearly brings a new dimension into the 'sanctity' of marriage.

The lack of effective and equal health care provision, across the globe, is a major cause in the perpetuation of the HIV pandemic, and the suffering caused through lack of treatment options. The images here represent HIV PEP (Post Exposure Prophylaxis), therapeutic options to prevent mother-to-child transmission, and the 'pill burden' of current HAART regimes (HAART = Highly Active Anti-Retroviral therapy, or 'combination therapy'). These three prevention / treatment programmes are not widely available outside of resource-rich societies.

Workplace policies need to address the clinical, as well as the social, psychological, existential and practical needs of people infected with / affected by HIV. HIV health promotion strategies are often completely undermined by state-sponsored hostility to the people most vulnerable – through their personal life-ways – to infection (e.g. denial that non-heterosexual sex, commercial sex, and injecting drug use happens; hostility towards condoms, needle exchange schemes, contraception and abortion).

Slide 24

Ensuring that national and international Codes of Conduct protect those who are vulnerable to the effects of stigma and discrimination from health care professionals and services.

Slide 25

10 Strategies to counter discrimination
UNAIDS - 2002

■ **Creating mechanisms to address and redress HIV/AIDS related discrimination**

© 1993 Smithsonian Institution

Encouraging nurses and nursing to play an active political role in advocating for those whose voices cannot be heard.

The UN AIDS Strategies are particularly appropriate on the national and international levels. The ICN recommendations are clearly focused on the individual and local level.

A sad reflection on specialist nursing care: whilst the numbers of newly infected people increase every year, the European Association of Nurses in (HIV) AIDS Care (EANAC) formerly disbanded in 2002.

Post Exposure Prophylaxis is not only a case of having the money to support the systems that deliver the service and pay for the medications; "AIDS dissidents", such as the President of South Africa, have delayed implementation of these services due to personal beliefs that HIV does not lead to AIDS.
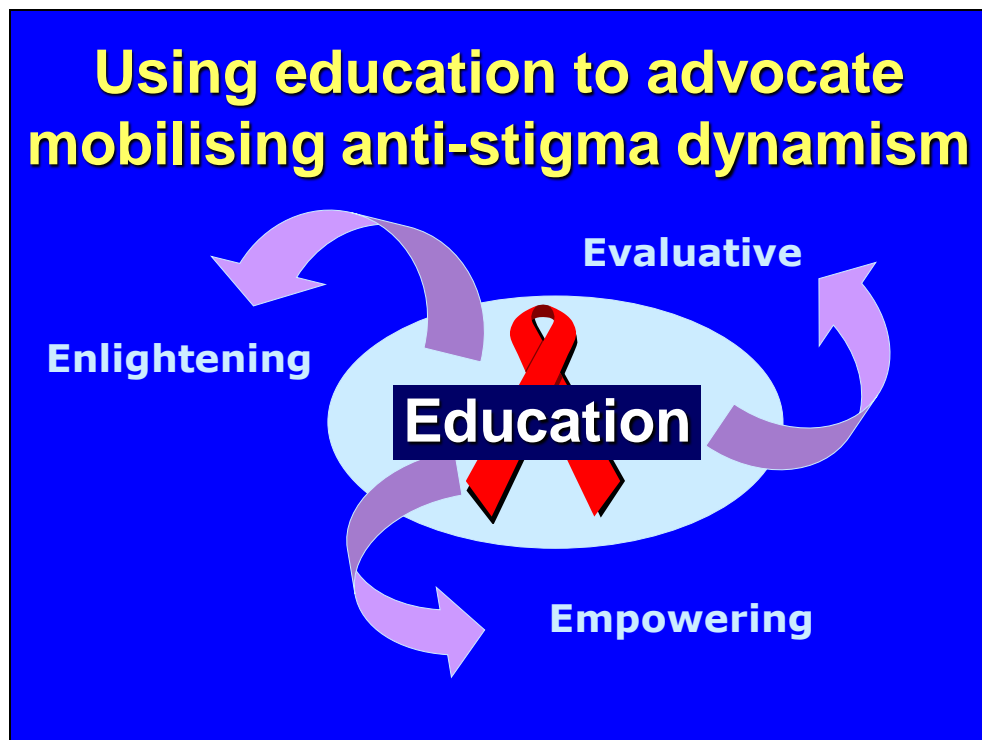
In the light of all that has been covered in this part of the workshop, the final activity was for participants to discuss the educational model explained in this slide. If education can be used as a tool to enable both of these (UN AIDS and ICN) Strategies to work for nurses, nursing and the clients of nurses, what aspects of Evaluative, Enlightening and Empowering education need to be applied and how?

Brief examples were given of each:
- Evaluative education includes clinical and educational audit; monitoring and recording complaints or issues of bad practice; undertaking qualitative research into the experiences of people regarding stigma and discrimination, etc.
- Enlightening education includes proactive and effective professional learning; reflection in and on practice; enabling constructive reporting of poor or bad practice, etc.
- Empowering education includes not only issues of care at the micro level, e.g. empowering clients to 'stand up' for themselves, but also on the macro-level, as a profession in particular, confronting the injustices in society which negatively impinge on equitable and all-inclusive health promotion and disease prevention, and against the inequalities and injustices in health service provision.

Slide 29

At this point, the participants were encouraged to complete Section C of the handout questionnaire, and then discuss this with their neighbours, before feeding back to the whole audience. An exhilarating discussion occurred.

Appendix 3

List of HEIs

offering any sexual health courses

(January 2007)

List of Higher Education Institutes in England

providing courses on the sub-specialities of sexual health

(January 2007)

*as identified through the web pages of GUNA, NMAS and UCAS,
some with more than one teacher identified.*

Buckingham Chilterns University College
Bournemouth University
Christ Church Canterbury University
City University (London)
Colchester Institute of Higher Education
De Montford University
Guy's & St Thomas' Hospital (KCL)
Hammersmith Hospital (Imperial)
Keele University
Kings College London
Kingston University
London South Bank University
Luton (Beds) University
Manchester Metropolitan University
Northumbria University
Oxford Brookes University
Sheffield Hallam University
Staffordshire University
St George's University of London
Thames Valley University
University of Birmingham
University of Bradford
University Campus Suffolk
University of Chester
University of Derby
University of East Anglia
University of Essex
University of Greenwich
University of Huddersfield
University of Leeds
University of Manchester
University of Northampton
University of Nottingham
University of Surrey
University of Salford
University of Southampton
University of Teeside
University of Worcester
University of York

Appendix 4

University of Greenwich

Research Ethics Committees:

relevant documentation

Dear David

Minute 07/2.4.1 - Mapping client need and professional sexual health education for nurses in England

My apologies for the delay in contacting you. The minutes from the meeting were quite complex and I wanted to ensure the Committee Chair was happy with them before communicating the relevant part to you. The minute reads as follows:
_____
The Committee approved the application in principle subject to the following caveats and amendments:

§ Section 2.4 item 3) - Participants should complete a consent form. The Committee recognised the researcher's desire to maintain anonymity and recommended that an independent third party handles the receipt of consent forms and then assigns the participant a unique number which is then used as the identifier when the data is passed to the researcher. This change will need to be reflected throughout the remainder of the application.

§ Letters – All letters should be on University of Greenwich headed paper and use university recognised logos. The researcher should use university addresses, e-mails and telephone numbers rather than home contact information for themselves and their supervisors, who should also be detailed. The sentence inviting participants to see the full research ethics application should be removed.

§ Should the Avery Hill Research Degrees Committee require any amendments to the project the applicant will need to advise the UREC of the changes and indicate if this results in any further amendments to the University research ethics application.

Action: The applicant should make the required amendments to his application, highlighting the amendments, and send it to the Secretary who will present the application for final approval under Chair's Action
_____

If you have any questions please do not hesitate to contact me. Please assist the Chair of the Committee by highlighting the amendments made in the resubmitted application, e.g. by making them bold. I look forward to receiving your amended application in the near future.

Regards

Bob Odle

```
--------------------------------------------------
Dr Bob Odle
Administrator & Acting Secretary
Research Ethics Committee
c/o Research Student Administrative Office
Office of Student Affairs
University of Greenwich
Central Avenue, Chatham Maritime
Kent. ME4 4TB
Telephone: 01634 883870
Mobile: 07906 661520
Fax: 01634 883738
```

School of Education and Training

David T Evans

EdD Programme: Year 3 2006 - 7

Ethical Approval

(EdD thesis / research approval form – version 1)

ACAD 1060

Mapping client need
and professional sexual health education
for nurses in England

Doctorate in Education (EdD)

Application for Ethics Committee approval

The University of Greenwich
School of Education and Training

1   **Name:**   David Thomas EVANS

Research project (provisional title)**:**

Mapping client need and professional sexual health education for nurses in England

My current work, out of which this wider EdD research project emanates, is as freelance / contracted manager of the Royal College of Nursing's (RCN) *Sexual Health Skills* distance-learning course, a double module credit rated by the University of Greenwich (UG) (www.rcn.org.uk/sexualhealthlearning). I do not have personal contact with students, but manage the UK-wide process of learning, including the course administrator, finances, and around fifty senior specialist nurses who facilitate the two compulsory 'Away Days' for me, at centres around the United Kingdom and Northern Ireland.   The key stakeholders I report to are the RCN, the University of Greenwich, Department of Health (DH)(England), and the Teenage Pregnancy Unit of the Department for Education and Skills. The course has enrolled over 1,600 students in almost three years.

I wish to look beyond this course, exploring discourses pertaining to the shortfall in professional sexual health education for nurses, when compared to officially defined clinical and epidemiological need.   Discourses are here understood in a Foucauldian sense of *'language in action'* (Danaher, Shirato and Webb, 2000), i.e. 'practices that systematically form the objects of which they speak (Foucault, 1972 cited in Mills 2002). A prime example is found in the media naming babies with HIV disease "AIDS victims", therefore potentially constructing notions of innocence and stigmatising guilt (Sontag, 1991). Despite the RCN course being UK-wide, and comparison between the four countries potentially beneficial, I consider such analysis too wide a remit for this current study, and so will limit it to England. My proposed research topic also forms a significant element missing from the data on specialist areas of nurse education held by the Department of Health (England) and the Nursing and Midwifery Council (NMC).

