

“Conversations Surrounding “Consent”: Are those working within sexual health services equipped to facilitate conversations around consent?”

by
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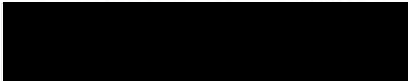
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Signed Declaration

I can confirm that:

- The work within this thesis has not been submitted for any other degree or professional qualification.
- This thesis is as a result of my own independent work.
- The thesis presented is one of individual contribution with supervisory support.

Signed:

A black rectangular box redacting the signature of Victoria Jones.

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Abstract

Sexual health is a concept in which the definition adapts to fit the current “socio-cultural, historical, and political climate” (Coleman, 2011:19). As we see our society becoming more concerned with the idea of consent within sexual relationships, we also see a shift in our sexual health definition. Movements such as the “#metoo” campaign highlight the way in which consent in sexual relationships is now being discussed in more public forums including health policy and practice.

Outcome 4 of the “Sexual Health and Blood Borne Virus” framework addresses the aim to make sexual relationships safe, respectful and free from coercion. This project will measure the progress of this outcome by conducting interviews with sexual health staff who are working closely with service users. As the outcomes set out in the SHBBV framework are to be achieved through the work of the NHS, third sector organisations working collaboratively, the interviews will take place across sectors. The research aim of this project is to evaluate these conversations and highlight if more support is required to facilitate discussions surrounding sexual consent.

In order to examine at how conversations are being facilitated, it is important to understand how sexual health providers and users understand the concept of sexual consent. Within this project, NHS and third sector organisations understood their roles within sexual health differently. Therefore affecting the way in which they discuss and deal with sexual consent within their role. In addition, service-users generally failed to understand the complexities of consent, thus hindering sexual health professionals ability to have these conversations. This project advances a case that consent is a complex subject, and in order for beneficial conversations to be had around consent, providers and service-users alike must understand consent in its entirety.

Additional Information

Tables

Table 1:	Participant Biographies
Table 2:	Themes

Abbreviations

LGBT:	Lesbian, Gay, Bisexual, Transgender
MSM:	Men who have Sex with Men
PrEP:	Pre-Exposure Prophylaxis
SHBBV:	Sexual Health and Blood Borne Virus
STI:	Sexually Transmitted Infection
WHO:	World Health Organisation

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1.0 Introduction

1.1 Background

Consent in sexual relationships has emerged as an important and timely topic in cultural discourse despite historically being difficult and uncomfortable to discuss. It could be argued that this is because the wordings that were used and the explanations available were confusing and unclear. However, in recent times, particularly with the rise of social media, we are seeing this discussion transition into mainstream areas. Online social movements such as the “#metoo” campaign in 2017, highlight the way in which respect and consent in sexual relationships are now being discussed in more public forums. A key part of this conversation is that many victims did not understand that their consent had been breached. Going forward, it is important that the structures in society inform, help and support all in our communities to ensure that every sexual relationship has consent at the core of its nature. Sexual health is defined as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.” (WHO, 2006; Lorimer et al, 2018:27). Within this definition, there is acknowledgment of the fact sexual health should encompass more than just the physical aspects of sexual health which are traditionally discussed. Furthermore, this supports the idea that sexual health provision should be aiming to deal with all the sexual rights of an individual.

1.2 Sexual Health and Blood Borne Virus Framework

The Sexual Health and Blood Borne Virus Framework (SHBBV) was set out by the Scottish government as they chose to bring together their, previously separate, policies on sexual health and wellbeing, hepatitis C and HIV. As such, the SHBBV framework’s foundations are built upon the government’s sexual health strategy, “Respect and Responsibility”, and the “Hepatitis C Action Plan”. The 2011 framework was updated in 2015, and sets out the aims and objectives of the government to 2020. The outcomes set out in the framework are to be achieved through the work of the NHS, third sector organisations, and local authorities. As such, it is important to evaluate whether sexual health provision is working, or if more can be done to support the staff working to achieve these goals. The Scottish Government acknowledges the fact that the outcomes to be

solved through the implementation framework have active links to other concerns in our society such as alcohol and drugs misuse; gender based violence; and poverty.

The framework can be split into two different types of outcomes. Outcomes 1, 2 and 3 focus on the management of physical sexual health, aiming to decrease numbers of viruses, infections and unplanned pregnancy. These aspects of sexual health can be measured and monitored through statistics over a period of time. Outcomes 4 and 5 focus on management of emotional and social sexual health and as such prove more difficult to monitor. While outcome 4 sets out to make sexual relationships “free from coercion and harm” (SHBBV, 2011:5), outcome 5 aims to make the views of society non-stigmatising and supportive. The progress of outcomes 4 and 5 are more difficult to assess as they cannot be measured statistically. Therefore, when assessing and evaluating the progress of these outcomes it is important to engage with the sexual health staff employed to work closest with the service users. These workers are those most qualified to understand the purpose of the outcomes, and can draw upon their experience to monitor the progression of the aims.

Outcome 4 of the SHBBV framework addresses the aim to make interpersonal relationships safe, respectful and free from coercion. The framework states that “there are particular issues with... the perception of ‘normal’ healthy relationships amongst peers, but challenges also remain around coercion and harm in other relationships” (SHBBV, 2015:5). Consent is a significant aspect of healthy sexual relationships (Humphreys & Brousseau, 2010) and as reflected in cultural change, it is a concept which individuals are becoming concerned with. In order to measure the progress of this outcome, it is important that sexual health services are concerned about the type of sex that service users are having.

1.3 Research Question

The SHBBV framework is set to renew in 2020 and before creating new areas of focus, it is important to establish the extent to which the current outcomes have been met. In order to measure the progress of outcome 4, it is beneficial to monitor the types of conversations which are being had about the sex that service

users are having. By asking providers about these types of conversations, it provided insight into the experiences and opinions of service-users who interact most with the services. This research set out to evaluate the extent to which discussions around consent took place during consultations and furthermore, how provider's reflect upon their own roles within these discussions. With the renewal of the SHBBV framework imminent, it is important to monitor how service-users are talking about the sex that they are having in relation to consent. If these conversations are not taking place, then it is important that the appropriate support is put in place to facilitate these types of conversation. As such, the core research question of this thesis is:

“Are those working within sexual health services equipped to facilitate conversations around sexual consent?”

1.4 Research Aims and Objectives

The first research objective of this study was to map initiatives in sexual health provision in Scotland, with a focus on the Lothian area. In order to understand the conversations which are being had around consent, it is important to understand the context of where these conversations were taking place. As such, it was beneficial to explore the range of services explored by the NHS, how they operate and for whom. In addition, it was important to look at the services provided by third sector organisations in the Lothian area. The SHBBV framework places importance on collaborative working between the NHS, third sector organisations and local authorities. As local authorities do not provide sexual health services, conversations around consent with service-users would not be present and as such were not focussed on in this research.

The second objective was to evaluate the extent to which conversations surrounding consent were taking place. This was important as it was an objective specifically linked to outcome 4 of the framework. In order to evaluate this outcome, sexual health professionals who work with service users were interviewed and were asked to reflect upon the services and conversations that they have with service users. Furthermore, it is important to understand the way in which consent is being discussed in the consultations and the context and

language associated with these discussions. After highlighting the way consent is discussed in service settings, another area of focus was what sexual health providers feel that should be done to further these conversations. An important part of this objective was to gain insight into the way that the service provider viewed their role within the discussions taking place. For example, whether the service provider felt this was part of their job, or that they had enough resources to successfully create this type of dialogue with the service users.

Subsequently, another objective of this study was to investigate any differences between the NHS and third sector organisations regarding their understandings of sexual consent and the way they facilitate conversations. As the framework encourages cross-sector collaboration, it was important to see the way that this approach affected conversations. Interviews were carried out across sectors to examine the way that conversations are being had and to highlight any disparities across the key definitions which are used within discussions around sexual health and consent.

The final objective of this research was to consider how discussions around sexual consent can be better facilitated across sexual health services in the future. The aim of health-care evaluations is to assess the operations going on within that service. However, it is critical to the evaluation process to highlight potential areas of growth (Shearn et al, 2016) and recommend ways that this growth can happen (Burtney, 2011). Relating this to the present study, it is important to understand the way that conversations around consent are taking place. Moreover, it is also necessary to recommend how these conversations could improve inside and outside of sexual health provision.

2.0 Literature Review

In this chapter I define the key concepts which are used throughout the thesis and how existing sexual health literature discuss these concepts. By firstly defining consent generally (2.1), I provide general context for the concept before applying the term to the context of sexual interaction. Secondly, I discuss sexual consent (2.2) and consider its complex nature and the narratives which frame discussions around this topic. Lastly, I explore the concept of sexual health (2.3) in order to provide a foundation for discussions surrounding the main elements and workings of sexual health services which will develop throughout this thesis. Towards the end of this chapter, I relate the extent to which sexual consent is focussed on within sexual health services, in order to develop these ideas with the findings of this current research (4.0).

2.1 Consent

2.1.1 Defining Consent

Consent is defined as the permission given by a party to allow certain actions to take place (Selinger, 2009). It is defined by Manson as “actions by which an agent knowingly expresses willingness to set aside certain rights” or to “offer something to another party” (2013:33). It is a concept which is used within various contexts including, but not limited to, research, medicine, information sharing and sexual encounters. There are various types of consent and different perspectives on the ways individuals can consent (Saunders, 2010). As such, explicit consent, implicit consent, and opt-out consent are discussed as the main ways in which consent manifests itself. Despite the different ways that consent exists, consent by nature (Herring & Wall, 2017) is agreeing to something by choice (O'Connor, 2017). Therefore, the freedom and capacity (Stone, 2013) of the individual to make that choice should also be considered when monitoring consent as a concept. It is argued that consent is a prop that “rational individuals” use to successfully carry out their agency in their actions (O'Connor, 2017). Furthermore, it is paramount that the individual has the capacity to process the information available, in order

to make an informed decision. If consent is not given; has been wrongly assumed; or has been “given” by someone who does not have the capacity to make informed decisions, then the action is deemed unconsensual.

2.1.2 Types of Consent

Explicit consent, often referred to as “expressed” or “direct” consent (Saunders, 2010), means that an individual’s wishes are clearly stated. Explicit consent is present when the individual is active in the way that they are providing their consent. For example, this type of consent could be displayed as an individual completes a permission slip or consent form (Saunders, 2010). This is considered the most desirable type of consent as clear permission has been given by the party or individual (Husak & Thomas, 1992). Furthermore, if it is provided in a hardcopy form it can be revisited to understand what was consented to if either party was unsure. Husak and Thomas (1992:112) argue that where possible the consent receiver should “insist on explicit indications of consent, thus helping to avoid misunderstanding and its painful consequences”.

“Implicit” consent, which is also referred to as “implied” or “non-direct” consent, has not been granted by an individual directly, but rather by the way that the person acts or behaves in a situation. This could in some cases be perceived through inaction or silence which have shown that the consenting party wishes to proceed or participate. In contrast to explicit consent, implicit consent is given in a more passive way. Saunders (2010:84) discusses this idea in the context of a competition whereby consenting to enter the competition you are assumed to be accepting of the rules. Consent in this instance is suggested but not confirmed (Husak & Thomas, 1992) by a party or individual.

Opt-out consent, or “presumed consent”, is when consent is assumed as there has not been any objections or withdrawals from the subject (Saunders, 2010). An example of this would be a company stating to a customer, “if you do not wish for your details to be passed on to third party sources, then please uncheck the box below”. Manson (2013) discusses the idea of consent via opt-out systems such as is seen with organ donation in certain nations. He critiques such systems by arguing that “presumed consent” (2013:32) is not consent at all as it is not

explicit in its nature. It should be noted that in all cases of consent, the individual should be fully informed about the decision that they are making, and free from any influence that could alter their decision.

2.1.3 Influences of Consent

Consent is discussed within Section 73 of the Sexual Offences Act 2003 as 'where a person agrees by choice and has the freedom and capacity to make that choice' (Munro, 2010: 52). As mentioned, it is important that the party or individual is able to provide consent whilst being fully aware of the facts and factors surrounding the decision they are making. In order to do this, the consent giver must have the "capacity" to make an informed decision and furthermore, there must be no impairment (Muehlenhard et al, 2016) or influence affecting their decision. The ability to make a "reasoned judgement" (Calveley, 2012: 559) is imperative when monitoring consent, and it must be established before exploring any additional influences which could alter any decisions made. Those who do have the capacity to make informed choices are considered to be "active" and "rationally-thinking" (Gill & Arthurs, 2006:445) beings. As decisions are made, it is assumed that rational human-beings will be responsible and accountable for their decisions. However, when external influences alter an individual's decision to consent this questions the "free" choice that individual had. If it is assumed that all instances of consent have been made through free judgement, then this can be problematic. Taking "presumed consent" as an example, whereby consent should be assumed until an individual refuses or resists (Burkett & Hamilton, 2012), can exemplify these issues. Presumed consent could be argued to be problematic as there are numerous reasons why someone who is not wishing to consent may not display resistance. These reasons could include confusion or fear produced by an external factors or an imbalance in power between the consent giver and receiver (O'Connor, 2017). If pressure is applied to a party or individual to consent, then this consent is coercive by nature and restricts the ability to carry out individual agency (Millum, 2014). Therefore, it is important to understand the external context surrounding consent as if making no response is viewed as consensual, "the coercive... could be seen as consensual." (Millum, 2014: 259).

“Freedom” in the context of making choices, refers to an individual acting in accordance with solely their own autonomy (Coggon & Miola, 2011:4). Therefore, freedom of choice refers to decisions which do not include any external or additional influence. The deeper consent is explored as a concept, the more apparent it becomes that context plays an integral part in consenting behaviour. The element of choice that individuals have in their actions could be limited in certain situations and this complicates the process of consent. Therefore, if coercive factors are limiting the free-will of the decision maker, then the decision maker is not carrying out true agency. It is important to understand the role that coercion plays in exchanges of consent. By looking at the potential presence of coercion, the power balance of the parties involved can be explored. Millum (2014) argues that when an individual is coerced into carrying out an action, the consent giver does not have control rendering “that consent invalid” (2014:115). Burkett & Hamilton (2012: 817) refer to the “just say no” discourse that is talked about surrounding sexual consent and the idea that if an individual does not wish to consent, then they are innate human beings who can simply make that decision. However, if external factors are influencing the decision of that individual then it may not be possible to simply “say no”, this introduces concerns when monitoring consent. If discourses around consent dictate that we can always ‘just say no’ and not be forced into making decisions, then any decision that an individual makes would be looked on as consensual. The “yes”/“no” discourses surrounding consent will be discussed throughout this piece of work, particularly in relation to sexual consent. As discussed throughout this section, the context of consent is particularly important when monitoring if consent has been given freely, and this is particularly evident in sexual encounters, where coercion and influence can lead to problematic outcomes and can be hard to interpret.