The Methods will include:

Stage 1) **electronic survey questionnaires** to teachers at Higher Education Institutions across England, on the provision – or lack thereof - of sexual health education, followed by epidemiological comparisons with official statistics on sexual ill-health (defined narrowly as sexual infections,

HIV, and unplanned / teenage conceptions) in the geographical regions of these HEIs.

Stage 2a) **qualitative data focus groups** of a number of post-registration nurse learners who have identified a gap in their sexual health learning, and are therefore personally trying to redress this by participating in the *RCN Sexual Health Skills* distance learning course. To some extent, this makes me an 'insider-researcher', however, prior to these focus groups, I will have had no face-to-face contact with the students, and only exceptionally limited contact with a very few of them e.g. e-mail tutorial support, with possibly 10 out of 100 students. *I will not be able to put 'faces to names' in relation to my management of the course and my research data collection procedures.*

The course is divided into regional cohorts, with students and facilitators meeting on two compulsory Away Days. I propose conducting the focus groups at some of these Away Days, which run at centres right across England, within a couple of weeks of each other (July 2007). Attendance at my research study focus group (to last about an hour) will be unlinked to the course and its completion, be on a voluntary (informed consent) basis, and held before or after the day's official programme.

Stage 2b) **qualitative data, self-completion, schedules**, based on the focus group discussion points: to learners on this same course, but at cohort centres running simultaneously to those in 2a) above, which I therefore cannot geographically attend at the same time. This can have the added benefit of greater individual (as opposed to group) anonymity, which might permit a more in-depth exploration of certain discourses, as well as assisting me, as researcher, in validating or challenging the themes that I have 'read out of' the various focus groups' data.

NB. Themes for the semi-structured schedules for 2a) and 2b) will emerge out of the literature reviewed, and particularly from the discourses and data analysis from Stage 1) above.

Members of the focus groups (2a) and those completing the written schedules (2b) will explore certain issues from the HEI surveys in greater depth, hopefully addressing some of the key discourses from alternative perspectives, for example, from the point of view of clinical practitioners and on-going students of learning, as opposed to the formal providers of education.

After comparing three acceptable processes found in research literature for dealing with mixed-genres in epistemologies, methodology and data, namely Triangulation, Kaleidoscopy and Crystallisation, I will argue in favour of using the latter approach. This has been explored in assignment ACAD 1065, with further clarification proposed for the Methods Chapter of the thesis. The definition of crystallisation, as a social scientific methodology, employed here, involves the focusing-in, or convergence of, a number of discursive sources including literature, methodologies, and

qualitative and quantitative data. This process results in an output which is essentially changed through the intermingling (refraction) of these particular sources. The methodology of crystallisation is more than a corroboration of findings by testing data from a number of sources; that would be triangulation. Crystallisation involves a dynamic relationship between that which makes the study work (methodology), what goes in to it (epistemology, supporting literature, respondents' data) and the end product which emerges from this unique relationship (the findings, discussion, results and policy recommendations). Richardson (2003) shows how this dynamic approach is favourable to social and educational enquiry. For me, this is especially important given my proposed use of predominantly qualitative genres, augmented by a small amount of quantitative data analysis.

2   A description of the value my research is likely to have for advanced professional practice

Hopefully, the value will be wide ranging. I intend to submit the findings to two key institutions currently missing such information - the Department of Health and the Nursing and Midwifery Council of the United Kingdom. I will also attempt to publish aspects of the findings in key professional journals for education and clinical practice. All of this could culminate in a more concerted effort to provide greater quality, quantity and consistency of professional sexual health learning initiatives for nurses, midwives and community practitioners / health visitors, thus contributing to the clinical improvement of certain sexual health indices in England.

'Mapping client need and professional sexual health education for nurses' does not intend to focus on a gap, a deficit, but more importantly to explore the discursive questions 'why' and 'what'. 'Why' do such gaps exists? and, 'what': a) are the implications of, and from, these gaps between client need and professional carers, and b) what can be done, educationally, to redress them? This means framing the research "around an intellectual problem or a paradox […], on phenomena that ask for explanation" (Dunleavy 2003: 23). Framed in Foucauldian terms, the study will incorporate a discursive analysis of the knowledge / power between clients or patients and their holistic sexual health needs, and professional carers (nurses and midwives) and their perceived educational preparedness to address these needs commensurately.

3   Am I investigating what is already known, and what is currently available in the literature?

No. The DH has formerly stated that there is a gap in knowledge in relation to the provision of professional sexual health learning for nurses. Similarly, the NMC, unlike its forerunners, the National Boards of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, considers it outside its remit to monitor the provision of sexual health learning, both at pre-and post-registration levels. My study intends to look at more than just providing such information; it is to map and explore the

discourses around the provision, and lack thereof, and to understand more about what is *not* said, what is problematised, marginalized and invisibilised, over and above that which is traditionally said in relation to sexual health and illness. It will analyse "explanations, relationships, comparisons, predictions, generalisations and theories" (Phillips and Pugh 1996: 47), by which to problematize the central research question:

- ***In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?***

4   What value is this research likely to have to the participants?

a)   *to the respondents of the HEI e-survey:* to consolidate awareness of the current state of sexual health learning opportunities, at HEIs, across England. Equally, to encourage them to add their institution's course details onto the national database of sexual health programmes, maintained by the Genito Urinary Nurses Association (www.guna.org.uk) supported by the Department of Health. This will enable more HEIs / teachers to consider: the local needs of people with epidemiologically defined sexual health problems; the associated learning needs of healthcare staff, and to compare both of these to actual or desired provision of professional education

b)   *to the post-registration respondents of the qualitative data schedules / participants in the focus groups:* to give them adequate space to contribute to the discourses; to listen to their voices, encouraging their contribution in a study that will hopefully improve healthcare practice and educational provision across England.

Am I wasting their time?

No! The subject area of this study is something which is routinely absent from clinical and educational professional journals, as well as from many HEI programmes of study. In as much as this study will hopefully have its findings disseminated across numerous media and professional fora, the results will support education and practice development.

5   How will I obtain informed consent from participants / particularly vulnerable groups?

a) This study is enrolling participants professionally registered as nurses, midwives, health visitors and their HEI educators, and not from any groups typically designated or labelled as "vulnerable"

b) Informed consent for the on-line HEI questionnaires will be highlighted in a covering e-mail and letter and ~~presumed granted by the very fact of the survey being voluntarily completed and electronically returned to me~~ acknowledged by return of an e-mail

c) Participation in the digitally recorded focus groups / self-completion written schedule groups will be voluntary, evidenced by acceptance of an invitation sent to students of the *RCN Sexual Health Skills course*, across England

      i. Written consent forms ~~will not be used for the focus groups, so as to avoid any concerns over confidentiality, or the linking of names (which I do not intend to do, anyway) to personal comments which may be of a sensitive nature e.g. relating to matters of sexual health, or criticism of lack of adequate service provision~~. to be facilitated by a third part, are contained in accordance with UREC requirements; see Appendices 4 a – d of amended UREC ethics application form)

6 How I will ensure that participants know they have a right to withdraw and feel able to withdraw without reason at any stage

a) This will be stated clearly in the various cover letters sent to prospective participants, asking for their voluntary participation in one of the key stages of the study

b) For the focus group participants: this will be reiterated, verbally, at the commencement of the sessions.

7 Steps to maintain privacy and confidentiality throughout the entire research process including the finished thesis

a) No individual names are required on any aspect of the data collection methods

b) Code numbers will be used on individual student schedules and by the focus group participants, e.g. "London participant No. 24" merely to distinguish the 24th respondent's comments from the North West England's 23rd's comments

c) Any personally identifying details will be anonymised in the thesis and published works (so that published reporting remains anonymous and unlinked)

8 Any negative reactions likely to the research, by either the participants or others at your workplace? For example, could anyone be so upset with your interventions that they take time off work, be disadvantaged or suffer some other reaction?

Not really, but there are a few related issues to comment on:

a) The first concerns 'gate-keeping' procedures for the HEI survey. I have ensured that my survey questionnaire adheres to acceptable good practice (Oppenheim, 2005), confirmed through pre-piloting various stages of development and change with EdD students and some sexual health peers, and by successfully piloting the questionnaire at fourteen HEIs across the UK (see: assignment ACAD 1065 – Preliminary Investigation). It also fully complies with ethical requirements of this University. Important to remember is that all HEIs offering sexual health courses have such details in the public domain (Internet / prospectuses / staff directories) – even though often difficult to find. A number have also added these details, voluntarily, to the DH sponsored Genito-Urinary Nurses' Association (GUNA) website. There are no warnings on HEI websites that research students of other institutions should not contact their staff without ethical approval from the recipient organisation's ethics committee. However, in January 2007 I sent an e-mail to all 114 HEIs in England enquiring i) as to whether they offer any courses at all in sexual health (for nurses and midwives) and ii), if so, for the contact details of the teacher(s) concerned. Despite almost every single response being positive, and after discovering a number of relevant courses hitherto missed (including by GUNA), one individual said they were not entitled to share such information with me, and two said I would need to apply through their own research ethics committees for permission to contact their staff! The possibility of such a response was previously drawn to my attention by one of my supervisors.

I have fully discussed this matter with the programme leader and my supervisors, and follow Dr Hall's guidance without exception.

b) The second issue concerns my dual role as course manager, including assignment co-moderator, and here, EdD researcher.

As course manager of a nation-wide distance learning programme, my role is essentially that of overseer: I do not routinely have any contact with individual learners. Sometimes a person may contact me for tutorial support, by e-mail or, occasionally, by telephone, but a) I do not keep any record of the person's name or details, and b) the EdD research study will not require names or student numbers, so that they will be totally anonymous and unlinked between my research and their course profile.

As co-moderator: All assignments are first marked by the expert facilitators of the Away Days, and then sent in to the course administrator's office. As from September 2006, along with two colleagues from the University of Greenwich, I co-moderate a third of the assignments selected for moderation. For the same reasons as above, there would be no problem in me moderating assignments (which are identified by a student number only) as I

would not be able to recognise them, through any identifying marks, as the same participants in my doctoral study. If the Committee deemed this a problem, however, I could always instruct the students who have participated in the EdD research study to put a particular mark on their assignments' front-sheet, and then these will be moderated by the university team, and not me.

c) Through over 17 years of teaching 'sensitive issues' in sexual health, HIV, and counselling - at home and abroad – and in my former MPhil research (Evans, 1998), and along with other research and counselling studies and qualifications, I will make every effort to ensure the design of this current study is fit for purpose, without leading to the potential for unnecessary and traumatic (personal) self disclosures by any of the research participants.

i. Should potentially hurtful, derogatory or offensively discriminatory remarks be conveyed, e.g. during the focus groups, I have an abundance of proven experience to deal with the matters and the individual(s) involved positively and sensitively

ii. Likewise, volunteers for the focus groups will be encouraged to participate equally, but not forced, if they choose to be relatively non-participatory (but I will constructively 'manage' situations when some people's voices are not being heard because of the over-dominance of others)

iii. Finally, I will also avail all participants of my university e-mail address and guarantee that I will assist any individuals with problems raised specifically by this study, for example, by referring them to appropriate resources and services other than myself

iv. *I must emphasise here that the design of this research is <u>not</u> intentionally geared towards exploring in-depth personal or highly sensitive issues, outside discourses on the provision (or lack) of professional sexual health learning opportunities.*

9 Appropriateness of the research paradigm and methodology: justification with evidence.

This has already been established, with positive feedback from Dr Neil Hall [i], in the ACAD 1062 assignment:

<u>Sexualities and Gender Epistemologies</u> (S&GE):
Constructing a research paradigm - mapping client need and professional sexual health education for nurses in England

10 Are there other ethical issues you have considered that have   not been mentioned elsewhere in this form?

Comments for Section 8 above withstanding, I consider this study clearly embraces the University's research degrees' ethics policy, with particular regard to the following general principles from Section 2 of that policy:

- [NO] risk of harm to participants and researchers
- Potential for benefit by society - *especially sexual health in professional nursing education and clinical practice*
- Maintenance of the dignity of participants
- Voluntary informed consent by participants, or special safeguards where this is not possible
- Confidentiality of information supplied by research participants and anonymity of respondents
- Appropriate publication and dissemination of research results - *to make a significant contribution to professional development*
- Independence and impartiality of researchers.

David T Evans
24 April 2007
Amended (as highlighted in text) in full accordance
with UREC requirements (07/2.4.1)
28 June 2007

References

Danaher, G., T. Schirato, and J Webb (2000). Understanding Foucault. London, Sage Publications.

Dunleavy, P. (2003). Authoring a PhD - how to plan, draft, write and finish a doctoral thesis or dissertation. New York, Palgrave MacMillan.

Evans, D.T. (1998). The Psychic Shadows of HIV and AIDS – and the role of social representations in post registration nurse education. MPhil (unpublished), University of Wales, College of Cardiff.

Mills, S. (2002). Discourse. London and New York, Routledge.

Oppenheim, A. N. (2005). Questionnaire Design, Interviewing and Attitude Measurement. London, Continuum.

Phillips, E. and D. Pugh (1996). How to Get a PhD - a handbook for students and their supervisors. Buckingham, Open University Press.

Richardson, L. (2003). Writing: a method of inquiry. Collecting and Interpreting Qualitative Materials. N. K. Denzin and Y. S. Lincoln. London, Sage Publications**:** 499-542.

Sontag, S. (1991). Illness as Metaphor: AIDS and Its Metaphors. London, Penguin Books.

---

[i] Comments:
Sexualities and gender epistemologies (ACAD 1062)

You have provided a well structured and a well argued essay.
You have used a genre that is effective in presenting your ideas.
Your written expression is clear and convincing.
You have engaged in important ideas and have provided a thorough analysis of issues.
You demonstrate a broad and deep knowledge of research issues and their underpinning philosophies.
You have used an impressive and extensive list of important and current literature.

This is a pleasing essay to read, one clearly of doctoral standard.

Dr Neil Hall
Reader in Educational Research

Appendix 5

HEI questionnaire survey

(the paper-based, not on-line version)

A survey of teachers

Providing Sexual Health Learning and Education
to Nurses, Midwives, Community Practitioners and Health Visitors
in England's Higher Education Institutions

Section 1

Your role in providing sexual health education

1a **What is your (main) teaching title and speciality, e.g. 'lecturer in sexual health nursing'**

Teaching Title

Are you ...

1b the programme leader / manager of the person responsible for delivering (some or all of) the sexual health learning and education? ○ YES ○ NO

1c a teacher responsible for providing (some or all of) the sexual health learning and education at your HEI? ○ YES ○ NO

1d **Which particular sub-specialities of sexual health do you teach in?**
Please tick all that apply

☐ Contraception & reproductive health / "Family Planning"
☐ Genito-urinary nursing
☐ HIV nursing
☐ Gender / female / male sexual health   Other sexual health teaching
☐ Other (please state)

1e Is your sexual health teaching:
   ○ Pre Registration   ○ Exclusively
   ○ Post Registration   ○ Both   ○ Predominantly   ○ Equally

1f How many teachers (including yourself, if relevant) currently spend 50% or more of their role in delivering sexual health learning / education?

1g Did you personally choose to teach / deliver the sexual health courses / programmes?
   ○ YES - *now go to Question 1h*   ○ NO - *now go to Section 2*

1h How did you acquire the sexual health role? *Please tick the most appropriate response:*
   ☐ Personal choice / career development
   ☐ Linked to clinical practice area
   ☐ By default / no one else to do it   Other:
   ☐ Other - please state:

Section 2

2a
In which town or borough is your HEI's main campus?
(e.g. "Southwark" for LSBU & "Ealing" for TVU, not "London")

2b
Which faculty / school provides the main sexual health
education for nurses

2c
Your faculty / school provides programmes of education for:

Please tick all that apply

Pre Registration   ☐ Nursing ☐ Midwifery ☐ Community Practitioners / Health Visiting

Post Registration   ☐ Nursing ☐ Midwifery ☐ Community Practitioners / Health Visiting

Section 3

Now please tell me about your institution's provision of sexual health learning and education

Your chance to fill in the blanks!

3a
How does your HEI prepare learners to implement the key aims of the Department of Health's
National Strategy for Sexual Health and HIV (NSSHH)?
Please list one primary way for each of the following:

NSSHH Aim 1 - reduce new incidence / transmissions of HIV and STIs

Reducing new infections

NSSHH Aim 2 - reduce the prevalence of *undiagnosed* HIV & STIs

Improving diagnosis rates

NSSHH Aim 3 - reduce unintended conception rates

Reducing unintended conceptions

NSSHH Aim 4 - improve health & social care for people living with HIV

Improving care for HIV+ people

NSSHH Aim 5 - reduce stigmas associated with HIV & STIs

Reducing stigmas

Regarding initial or pre registration education *only*:

3b   Over and above individual lectures, does your institution provide at least one *full* module or course (compulsory or optional) specifically on an area of sexual health e.g. 'foundations in sexual health', 'introduction to sexual infections (STIs)', 'contraception and reproductive health', to pre-registration student:

Nurses	○ Yes	○ No	○ Don't know
Midwives	○ Yes	○ No	○ Don't know
Community Practitioners / Health Visitors	○ Yes	○ No	○ Don't know

Other(s): please state which profession(s), e.g. "social workers"

If you answered "yes" to any of these please answer 3c, otherwise go to 3d

3c   *If such a module is provided:*

How many academic credits?   At which academic level(s)?

☐ diploma / Level II
☐ degree / Level III
☐ not applicable

3d   If this education is less than a whole module, e.g. a few hours, roughly how much time is *specifically* assigned for:

	less than 1 day	up to 1 week	some, but don't know	don't know if any at all
Sexual health (generic / holistic)	☐	☐	☐	☐
Safer sex / sexual health promotion	☐	☐	☐	☐
Contraception / reproductive health	☐	☐	☐	☐
Issues of teenage / unplanned conceptions	☐	☐	☐	☐
Genital & sexual infections / STIs	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Gynæcology / female sexual health	☐	☐	☐	☐
Male sexual health	☐	☐	☐	☐
Sexualities / diversity / anti-discrimination	☐	☐	☐	☐
Sexual health customised for local needs	☐	☐	☐	☐
Other	☐	☐	☐	☐

Please tell me more about your institution's provision of sexual health learning and education

Regarding post registration education only:

This might possibly refer to courses or modules similar to the former National Board courses, e.g. ENB 276 (GU nursing), ENB 934 (HIV), ENB 901 / R71 "Family Planning Certificate" etc.

4a Does your institution provide at least <u>one full module</u> (compulsory or optional) specifically on an area of sexual health, e.g. 'foundations in sexual health', 'sexual infections (STIs)', 'contraception and reproductive health' to post registration students of:

Nursing	○ Yes	○ No	○ Don't know
Midwifery	○ Yes	○ No	○ Don't know
Community Practitioners / Health Visiting	○ Yes	○ No	○ Don't know

Others, e.g. "social workers"

4b Does your institution offer a <u>full award</u> (majoring) in sexual health or a sub-speciality, e.g. a top-up bachelor degree, post graduate certificate, diploma or master's degree?

○ No *now go to 4c*

○ Yes *please list the award(s)*

Award title(s)

4c If independent sexual health modules are provided e.g. courses in contraception, HIV, promoting sexual health, etc. please list them here, and their academic values:

Module title	No. of credits	diploma/ degree	Post Grad Cert / Dip	Masters	Other
1		☐	☐	☐	☐
2		☐	☐	☐	☐
3		☐	☐	☐	☐
4		☐	☐	☐	☐
5		☐	☐	☐	☐
6		☐	☐	☐	☐

Academic levels (please tick all that apply)

4d If post registration sexual health educational provision is less than a whole module, roughly how much time is *specifically* assigned for the following (in which ever programme):

	less than 1 day	up to 1 week	some, but don't know	don't know if any at all
Sexual health (generic / holistic)	☐	☐	☐	☐
Safer sex / sexual health promotion	☐	☐	☐	☐
Contraception / reproductive health	☐	☐	☐	☐
Issues of teenage / unplanned conceptions	☐	☐	☐	☐
Genital & sexual infections / STIs	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Gynæcology / female sexual health	☐	☐	☐	☐
Male sexual health	☐	☐	☐	☐
Sexualities / diversity / anti-discrimination	☐	☐	☐	☐
Sexual health customised for local needs	☐	☐	☐	☐
Other	☐	☐	☐	☐

4e Do you (personally) consider that the provision of sexual health learning and education, <u>at your institute</u>, is appropriate for:

Pre registration students   Post registration students

○ Yes   ○ No   ○ Don't know   ○ Yes   ○ No   ○ Don't know

4f

Please say why you chose these responses:

4g Are nurses, midwives / CP-HVs able to access professional / academic learning elsewhere in the local area, e.g. training organisations or charities, such as the *fpa*, Terrence Higgins Trust, etc?