2.2 Sexual Consent

2.2.1 Defining Sexual Consent

The concept of consent is used in many different contexts and situations with, in recent times, an increased focus being placed on consent in sexual settings. A leading definition used widely states “Sexual consent is defined as the freely given verbal or nonverbal communication of a feeling of willingness to engage in sexual activity” (Humphreys & Brousseau, 2010:1). It is a concept studied within the field of sexual communication and sexual coercion (Humphreys & Brousseau, 2010) regarding how rational human-beings communicate their expectations and wishes in a sexual exchange (Hickman & Muehlenhard, 1999). Sexual consent is important as it signifies the permission given by each party for sexual interaction to go ahead (Humphreys & Herold, 2007). As with all instances of consent, sexual consent requires knowledge and clear understanding of the context and potential outcomes of making the decision to consent (2007:306). Sexual consent is only legitimate if given freely by an individual who understands the nature of the situation (Lim and Roloff, 1999). Therefore, consent provided when being influenced by substances or external factors is not considered to be consent which has been given freely.

2.2.2 Representations of Sexual Consent

As previously discussed, “explicit” consent is the most direct way to consent and represents clearly what is intended within the interaction (Humphreys & Brousseau, 2010). “implicit” consent may leave the consent seeker unable to identify if consent has been given (Husack & Thomas, 1992). Within sexual interaction both “direct” and “non-direct” consent is navigated through social signals. Hickman and Muehlenhard (1999) reconfigure the idea of verbal and non-verbal signals into direct and non-direct behaviours which display an individual’s wish to engage in sexual activity. Labels referring to “direct” signals are those which are clear and straightforward, such as verbally stating your consent, and do not result in ambiguity and confusion. However, signals which are ambiguous and questionable, such as physical movement and action, are referred to as “indirect”. It is significant then that methods of “indirect” consent

are more prevalent in the sexual interactions taking place, despite the confusion which occurs from them (Humphreys, 2004). In theory, sexual consent can be sought by asking simply “would you like to...?”, however, this does not follow the normative sexual script of most adults (Humphreys, 2004). Displays of consent are more likely to rely on a more non-verbal method of consent such as kissing. Moore and Butler (1989) state that there are at least fifty-two documented non-verbal motions of consent such as “glancing, primping, smiling, laughing, nodding, kissing, touching, and caressing” (1989:115) in sexual interaction. Non-verbal consent creates a space for ambiguity, as when a frank discussion is not had surrounding both partners’ wishes to consent, misinterpretation could occur. If two people perform the same action, they could have different feelings about what that action represents in regards to consent (Hickman & Muehlenhard, 1999). Furthermore, non-direct signals could lead to sexual exchanges taking place when one party might not have necessarily been comfortable with that activity.

Hickman and Muehlenhard (1999) concluded that different individuals may interpret and read signals differently. Individuals understand things differently in accordance with age, culture and experience, and this could lead to further ambiguity when reading the “non-direct” signals used. Taking the example of differences between the genders, Hickman and Muehlenhard (1999) refer specifically to the gendered differences between individuals when reading signals within sexual interaction. Given the “overwhelming evidence that gender affects perceptions of sexual intent, it is likely that gender also affects perceptions of gender consent” (Muehlenhard et al, 1992: p260). This is problematic as it may mean that whilst a male and female partner display the same sexual signals, they are not meaning the same thing. It is argued that women are more concerned with sexual consent than men, and as such have been the decider on whether that sexual exchange shall proceed. Hickman et al (1999) examine several studies that conclude that men overall view persons and interactions more sexually than women. This then relates to the roles that each gender traditionally play in sexual scripts and perceptions of consent. They highlighted that the normative heterosexual script would be men initiating or pursuing the sexual encounter, with women acting as the gatekeeper for such encounters happening. Missing from this heteronormative social script is the direct or verbal signalling of

consent taking place. Conversations surrounding consent have traditionally had a continued focus on heterosexual interaction. It could be argued that the heteronormative narrative of this discussion is present, as discussions around consent have evolved through the appearance of gender-based violence and overwhelming rates of male perpetrators.

Whilst consent within heterosexual relationships should be discussed due to the prevalence of male offenders (Humphreys & Herold, 2007), it is important to also examine the use of consent within LGBT exchanges (Beres, 2004). By looking at sexual consent with heteronormative lens, then it is not examining the experiences of males as victims of sexual violence (Messinger, 2011; Humphreys & Herold, 2007; Hirst, 2004). With sexual assault experiences of LGBT people being higher than that of heterosexual people (Harris, 2018:155), it is clear that sexual consent must be examined throughout these contexts. Beres et al (2004) introduced ideas about sexual consent within same-sex exchanges and explored how the dynamics differ to that of heterosexual encounters. Furthermore, exploring same-sex exchanges is necessary to understanding sexual consent. Hequembourg et al (2015) suggest that the work conducted by Beres (2004) provides a close examination of further complex dating scripts and that this examination is necessary to “understand experiences of sexual victimization in this population” (2015:292). By exploring the concept and mechanisms of consent in same-sex interaction, it would be possible to also develop effective interventions to reduce risks amongst vulnerable populations, such as those who are LGBT and have more complex identities (Hequembourg et al, 2015).

Sexual consent is often discussed within the field of social communication (Humphreys & Herold, 2007:306). Sexual Script Theory (Simon & Gagnon, 1986) highlights that there are frameworks learned through socialisation which dictate how people are supposed to act within sexual interactions. Such sexual scripting occurs on different “cultural, interpersonal and intrapsychic” (Humphreys & Herold, 2007:306) levels. These scripts are often used interchangeably to suit the expectations of others. Consent could be argued to change within different cultural contexts. An example of such cultural script could be individuals concealing their interest in sexual relationships as they are apprehensive of being perceived as promiscuous (Muehlenhard & Hollabaugh, 1988), complicating the

consent given by individuals as they may display a different level of consent in public and in private (Lindau et al, 2007). Cultural factors such as this critique the argument that it is simple to say “yes” or “no”, and that this utterance will be accepted as such. The complexity of consent is further reiterated by McGregor (1996) who emphasises the idea that there is something unique about consent in the sexual arena. For example, if a perpetrator took a victim’s money and the money was given out of fear that the victim would be (further) harmed, the giving of money would not be viewed as consensual. However, if a perpetrator made sexual advances towards their victim and the victim partook in sexual activity out of fear of further harm it is viewed more complexly. Gravelin et al (2018:1) support this idea by stating “victims of sexual crimes are uniquely vulnerable for being blamed for their assault” in comparison to victims of other interpersonal crimes.

2.2.3 Discussions around Sexual Consent

Historically sexual consent was a concept used within legal terminology, and was focussed on within the remit of the law. It continues to be used to examine whether sexual instances were consensual (Leahy, 2014). McGregor (1996:177) discusses the “rules of consent” as discussed within the context of the law and the courtroom. Traditionally, there has been a lack of exploration as to what consent is, instead focussing on what it is not. Rape is defined as sex without consent (McGregor, 1996) and is an important concept when defining rape in research and legal contexts (Hickman & Muehlenhard, 1999). McGregor (1996) highlights how historically rape laws have used the word “forced” sexual contact to define rape, stating that “force is defined in terms of the victim's resistance: If she did not resist there was no force—and, therefore, no rape” (p180). This definition does not acknowledge those who comply out of fear or lack of choice (Burkett & Hamilton, 2012) when physical force was not present, and can have severe consequences for the victim in a court of law. McGregor (1996:178) states that, “resistance is interpreted to be physical resistance” and can be examined as such with evidence able to be found, provided and a conviction sought. Unless there is seen to be resistance from the victim, it would not withstand as “non-consensual behaviour” both inside and outside of courtrooms. This resistance must be physical, as by definition physical force only is deemed to satisfy the requirements of rape. However, physical resistance is not the only marker of an

instance of non-consensual sex and it is problematic for it to be the only way to measure this in the courtroom. Instances of non-consensual sex occur without force in instances of fear, where verbal protests make an individual's lack of consent clear (Burkett & Hamilton, 2012). In a courtroom, these instances have lower levels of conviction, if they indeed make it to court. Instances of verbal protests have traditionally implied that the victim is lying and have been critiqued by feminist thinkers that it is putting the victim on trial rather than the perpetrator. Furthermore, it frames a narrative around instances of non-consensual sex that the emotional strain of the encounter is not as important or justified as any physical pain. In the context provided here, the complex nature of consent and the many ways it can be rendered invalid are not discussed and as such, fields of sociology and communication have begun to reconsider the concept and explore its complexities.

As sexual consent has become a focus within the fields of sociology and communication, the complexities of the concept have begun to be explored. In addition, aspects of sexual consent have been uncovered that were out with the "yes"/"no" discourse which formed the main perspective promoted by the legal field. The definitions and discussions surrounding consent, in the context of the law, are framed around simplistic "yes"/"no" narratives which look at consent as a decision in which an individual can agree or disagree to. Harris (2018:158) discusses the two traditional mantras stating that "yes means yes and no means no" whilst also critiquing this discourse for not looking at the complexities or external factors which affect sexual decisions. As the concept of sexual consent has evolved to become a concern within sexual interaction and communication, it becomes clear that there are many aspects, related to consent in sexual relationships, which were not being examined. Viewing consent as a straightforward question, while applicable in some sexual interactions, does not account for the negotiation which takes place within sexual interaction. Negotiations of sex take place often in order to provide clear consent about what an individual is willing and able to do. This is out with that of the simplistic "yes/no" discourse which applies consent to instances of penetrative sex (Buchhandler-Raphael, 2011), and ignores other forms of sexual activity.

2.2.4 Complexities of Consent

Sexual consent is said to have two dimensions (Walsh et al, 2019), internal want and external expression. Whilst external expression has been discussed previously in this section, the idea of internal want has not. This mimics discussions around sexual consent as a whole, where focus is often placed on how consent is displayed rather than the relationship between expression and internal desires. “Internal want” (Walsh et al, 2019:802) refers to the “mental act of wanting or being willing to have sex” and with this provides an internal marker for how an individual feels when entering into sexual interaction. The relationship between internal want and external expression adds to the complex nature of consent (Willis et al, 2019), as there are factors which could lead to consent being expressed differently how an individual is feeling internally (Peterson & Muehlenhard, 2007). Sexual autonomy and the way that wishes in sexual interaction are communicated are affected by the psychological and emotional wellbeing of the consent giver. Hensel et al (2015:11) support this idea by finding that those with higher levels of self-esteem are more likely to negotiate within a sexual exchange or refuse unwanted sex. It could be argued that this ability and willingness to communicate is directly related to the confidence that an individual has within themselves that they have a right to body autonomy and integrity. In contrast then it could be seen that those who do not have the confidence to convey their wishes could act passively in a sexual encounter and lead to them partaking in interactions which are not based on their desires. This supports the idea that sexual consent is complex, and it is not as simplistic as “just saying no”. Furthermore, if individuals require a level of emotional wellbeing in order to confidently communicate their wishes, then it highlights that there are other dynamics within sexual consent that must be considered.

2.2.4.1 Grey Areas of Consent

Whilst it is understood that sex without consent is wrong (MacNeela et al, 2014), grey areas of consent still appear in the interactions taking place in sexual relationships in instances that include influence and coercion. The influence of substances, such as alcohol and drugs, is seen to have a role in “impairing the ability to read and give consent” (MacNeela et al, 2014:64). Intoxication and

inebriation have been noted to produce higher risk sexual behaviour and can lead to implications such as memory loss and regret (Jozkowski & Wiersma, 2015). If regret is present after an instance of sexual interaction has taken place this brings into question the wishes of the consent giver at the time of the interaction and whether or not they were capable to make informed decisions about the sex that they were having. Humphreys & Herold (2007) discuss sexual consent has being a decision taken where an individual is fully aware of the situation which is occurring. Therefore, if alcohol or drugs affect the clarity of a situation for the individual, then the consent given has been rendered questionable. This further exemplifies the complexities of consent and questions the simple “yes”/“no” narrative that is present in discussions surrounding consent.

In addition to influences such as alcohol and drugs, there are factors external to that of the sexual encounter itself which affect an individual’s ability to consent. Coercion is the term used within discussions of consent which described the process of forcing or manipulating an individual to comply with the demands of the consent seeker. Conroy et al (2014:1829) discuss coercion as three different types: “physical”, “threatened physical”, and “interpersonal” coercion. Whilst “physical” and “threatened physical” are understood as the use or threat of physical force into sexual compliance, “interpersonal” coercion is a more complex concept. Interpersonal or social coercion refers to the manipulation or control of one’s feelings into acting a certain way in a sexual exchange. The complexity of this concept is grounded in the fact that the consent giver may not even understand that they have been manipulated as social coercion can be covert (Conroy et al, 2014:1829). Furthermore, interpersonal coercion could be present in instances of direct consent, where the consent appears clear but is questionable, thus reinforcing the complex dichotomy of the grey area. Forms of covert coercion could include; pressure to meet relationship obligations or fulfilling certain societal pressures. If one party is not giving consent in conjunction with their sexual wishes, or desires, then this brings into question, again, the consent that has been provided. This is another example of the complexities of consent, as the intersecting power dynamics go beyond the sexual arena.

Feminist discourses have traditionally been concerned with the power dynamics between the sexes (MacKinnon, 1989) and how these are reflected within

relationships (Brownmiller, 1975). Traditionally, feminist analysis on consent mapped out a narrative which was focussed on sexual violence and rape. Although these narratives were first developed in the 1970s, they remain vigorous today (Karlsson, 2019:212). Feminist thinkers such as MacKinnon (1989) have focussed on societal structures and the way that these structures reinforce the patriarchy and facilitate the sexual abuse of women. MacKinnon states that the sexuality of a woman is something which will never be owned by a woman (1989:72) and that rape is inevitable in the female experience, as consent is impossible within the patriarchal conditions in which we live. While some radical feminists believe that consent is not possible, others have suggested that sexual encounters can be either consensual or rape (Brownmiller, 1975). However, by framing rape as solely a female struggle, the focus is primarily on heterosexual partners and does not account for any assault which takes place in same-sex couples. These feminist discourses are useful when framing rape narrative as they reinforce the need to consider the steps and signals required to learn and recognise a sexual encounter (Malinen, 2012). However, as the complexities of consent are uncovered it is clear that sexual encounters cannot always be viewed in the binary terms of consensual or rape.