○ No   ○ Yes   If 'yes', which ones?

4h A number of sexual health courses at various HEIs are shown on the Genito Urinary Nurses' Association website, at www.guna.org.uk : are yours?

○ Yes   ○ No   ○ Don't know

4i Are you aware that the Royal College of Nursing has been providing a professionally approved and academic credit rated (30 CATS points) *RCN Sexual Health Skills* distance learning course for the past three years?

○ Yes   ○ No

Some questions about sexual health demographics in your HEI's local area e.g. town or (part of) city

5a   Please tell me how the various sexual health needs of your own HEI's students are catered for, e.g. free condoms in campus bars, local STI and contraception services, university health centre etc.

5b   In relation to teenage / unplanned conceptions, and sexually acquired infections, how (relatively) aware are you of the <u>current</u> state of sexual health in <u>your</u> institution's town or borough?

○ well aware - regularly updated   ○ local media-level knowledge   ○ relatively unaware

5c   In relation to *your HEI's* local town population, how would you rate the following in comparison with what you know, generally, of the UK's national statistics?

	lower	about the same	higher	don't know
Chlamydia rates	☐	☐	☐	☐
HIV rates	☐	☐	☐	☐
All sexual infection rates	☐	☐	☐	☐
Teen conception rates	☐	☐	☐	☐

5d   In a few words, what do <u>you</u> consider to be some of the most significant **sexual health problems** facing the following people <u>in your HEI's local town / area</u>? *(please answer all you feel able to)*

Children and adolescents	
Teenagers	
Pregnant teenagers	
Bisexual females	
Bisexual males	
Gay males	
Heterosexual females	

Heterosexual males

Lesbian females

Transgender people

Old people

People with mental health problems

People with physical and / or learning disabilities

People from cultural / minority ethnic groups

Socially deprived / vulnerable people

Local people with particular issues, e.g. commercial sex workers (prostitutes), illicit drug users (including 'disco'drugs), prison / Young Offenders' Institutions' inmates, Care Homeresidents, HEI populations, Military personnel (others)

5e   Please list up to three local sexual health problems you consider your HEI could address / include / improve on, in the educational programmes for professional carers

Problem 1

Problem 2

Problem 3

5f   If you consider these subjects are not currently addressed (adequately) by your HEI: what would you say are the main reasons for this?

And now just a few final questions - thank you for sticking with this form so far!

5g Where is the nearest service (to your HEI) <u>that you are you personally aware of</u> that provides <u>free</u> access to:

Male condoms

Female condoms

Emergency contraception

Post Exposure Prophylaxis (PEP) after sexual risk to HIV

5h Do you make this information <u>routinely</u> available to the students on your courses, concerning the availability of:

Male condoms	○ Yes	○ No
Female condoms	○ Yes	○ No
Emergency contraception (EC)	○ Yes	○ No
Post Exposure Prophylaxis (PEP)	○ Yes	○ No

5i How well do you consider your HEI's courses contribute towards 'normalising' / de-stigmatising sexual ill-health, and other sexually-related stigmas, on matters of:

	poorly	neither poorly / well	well
Teenage / unplanned conceptions	☐	☐	☐
Contraception	☐	☐	☐
Emergency Contraception (EC)	☐	☐	☐
Condom usage / safer sex practices	☐	☐	☐
(In-)fertility awareness	☐	☐	☐
Termination of pregnancy / abortion	☐	☐	☐
Sexual infections (STIs)	☐	☐	☐
HIV	☐	☐	☐
Minority sexual life-styles / practices	☐	☐	☐
Anti-bullying / promoting equality for all	☐	☐	☐

5j   Do *you* consider that the sexual health education provided by your HEI for nurses and midwives:

Adequately addresses the local population's clinical sexual health needs?   ○ Yes   ○ No

Sufficiently prepares <u>an adequate number</u> of *specialist* qualified staff for the local service requirements (e.g. 'Family Planning' and genito-urinary nurses)   ○ Yes   ○ No

Enables health care learners, participating in these courses, to proficiently address the sexual health needs they routinely face in the clinical encounter?   ○ Yes   ○ No

Meets local service needs with a sufficient number of places on such courses?   ○ Yes   ○ No

5k

What formal sexual health education / learning did you receive when you were a student nurse / midwife? (and when was this?)

5l

Please add any other comments that you consider important, regarding sexual health education and learning for nurses, midwives and community practitioners / health visitors today:

Thank you so much for giving up your time to complete this form for me. I will keep your identity confidential, whilst I use this material towards my doctoral research and in advancing sexual health education for our professional colleagues.

All you need do now is post this back to me, as soon as possible, in the stamped, addressed, envelope provided.

David

ed409@gre.ac.uk

David T Evans
EdD research student
University of Greenwich
School of Education and Training

(David T Evans)

ed409@gre.ac.uk

Educational Database of the Genito-Urinary Nurses Association (GUNA) website

(Original 2007 listing

kindly provided by GUNA December 2010)

GENITO-URINARY NURSES ASSOCIATION

20 May 2009

spreading

| Nurse of Year Award 2008 | WELCOME | NEWS & EVENTS | CLINICAL MEETINGS | MEMBERS | EDUCATIONAL COURSES DATABASE | JOIN GUNA |

→ Education Database

→ Search

→ Course Providers Registration

→ Login for Course Providers

→ User guide

Name of Institution	Course No	Course Title	Course Leader	by Date	View Details
University of Central Lancashire	MW2118	Prevention of Unplanned Pregnancy	Debbie Mennim	20-05-2009	Details
University of Central Lancashire	MW3041	Asymptomatic Screening in STIs and HIV for Contraceptive Practitioners	Jason Flannigan	20-05-2009	Details
University of Central Lancashire	MW3641	First Issuing of Hormonal Contraception in Practice	Debbie Brittain-Williams	20-05-2009	Details
University of Central Lancashire	MW2599/MW3599	Mens Sexual Health	Jason Flannigan	20-05-2009	Details
Glasgow Caledonian University	NCHMM65	Sexual Health: Practicum	Angela Poat / Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHMM63	Sexual Health: Genitourinary Health	Angela Poat / Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHMM62	Sexual Health: Contraception	Angela Poat / Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHMM61	Sexual Health: Sexuality and Sexual Health	Angela Poat / Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHSD	Genitourinary Nursing	Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHS	Contraception and Reproductive Health	Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHS/ NCHSD	Sexuality and Sexual Health	Nancy Graham	20-05-2009	Details

Glasgow Caledonian University	NCHSD	Genitourinary Health	Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHS	Contraception and Reproductive Health	Nancy Graham	20-05-2009	Details
Glasgow Caledonian University	NCHHD/ NCHHS	Sexuality and Sexual Health	Nancy Graham	20-05-2009	Details
Oxford Brookes University	U44220	Caring for People with Sexually Transmitted Infections	Bridget Taylor	20-05-2009	Details
Terrence Higgins Trust	PEP2006	Basic PEP Awareness Training (for Health Promoters working with African Communities)	Elias Phiri	20-05-2009	Details
	NQMS3009 or NQMS2007	Contraception and screening for sexual and reproductive health	Maggie Duckett	20-05-2009	Details
	NQMS 3010	Advances in Genito-Urinary Medicine	Mrs Margaret Ellen Duckett	20-05-2009	Details
fpa (Family Planning Association)	fpa011	Delivering Sex and Relationships Education in the Classroom	Varies	20-05-2009	Details
fpa (Family Planning Association)	fpa010	Sexual Health Teaching and Learning Practice	Varies	20-05-2009	Details
	University Certificate in Gay Men\'s Health Promotion	University Certificate in Gay Men\'s Health Promotion	Gerard McGuickin and Ilana Morrissey	20-05-2009	Details
University of Central Lancashire	MW3021	Principles of Gynaecological Care	Debbie Brittain-Williams	20-05-2009	Details
University of Central Lancashire	MSc Sexual Health Studies	MSc Sexual Health Studies	Debbie Wisby	20-05-2009	Details
University of Central Lancashire	MW2602 and MW2715	Contraception and Asymptomatic Screening for STIs and HIV	Debbie Wisby	20-05-2009	Details
University of Central Lancashire	MW2134	Family Planning Update	Debbie Wisby	20-05-2009	Details
University of Central Lancashire	MW3118	Prevention and Management of Unplanned Pregnancy	Debbie Brittain-Williams	20-05-2009	Details
University of Central Lancashire	MW3603	Developing Skills in Cervical Screening	Debbie Brittain-Williams	20-05-2009	Details
University of Central Lancashire	MW2148/3128	Principles of Contraception and Fertility Control	Debbie Mennim	20-05-2009	Details
University of Central Lancashire	BSc (Hons) Sexual Health in Practice	BSc (Hons) Sexual Health in Practice	Debbie Wisby	20-05-2009	Details
University of Central Lancashire	MW2604/3604	Sexual Health Care for Teenagers	Debbie Mennim	20-05-2009	Details