In more recent times feminist perspectives suggest that there is a grey area between consent and assault which needs to be examined. Gavey (2005) examines the traditional discourses of rape and introduces a new set of questions as to how consent manifests itself within sexual interaction. The final chapters of her book (2005) form a discussion regarding the area between consensual sex and rape and argues that there are some grey areas of sexual interaction which are “ethically questionable without rising to the category of rape” (Cahill, 2006:1). Within this chapter, one interviewee is particularly clear in highlighting the grey area, saying “he, he didn’t rape me because I really more or less consented” (2005:159) despite stating that she didn’t wish to go to bed with him as he was “pushing” her around. The interviewee directly communicated her “wish” to have sex despite not actually wanting to and this was analysed by Gavey to be a case where the victim provided direct consent in order to “remain” in control. The interviewee chose to comply with the sexual encounter in order to avoid the experience of rape. The consent, though seemingly directly and clearly expressed, is questionable in this context and emphasises the need to examine

this area further. Relating this example to sexual assault in legal terms, this case would not stand up in a court (McGregor, 1996) as it appears the interviewee gave permission for the act to take place. Gavey (2005) states that this example highlights that feminist analysis must shift to incorporate consent and its complexities into their focus, in addition to traditional concerns of rape and sexual violence. Karlsson (2019) supports this notion as she draws attention to the differences between traditional feminist discourse and the modern lived experience. Karlsson (2019:210) discusses the different feminist perspectives on instances of non-consensual sex in order to examine the way sexual interaction exists. She refers to the grey area as being the area which a sexual encounter “resides” in when it is somewhere between consensual and coerced. By, again, acknowledging the grey area of sexual interaction, she states that we must work towards a language which frames the ambiguity within the grey area. In addition, by acknowledging the grey area of consent, it allows further analysis on the many instances of sexual interaction where consent is questionable.

The “grey area” of sexual interaction refers to a space of ambiguity between a consensual sexual encounter and a sexual assault (Karlsson, 2019), where instances of sexual consent are questionable. As discussed previously, the “yes”/“no” mantra (Burkett & Hamilton, 2012) surrounding sexual consent refers to the narrative that an individual has the ability to, or to not, give consent by stating “yes” or “no”. The grey area of sexual consent challenges this narrative by introducing ideas that it is still possible for ambiguity even when an individual consents in a seemingly explicit and direct way.

2.2.4.2 Consent is Constant

Consent must be sought in every interaction (Kelly, 2015) and it can never be implied or assumed within relationships. As discussed throughout this chapter, the context of consent is ever-changing and ever-dependant. Therefore, it is important to reflect on context when seeking consent in a sexual encounter. Shotland & Goodstein (1992) suggest that there is a belief within individuals that if sexual contact has occurred in the past, then it can be assumed that it will take place in the future. However, it is important when seeking consent, each sexual encounter must be treated as an isolated interaction. It is important that

we look at the relationship between body autonomy and the right to withdraw any consent given at any time. Lyon (2004:277) sets out in the case of *People vs John Z* that “[A] withdrawal of consent effectively nullifies any earlier consent and subjects the male to forcible rape charges if he persists in what has become non-consensual intercourse.”. Lyon explains here that any withdrawal of consent renders the initial consent invalid, and as such is considered assault from then on. As traditional feminist narratives around consent disclose that an individual either agrees or disagrees to sexual activity (Cahill, 2006), they do not account for any revoking of consent after the interaction has begun. As discussed previously, the change in feminist perspective is evolving to view interaction out with two binary points of consensual or assault (Gavey, 2005). Karlsson (2019) discusses areas of ambiguity within sexual interaction in which consent is questionable and examines the discomfort felt in situations which often started out as consensual (2019:221). As individuals revoke their consent in situations, it is important that clear boundaries are communicated and respected in order for the ambiguity of consent to diminish (Karlsson, 2019). However, in order for this to be communicated effectively, individuals must have the confidence to use their agency to communicate their wishes. The ability to confidently communicate sexual wishes is one aspect, of many, which is a marker of a state of good sexual health (Karlsson, 2019).

2.3 Sexual Health

2.3.1 Defining Sexual Health

Sexual health encompasses many aspects which “contribute to an individual’s sexual well-being throughout their lifetime” (Hensel et al, 2016:3). Sexual health is the field of medical practice which refers to the health of an individual relating to the sexual lifestyle and reproductive care. It is described by Russell (2010:81) as being concerned with “freedom from sexually transmissible infections (STI), unplanned pregnancy, coercion, and physical or psychological discomfort associated with sexuality”. When good sexual health is present, through a good standard of the previously listed aspects, safe and enjoyable sexual can be had (Mace et al, 1974). Furthermore, the World Health Organisation (1975) have identified sexual health as being fundamental to enriching a person’s sexuality and enhancing their “personality, communication, and love” for themselves and their partners. The World Health Organisation (2002:4) defines sexual health as “the integration of the somatic, emotional... and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love”. These aspects of sexual health can be defined as the physical, emotional and social elements of sexual health (Hensel et al, 2016;WHO, 2002), and are the different areas which will be focussed on when discussing the concept. While these areas are interconnected, they require clear understanding of the remit within them, and where further exploration is needed. In order to create a clear understanding about what sexual health is, and the way that it is focussed on, then we must understand each of these elements of sexual health.

2.3.2 Elements of Sexual Health

Physical:

Within the field of sexual health, there is a significant focus on physical sexual health issues as the implications of physical conditions are visible and treatable amongst patients (Jones & Barton, 2004). This includes focussing on “disease, dysfunction or infirmity” relating to the sexual health of an individual (WHO,

2002:5). Physical sexual health discussions and services focus on sexually transmitted infections (STIs), HIV, contraception, psychosexual medicine, abortion services, and sexual & reproductive health (RCN, 2019). The World Health Organisation (2002) acknowledges the importance of focussing on aspects of physical health as to keep individuals healthy, but also to prevent any mental or emotional implications. However, the physical narrative of sexual health has led to the knowledge of individuals being focussed on the same aspects. Moore and Smith (2010) conducted a study looking at sexual health knowledge in college students where students were consulted as to what they knew about sexual health. They then had to participate in a sexual health intervention and at the end of which, they were asked if they had learned anything new. 90% of students indicated that they had learned “about the different types of STIs, the symptoms of STIs and the fact that often there are no visible symptoms of infection, the high prevalence of STIs among young adults, how to correctly put on a condom, and the availability of treatment and testing for STIs.” (2010:448). The sexual health interventions were centred around physical elements of sexual health such as STIs and pregnancy. Therefore, the participants were not consulted on what they knew about emotional sides of sexual health such as consent and coercion. This is problematic, as it is reflected in discussions around sexual health, as not being considered as a part of sexual health definitions. This claim is supported by Pound et al (2017) who investigated the best way to practice sex and relationship education. It was found that there was more focus on the physical aspects of sexual encounters than that of emotional interaction. The young people who participated in this sex education stated that they felt that physical sides of sexual health were discussed more. They felt this was because educators could discuss the physical implications of sex without discussing the awkward elements of sexual encounters.

Emotional:

With a focus on the physical side of sexual health, the emotional side of sexual health is often neglected. Emotional sexual health is concerned with the emotional and mental wellbeing of an individual (Russell, 2010). Coleman (2011:19) supports the notion that sexual health is a construct in which the definition adapts to fit the “socio-cultural, historical, and political climate” of that

time. Sexual health has historically been defined as the absence of disease (Russell, 2010; Coleman, 2011) but as the concept of sexual health becomes broader, it is now understood that “sexual health should include feeling safe and respected in sexual relationships” (WHO, 2017:3). An important component of this is consent and freedom from coercion in sexual exchanges. This is an element of the discussions which has not been at the forefront until recently so there are gaps in the literature surrounding sexual consent. However, as sexual health becomes more concerned with the emotional aspects of sexual health, our sexual health definitions begin to shift. As Pound et al (2017) did not focus strongly on the emotional and mental side of sexual health, this could be explained by the fact more than half of the young people interviewed stated that they wished for more information about STIs and contraception. However, it could be argued that this was due to the fact the participants were not aware that there is emotional and mental elements to sexual health. Moreover, this signifies that it is important that emotional within sexual health is included in discussions.

Social:

Social aspects of sexual health refer to lifestyle choices and circumstance which could potentially affect the sexual health of an individual (Roberts et al, 2005; Dew et al, 2016). Although social factors may not directly affect the sexual health issue that an individual is dealing with, the social context of the issue could have contributed. Burtney and Duffy (2004:99) provides an example to display the way that social factors can affect the sexual health of an individual, by looking at the care system. Research indicates that that young people who have been “looked after” by the state (2004:99) are 2.5 times more likely to become teenage parents than those brought up by two natural parents. The lack of information provided to these young people about sex is one reason that these young pregnancies are happening, however, there are many additional reasons which apply to these individuals which may make them opt for this route. Pressures to engage in sexual activity from partners or peer groups has been noted across young people generally, but when looking at these pressures within groups of young people who have been “looked after” the pressures are intensified. The fear of being excluded is intensified within individuals who have experienced rejection previously, and as such engage in interaction that they do not internally consent

with. Although being in care did not directly affect the pregnancies that may occur, the context is seen to have implications on the sexual health of the individuals. Any attempt to understand an individual's sexual health must incorporate all aspects of physical and emotional conditions. Furthermore, the social side of sexual health must be looked at in order to provide a broader context for the sexual health issues experienced (Secor-Turner et al, 2011). Only when all three elements have been consulted will the "attitudes, expectations and behaviours" of individuals' sexual health be understood.

2.3.3 Focus within Sexual Health

Age:

There is a significant focus on the sexual health of young people in our society (Shearn et al, 2016). It could be argued that this is because there are discourses surrounding young people that suggest that they are less educated, less experienced and more likely to take risks in their sexual encounters (Fullerton & Burtney, 2010, Bailey et al, 2015). One reason for this is that younger people tend to have more sexual partners and as such put themselves in varying sexual contexts more frequently than any other age group (Bailey et al, 2015). Evidence of this is research which shows that young people use condoms inconsistently in their sexual encounters, when levels of knowledge is low (Gullette & Lyons, 2006). These low rates of usage are said to stem from the limited knowledge regarding how to use such protection, but furthermore the lack of confidence which stems from not possessing the knowledge (Moore & Smith, 2012, p.436). Furthermore, young people, particularly females aged under 25, remain the group most at risk of being diagnosed with an STI (Health Protection Scotland, 2019) in Scotland. While this suggests the poor physical sexual health of young people in our society, the emotional sexual health of this group is not examined. This exemplifies the fact that physical elements of sexual health are focussed on more. By neglecting both the emotional and social side of sexual health, important elements of sexual health are being ignored.

Lusti-Narasimhan and Beard (2013) suggest that the sexual health of the older members of society is often overlooked in sexual health discussions in

comparison to that of younger people. The Public Health England report (2016) highlights that STI diagnoses in people aged between 50 and 70 have risen by a third. Although rates of STI diagnoses are not as high as within younger groups, it is nevertheless on the rise and should be focussed on as to prevent and limit sexual health implications. It could be argued that as divorce rates are going up, many of the “baby-boomer” generation are re-entering single life and do not possess the knowledge of how to implement safe sex. Reflecting back on the reasons why young people do not consistently use condoms, it was found that this was due to poor knowledge on how to use them (Gullette & Lyons, 2006). Those re-entering the dating scene from older generations could find themselves having the same limited knowledge on these processes. Lusti-Narasimhan and Beard (2013) support this argument stating that as people are re-start dating, they are having to re-learn dating protocol, and accepted scripts (Simon & Gagnon, 1986), which may be significantly different to decades previously (Watson & Steele, 2011). This would then suggest that there is no disparity between young people who lack knowledge on condom use, and older adults who similarly lack this knowledge. It is then wrong to favour the sexual health of young people.

If there is a lack of clarity on how to manage new sexual exchanges, then it could be argued that adults are susceptible to emotional sexual health issues concerning consent. Watson & Stelle (2011) also discuss older women who are returning to dating. Their work highlights the gendered positioning within sexual relationships, which default to traditional relationships with regards to household jobs and monetary possession. Their participants grew up with sex only having a place inside of the marriage and as such, have difficulty thinking and learning about sex as they returned to the dating scene. Therefore, participants faced certain fears as they began dating again. The fears stemmed from the idea of being “taken advantage of emotionally, financially and/or sexually” (2011:6). Participants feared that within relationships that they would be pressured to have sex, and they had heard “horror stories” (2011:6) from friends who had encountered this. Therefore, highlighting that older women may be unsure of how to represent and display their sexual wishes and this could be problematic in ensuring that they are having safe consensual sex. This is challenging, as it is also known that older generations of women are more likely to be victims of

violence, including that of a sexual nature (WHO, 2017), due to their socio-economic dependency (Watson & Steele, 2011). Lusti-Narasimhan & Beard (2013) discuss the fact that across the lifetime, our sexual identities change in nature and in form. To facilitate this change, it is vital going forward that a focus on emotional and social sexual health for older adults is provided (Lindau, 2007).

Sexuality:

As discussed throughout this section, discussions surrounding consent focus primarily on physical forms of sexual health. These discussions are framed and focussed primarily around young people and other high risk groups. Men who have sex with men (MSM) are another group who account for the majority of new STI diagnosis (Long et al, 2016:365) and as a result are another focus when discussing physical aspects of sexual health. MSM are a high risk group when looking at HIV and STI rates globally (Barber et al, 2011; Coleman, 2011; Public Health England, 2016) and discussions around this aspect of sexual health have framed that. However, discussions around emotional aspects of sexual health do not focus on MSM and LGBT groups when there is evidence to suggest that they could be vulnerable (Harris, 2018:155). As mentioned, discussions around non-consensual sex are often framed in a heteronormative way (Hequembourg et al, 2015; MacKinnon, 1989), with males often being framed as the consent seeker and females being the consent giver (Lyon, 2004:302). If an instance of non-consensual sex or sexual violence was to take place, these narratives cannot be transferred to LGBT interactions in the same way.

2.3.4 Consent within Sexual Health

As discussed throughout this section, it is clear that emotional and social aspects of sexual health are not discussed as regularly as that of physical sexual health. Given that sexual consent is a concept which could have both physical and emotional ramifications on an individual's sexual health, it could be argued that as emotional aspects of sexual health are neglected. This can be problematic for the prevention of non-consensual sexual activity, where individuals are not equipped with the tools in which to understand and affirm their consent in align with their sexual wants. Fantasia et al (2015) found that women who had past

sexual encounters of a non-consensual nature, were more likely to be aware of consent. This is because it is often after an experience of non-consensual sex that individuals reflect back and educate themselves as how to prevent this in future encounters. Furthermore, women who had not had a forced sexual experience were less likely to understand consent and how this is displayed in sexual encounters. Relating this information to the current project, it is important that in society, conversations around consent are taking place in order to prevent non-consensual interaction and support those who have experienced it. It is important that the institutions in society, such as the NHS, are promoting awareness on consent, rather than having people learning only about consent after the interaction has occurred (Fantasia et al, 2015).

2.4 Chapter Summary

This literature review has examined the key concepts of consent (2.1), sexual consent (2.1) and sexual health (2.2) in order to provide a foundation for the current research. Consent within sexual encounters is a complex concept which evolves as contexts change. In order to examine when consent is questionable, and how to combat this, it is important to understand the narratives which examine the “grey” areas of ambiguity between consent and coercion. The relationship between sex and consent is crucial to maintaining the emotional sexual health of an individual. As such, sexual health as a concept was discussed in order to consider the different elements of sexual health and the role which sexual consent plays within the field of sexual health as a whole. Understanding these key terms was crucial when creating the research design as it was necessary to explore how consent and sexual health concepts relate. Furthermore, by consulting the literature prior to asking service providers about how they work with these concepts within their role, better discussions could be had regarding the conversations taking place.

3.0 Methods

Sexual health improvement outcomes for Scotland were stated in the Sexual Health and Blood Borne Virus framework 2015. This project focusses on Outcome 4 of the framework, which aims to make sexual interactions free from coercion. The aim of this study is to investigate how sexual health service providers discuss this concept with their service users and what can be done to better facilitate these conversations. In this chapter, I discuss and justify the chosen methodology (3.1). This is followed by looking at the research process as a whole and what was to be achieved (3.2). Subsequently, the data collection methods are discussed (3.3) and lastly, how the data was analysed (3.4).

3.1 Methodology

3.1.1 Choosing a Research Methodology

Qualitative research has been defined as an investigative research method which is used to understand the reasons or motivations for a particular aspect of exploration (Strauss and Corbin, 1990). The qualitative research process is one which provides insight into a particular area of focus to uncover problems and offer an opportunity for the researcher to investigate how they might be best solved. Qualitative research, therefore, requires focus to be placed on the experiences of the participants and can produce beneficial results which are grounded in the area of focus. Critics of qualitative data would suggest that by focussing on individual experience, then the findings can not be generalisable to the wider population. However, the aim of qualitative research is not generalisability but for transferability and transparency. This study the aim is not to generalise to the wider population but to examine the conversations and roles specifically within the sexual health field. Furthermore, how improvements in these conversations can be transferred across different provision and across sectors. This type of exploration is suited to qualitative research methods as it is grounded in personal experience and context (Bryman, 2012).

Qualitative research seeks to understand how the phenomena came to be, exists, or is moving forward. Thus, providing another reason why qualitative methods

have been chosen for this research; to gain in depth insight into the types of conversations around consent that take place in sexual health. The mechanistic nature of quantitative research (Silverman, 2006), through questionnaires or surveys, would not allow participants to share their experiences as fully as in the chosen method of face-to-face interviews. For explorative research questions, such as the one posed in this thesis, it is about asking the right questions (Bryman, 2012) to discover the answers. Qualitative research methods allow a degree of flexibility when asking these questions which resulted in a research space where participants could share their experiences and expertise within the interviews (Lowe et al, 2018). As the SHBBV framework is due for renewal in 2020 it is the aim of this research to measure the progress of outcome 4 of the current framework in order to feed back into policy and practice. As outcome 4 is an outcome which is hard to measure, it is important to draw upon the expertise of those working in sexual health services and closely to service-users. As such, a qualitative approach is most appropriate as it allows the expertise and experiences of sexual health professionals to be utilised in order for recommendations to be made.

3.1.2 Qualitative Method: Interviews

Face-to-face interviews took place with sexual health providers in the NHS and third sector organisations in order to understand the way in which sexual consent is discussed within sexual health services. The focus of this study was developed in order to understand the way the progress of outcome 4 of the SHBBV framework and to understand the way that sexual health services are furthering this progress. By understanding the types of conversations, which are being had surrounding consent, it is possible to gain insight into the types of sex that is being had by the service-users, and the role that consent plays within the interaction. The study is based on experiences of service providers as this provides a key understanding of the scope of the programmes and it will allow for comparison between the work being conducted by the NHS and those within third sector organisations.

3.1.3 Realist Evaluation

Throughout the research process, a realist approach was employed in order to provide not only the findings of the research, but to propose recommendations

which would be grounded in the context of the provision. Pawson and Tilley (1997) developed a model of evaluation which was focussed on not only whether a service worked, but for whom and in what context. In order for this type of evaluation to be carried out it was important to engage with those working within the services and highlight when successful conversations were being had surrounding and where they were not. Another focus of realist evaluations is to ensure that “real problems” (2004:16) are dealt with and to inform realistic developments in policy making. As the purpose of this project is to evaluate the extent to which outcome 4 of the SHBBV framework is being met, a realist approach allowed feeding back into policy to remain one of the main priorities of this study.

3.2 Research Procedure

3.2.1 Ethics

Ethical approval was obtained internally from Edinburgh Napier University to conduct the research (Appendix A). In addition to this, external approval was granted from the NHS Lothian research governance department (Appendix B).

3.2.2 Researcher Identity

Within qualitative research, it is important to understand the positioning of the researcher within the study whether that be their identity, experiences or personal and political beliefs (Berger, 2015). It is important to reflect upon these personal attributes in order to assess any possible impact that it may have on the collection and interpretation of data throughout the research process. My personal interest in this topic stems from feminist thinking which explores the gender-based violence which takes place in sexual relationships. Movements such as “#metoo” have given voices to women who have experienced non-consensual, and thus, non-respectful sexual encounters for decades. Furthermore, as the movement has developed, the voices heard have opened up to include a wide range of people, not just women. It is important that all people from all backgrounds are aware of the importance of consent, and that they are supported in society by those in authority as policy and programmes are implemented. As discussed previously, this is the basis for the research taking place, but it is beneficial to

reflect upon the researcher identity in order to highlight and address any potential biases from the outset. Thomas (2017) states that the presence of researchers can impact on the whole research process, from data collection to narrative construction. When reflecting upon my position as a researcher I have identified that aspects of my identity which had the potential to impact the study most would be that of my gender or my lack of experience within the sexual health field.

3.2.2.1 Impact on Research Process

It is important to reflect on the subjectivity of the researcher and how their lived experience may impact data collection techniques (Walsh, 2000). Therefore, whilst investigating my topic area, it was important to be conscious of my identity and experiences as a woman. This is a common reflection from qualitative researchers (Thomas, 2017), with literature often exploring the identities of female researchers in certain spaces. The experiences of these female researchers often denote issues of gender stereotypes or the entering of “male dominated” spaces. Due to the female-dominated culture of sexual health provision, this was not a challenge that I felt I had to deal with, nor did I feel that I had any gendered stereotypes that I had to break as a researcher. However, the role of a researcher is also understood to be related to our identities in regards to how researchers interact with our participants (Beck, 1993). I was aware that the study had primarily female participants (Table 1), and as a female researcher, it was important to acknowledge any shared experiences or unspoken assumptions.

One common assumption which occurred throughout the research process was that men are often seeking consent, while women are the consent givers. This was more evident with my interaction with female providers, arguably because I was also a woman and it is easier to draw upon shared experiences (Thorpe et al, 2018). In order to combat this, I ensured that my line of questioning did not frame men as the sole perpetrators for sexual consent, nor women were the sole givers. While the literature often frames this narrative, I formed the interviews (Appendix C) in such a way that allowed for the sexual health providers to tell me any significant gender differences without being prompted by a specific question. Providers, particularly those who were female, did frame men to be the consent

seekers then I asked further questions to ensure that roles of consent were being discussed across the genders. The semi-structured interview guide allowed for a degree of flexibility to ask additional questions or clarify why one gender was discussed over another. By understanding that this framing was occurring within the providers' answers, and by continuing to monitor it over the course of the research process, implications were minimised:

Michelle:

"Yeah say they've had sex with a girl who was asleep or who was drunk."

Interviewer:

"It is interesting that you have framed it in that way, could you say a bit more about that? Are those gendered dynamics something you see a lot in your work?"

As a researcher who has never worked in the sexual health field, clinically or otherwise, my position is one which would be called by Berger (2015:227) as a "stranger in a strange land". This presented difficulties when developing interview questions and required preliminary research of the available sexual health services available (3.3.4.1), before formulating and asking questions about the conversations which are had within them. However, being unfamiliar in the environment also offered advantages during the data collection process as it meant that my participants were the expert in the interaction. It was stated at the beginning of the interview that I was inexperienced in sexual health procedure, particularly with the NHS protocol, and asked for patience should I need to clarify anything. Furthermore, this disclosure opened a space where I could account for any use of insensitive language should it occur on my part. Berger (2013) reflect on the idea of the respondent being in the "expert position" and state that it enables participants to feel respected and validated for their expertise and contribution.

3.2.3 Recruitment

Participants were recruited throughout different departments in the NHS Lothian sexual health field. By recruiting participants from different staff groups, it was possible to gain insight into the types of conversations which are being had about consent across the sexual health departments. This was important as it was then possible to compare and account for any differences in what the service-

providers were telling me about the discussions which take place. This then contributed to the recommendations made about sexual health provision in the future.

Recruitment posters (Appendix D) were circulated in a number of ways in order to reach both NHS and third sector providers. Firstly, posters were displayed in NHS Chalmers staff room and monthly newsletter, this was to enable clinical staff to read and reach out to the research team about the study. Next, posters were sent to third sector organisations across Scotland to advertise and inform them about the study taking place. Lastly, and most successfully, the posters were shared on social media such as Facebook and Twitter in order to recruit participants. While a potential downfall of this method was that the poster would only have been seen by those within my social media reach (Shere et al, 2014), the posts were shared widely by those in the sector and led to participants being recruited.

3.2.4 Participants

Purposive sampling was employed in this research as to select a specific group, of sexual health providers, on the basis of their relevance to the research question (Silverman, 2006). Furthermore, the procedure of purposive sampling allows for a degree of flexibility during the research and meant that other channels of interest could be investigated as they opened up. For example, it was evident when speaking to clinical staff in the NHS that conversations around consent were more likely to take place with staff who had more of a social care role, such as youth workers. Purposive sampling allowed the flexibility to investigate this route of inquiry more so than methods such as statistical sampling (Mason, 1996). The inclusion criteria for the study was sexual health providers who works across the NHS or third sector organisations. They did not need to be based in any particular department, and diversity in job roles was encouraged as to get a broad understanding for the way conversations are being had across the services. Eleven sexual health providers were interviewed as this was the point where theoretical saturation had been reached (3.3.5).

Table 1		
Name	Sector	Job Role
1. Bessie	NHS	Youth Worker
2. Carly	NHS	Clinical Support Worker
3. Janet	NHS	Senior Doctor
4. Mark	NHS	Doctor
5. Michelle	NHS	Nurse
6. Emma	NHS	Nurse
7. Lisa	Third Sector	Support Worker
8. Alice	Third Sector	Volunteer
9. Lily	Third Sector	Youth Worker
10. Tim	Third Sector	Support Worker
11. Paul	Third Sector	Health Improvement Worker

3.2.5 Participant Information and Consent

Participants were fully aware of the facts throughout the research process, this began at the first point that they contacted the research team with a note of interest, and they were provided with the information pack. The information provided in the pack were in the form of a participant information sheet (Appendix E) to provide information about the study's aims and objectives; the data information sheet which provided information about how their data would be stored and used (Appendix F); and a consent form (Appendix G) to read and sign just before the interview commenced. At this time, participants were also given an opportunity to ask any questions which they should have about the study and data protection to ensure they were fully comfortable to consent. The participants were made aware that they could withdraw their consent and data throughout the research process. However, participants were also made aware that data would no longer be able to be withdrawn 3 weeks after their interview as by this point data analysis would have been started.

3.3 Data Collection

3.3.1 Service Overview

The preliminary service overview was undertaken to explore the range of sexual health services available in Scotland. As the Lothian area is the main focus of this study and as this project is concerned with the conversations that are taking within each of its services, it was imperative to understand what these services are. By conducting a service-overview, I could familiarise myself with the services and terminology before entering the research field. In addition to scoping the Chalmers centre's services, the Glasgow Sandyford Clinic's services were also investigated (Appendix H). This was important as it allowed for exploration into the consistency of sexual health services across different sexual health clinics. Furthermore, it would allow for any differences in provision to be uncovered. It was important to understand what these services were; what their purpose was; and to whom they were focussed towards (Pawson & Tilley, 2014) before understanding how each service approached the topic of consent in their work. When looking at the provisions provided in the two largest and most prominent clinics in Scotland, it is apparent that the services are broad and accessible (Appendix I). However, there is differences between Lothian and Glasgow as to how these services are organised. Taking the two main clinics, Chalmers and Sandyford, as an example many of the services cover the same elements of care but are offered in different services. Furthermore, many of the services offer similar care but are named and referred to under different names. It was not possible to ascertain from the service overview the extent to which consent is discussed as part of service provision. As such, the interview phase of the study was designed to explore the conversations that are taking within each of these services.

3.3.2 Interviews

One-to-One, semi structured, interviews (Birch, 2015) were conducted as the primary source of data collection while interviewing sexual health professionals within NHS Lothian and third sector organisations. There are various reasons for his choice, however, the main reason is the ability to gain insight into the perspective of your participant with little distraction during interviews (Kvale, 1996). Moreover, by semi-structuring these interviews with vague themes and only suggested questions, this allowed the participants to change the sequence should they wish to offer their insights about a particular matter. By employing a semi-structure method to the interviews, this allowed for comparability across the

interviews (Gill et al, 2008), whilst also remaining flexible and informal (Silverman, 2006). Another reason for this choice is that interviews allow the researcher to cover concepts on both a factual and a meaning level (Kvale, 1996). Whilst I wanted to reflect upon the facts and procedures of their roles, I wanted the participants to engage with their interactions and conversations with service-users in a way that they would talk about the meaning of their role and experiences. Furthermore, it was important that participants considered what was not there, rather than only what was.

Following the recruitment and selection process, contact between the participants and myself took place across email. The interviews were organised in accordance with the schedules of the participants and took place between March and May 2019. All interviews were conducted in the participants place of work in a private room which provided the quietness and privacy necessary for the interviews to take place. The aim of the interviews was to understand what they believed their role to be, and how they discuss consent with their service-users. The link between the research question and outcome 4 of the SHBBV framework was explained to the participants in order for the interviewee to be aware of the purpose of the study. A semi-structured Interview schedule was created for the purpose of the interviews, with guided questions being used to prompt the participants about different talking points (Appendix C). The questions contained were constructed around the findings of the literature review and the overall research question of the study. The questions were open-ended to allow for further exploration of the topics being discussed and a flexibility to occur should the interviewee wish to explore other, related areas.

The interviews ranges from 45 minutes to 1 hour and at the end of the interview, participants were given an opportunity to say anything that they wished to mention but were not given the space. At the beginning of the interview session, the participants were asked to define two concepts: “sexual health” and “sexual consent”. After hearing their responses, the terms were then defined using WHO’s (2006) definition of “sexual health” and Seligner’s definition of “consent” (Appendix C). It was explained to the participants that by asking this it would make the definitions of the key concepts comparable across interviews. Furthermore, it was beneficial to provide the definitions that would be worked

from in this research in order to clarify what the researcher understands these terms to be. (Courvoisier et al, 2011). The SHBBV framework sets out that there are many potentially vulnerable groups at risk of bad sexual health and non-consensual relationships. These groups include, but are not limited to LGBT groups, women, young people and older people. Therefore, the questions were not focussed towards one particular group when asked; as according to the literature, many groups are vulnerable (Lusti-Narasimhan & Beard, 2013)(Shearn et al, 2016) but potentially for different reasons. This is why, during the interviews the sexual health staff, without prompt, were able to highlight any particular at groups that they feel to be high risk. This makes the data generated more valuable as the interviews were not led from assumptions, but instead, from the insights of the service providers (Lowe et al, 2018).