University of Central Lancashire	MW2718/3718	Principles of Sexual Health and STIs	Jason Flannigan	20-05-2009	Details
Imperial College London	06.08	Women\'s Health Issues - from menarche to menopause	Mrs Gilly Andrews	20-05-2009	Details
Imperial College London	06.07	Psychosexual Medicine in Practice	Dr Heather Montford	20-05-2009	Details
Universtiy of East London	HS1101 / HS1102	Gay Men\'s Health Promotion	Ilana Morrissey and Gerard McGuickin	20-05-2009	Details
GSTT	gstt/01/2006	HIV-Education Course	Dr Cindy Sethi	20-05-2009	Details
	TSH.02	Training in Sexual Health - Setting Up a Level 1. Service	Rebecca Bussy	20-05-2009	Details
Training in Sexual Health	TSH.01	An Overview of Sexually Transmitted Infections	Rebecca Bussy	20-05-2009	Details
Royal College of Nursing	Not Applicable	Greenwich University Sexual Health Skills distance learning course (Level III)	David T Evans	20-05-2009	Details
Royal College of Nursing	Not applicable	Greenwich University Sexual Health Skills distance learning course (Level II)	David T Evans	20-05-2009	Details
fpa (Family Planning Association)	fpa009	Beyond Barbie - Young Women \\\'s Sexual Health	varies	20-05-2009	Details
fpa (Family Planning Association)	fpa008	Basics of Contraception	varies	20-05-2009	Details
fpa (Family Planning Association)	fpa006	Sexually Transmitted Infections - an Introduction	varies	20-05-2009	Details
fpa (Family Planning Association)	fpa005	Moving the Goalposts	Varies	20-05-2009	Details
University of Wales, Bangor	Contraception and Associated Health	Contracpetion and Associated Health	Lynne Edgerton	20-05-2009	Details
Thames Valley University	CPPD	Discussing Sexual Health and Contraception	Sandy Nelson	20-05-2009	Details
Thames Valley University	CPPD	Delivering Sexual Health and Contraceptive Care	Dorothy Lepper	20-05-2009	Details
Thames Valley University	CPPD	Exploring Teenage Sexuality and Sexual Health	Sandy Nelson / Karen Gibson	20-05-2009	Details
Thames Valley University	PC6009W	An Introduction to Care and Management of Individuals with HIV Disease	Karen Gibson	20-05-2009	Details
Thames Valley University	PC20011W	Exploring Sexually Transmitted Infections	Jonathan Davies	20-05-2009	Details
Middlesex University	PHC3616	Contraception and Reproductive Sexual Health	Su Everett	20-05-2009	Details

Queen\\\'s University of Belfast	Breast & Cervical Screening	Breast & Cervical Screening	Mrs Gail Anderson	20-05-2009	Details
Queen\\\'s University of Belfast	Foundation in Family Planning & Reproductive Sexual Health	Foundation in Family Planning & Reproductive Sexual health	Mrs Jill Stewart-Moore	20-05-2009	Details
Queen\\\'s University of Belfast	The Theory & Practice of Family Planning & Reproductive Sexual health	Theory & Practice of Family Planning & Reproductive Sexual health	Mrs Jill Stewart-Moore	20-05-2009	Details
Queen\\\'s University of Belfast	The Theory and Practice of Family Planning & Reproductive Sexual Health	The Theory and Practice of Family Planning & Reproductive Sexual Health	Mrs Jill Stewart-Moore	20-05-2009	Details
University of East Anglia	NAM3REY	Family Planning and Reproductive Sexual Health	Katrina Emerson	20-05-2009	Details
	APPS 3051	Contraception and Sexual Health	Kim Russell	20-05-2009	Details
University of Glamorgan	FC2D015	Sexual Health	Nan Morse	20-05-2009	Details
	FC2D012	Family Planning in Clinical Practice	Mrs N Morse	20-05-2009	Details
Plymouth teaching Primary Care Trust in parnership with University of Plymouth	HEAB356	An introduction to working with people with sexual problems	Mike Kirkpatrick	20-05-2009	Details
University of Bradford	HM2000D	Foundations in Reproductive Sexual Health and Family Planning	Mel Barlow	20-05-2009	Details
University of Bradford	HM-3266M	Cervical Screening	Jan Porter	20-05-2009	Details
University of Bradford	HM-3000D	Developing Theory in Family Planning, Cervical Cytology and Reproductive Sexual Health	Jan Porter	20-05-2009	Details
	HM-3002D	Clinical Practice in Family Planning, Cervical Cytology and reproductive Sexual Health	Jan Porter	20-05-2009	Details
fpa (Family Planning Association)	fpa004	First Contact	Varies	20-05-2009	Details
fpa (Family Planning Association)	fpa003	Choice, Chance and Consequences	Varies	20-05-2009	Details
fpa (Family Planning Association)	fpa002	Is Everybody Doing It	Varies	20-05-2009	Details
University of Hertfordshire	Practice of Contraception and Reproductive Sexual Health 3NMH0076	Practice of Contraception and Reproductive Sexual Health 3NMH0076	Lyn Dolby	20-05-2009	Details
University of Hertfordshire	Legal, Ethical and Emotional Issues within Sexual Health Care 3NMH0032	Legal, Ethical and Emotional Issues within Sexual Health Care 3NMH0032	Emma Dwason-Goodey	20-05-2009	Details

University of Hertfordshire	Sexual Health Promotion, Surveillance & Screening 3NMH075	Sexual Health Promotion, Surveillance & Screening 3NMH075	Mary Shaw	20-05-2009	Details
University of Hertfordshire	Fertility and Contraception within Sexual Health care	Fertility and Contraception within Sexual health Care	Lyn Dolby	20-05-2009	Details
University of Brighton	N/A	One day HIV Update	Sian Edwards	20-05-2009	Details
University of Brighton	NS315	Developing the Clinical Expertise of Nurses in Sexual Health: advanced skills in assessment, management and clinical practice	Sian Edwards	20-05-2009	Details
University of Brighton	NS318	The Developing Role of the Sexual Health Adviser	Sian Edwards	20-05-2009	Details
University of Paisley	Sexuality,Reproduction & Contraception.Genito-Urinary Medicine.Clinical Practice in Sexual and Reproductive Health	Sexual and Reproductive Health Course	Jackie McFadyen	20-05-2009	Details
University of Brighton	NS214	Current Issues Relating to HIV Infection (diploma level - shared delivery)	Sian Edwards	20-05-2009	Details
University of Brighton	NS316	Current Issues Related to HIV Infection (degree level - shared delivery)	Sian Edwards	20-05-2009	Details
fpa (Family Planning Association)	fpa001	Let\'s Make It Happen	Varies	20-05-2009	Details
University of Central Lancashire	MW3031/MW4301	Health Promotion within Sexual Health	Jason Flannigan	20-05-2009	Details
University of Central Lancashire	MW3062/MW4062	Management of individuals affected by Blood Bourne Viruses (HIV and Hepatitis)	Jason Flannigan	20-05-2009	Details
University of Central Lancashire	MW3005	HIV in the 21st Century	Jason Flannigan	20-05-2009	Details
University of Greenwich	NURS 1146	Promoting Sexual Health	Nuala McBennett	20-05-2009	Details
University of Greenwich	OMED 1145	Current Issues in HIV/AIDS	Nuala McBennett	20-05-2009	Details
University of Greenwich	NURS 1207	Cervical Cytology & Breast Awareness	Ros Delaney	20-05-2009	Details
University of Greenwich	NURS 1169	Introduction to Sexually Transmitted Infections	Ros Delaney	20-05-2009	Details
	)MED 0231	Developing Skills in Contraception & Reproductive Sexual Health	Ros Delaney	20-05-2009	Details

	OMED 0231	Developing Skills in Contraception & Reproductive Sexual Health	Ros Delaney	20-05-2009	Details
University of Central Lancashire	MW3060	Management of Individuals Affected by Sexually Transmitted Infections	Jason Flannigan	20-05-2009	Details
University of Central England in Birmingham	GM661	Psychosexual health	Ms Joy Hall	20-05-2009	Details
University of Central England in Birmingham	GM6062	The principles of management of people affected by HIV infection	Ms Joy Hall	20-05-2009	Details
University of Central England in Birmingham	GM60V8	The management of sexual disease in society	Ms Joy Hall	20-05-2009	Details
Staffordshire University	SHM58052-M	Contraceptive Care	Jenny Brimelow	20-05-2009	Details
Canterbury Christ Church University	Specialist: Contaception and Sexual Health	Specialist: Contaception and Sexual Health	Maureen Williams	20-05-2009	Details
	Sexually Transmitted Infections and HIV.	Sexually Transmitted Infections and HIV.	Maureen Williams	20-05-2009	Details
	Contraception and Fertility Control	Contraception and Fertility Control	Mauren Williams	20-05-2009	Details
University of Surrey, EIHMS	M02/009/105G	Developing Skills in Contraception and Reproductive Sexual Health Care	Jill Shawe	20-05-2009	Details
University of Surrey, EIHMS	M03/038/105G	HIV & AIDS Continuing Care for the Client	Jill Shawe	20-05-2009	Details
University of Surrey, EIHMS	M02/011/105G	HIV & AIDS Continuing Care for the Client	Jill Shawe	20-05-2009	Details
University of Surrey, EIHMS	M03/019/105G	Developing Skills in Contraception and Reproductive Sexual Health Care	Jill Shawe	20-05-2009	Details
	M02/009/105G	Developing Skills in Contraception and Reproductive Sexual Health Care	Jill Shawe	20-05-2009	Details
University of Surrey, EIHMS	415	Sexual Health	Dr Vasso Vydelingum	20-05-2009	Details
University of Hull	92336	Practical Aspects of Family Planning	Susan Hannigan	20-05-2009	Details
University of Hull	92129	Foundation in Family Planning and Reproductive Health	Susan Hannigan	20-05-2009	Details
University of Hull	92130	Foundation in Family Planningand Reproductive Health	Susan Hannigan	20-05-2009	Details

RCN Institute	DYIO06	Discover Yourself Inspire Others - a leadership development programme for health and social care practitioners	Anne Benson	20-05-2009	Details
University of Central England in Birmingham	GM608Y	Innovations in Gynaecological Care	Mrs Dee Amos	20-05-2009	Details
University of Central England in Birmingham	GM60V9	Contraception & Sexual Health	Mrs Linda Hayes	20-05-2009	Details
University of the West of England, Bristol	Practice of Contraceptive and Sexual Health module	Practice of Contraceptive and Sexual Health module	Julie Williams	20-05-2009	Details
Staffordshire University	Delivering Sexual Health information and advice to young people	Delivering Sexual Health information and advice to young people	Margaret Cunnion	20-05-2009	Details
Staffordshire University	SHN56060-3	Sexual Health Advising - Widening the Remit	Margaret Cunnion	20-05-2009	Details
Staffordshire University	SHN55043-2	Sexual Health Advising - Widening the Remit	Margaret Cunnion	20-05-2009	Details
Staffordshire University	SHM58050-M	Delivering the national stratgy for sexual health and HIV in primary care	Margaret Cunnion	20-05-2009	Details
Staffordshire University	SHM58018-M	Understanding Sexual Abuse	Sally Scattergood	20-05-2009	Details
Staffordshire University	SHM58059-M	Law and Sexual Health	Joanne Beswick	20-05-2009	Details
Staffordshire University	SHM58049-M	Introduction to Sexual Health	Margaret Cunnion	20-05-2009	Details
University of Stirling	Sexual Health NUR163	Sexual Health, an advanced degree module	Ethne Brown	20-05-2009	Details
Manchester Metropolitan University	2730	Developing Skills in Contraception, Reproductive & Sexual Health (CRASH)	Margaret Presho	20-05-2009	Details
	NM2041	Introduction to Sexual Health	Mark Jones	20-05-2009	Details

© GUNA 2005

Appendix 7

Cover letter and research explanation accompanying
the HEI Survey Questionnaires

the
UNIVERSITY
of
GREENWICH

19 March 2008

Dear Colleague,

Re: **The Provision of Sexual Health Learning and Education**
to Nurses, Midwives, Community Practitioners and Health Visitors

A Survey of Higher Education Institutions in England, as part of my
doctoral (EdD) research studies, at the University of Greenwich.