3.3.3 Theoretical Saturation of Data

Theoretical saturation is used in qualitative research as a “criterion for discontinuing data collection and/or analysis” (Saunders et al, 1894), and was the method employed to stop data collection in this study. Saturation has gained acceptance as a “methodological principle” of qualitative research (Saunders et al, 2017:1893) to ensure that the research is conceptually adequate (Strauss & Corbin, 1990). In order for a concept to be conceptually adequate, it requires exploration into what the concept is and how it relates to other constructs. Subsequently, data saturation is common practice in health science research (Guest et al, 2006) and as such was appropriate to use with a purposive sample such as with this study. Hennink (2019:248) state that code saturation has been reached when the researcher has “heard it all”. Towards the end of this process, the data which was being collected was repetitive and had been stated by participants before. While this could account for the data being saturated and no new information being collected, it was important to examine whether this was the end of the process. Ensuring data saturation has been reached, during collection, can be done in a variety of ways and by drawing upon the “information knowledge” which is present within the sample (Malterud et al, 2016: 1754). Malterud et al state that it is important that the knowledge gained by conducting research should be gathered in order to reach an important goal. As these goals evolve and adapt throughout the research process, “tools to guide sample size... should not rely on fixed procedures” (2016:1754). Within this study, it was

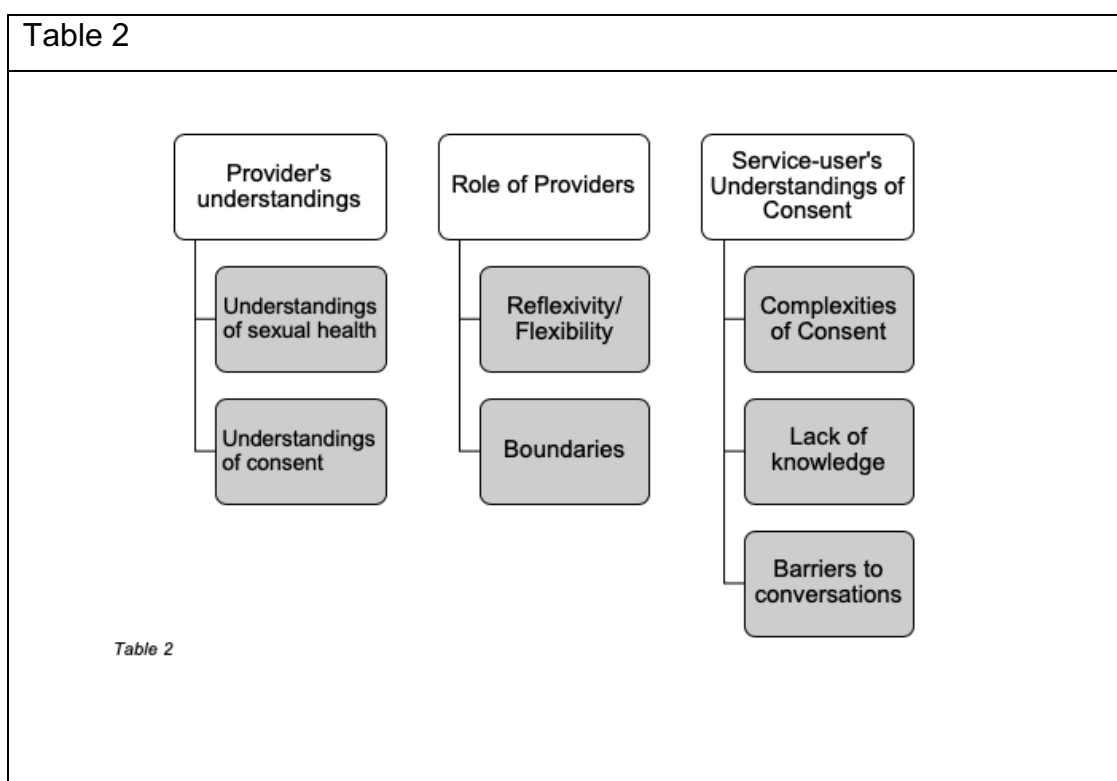
important that the information gained from the data was grounded in the aims of the study and had a sample specify that was dense. Furthermore, by carrying out longer interviews, with a smaller sample, the theoretical saturation was reached. When theoretical saturation was reached in this research process, i.e. when there were no new concepts emerging from the data. In the case of this research, all areas of focus had been explored and any potential gaps had been considered and decided unnecessary to explore. To ensure this point had been reached, it required analysis to the point that thematic categories were accounted for and that findings had emerged. Data saturation within this study was reached after the sixth interview conducted, however, due to the varying nature of the roles of the participants, I continued to ensure that there was no new information to emerge. After the interviews continued, the amount of new information diminished, and the predictability of responses increased.

3.4 Data Analysis

Data analysis is an ongoing part of the research process and can even begin before the first interview has even taken place (Rapley, 2004). Within this study, data analysis began after the research question was formulated and literature was collected. Initial reading allows for the researcher to begin to think about “potential participants, interview questions and analytic themes” (2004:23) as occurred in this study. Despite this stage of the research process not seeming to be a significant part of the data analysis method, it was the foundation for the analysis to come (Seale, 1999). As the interview questions were formulated, and interviews were conducted, analysis was heightened. During data collection, I noted anything that I felt of interest and that may be relevant in more formal data analysis later. This included, but was not limited to, further areas of investigation during the interview and any overlap across interviews. Within this study, each of the participant’s voice recordings were fully transcribed and saved on a password protected computer. As the interviews were transcribed and anonymised (Saunders et al, 1984), the recordings were deleted in accordance with the ethical approval given for this study. By personally transcribing each interview, this offered an opportunity to make further notes about the data I had gathered as I heard the interviews back (Rapley, 2004). After all transcripts had been produced, the formal analysis process began which employed a method of

thematic analysis. Thematic Analysis was used in this study in order to “interpret patterns of meaning” (Braun & Clarke, 2016:297) to the qualitative data generated throughout the research process.

Thematic analysis was chosen as the most appropriate method as it offers a level of flexibility in the theory which has been applied to the data (Braun & Clarke, 2016). Furthermore, by analysing patterns and themes, it allowed parallels and differences to be drawn from participants across the different sectors. The process required coding the transcripts with relevant descriptive words (Mills 2010). Initially, the transcripts were analysed using line by line coding, applying descriptive labels to each line. However, it should be noted that due to the way that natural speech is transcribed, not every line had content that could be analysed. When this occurred, larger sections of text were given a label rather than singular lines. The descriptive labels were created from research notes which had been noted as potential areas of interest during the interviews and whilst transcribing. However, the specific word choice of the labels were drawn from the theory and literature which had previously been explored (Appendix J). By using terminology already used in the literature, this allowed for generability of the findings to occur. Glaser and Strauss (1967:) detail a “back and forth” process which involves going back and re-reading transcripts, using comparisons across the different data sets. This process was employed within the study as to highlight the most significant themes but also to compare the opinions between NHS and third sector providers. For a particular code to be deemed significant, it was to be present in at least four transcripts out of eleven. This would account for a pattern across the data sets, whether that be across or within sectors. After the coding process was complete, an explanatory framework was created which organised the emerging patterns into themes (table 2). After the themes, and sub-themes were created, a final read-through of all transcriptions occurred in order to ensure the explanatory framework mapped onto data from each individual provider, or each sector.



3.5 Chapter Summary

The research of this design is discussed in depth throughout this chapter. Semi-structured interviews, and the reasons for choosing such, are explored while also explaining the realist perspective used throughout the research process and why it was employed. This includes how participants were selected and treated throughout the process of this research in order to best evaluate outcome 4 of the SHBBV framework. After the interviews took place, data analysis took place in order for grounded recommendations to be made to feed back into practice and policy. As such, it was important to evaluate what works; for whom; and in what context (Pawson & Tilley, 1997) in order to make sure conversations surrounding context be facilitated in every context. The research was carried out and analysed with the research aim and ethical conduct in mind.

4.0 Findings & Discussion

The results of this research have been analysed into 3 different findings. The first finding (4.1) reflects the way that providers understood the key terms of this study, sexual health and sexual consent, and the way that they reflected upon these terms within their work. This provided a base understanding of the knowledge that they possessed and how they understood the concepts which they discuss with service-users. The next finding (4.2) provided in depth analysis of the way that the participants reflected upon their own role of a health care provider and the conscious and unconscious methods they use to fulfil their role. The way that they reflected upon their own role led to understanding about the way that aspects of their role positively and negatively affect the conversations which take place with service-users. The final finding (4.3) discussed the complexities of consent, and the impact these complexities have on discussions around sexual consent in general, and within sexual health provision.

4.1 Key concepts as understood by providers

At the beginning of each interview providers were asked to define two key terms: sexual health and sexual consent. Providers highlighted the multi-dimensional aspects of sexual health. While some providers provided concise definitions, some spoke at length about the many concepts that are encompassed within sexual consent.

4.1.1 Sexual Health: Provider's understanding

Definitions of sexual health (2.3.1), in recent times, acknowledge the different aspects which exist within sexual health; including physical, emotional and social components. Coleman (2010) states that sexual health is a construct which evolves to suit the social culture of that time and as such, the definition of sexual health is now evolving to encompass more than just physical health, that was focussed on traditionally. The views of the providers echo this idea, with the health-care providers all making reference to the importance of the physical, social and emotional aspects of sexual health (Mace et al, 1974). However, the prioritisation and focus on each aspect of sexual health practice varies in

accordance with the sector and context in which the service-user is being treated. The way in which sexual health providers, across sectors, approach these aspects will be discussed later in this section.

4.1.1.1 Physical:

Physical aspects of sexual health, as stated previously, have traditionally been the primary aspect focussed on throughout sexual health care. This refers to the detection and treatment of conditions, illness and disease within the body (Long et al, 2016). Relating this specifically to sexual health practice, this could be the detection of pregnancy, treatment of sexually transmitted infection or anything further that refers to a physical component of the body (Jones & Barton, 2004):

“So that will be things like routine screenings for people who may be concerned about infections. So that will be swabs and taking bloods, through to treating people for diagnosed STIs. These are all the practical things we do.”

- Emma (NHS)

Sexual health providers in the interviews were asked directly to define sexual health and throughout discussions they reflected upon what the concept meant to them and their role. All providers shared that sexual health care included physical health being paramount to good healthy lifestyles. Furthermore, it was evident that when reflecting back on their role, NHS staff provided care which focussed on physical aspects of sexual health more so than third sector providers did. Throughout the discussions had about the roles that they carried out, NHS staff reflected on the ways in which they dealt with physical forms of sexual health, as shown in the above quote by Emma. The reflection of physical aspects of sexual health can be accounted for by the clinical nature of the NHS and the purpose of the services that they provide. Although they did express the importance of social and emotional sexual health, as will be discussed further in this section, matters were discussed in a way that would lead to the optimum sexual health of the service-user, not as a separate aspect of sexual health which needs to be treated. Physical elements of sexual health can be detected and treated in an analytical way. For example, tests can be carried out which will produce positive or negative results. Furthermore, the treatment for positive results will be dealt with in a structured process which will lead to the service-

user being healed. This result cannot be achieved with the other aspects of emotional and social sexual health as with these there is not a clear answer or treatment to be made.

4.1.1.2 Emotional:

Russell (2010) highlights the importance of good sexual health in impacting the sexual life and experiences of individuals. In order for this to be fully achieved it is paramount “physical and psychological” (Russell, 2010:81) aspects of sexual health are addressed and treated. As discussed previously, physical sexual health is a well-established aspect of sexual health. However, organisations such as WHO (2002) and the Scottish government (2015) are recognising that sexual health also includes the emotional wellbeing of sexual individuals. Relating this to sexual health practice, emotional care would be provided in order to make sure service users are at good levels of mental and emotional health in relation to their sexual lifestyle. This could be shown via the counselling and support of those who are not feeling positive emotions regarding the sex they are having. This is recognised by the providers interviewed, as they reflected upon the concepts of emotion and mental state in their definitions of sexual health:

“I would initially think of things like pleasure, consent, healthy relationships and feeling comfortable in your own body when having sex”

- Lily (Third Sector)

Sexual health providers referred to the emotional element of sexual health and how individual attributes can affect the sex that they are having. For example, providers discussed the importance of mental health in having healthy sexual interaction. Michelle specifically discussed the interconnections between self-esteem, self-confidence and sexual health, and this was supported by other providers. This is consistent with the literature (2.2.5) which states that higher levels of self-worth, as measured through an individual’s self-esteem, account for higher levels of sexual health (Hensel et al, 2016). The emotional aspect of sexual health could also account for the presence of sexual want felt by the individual within sexual interaction. Sexual want is defined by Darden et al (2016) as the desire to engage in sexual activity and is seen as a marker for consensual and welcomed sex. Darden et al (2016) state that sexual interaction where an

individual is low in sexual assertiveness and want resulted in high levels of compliance i.e. “consenting to/engaging in sexual activity even when self-reported sexual want was low” (2016:1). Furthermore, when negotiation of sexual behaviour takes place to fit the wants of the individual, this has been associated with lower levels of depression (Hensel et al, 2016). Therefore, if levels of self-esteem are high, then individuals will have more confidence to unpick their emotions about sex that they want to be having and to identify their sexual want. These concepts are different to that of physical health as they are not tangible and cannot be treated as structured as could a positive result in a clinical setting. The complexity of human emotion within sexual health, while acknowledged by both NHS and third sector staff, is not approached in the same way. This will be discussed later in this section.

4.1.1.3 Social:

Health-care providers highlight that the life, environment and experiences of an individual has a direct impact on their sexual health. Furthermore, providers believe that social factors surrounding individuals’ sexual health are interconnected with the sex that they are having, and the sexual health of the individuals involved. As such, providers highlighted the social aspect of sexual health has evolved to become an important concern of the providers. The providers discussed the move from clinical models of care to more holistic approaches. This shift has happened as a result of health-care providers understanding the importance of building the “full picture” of a service-user in order to combat health issues. For example, it can be possible to treat a health problem easily, but if this health issue is recurring, then it is important to also look at the environment of that service-user. Social aspects of sexual health are the factors which influence the physical and emotional health of a service-user. The importance of a social dimension was discussed by providers across sectors, specifically with Tim mentioning it in his self-definition:

“Sexual health isn't just about that, it's actually about a much wider thing of everything that happens. Way before someone's got to that point.”

- Tim (Third Sector)

The social aspect of sexual health can be used to effectively identify potential sexual health risks in order to stop recurrence and promote preventative measures. As mentioned previously, the providers believed that a focus on social aspect of sexual health can improve both the physical and emotional sexual health of their users. Providers within the NHS discussed the minimum data set¹ that they are encouraged, and often required, to complete. After gathering this data, there would be an opportunity for a brief intervention² to take place. By gathering this data, NHS staff can build better pictures about the context and environment of a patient's lifestyle and sexual history in order to assist and advise appropriately. These interventions could include alcohol and smoking consumption and other lifestyle choices. Jones & Barton (2004) refer to the benefit of sexual history data collection as a tool to look at the context of the sex being had. Furthermore, they understand that in instances where sexual history conversations have resulted in an intervention taking place, STI rates have been reduced in the future. By including this data collection within the role of sexual health providers, it highlights that institutions such as the NHS, understand the social context of an individual is impacting on the sexual health of the service-user. This in turn means that the training and teaching of this aspect of sexual health could lead to better provision and all-encompassing practice.

Throughout the interviews, providers spoke in depth about the different measures that services were carrying out to manage the social as well as the clinical sides of sexual health. For example, the introduction of C-Card³ access points in areas of high STI rates could encourage people to utilise contraception provided to them. This would in turn manage a physical issue within sexual health. Furthermore, by exploring the use of substance use in relation to instances of non-consensual sex, measures could be carried out to form a better relationship between the two. This would in turn combat the poor emotional sexual health associated with non-consensual sex.

¹ Minimum data set refers to a standardised question set which aids assessment of the health status of a service-user.

² Brief intervention is a short, opportunistic intervention which takes place with a service-user in order to give focussed advice which is appropriate and tailored around the information gathered in previous data sets.

³ C-Card refers to a scheme in which free condoms are provided to those registered with a "C-Card". The scheme is managed by the NHS and facilitated by a number of different partner agencies across sectors.

4.1.1.4 Focus across sectors:

Physical aspects of sexual health can be treated in a very technical manner as these types of health issues usually stem from a positive or a negative result. This enables health care providers to deal with these problems in a structured way. This fits in well with the role of NHS health providers and speaks to the strengths of the NHS in carrying out this type of clinical care. Whilst third sector organisations understand the importance of the physical aspect of sexual health, the NHS have the resources and set up to deal with these issues primarily. Furthermore, physical aspects of sexual health appear to be the first priority of providers within the NHS:

“I think you need to steer them in the right direction, because if you try and force people that will make them back into a corner and remove themselves from the service completely”

- Mark (NHS)

In the above quote by Mark, he explains the tensions that exist between physical and emotional aspects of sexual health and furthermore, within his role as a health care provider. Whilst those in the NHS frequently highlighted the importance of good emotional sexual health; within their role they feel that they try to address these issues but not to the detriment of treating physical illness and disease. A concern of NHS providers was that bringing up emotional elements of sexual health to a service-user, such as non-consensual sex or sexual assault, could lead to a shut down in communication and the service-user not returning to the service again. Therefore, meaning that the service-user would not again receive the treatment of any physical illnesses that they could contract. While this is a justified concern of NHS staff, it emphasises the idea that NHS staff view physical sexual health as more of a priority than emotional sexual health. When asked how they would proceed with a disclosure of non-consensual sex, one of the methods discussed would be to sign-post that service user to a third sector organisation such as “rape crisis or shakti women's aid”. This again suggests that NHS providers understand that the treatment of emotional sexual health issues are understood to be important, but not necessarily in their remit. By signposting service users to third sector services, as mentioned previously, it could allow users to understand that these aspects of sexual health are dealt with separately. This was thought to be beneficial by the NHS providers as users can understand

that if they require physical treatment, the emotional aspects do not need to be discussed.

Continuing this idea of prioritisation, third sector providers discussed emotional aspects of sexual health to be the main area that they focussed on. When reflecting upon their role, and daily tasks, it was apparent that they were centred around the emotional wellbeing of the service users. Contrasting this to the context of the NHS, where providers discussed the way in which they could manage and “fit in” emotional treatment to their clinical duties:

“So realising that mental health and emotional wellbeing has huge impacts on people's sexual health. So, my role is to assist service users that are having issues around that.”

- Paul (Third Sector)

Emotional sexual health has been seen to be prioritised by third sector organisations over physical sexual health. This could be accounted for as third sector organisations do not have the clinical resources that the NHS do. Furthermore, they aim to fill the gap of emotional health treatment that is being missed under a strained NHS. Providers across sectors made reference to the strain that the NHS was experiencing in time and resources. Moreover, third sector organisations are stepping in to provide emotional care where it may be being missed. This idea is exemplified by third sector organisations maintaining relationships with the NHS where both physical and emotional aspects of sexual health can be addressed. Waverly Care operate a gay man and MSM⁴ drop in clinic where STI testing takes place in their establishment. By developing this opportunity to be tested outside of NHS settings, they are accounting for the emotional wellbeing of the service user who, as discussed by Paul, may fear stigma from entering that type of public place. Furthermore, the drop-in clinic allows one-to-one sessions with Waverly care support workers who can discuss the type of sex that the men are having whilst they wait for the physical aspect to be taken care of. As third sector organisations put measures in place such as these, they are focussing on the emotional wellbeing of their users related to their sexuality.

⁴ MSM: Men who have sex with men

As third sector providers focus on the emotional side of provision, they were clear about the fact that sexual health to them was concerned with “emotion, consent and comfort”. NHS staff also acknowledged the importance of an individual’s psychological well-being within sexual relationships, however, focus primarily on the physical side of sexual health provision. Both of these elements of sexual health derive from social factors, and this is agreed on across sectors.

4.1.2 Sexual Consent: Provider’s Understanding

Darden et al (2018:2) define sexual consent to be considered as “the behavioural expression of desire or willingness. Sexual consent may include both verbal and nonverbal acts indicating one’s desire and/or agreement to engage in sexual activity”. Whilst highlighting what consent is, Darden et al (2018) also discuss the relationship between consent and sexual want. Ideas surrounding desire and sexual want are discussed in the previous section as being in the domain of emotional sexual wellbeing. Therefore, the ways in which the concept of consent is discussed in sexual health is significant considering the priorities of different sexual health providers. Furthermore, the ways that sexual consent is considered in accordance with physical, emotional and social aspects of sexual health. This section will focus on the understandings of sexual consent by sexual health providers and how this differs across sectors.

4.1.2.1 Definitions of Sexual Consent

In addition to being asked to provide a definition of sexual health, providers were asked to define what sexual consent meant to them as a health-care provider. All providers were at least able to provide a basic understanding of the concept of consent. However, when reflecting on the detail given by providers, the definitions were not as consistent as what had been provided for the sexual health definitions. Providers were clear in their sexual health definitions about the different aspects which made up sexual health, and the way in which these contributed on the work that they undertook. It was apparent that providers could more accurately and concisely define sexual health than they could that of sexual consent. This could be accounted for by the complex nature of consent and the ever-changing context which is involved in making an encounter consensual. The

many dynamics which make-up the concept of consent can account for the fact that the responses given varied from one individual to the next. Furthermore, detail of responses provided also differed between individuals within the same and across different sectors.

4.1.2.2 Complexities of Consent

Throughout the discussion as a whole, providers were able to convey that they understood the concept of sexual consent. The complexities of consent and negotiations which take place in sexual interaction were discussed throughout the interviews, and providers were able to share knowledge organically rather than being asked for a specific definition:

“Okay, I'll have vaginal sex, that's fine. But then you could get, you know, anally raped. Do you know what I mean? So, there is a lot that isn't clear cut. It is not just a case of saying yes or no to that. So many different dynamics.”

– Carly (NHS)

Consent is a complicated concept (2.2.5) and when asked to provide concise definitions of consent at the beginning of the interview, the complex nature of consent was not included. However, despite the complexities not being discussed within their first definitions, it became clear that providers do understand the complex nature of consent. As the interviews continued these complexities were discussed in depth, Carly in the above quote, highlights a dynamic of consent which contributes to its' complicated nature. Consent is constant, this is discussed in depth in finding 3, and it varies dependant on individual, context and other factors. As such consent should never be assumed, and it is important that providers understand this in order for them to fulfil their role in supporting service users. The use of negotiation in sexual situations is one which is not spoke about often, however, it was clear amongst providers that this is something which should be encouraged to service-users. This is to reinforce the idea that service-users are entitled to state their wants and to come to an agreement before entering a situation. Therefore, decreasing any grey areas of consent which could in turn render the interaction non-consensual. If providers understand the complexities of consent, and thus any strategies to combat these complexities, then this will lead to a better standard of practice across the board.

Further in the interviews, providers were asked to consider the different contexts of sexual consent in order to understand their knowledge of consent further. As the discussions continued in the interviews, the complex nature of consent and the way that this influences their work was also discussed. As previously said, when specifically asked to define sexual consent, the providers varied in their response. However, as the concept was discussed throughout the interview, provider's understandings of consent developed. Providers were prompted to discuss an instance of sexual interaction which had taken place in order to examine whether the sex had been consensual. The situation provided was similar to a real-life situation that could occur in a consultation, this allowed the providers to discuss consent in the way they would within their role. The vignette was framed as follows:

"A service user has come into the consultation and stated that they had had a consensual experience of sex when you asked. However, later in the consultation they state that their partner had removed the condom without them knowing until afterwards. They didn't seem to be bothered or understand the implications of what had happened, mentioning it to you only in passing. What do you feel about that/ How would you handle that situation?"

The providers all understood this to be a breach of the service-user's consent and reflected upon how they would support and discuss this with the user. What is significant here is the way in which providers understood sexual consent in a context which is out with the "no" and "yes" discourse (2.2.2) which has been traditionally upheld:

"It's absolutely a real issue. And it instantly becomes non-consensual sex and rape. They weren't in control, or in full knowledge of the facts so it was sexual assault."

- Tim (Third Sector)

The vignette which was provided to the providers highlights issues with the status of consent in the situation. These issues include, but are not limited to, the lack of knowledge that the consent giver had surrounding the sexual exchange; and the lack of opportunity to withdraw consent after the condom had been removed. The providers reflected upon these issues and in turn how they rendered the consent invalid, despite only Paul providing the idea that consent must be

constant in their definitions. Whilst the different ways in which consent is complex will be examined in depth in Chapter 5 of this thesis, it is important to highlight the level of understanding that providers had surrounding these complexities. As discussed previously, providers did not provide consistent answers when prompted for definitions. However, when prompted through vignettes of sexual interaction, conversations surrounding the complexities of consent were successfully had. Providers understood the complex nature of consent and the importance of examining context in sexual situations. It could be argued then that when comparing the definitions given about sexual health and sexual consent, providers are more able to give definitions of sexual health when prompted. This is because they do have the knowledge and instincts to determine consensual and non-consensual sex. However, when asked about sexual health in general, despite having the knowledge, they find it more difficult to provide definitions which encapsulates the emotional aspect of sexual consent.

4.2 Role of Providers

4.2.1 Reflexive about their position

When discussing the ways in which providers could better facilitate conversations surrounding consent in their work, they reflected upon their own position in society. This was done in a way where, by being reflexive upon their role, they could see the way in which the interactions between different groups of clients could alter. Furthermore, providers reflected on how they aimed to combat any difficulties that they could encounter due to traits such as their job role and gender when tending to service-users.

4.2.2 Job Role

Landy et al (2016:1) state that reflexivity is the identifying of how “one’s social locations and experiences of advantage or disadvantage” shapes the way that they view and are viewed by the world. It is imperative that reflexivity is a component of the role of a health-care professional. This is highlighted by Dohn (2011:671) who understands reflexivity to be the process of “thinking, communicating, and acting” which is an important process to undertake, particularly when having to facilitate conversations surrounding consent. As these conversations can be complex and everchanging in context, depending on the experiences of the service-user, health-care professionals must rationally think about their own position and communication skills in order to make these conversations as beneficial as possible. This type of reflection was conveyed by providers who highlighted that they felt that their job role, and the reputation that it has in society, had the potential to affect the conversations that are being had:

“I feel like when you are a doctor, talking to a patient they sometimes feel that they are obliged to answer every single thing I ask them. So, they are ready to tell you if they really have to but they don’t want to. Or worse, they are always ready with what they think you want to hear.”

-Mark (NHS)

Those within the NHS, in particular doctors, stated that during interactions with service users they felt that users felt obliged to share a response when asked by sexual health providers. They stated that this did not promote beneficial

conversations with service users as an open dialogue could not be created with patients who feel they have been forced to open up and it could in turn result in them withdrawing from the service completely. Furthermore, health-care professionals stated that they were aware that some service users, when prompted, provided the responses that they believed that the doctor or nurse were looking for. This supports what is set out by Fritzsche et al (2014:163) which states that health-care interactions include “complicated communications; each group withholds, distorts, obfuscates, fabricates, or lies about information that is crucial to the doctor-patient relationship and to effective treatment”. When dealing with conversations surrounding consent, it is important that service-users are being truthful of their situation in order to get the best support. This support can be harder to provide if it is being based from untruthful accounts of the sex that service-users are having. Hardavella (2017:134) refers to the tensions which can occur between a patient and a health-care professional and states ways in which the health-care professional can “help the patient get emotional control”. As spoken about in the previous finding (4.1.1.2), consent is a concept which intertwines with the emotional sexual health of an individual. Therefore, in order to best support the emotional health of a service-user then honest interaction must be had between providers and users. Hardavella (2017) supports the idea of the providers who have stated the gentle nature necessary to deal with topics of consent as to not “make them shut down” and further distance themselves from providers and the service. Highlighting the complex nature of the patient-provider relationship, is the first step to building upon the patient-provider rapport as by understanding that patients can sometimes lack transparency or have things that they are not ready to share. Providers can support service-users highlighting the potential lack of honesty or transparency from patients which enables them to combat these challenges.

4.2.3 Gender

Providers, particularly in the NHS, reflected upon their role as health-care providers and how this affected the patient-provider interaction. However, it was more apparent that in third sector organisations, providers understood the significance of reflecting upon different elements of their position. Third sector staff reflected on the way that their gender created potential barriers between

them and their service-users. Participant Lily reflected on the role her gender related to the interaction with service-users both in her sexual health inputs in school and as a youth worker:

“And I think it's really hard as a young woman to work in sexual health without being sexualised. So often, I have to be actively thinking about how I present myself when I'm doing these inputs to not be sexualised”

-Lily (Third Sector)

In contrast, NHS staff reflected on the fact that elements of their gender made their interactions more beneficial, particularly when female to female consultations took place:

“It gets to a point when I see them that eventually, they will start talking about it. Usually my patients are women, and I am a woman, maybe that has something to do with it.”

-Janet (NHS)

This finding is consistent within the literature with Weisman (1987) referring to the communication between patients and health-care professionals. Weisman (1987:150) states that when the consultation is female to female, “communication is enhanced” and less interrupting takes place. Weisman also states that female physicians are also expected to be better decoders of “non-verbal cues” and particularly facial expressions. Linking this to the way that health-care professionals facilitate conversations surrounding consent, providers highlighted that disclosures of consent are often hinted at by body language which leads to the professional probing further with the patient, with Michelle stating that “in the end most people, they give themselves away”. If female consultants are more likely to provide a space where disclosures of non-consensual sex have occurred, then it is good practice that providers are reflecting upon elements of the self, such as gender to provide best practice. Male providers did not reflect on the benefits of their gender in their role as a health-care provider or the way that their gender affected medical consultations that they undertook. Whilst this does not mean that male practitioners do not communicate with patients successfully, the accounts provided by female NHS participants are consistent with that of the literature which suggests strong communication from female physicians (Hall, 2014).