This survey is being sent to teachers / programme leaders providing learning opportunities, in sexual health, to nurses and midwives. Many of your courses are listed through the websites of the Nursing and Midwifery Admissions Service (www.nmas.ac.uk), the Genito Urinary Nurses' Association (www.guna.org.uk), the Universities and Colleges' Admissions Service (www.ucas.ac.uk), and / or I have received your contact details from your HEI's admissions office.

Given the pressures on time, I'm sure there's never a 'right' time to send you even more work! However, I would like to invite you to voluntarily participate in this survey, which will take about 30 minutes. After completing the attached questionnaire, simply return it to me in the stamped, addressed, envelope, within two weeks of the above date. Please answer as many questions as you choose to. You may omit any you do not wish to answer, and stop at any time, sending the form back incomplete if you so wish. **The form is confidential, anonymous, and unlinked to you as a person.**

The survey is one element of my doctoral study, focusing on "Mapping client need and professional sexual health education for nurses in England". The central research question is: *"In which ways do specific discourses pertaining to sexual health and illness inform the need for, and provision of, professional education for nurses in England?"*

Ethics and Confidentiality: This study has received approval from the Research Ethics Committee of the University of Greenwich. *I guarantee your anonymity and confidentiality*. Nowhere do I ask for your name; *I also guarantee* that I will not be linking personal comments with the name or place of your HEI. I simply ask for the place of your institution to correlate HEIs in the official English regions with epidemiological incidents of recorded sexual ill-health (defined in this study as incidence of sexual infections, HIV, and unplanned / teenage conceptions).

I thank you in advance for taking time to work on this survey and getting it back to me within two weeks of the above date. As with the work you all do, my intention is that this study may go some way in helping to improve the sexual health of people in our nation. I wish you well, and look forward to hearing from you. *Please feel free to forward this e-mail and attachments on to any other colleagues, at your HEI, who provide (aspects of) sexual health learning.*

Respectfully yours,

David T Evans – EdD research student
RN BA(Hons)(Kent) PGDip Psychol Couns. PGCE(*Health Professions*) MPhil (Wales)
e-mail: ed409@gre.ac.uk

D.T.Evans@gre.ac.uk

the
UNIVERSITY
of
GREENWICH

> ## "Mapping client need and professional sexual health education for nurses in England"

Research Project Information Sheet

Never before has sexual health had such a high, national, profile! The House of Commons Health Committee said that the UK's sexual health was at "crisis" level in 2003, and official statistics, interested parties, and the media are constantly reminding us that sexual infections and unplanned / teenage conceptions continue to be the highest in western Europe. At the same time, nurses, midwives and other health and social care professionals are often in a prime position to be working with their clients or patients in addressing many of the aspects of sexual health, as it relates to the client's holistic health and well-being.

However, knowledge and skills sufficient for optimum sexual health prevention and care - what clients / patients actually seem to require from professional carers - are often times lacking. This is evidenced in literature and by the opinion of nurses and others who voice concern that their initial professional education paid insufficient attention to sexual health, and that even after qualifying the opportunities for learning are frequently difficult to access, leaving sexual health care inadequate for optimum practice. My doctoral research is clearly focused on these matters.

Although entitled "Mapping client needs …" I am not actually asking healthcare clients or patients themselves. Instead, this research focuses on nurses and their educators, on what *they* consider these needs to be, and their considerations on how professional nursing education may help address these issues. Of particular interest to me are the various issues in sexual health that are frequently missing, sidelined or invisibilised, i.e. sexual health matters other than the headline news of "teenage pregnancies" and "sexual infections". My programme of research is for the professional doctorate in education (EdD). Due to constraints, the study focuses on sexual health learning in England alone. My primary aim is to use this research, for example, through publications and conferences, to highlight the issues of sexual health learning for nurses, ultimately for the promotion and advancement of client / patient well-being and care.

David T Evans, doctoral research student (EdD)

Academic Supervisors:

Dr Jill Jameson
Director of Research & Enterprise
School of Education and Training
University of Greenwich

j.jameson@gre.ac.uk

Prof Elizabeth Meerabeau
Head of School
School of Health & Social Care
University of Greenwich

E.Meerabeau@gre.ac.uk

Example of a Focus Group
'register' of consenting participants

D.T.Evans@gre.ac.uk   (David T Evans)

Research by David T Evans
for the professional doctorate in education (EdD)

Consent Forms

for voluntary participation in a focus group conducted by the researcher

Consent form
number

Participant number
allocated to consent form

01		11		21	
02		12		22	
03		13		23	
04		14		24	
05		15		25	
06		16		26	
07		17		27	
08		18		28	
09		19		29	
10		20		30	

* The independent facilitator will administer the consent forms to those participants of the RCN Sexual Health Skills course agreeing to take part in this doctoral research focus group. The facilitator will give the participant a numbered sheet of paper (between 1-30), to be used in place of their personal names, for transcription of the recorded data. The facilitator will seal the consent forms in an envelope, and will have nothing more to do with this focus group.

Date: _____   Regional cohort centre: _____

Facilitator's name & signature   _____

Research by David T Evans
for the professional doctorate in education (EdD)

"Mapping client need and professional sexual health education for nurses in England"

Consent Form

for voluntary participation in a focus group conducted by the researcher

I _____ freely and voluntarily agree to participate in an audio-recorded Focus Group convened and facilitated by David Evans (researcher) for the above study, and on this particular topic. I understand that my name will not be linked to any comments I might make, an anonymous number being used for that purpose. I also understand that I am free to contribute as much or as little as I choose to in this session, and that I am free to leave at any point, without having to give a reason. I have read the recruitment letter and research proposal information sheet, from David Evans, and understand that this session is in part contribution towards his doctoral research on this subject. I also understand that my participation in this focus group is completely independent to, and unlinked from, my enrolment on the *RCN Sexual Health Skills* course and the outcome of my course assignments. I will respect the ethos of my Code of Professional Conduct in relation to my participation in this research and my comments and interactions with others in this group.

Signature: _____

Date: _____   Cohort centre: _____

Participant number issued by independent facilitator:

Appendix 9

PowerPoint Slides of

the Focus Group session -

semi-structured discussion points

Slide 1

Slide 2

Slide 3

<u>Key aspects of data collection</u>

- (E-)surveys to teachers of sexual health nursing at Higher Education Institutions across England

- Focus groups with registered nurses undertaking the **_<u>Sexual Health Skills</u>_** course across England

- The same focus group topics, on self-completion questionnaire schedules, to registered nurses undertaking the **_<u>Sexual Health Skills</u>_** course at other centres across England
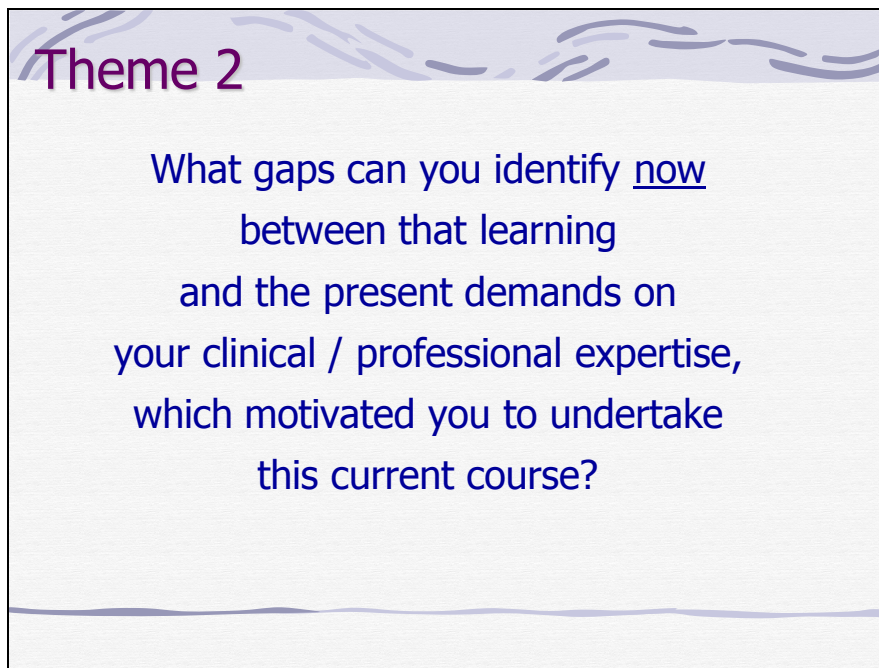
Slide 4

Theme 1

Freely discuss the quality and quantity
of sexual health learning,
either through the formal curriculum
or clinical-based experience,
that <u>you</u> gained during your

pre-registration student programmes.