Within NHS and third sector organisations, the gender of the provider influences their interaction with service-users. The ability of providers to highlight this is beneficial as it is this acknowledgement and reflexivity which provides the best practice possible. Furthermore, allowing people to open up and feel comfortable discussing the sex they are having without withdrawing from the service.

4.2.2 Boundaries

Providers reflected upon their role as health-care providers and the boundaries that had to be maintained within their role. Providers were asked how they believed that they should approach conversations surrounding consent within their role. Whilst it became clear that providers felt that they had a duty of care to make sure that all users were having consensual sex, the relationship between this responsibility and the individual's right to privacy is one which was discussed. NHS professionals understood this balance as an ongoing issue which was discussed in the health-care field. Moreover, they discussed that within their role they continually consulted how to manage these tensions with every interaction that they found themselves in. Third sector providers reflected that it was something that it was difficult to manage especially when discussing emotional concepts such as consent in the majority of their role. King et al (2015) support this idea by discussing that the boundaries that health-care professionals upkeep and identify in their roles, is ever dependant on context. Furthermore, that the boundaries and duty of care differs in accordance with the health-care field in which they work. It could be argued that this occurs in NHS sexual health practice, as providers there view their role is to first and foremost to address the medical issues of the patients that they see. The emotional and social side to sexual health, whilst being important, is viewed as an extra and should be achieved where possible but it cannot always be. Thus, they could find that by opening up conversations about consent, they could be overstepping boundaries. This is emphasised when drawing on previous ideas that NHS staff have fears that probing too hard into the emotional concepts of consent too soon, could cause people to withdraw from the service:

“I'm not going to hold them against their will and say right, can you tell me about all this stuff. It just wouldn't work; they wouldn't come back”
-Emma (NHS)

This highlights that the NHS understand the value in their role to be the clinical side of provision, as they reflect that they would not like individuals to retreat from the medical services as a result of attempting to have a conversation about consent. In contrast, the third sector providers' main focus is on the emotional side of sexual health. As such, they viewed their service-users as people who were actively seeking out this type of support and in turn expecting to be asked these sorts of questions and have these types of conversations. Lily discussed her role within Rape Crisis and that the women who were referred or self-referred themselves to the service understood the type of care that was provided and were less likely to retreat from the conversations due to shock or surprise, which might occur more in NHS services. Tim exemplified this idea of the difference between clinical and social roles as he discussed the new guidelines produced for c-card points. Whilst it used to be procedure to ask certain questions surrounding the type of sex that the individual was having, it was adapted in order to protect users from withdrawing from the c-card service:

"I think that now that's not in the guidance, you are missing out on these opportunities to fulfil your duty of care. But again, their argument will be that they have opted for a more non-prying approach."

-Tim (Third Sector)

He reflected that this was an opportunity to start a conversation, particularly with young people, around consent within sexual relationships. He explained that this had been removed from the guidance as there had never been a child protection issue raised from one of these c-card conversations. However, that he felt it was still important to give users the opportunity to ask questions and have a dialogue about the concepts even if they were not going to disclose that they had had non-consensual sex. He referred to the adaptation of the process as favouring the "non-prying approach" over the duty of care that he felt that he had to the service users. As discussed throughout this chapter, NHS staff understand the way in which prying into emotional concepts with service-users can lead to implications such as the user withdrawing from the service. As the C-card guidelines were changed in order to be less intrusive for those using the service, whereas third sector providers highlighted the value of these questions in creating a dialogue. This presents tensions across sectors as to the way that they view their own role.

4.2.2 Filtering

Health-care providers spoke about the process of filtering that is required within their role. This was explained in two main ways, filtering patients as to whether to have a conversation about consent and filtering patients in accordance to how to discuss consent with them when they did choose to have a conversation about it:

“I think it is maybe relevant here that no questions should be mandatory for us to ask, we just need to use our brains to figure out where asking about that is appropriate.”

-Mark (NHS)

Service providers, particularly in the NHS, highlighted the fact that they only have conversations surrounding consent when they think it is most appropriate. This was explained as being down to a multitude of factors and that there was no “hard and fast rule” (Janet). These factors included, but were not limited to, the reason for attendance at the service; the age of the user; the vulnerability of the user; and the sexual interaction which occurred to lead the user to attend the clinic. Looking at these each in turn, it is apparent that the nature of filtering in the provider’s role is one which is necessary due to the time constraints that providers have within the services:

“You know, if you've got time, brilliant, if it works out, and you get all the information, fantastic, but no not everyone always gets asked everything.”

-Emma (NHS)

When providers within the NHS were asked about an instance that they felt that conversations surrounding consent would not be appropriate, they responded that it would be in a consultation when it is clear that an individual was not attending clinic as a result of one instance of sexual intercourse e.g. when attending for a repeat prescription of their contraception or for a vasectomy procedure.

When providers do believe it to be appropriate to have a conversation surrounding consent, further filtering takes place as to how to discuss the concept. Health-care providers reflected on the fact that they gauge the maturity of the service-user as to decide whether to break-down the term of consent or

whether they believed that the user would already understand what this concept meant:

“Just suppose as I said earlier it's more if somebody is maybe 13, we would maybe break it down and be much more explicit in terms of, you know, are you happy? Are you safe? Whereas if it was somebody who was maybe 18 who is a bit more mature and I think they would understand the concepts more.”

-Michelle (NHS)

Michelle highlights that this could occur by asking questions such as “do you enjoy the sex you are having”, “did you feel safe”. This filtering was used primarily when referring to young people and vulnerable adults. The role of filtering, particularly when judging who would understand the concept of consent best, can be problematic. This is because service-users understanding of consent is one which is poorly understood. This will be discussed in depth in the next chapter which explores the complexity of consent and how the service users’ lack of understanding of this can have detrimental effects on the conversations which are being had about consent in sexual health practice.

Whilst practitioners disclose that they have their own way of individually filtering their patients, it should be noted that the structure of the sexual health service also filters when conversations are appropriate before the service users are triaged to a consultant. Carly explained that the “no-talk testing” clinic has a procedure in place to risk assess the patients coming in by providing a short questionnaire to service-users and that if they can answer “no” to all the questions then they can attend a clinic in which they are not asked any further questions from the minimum data set:

“And so it's things like have you got any symptoms, have you been raped, do you have sex in exchange for money. And it's just sort of questions like that... then they can come to no talk testing because it is low risk.”

-Carly (NHS)

As the service streams their own patients into whether or not conversations around consent are needed, this could be problematic. As discussed previously, many users who have experienced non-consensual sex may only disclose this when a gradual rapport is built with a health-care professional. If service users are not honest on the questionnaire and chose to take the “easier” option where

they know these conversations are not going to be had, then this opportunity to build rapport is not provided meaning that these conversations about consent are being neglected. In contrast, it is also evident that open conversations around consent are only had when service-users are willing to discuss them. Furthermore, the benefit of such “no-talk testing” filtering is understood as it allows individuals to access the services even when they are not emotionally ready to have conversations surrounding consent. This reiterates the fear that providers within the NHS have that probing users to discuss emotional concepts could cause them to withdraw. However, this creates further distance between the communication and transparency which occurs between the service user and provider. As discussed previously, it is important that truthful conversations are had in order for users to get the best support, if users are answering these questions on paper and not with providers, then this could result in breakdowns in communication.

4.3 Service users' understandings of consent

4.3.1 Consent is complex

As discussed previously, sexual consent has been traditionally considered in simplistic terms. Consent has been framed as a concept in which explicit and direct communication can be used to express an individuals' wishes to engage in sexual intercourse. This has been referred to throughout this thesis as the "yes/no" narrative (2.2.4). The "yes means yes" and "no means no" mantras were promoted by radical feminist thinkers (2.2.4.1) as tools to convey affirmative consent (Harris, 2018) and as an attempt to regain bodily control and sexual liberation. While this mantra does have its place, it does not account for the ever-changing context which consent navigates. Framing sexual consent simply within a "yes/no" narrative is not useful when considering the instances which occur where sexual consent is more complex. Moreover, the realities of negotiation and communication within sexual relationships more accurately describe the way consent is manifested in sexual encounters. This section will discuss the complexities of consent and the way in which service-users understand these concepts. I will argue that the poor understanding of these complexities prohibits service providers having beneficial conversations around consent with their service-users.

4.3.1.1 Grey areas of consent

Sexual consent requires clear knowledge and understanding of the situation and the interaction which is about to take place (Humphreys & Herold, 2007). Therefore, when under the influence of substances, it is argued that the understanding of the individual consenting becomes less clear. Implications of substance can include memory loss and regret, and these exemplify the complex nature of complex. When intoxicated, high risk behaviours are amplified and with sex it is no different (Drouin et al, 2019: 741):

"If you're drinking booze at the same time having sex, often they'll start to make different decisions than they would have made before. If they're taking drugs at the same time having sex, then it's the same."

– Emma (NHS)

The link between alcohol and the poorer sexual judgement was discussed by providers. This is supported by Fantasia et al (2015:224) who state that alcohol often leads to “sexual risk-taking behaviours, including a decrease in safer sexual practices and non-use of contraception”. Whilst it is argued that being intoxicated often leads to less likeliness to use protection such as condoms (George & Stoner, 2000), the relationship between making these judgements and consent is not often examined. The above quote from Emma refers to the relationship between substance and consent decisions. If an individual normally used a condom in every sexual interaction but did not consider the risks properly due to being intoxicated, then this is another example of the complexity of consent and the way in which consent must be considered more deeply than in the “yes/no” consent narrative (Leahy, 2014).

Grey areas of consent occur when examining the relationship between sexual consent and the power dynamics of a sexual interaction. If one party in a sexual encounter has a higher power weighting than another this can complicate the presentation of consent. Buchhandler-Raphael (2011:151) introduces the term “sexual abuse of power” to encompass a broader meaning than that of “sexual coercion” while still similar. The term does so by introducing the idea that individuals may consent to sexual interaction when the power balance is skewed, and one party is placed by another “to fear that they would encounter professional or economic harm” (2011:207). Whilst Buchhandler-Raphael likens the situation to a power imbalance between employer and employee, there are various situations in which the complexity of consent is exemplified through power:

“So it is a kind of massive thing at the working girls’ clinic, because I think a lot of clients might think because they’re paying someone to do something, then that is fine, but actually everybody’s got their limits.”
- Carly (NHS)

An example of a power imbalance which further highlights the complex nature of consent is mentioned in the above quote by Carly. Sex workers, or those who exchange sexual interaction for monetary payment (West, 2000), are a group that Carly works with both inside and outside the designated “working girls’ clinic” in NHS Lothian. In the discussion she stated that usually explicit consent

(Saunders, 2010)(2.1.2), was given by the individual in an agreement for certain sexual acts to take place. However, linking to the idea of power dynamics, the consent given here could not be as clear as it seems. As mentioned previously, consent must be “given freely” (Humphreys & Brousseau, 2010:1) and with the incorporation of payment into the context, it should be examined whether this is true consent. Referring back to Buchhandler-Raphael (2011), consent is questionable when the consenting individual is fearing of “economic harm” so poses questioning of whether the consent is rendered invalid in this situation. This is supported by Lamb (2015) who explains the complex relationship between money and consent. Whilst it appears that sex workers have given their consent, in order to give sexual consent, the decision must be made free from influence. In the same way that alcohol could influence decisions, and render consent invalid, the same could be argued for monetary payment. Carly explains that those within the sex work industry have “got their limits” and could be further explained by saying that people will give “consent” until a certain point where the influence of money is no longer enough.

If you are examining consent within the “yes”/“no” narrative in each of the above instances, then both situations would appear to be consensual. However, there are grey areas in both of these instances where external influences have shaped the decisions that they have made. Beres (2007:99) states that “consent becomes something broader than just a “yes” to sex with a specific person” and it requires a situation to be looked at relating to the context in which it is in. It could be argued then that there is a difference between agreeing to a sexual encounter and truly wanting to consent to a sexual encounter. Therefore, here the complexities of consent are exemplified.

4.3.1.2 Consent is constant

In order for a sexual interaction to be considered consensual there must be the opportunity to withdraw the consent at any time (Lyon, 2004:277). The withdrawal must be respected and the consent givers wishes must be listened to. This introduces the important place that withdrawal has in sexual consent which further accounts for its complex nature. Post-penetration withdrawal is used as an example of the way that consent can be withdrawn and furthermore, adhered

to by the consent receiver. Post-penetration withdrawal is the withdrawal of sexual consent after a sexual interaction has already started (Odundo, 2017). Whilst in theory, it is simplistic that if consent has been withdrawn then the interaction should be stopped or renegotiated, in practice it is more complicated. This, therefore, highlights again the complexities that exist around sexual consent:

“I think the idea of withdrawal of consent, definitely with young people, but you know, with older people too, it's not as well understood. I think there is a little bit of ‘oh well I said yes. So, you know, I need to go ahead with it.’ But that's not the case.”

-Emma (NHS)

“Then with the idea of withdrawing consent is shocking to a lot of young people that worries me, because it means someone's potentially going to carry on doing something they don't want to do.”

-Alice (Third Sector)

Odundo (2017) explores the idea that initial consent to penetration, or that of other sexual activity, internally stops or limits the consent giver from stopping or interrupting any sexual encounter. Emma draws parallels with this as she explains that she believes some of the service users that use her service would continue with a sexual encounter, even should they wish not to, just because they feel compelled to due to their initial consent. This links back to the idea of internal consent (Peterson & Muehlenhard, 2007)(2.2.5). If consent comes in two forms, external and internal, then both must be considered in order for a sexual encounter to be viewed as consensual. The foundation of the internal consent argument (Marcantonio et al, 2018) is that this form of consent is conceptualised as the inner thinking and decision of an individual to perform in an act (Muehlenhard, 1995). Should the inner consent of an individual and the external (action) consent of an individual differ, then this creates some complex tensions in the individuals' consent giving. Further highlighting the complexities and tensions which can exist within an individual's ability to consent and therefore, the ambiguity that can occur in sexual situations.

Kelly (2015) states that sex is a continual process and not always an isolated act. The continuity of the process is upheld by the constant negotiation and renegotiation of sexual activities and furthermore, what the parties involved are

willing to consent to. As such, in order to give true consent, it must be possible to re-establish and reshape boundaries after the initial consent has been given:

“So that's a conversation we have with our gay men, with the club scenes and dark rooms about how consent is absent there. We've heard service users say, 'oh, if you go in there then everyone is consenting', and I was like, 'No, consent is constant.'”