(please start by indicating the year you commenced nurse training).
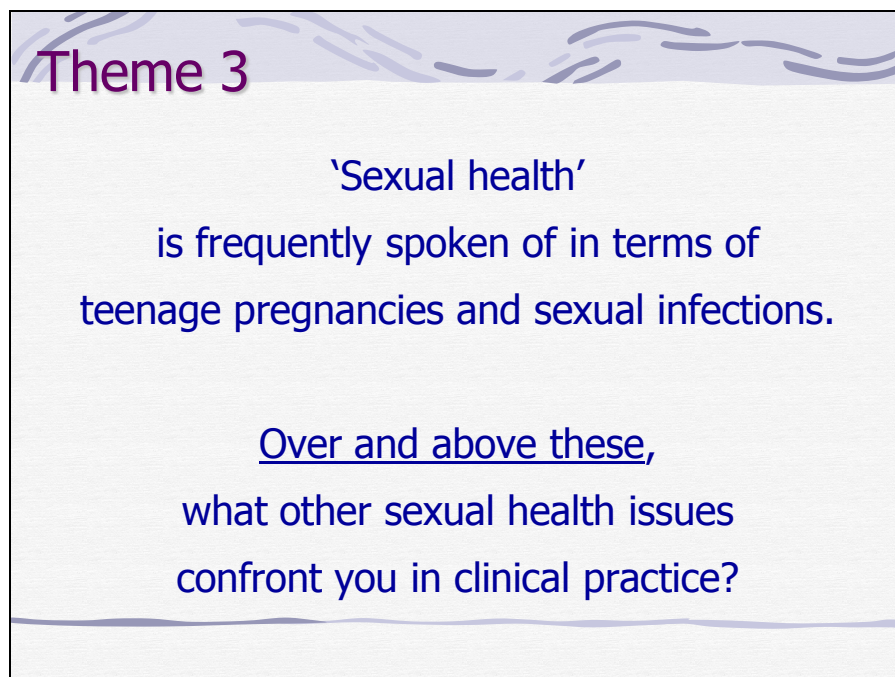
Slide 5

Theme 2

What gaps can you identify <u>now</u>
between that learning
and the present demands on
your clinical / professional expertise,
which motivated you to undertake
this current course?

Slide 6
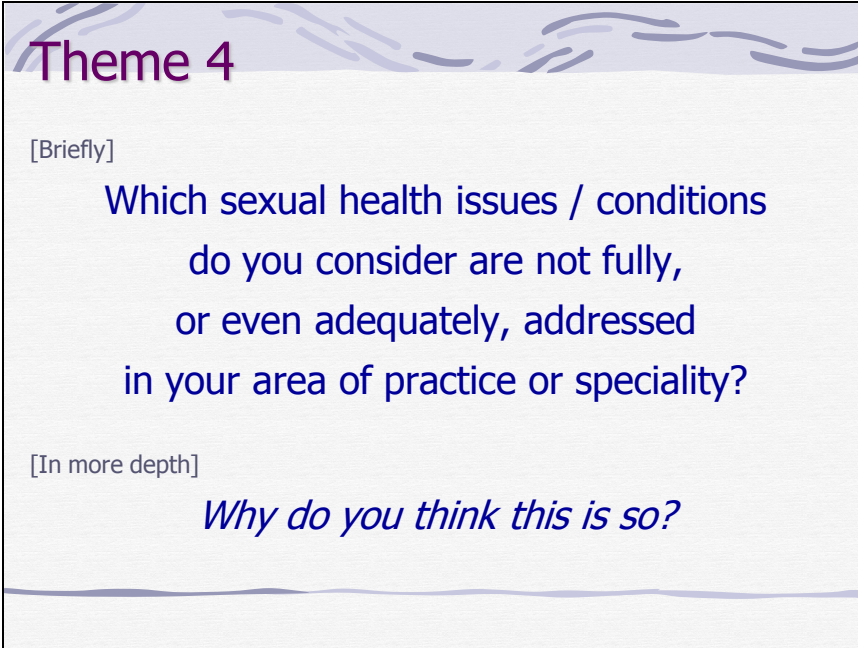
Theme 3

'Sexual health'
is frequently spoken of in terms of
teenage pregnancies and sexual infections.

<u>Over and above these</u>,
what other sexual health issues
confront you in clinical practice?

Slide 7

Theme 4
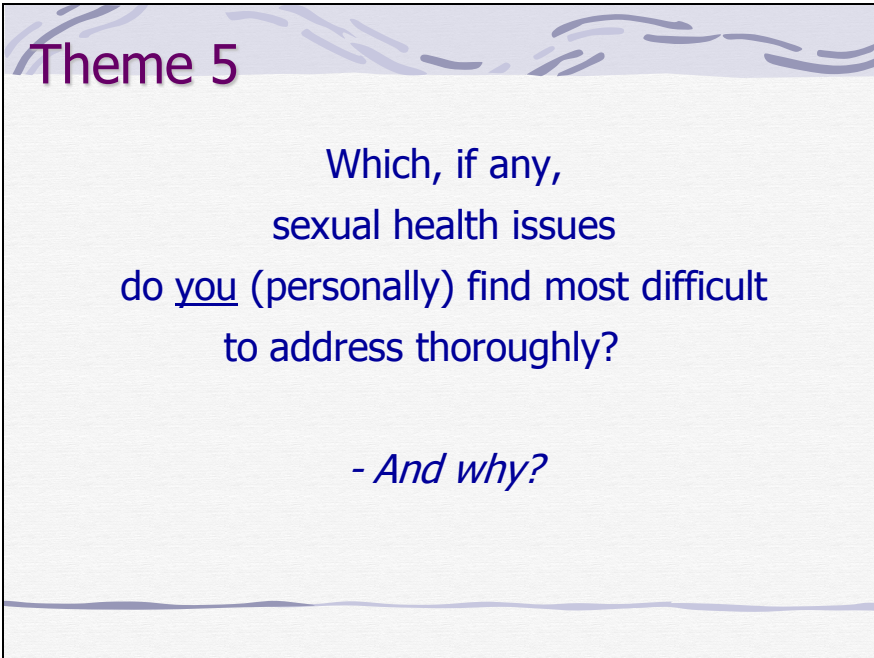
[Briefly]

Which sexual health issues / conditions
do you consider are not fully,
or even adequately, addressed
in your area of practice or speciality?

[In more depth]

Why do you think this is so?

Slide 8

Theme 5

Which, if any,
sexual health issues
do you (personally) find most difficult
to address thoroughly?

- And why?

Slide 9

Theme 6

Based on your current level
of learning or clinical experiences
of various client needs, to date,
and in relation to sexual health and illness:

what would you recommend to education providers
as being key areas of sexual health
for nursing curricula?

- [Briefly] *Why?*

Slide 10

Further information

the
UNIVERSITY
of
GREENWICH

"Thank you!"
for participating in this research study

David T Evans
research student (EdD)

D.T.Evans@gre.ac.uk

Appendix 10

Questionnaire Group

self-completion schedules

Dear Colleague, You have been given a unique number, which indicates that you have given written consent to participate in this completion of this form. This number <u>will not</u> be linked to your consent form / name. Please enter the number here:

<div style="border:1px solid black; width:120px; height:80px;"></div>

| **Mapping client need**
and professional sexual health education
for nurses in England |
| --- |

1) Freely discuss the quality and quantity of sexual health learning, either through the formal curriculum or clinical-based experience, that you gained during your **_pre_**-registration student programmes (please indicate the year you commenced nurse training).

2) What gaps can you identify now between that learning and the current demands on your clinical / professional expertise, which motivated you to undertake this current course?

3) 'Sexual health' is frequently spoken of in terms of teenage pregnancies and sexual infections.   Over and above these, what other sexual health issues confront you in clinical practice?

4) Which sexual health issues / conditions do you consider are not fully, or even adequately, addressed in your area of practice or speciality?

- Why do you think this is so?

5) Which, if any, sexual health issues do you find most difficult to address thoroughly?

- And why?

6)   Based on your current level of learning and clinical experiences
       of various client needs, to date, in relation to sexual health and
       illness: what would you recommend to education providers as
       being key areas of sexual health for nursing curricula?

       - Why?

Thank you so much for your time and effort in completing this form for me.

David T Evans
EdD research student
School of Education & Training
The University of Greenwich

Appendix 11

Position statement of the

Nursing and Midwifery Council

on sexual health education

(January 2011)

**Position statement of the Nursing and Midwifery Council
on sexual health education, 2011**

The Nursing and Midwifery Council (NMC) is the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. We exist to safeguard the health and wellbeing of the public. We set standards of education, training and conduct for nurses and midwives and hold the register of those who have qualified and meet those standards. We provide guidance and advice to help nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code. The standards that we set are generally broad and overarching. These should be sufficient to provide a regulatory framework around which programmes can be developed at local level in partnership with stakeholders that meet local and national need whilst safeguarding the public. In this way programmes remain dynamic, evidence based and responsive to change.

Our standards promote the need for nurses and midwives to understand and apply public health principles to their practice, which includes sexual health. Within the standards for pre-registration midwifery education (2008) there are specific references to sexual health, whilst within the standards for pre-registration nursing education (2004/2010) sexual health is more implicit and encompassed within meeting the essential physical and mental health needs of all people and all ages. It is for providers to determine the more detailed content of the curriculum at local level drawing on contemporary evidence based practice. It would however be anticipated that areas of practice such as sexual health would be well represented in all pre-registration programmes.

The NMC has also provided opportunities for sexual health advisers to become registered as specialist community public health nurses (SCPHN). Sexual health advisers were enabled to demonstrate achievement of key sexual health competencies needed for registration through portfolio between September 2007 and 2009.

Personal e-mail communication in response to my request for information on this matter, from Garth Long [Garth.Long@nmc-uk.org], Professional Adviser, Education, Nursing and Midwifery Council.

14.01.11

Appendix 12

PowerPoint Presentation

"Pleasure: Naughty but nice? Using the *ars erotica* to promote sexual health and well-being"

University of Greenwich

First Sexual Health

Research & Practice Conference,

Workshop Presentation

(November 2010)

Slide 1

Slide 2

Slide 3

WHAT DO WE MEAN BY "PLEASURE" …
in relation to sexual health and well-being?

"SEXUAL pleasure is the physical and / or psychological satisfaction and enjoyment one derives from any erotic interaction. This broad definition of pleasure attempts to capture the variability of individual experiences [...] It also attempts to avoid prescriptive and generalised ideas that normalise certain forms of pleasure but marginalise others.

Philpott *et al.* 2006: 23

Slide 4
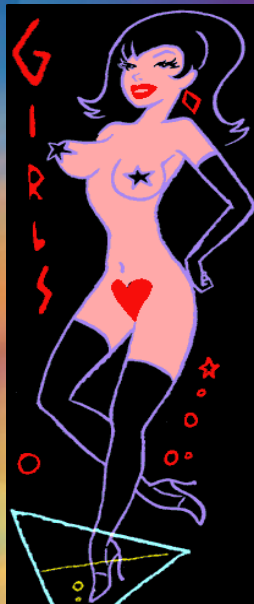
WHY, AND IN WHICH WAYS …
are the "pleasures", related to sexual health and well-being, even considered "naughty"?

Slide 5

MEDIA IMAGES OF PLEASURE PRIVILEGE SOME AND DISADVANTAGE OTHERS

⦿ "Pleasure [is] conceptualized as a lesser good, a sin, a sickness, and a perversion." (p. 286)

⦿ "The absence of quality sexuality education combined with learning about sex primarily from having genital intercourse, led to sexuality embodied in the genitals and cognitively focused on perfect performance with the goal of orgasm." (p. 288)

⦿ Too much sexual education is "genitally focused and performance orientated" (p. 288).

Tepper, M. S. (2000). "Sexuality and disability: the missing discourse of pleasure." Sexuality and Disability 18(4): 283-290.

Slide 6

MEDIA IMAGES OF PLEASURE PRIVILEGE SOME AND DISADVANTAGE OTHERS

'I bedded 200 women and I never worried about safe sex'

THE SUN 10 March 1993
PAGE 7 FELLA KEVIN DIES OF AIDS AT 31

LOVERS . . . Kevin and Susie

HUNK . . . Kevin was three times Page Seven Fella Of The Year

LOVERS . . . Kev and Page Three Sarah

"**Kevin lived life to the full.** Women went wild for him."
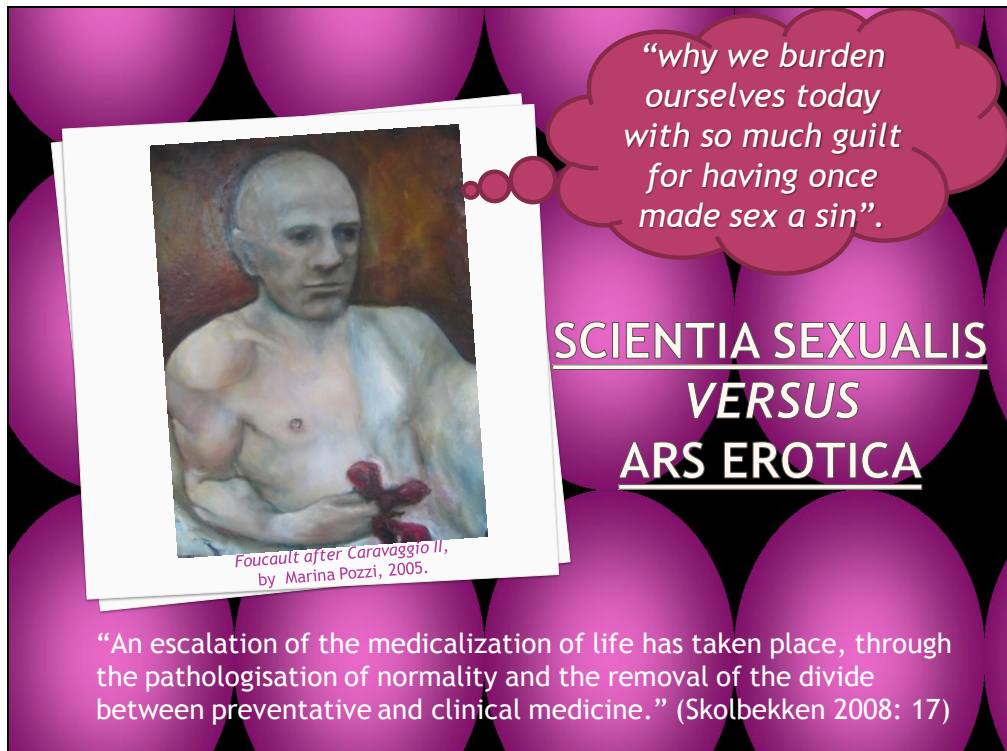
He said, "I cut myself on her G-string during foreplay. That may have been the night I caught it. But at the time I didn't worry."

Begging
"Girls just seemed to go for me."

"He believed he caught the infection when he had sex with a German model in 1986 ...

Slide 7

WHY, DO _YOU_ THINK ...

pleasure discourses
don't have a role
in sexual health promotion strategies
equal to scientific disciplines
such as epidemiology
& risk reduction theories,
pathophysiology and other ways of
the medicalisation of matters sexual?

Slide 8

"why we burden ourselves today with so much guilt for having once made sex a sin".

SCIENTIA SEXUALIS
VERSUS
ARS EROTICA

Foucault after Caravaggio II, by Marina Pozzi, 2005.

"An escalation of the medicalization of life has taken place, through the pathologisation of normality and the removal of the divide between preventative and clinical medicine." (Skolbekken 2008: 17)

Slide 9

Slide 10
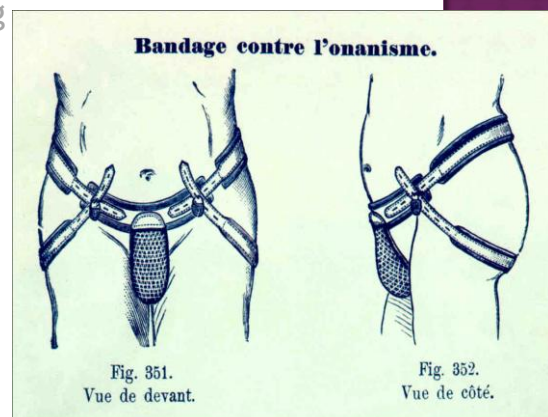
Slide 11

Slide 12

Slide 13

'POLICING DESIRE' / CONTROLLING SEX

Mills (2003: 93) describes the construction of the *scientia sexualis* as "a disciplinary regime [in which] one's comportment is overseen and subjected to a series of rules and regulations relating to control of appetite, movement and emotions".

According to Foucault, such a position is frequently associated with "biological reduction and medical authority" (Tiefer 2006: 273).

BUT ...

Robinson *et al.* (2002; 44) urge for "a more explicit focus on [...] desire, functioning and pleasure."

SHE MAY LOOK CLEAN - BUT

PICK-UPS
"GOOD TIME" GIRLS
PROSTITUTES
SPREAD SYPHILIS AND GONORRHEA
You can't beat the Axis if you get VD

Slide 14

ANTI-PLEASURE STIGMA (AND EROTOPHOBIA)

FOUCAULT'S "TRIPLE EDICT" ...

- Taboo
- Non-existence
- Silence

ME I'M A WANKER

EX-Masturbator

"There is no other sexual behaviour so thoroughly discussed, more roundly condemned, yet more universally practiced than masturbation."

Patton (1985) cited in
Kontula and Haavio-Mannila (2002: 50)

Slide 15

Slide 16

Slide 17

Slide 18

Slide 19

Dimitropoulou, Lophatananon *et al.* (2008)
case-control study

431 cancer cases / 409 controls

"[.] in agreement with the studies of Leitzmann *et al.* (2004) and Giles *et al.* (2003) [.]"

◉ "Our findings suggest that the risk of prostate cancer diagnosed at ≤ 60 years is associated with high SA in earlier life (20s) and low activity in later life (50s), in agreement with the studies of Leitzmann *et al.* (2004) and Giles *et al.* (2003). Intercourse was not associated with prostate cancer in the present study." p. 184

◉ "Alone, frequent masturbation activity was a marker for increased risk in the 20s and 30s but appeared to be associated with a decreased risk in the 50s, while intercourse activity alone was not associated with disease."

◉ "whereas frequent overall sexual activity in younger life (20s) increased the disease risk, it appeared to be protective against the disease when older (50s).

◉ **"Only age, family history of prostate cancer and ethnicity have so far been established as risk factors for the disease."**

▪ p. 178

www.3Dflags.com

Slide 20

"PROMOTING MASTURBATION
as a means of a public health strategy
for sexual health
is highly controversial;
however, there are arguments
and evidence that suggest that
this may be an important part
of any public health approach
to improving sexual health".

Coleman 2002: 5

Slide 21

BUT BE WARNED!

"For many, the forbidden
becomes the desired;
taboo produces cravings;
the return of the repressed
is made corporeal
and can be witnessed
as an enormous hunger."

Rofes 2002: 127

Slide 22

GOOD THERAPEUTIC COMMUNICATION

" […] humour,
reassurance,
compassion, and the
development of trust
are important elements of
communication strategies
employed in
prostate cancer
consultations".

Kelly (2009: 152)

Slide 23

OVER TO YOU ...

- An exploration of how to promote the power of "pleasure" related to sexual health and well-being.
  - Identify some appropriate / beneficial pleasures for your target audience
  - Perform a "force field analysis" with the aim of promoting such pleasures

Slide 24
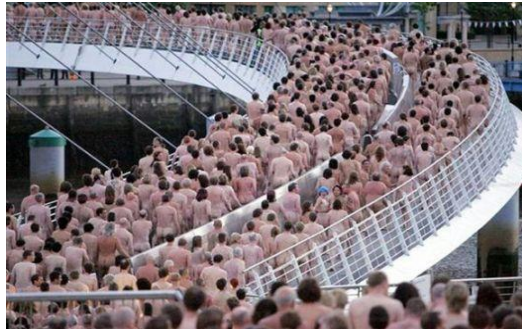
HOW TO PROMOTE PLEASURE ...
A Force Field Analysis
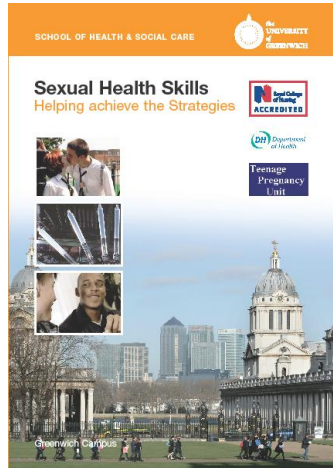
Restraining Forces

To promote the benefits of "pleasure" for sexual health & well-being

Facilitating Forces

Slide 25