-Paul (Third Sector)

This is an idea which was shared by the providers as shown in the above quote from Paul. The example given here is significant as he highlights the views of consent from someone who enters these spaces who is both a consent giver and a consent receiver. He uses the specific examples of LGBT spaces to denote the way that sexual consent is often assumed by people in that space. However, this does not uphold the discourse that consent is a constant entity and can never be assumed. Gotell (2008:886) explores this idea by looking at the discourses surrounding “high risk spaces” and the standards for consent within and around these spaces. If “sex-positive” places such as sex clubs and cruising establishments expect, and encourage sexual interaction to take place within them, it could be argued that consent seekers will not seek out consent as actively as they would in other situations. If this consent is not looked for, and as spoke about previously, individuals may have a difficult time withdrawing their consent verbally; this could lead to non-consensual interaction taking place. If certain contexts exist in which consent is assumed causing tension between the internal consent (Peterson & Muehlenhard, 2007) and the actions of an individual, then this further shows the complexities which exist around consent.

4.3.2 Complexities of consent are not understood

Consent is defined by Selinger (2009:1) as “permission for something to happen or agreement to do something”, this definition is not specific to a sexual context but represents consent as a general form of communication. This understanding is something which providers expressed that they felt was not understood by service users as they had failed to be educated on consent as a general concept:

“Consent and actually understanding what consent is away from just sex is important for people. It needs to be taught from a young age so that they can value themselves and value their bodies.”

Consent is viewed as a prop to exercise the right to bodily integrity (Herring & Wall, 2017). Body integrity, in short, is set out as the right “not to have your body touched or interfered with without your consent” (2017:568) and consent can be used in order to make decisions about one’s own body. By exploring consent in this way, it can be understood that consent appears in many different contexts including, but not limited to immunisation, medical treatment, surveillance and assault. By looking at the different ways in which consent can be exercised, it supports the argument of academics and educators who believe that consent should be taught as a life skill. This idea was mimicked by the providers who stated that consent should be taught from a young age. By refraining from explaining consent in a sexual context initially, it will allow people to have a foundational understanding of the concept which can be built upon to include sexual consent. Bessie supports this idea of consent and body integrity being interrelated as she states, “Talking about consent is so important because you are not only talking about sex, about relationships but you are talking about self-worth”. Positive relationships and individual self-worth are considered important within the emotional aspect of sexual and general health. Therefore, indicating that there is a link between consent and the emotional wellbeing of service-users and other individuals engaging in sexual activity. As previously discussed, sexual consent is complex in nature and as such, difficult to understand. By building on the knowledge around consent over a period of time, individuals would better understand the complexities of the concept and furthermore, feel in better control of their bodies and the choices that they are making.

Taking this idea further and putting knowledge of consent into a sexual context, providers expressed that they felt consent was not understood by service users as they had failed to be educated on consent as part of sexual education. As discussed previously, consent is a complex concept which incorporates many elements. The yes=yes and no=no discourses presented, do not represent the many dynamics within consent. Despite this, this is the narrative which is most commonly adopted by individuals:

“We do not educate people properly on these things. So how do you expect people to be good at it. You wouldn’t expect them to be good at

maths if you tell them about it once when they were 16 and hope their parent's will tell them about it the rest of the time."

-Mark (NHS)

Sex education was viewed by providers as not to a good enough standard as to maintain a good knowledge and have a positive sexually healthy lifestyle. For example, it focussed heavily on the physical side to sexual health while neglecting emotional and social aspects. Mark, Janet and Tim compared the nature and depth to other subject areas such as English and maths to highlight the sparseness and basic form that sex education took in schools in relation. Furthermore, providers highlighted that the "patchy" nature of sex education meant that when delivered the importance of emotional wellbeing was not conveyed. Their opinions showed that this was because there was not a regulated standard that students must obtain in sexual health like they would in other areas of education and as such, the teachers, who are overworked, naturally focus on other subject areas that are assessed. This lack of sex education has been present throughout generations, and as sex education now starts to evolve (Elliott et al, 2013) and incorporate more dimensions of sexual health, it hasn't always been this way. The providers highlighted the generations of people and sections of society who have never learned these elements of sexual interaction at school:

"And he said, "Oh I'm just a child of Section 28". We didn't learn these things."

- Paul (Third Sector)

Paul, in the above quote, is referring to a service-user who he was having a conversation within a consultation. The service-user explained that whilst he was not in a particular mood to be sexually involved with anyone that night, he had entered into a sex positive establishment and felt it was expected of him. Paul had explained that he was well within his right to decline any sexual activity and that just because he had entered into that space did not mean that he had consented. The response of the service user was that he was raised in a time where "section 28" was evoked which prohibited the promotion of any homosexual relationships or interaction within local authorities and schools. The service-user received education in a time where sex education was basic if not absent, but also in a time where LGBT individuals, and the sex that they were

having, was not being acknowledged. In turn, LGBT individuals were not being educated about consent and the complex nature that it manifests. Providers discussed this further by highlighting the contradiction in society between expectations and education. Individuals are expected to have a certain standard sexual health, comprising of the physical, emotional and social aspects. However, these same individuals are not being taught about sexual health across the board. If they do not hold the knowledge, then this standard will not be reached. Linking this idea back to the idea of sexual consent, knowledge around consent varies in accordance with the influences in which individuals learn from and furthermore, if sex education is not providing individuals with the tools to learn about sex then individuals will look to other information sources.

Other information sources include media such as film, television and the internet. These are sources which are easily accessible and are plentiful in supply. It is argued that one of the main sources of sex education is education of the self via the internet, especially in young people (Hirst, 2004). If individuals are basing their sexual health knowledge from sources as these then this is potentially problematic due to the under-representation of consent in these areas:

“Nine times out of 10 the first thing they’re going to find out about this stuff is Google it. What do they get? Some porn. And porn is very different dialogue around the idea of consent. And the roles of male and females within sex.”

-Lily (Third Sector)

Representations of consent are absent in mainstream pornography (Whisnant, 2016). Whilst behind the scenes porn workers “consent” to the filming and interaction taking place on camera, discussions of consent are not usually represented as part of the narrative. Whisnant (2016:3) discusses this fact stating, “it is fine to portray dominance, submission, pain, and hierarchy as sexually exciting, so long as women are shown consenting to them and even enjoying them”. In this quote she is discussing the heterosexual roles which tend to be positioned in pornography whereby the female is submissive, and the male is dominant. This is from the feminist perspective which values the sexual liberty of choice. Furthermore, that any activity or sexual interaction is deemed to be acceptable as long as it is free from influence and consent at the core of the interaction. Linking this back to the above quote by Lily, who links the education

and learning about sexual interaction to come from internet searches and inevitably pornography results. She discusses the narratives within pornography and mimics that of Whisnant (2016) as they discuss that there is no dialogue present about consent in these porn films. Lily goes on to voice concerns regarding this lack of representation as it ultimately provides unrealistic representations of sexual interaction and furthermore, the discussions and conversations which should be had prior to engaging in sex. Conversations around consent and negotiations about partner's wishes are important aspects of interaction which should be communicated, as spoken about previously, and if these conversations are not taking place then this is problematic. Moreover, as a source of information, people look to pornography to gain insight into the way that sexual interaction works. If there is no representations of consent, then it could be argued that viewers will not learn how to communicate these topics and they will then not be reflected in the real-life sexual interaction that viewers are having.

4.3.3 Negative impact on conversations with sexual health professionals

4.3.3.1 Effects on conversations

The lack of understanding from service-users means that the types of conversation being had between service-users and providers are not as beneficial as they could be, as service-users do not understand the concept of consent in its entirety. When linking back to the comparison between knowledge of consent and subject areas such as English and maths, it would be difficult to have a conversation with someone regarding maths who did not understand the topic. Furthermore, it would be difficult to have conversations surrounding consent with a service-user that did not understand consent or the complexities that exist around it. Street et al (2009) discuss the conversations of patients and providers in medical consultations and refer to the autonomy that takes place on both the service user's part and the part of the provider. Each party has to be aware of the way that the other facilitates conversations but also how they process information. This is important as in sexual health services when dealing with conversations, service-users have different understandings of consent and the complexities which have been discussed throughout this chapter. In order to have beneficial conversations surrounding consent, providers must be aware that

the complexities that they understand to be surrounding consent, their patients may not. Furthermore, they must negotiate the conversations depending on context.

4.3.3.2 Effects on ‘filtering’

As discussed previously in this chapter, filtering does take place within the service, and service providers stated that they asked about consensual sex where they felt that it was appropriate. This then could account for gaps in who is being asked about consensual sex in their consultations. Whilst this was put down to “time constraints” and “appropriateness” by the providers, this could mean that users who do not understand consent, and its complexities, fully are being missed. Taking this idea further, by linking back to the service-user that Paul had mentioned about having poor knowledge surrounding his consent in certain spaces, he is an example of a user that could have been missed. When talking to providers it was clear that there was particular focus on young people, females, and those using the service after an instance of sexual contact (e.g. not when coming for a repeat prescriptions etc). This service user may not have been asked about consent should he had just come in for a repeat prescription of a medication such as PrEp. Due to the complex nature of consent, providers have to negotiate the topics carefully and be aware that different service-users will have different understandings of what consent actually is. And different practitioners will deal with this in different ways. Linking this with the way that providers view their role and the idea of “filtering” the service users that they think would understand the terms, it is possible that service users who have a lack of understanding are not getting the terms broken down to them as more “vulnerable” users have been. For example, NHS staff stated that they further broke down the term consent to users dependent on what they felt was appropriate according to the age and vulnerability of their patient. If they were doing this, then they would have failed to break down the concepts to service users such as the middle aged male that Paul mentioned who accounted for his lack of knowledge due to the generational time that he attended school and the lack of LGBT sex education which was available at that time. This could potentially mean that users are being missed when these conversations are being

had. Furthermore, are not having the complexities of consent being broken down to them as the assumption is there that they already understand.

4.4 Chapter Summary

Within this chapter, the emergent themes are organised into three main findings which account for the way in which conversations are being had surrounding consent within sexual health provision. The first (4.1) discusses the level of understanding that providers have about sexual consent and how this differs across sectors. Understanding the level of knowledge that providers have is fundamental to understanding the types of conversations which take place with service-users as it is these providers who are facilitating the conversations. Furthermore, within sexual health any conversations are led by the knowledge of the providers. While having knowledge of these key concepts is a part of the provider's role, it emerged that there were additional aspects of their job which can affect the types of conversations had around sexual consent. The second finding (4.2) sets out that aspects of the role such as reflexivity, boundaries and filtering can alter the way that providers and service-users interact. The final finding (4.3) then explores the knowledge of the service-user surrounding consent. Much like that of the provider, it is important that service-users have a good level of understanding about these concepts before they can engage with them. As service-users fail to understand consent, and its complexities, this limits the extent to which sexual consent can be discussed. If sexual consent is not being discussed in depth within sexual health consultations, then it is difficult to measure the extent to which sexual relationships are free from coercion. Furthermore, it is then difficult to measure the progress of outcome four of the SHBBV framework.

5.0 Recommendations

This chapter reflects on the findings discussed in chapter 4 and recommends methods which could better facilitate conversations around consent in sexual health provision. It is important when evaluating health policy to ensure that the procedure in place works across contexts. As such, a realist approach was used to examine what works for all, in every context (Pawson & Tilley, 1997;2004). By evaluating the provision with this perspective, it was possible to propose three main recommendations which are grounded in the context of sexual health services and could arguably would work well for all service-users. The SHBBV framework aims to make sexual relationships safe and free from coercion, therefore, an aim of sexual health services should be to monitor whether users are having safe and consensual sex. In order for the progress of this aim to be examined, conversations around consent must be had across sectors and to all service-users. As the recommendations have been formulated around problems which have emerged in the findings, the proposed methods have been discussed with both the providers' opinions, and existing literature in mind. Drawing upon the opinions of sexual health providers' is beneficial in order to feed back into practice as to how to facilitate these conversations, and provide support when disclosures of non-consensual sex has occurred.

5.1 Framing Conversations

As previously explored (see 4.3.3.1), it is evident that service-users have poor understanding about the complexities of consent. As such, it is difficult for providers to have in depth discussions around the topic. It is recommended that as the role of the provider, these conversations should be accessible and allow all service-users to have these discussions despite their level of knowledge surrounding consent. This section will discuss and recommend processes or tools which could allow providers to facilitate these conversations better.

5.1.1 Blanket Questioning

Health-care professionals within the NHS stated that they aimed to ask every service-user that they see about sexual consent and their experiences of non-

consensual sex. This will be referred to within this section as “blanket” questioning and refers to asking all service-users about the sex that they are having. It is a concept which has been developed from the idea of “blanket rationale” (Zimmerman et al, 2018) which is a way of thinking that aims to be all encompassing in its focus. By applying a blanket approach when asking about consent, it would allow the questions to be asked as part of a routine. Being inclusive of all service-users when asking about consent within sexual interactions would have various benefits to facilitating conversations around consent in sexual health provision. Firstly, if this approach was used within the NHS and third sector organisations then it would provide consistency across the sectors with regards to how they ask service-users about their experiences. Secondly, by asking all service-users irrelevant of the service that they are seeking, it could allow discussions about consent to take place with service-users who are not traditionally focussed on. For example, as discussed in section 4.3.3.2, when talking to providers it was clear that there was a focus on young people and females. If the “blanket” questioning approach was used in all consultations, then this would include vasectomy clinics where the question is not often asked. This would allow an access point for male, older service-users to enter a discussion surrounding consent should they wish to in the same way that female service-users are provided with the opportunity in coil-fittings, where the question is asked. Lastly, another benefit of “blanket” questioning is that it would provide the providers with a tool to open up and facilitate these conversations. Providers are able to give context for the questioning by explaining to service-users that all service-users get asked these questions and having this explanation could make providers more confident to open up these discussions. As the interviews with providers progressed, instances in which they did not ask were discussed. These instances included but were not limited to no-talk testing⁵ consultations; consultations for repeat contraception/PrEP⁶; and vasectomy clinics. While NHS providers reflected on this method as a beneficial exercise, it was not being carried out to the fullest extent, therefore meaning that the, previously mentioned, benefits of using the method might not be achieved. In

⁵ No Talk Testing- This is a testing clinic for people who have no signs or symptoms of infection and who are at low risk of HIV and Hepatitis, but would like to book in for a sexual health check-up. NB: this clinic is now called “Full Screen- No symptoms” as of May 2019.

⁶ PrEP: Pre Exposure Prophylaxis is the drug which is a daily medication to prevent HIV from taking hold and spreading throughout the body.

order for the “blanket” questioning approach to be successful, it is paramount that these questions are asked to everyone.

5.1.2 Language

The language used during these conversations is the key part to opening a beneficial dialogue. Due to the differing knowledge of service-users surrounding consent (see 4.3.2), it is important to use accessible language to allow service-users to enter discussions with providers and for open discussions to take place. As discussed previously, it is beneficial to ask all service-users about their experiences with consent, but it is also important that the language used in these questions provide the same accessibility.

Health-care providers within the NHS discussed the minimum data sets which were there to dictate the information which the NHS would like fed back to them. Furthermore, they reflected that the minimum data set covered a question surrounding consent and instances of consent in sexual interaction by framing the question as, “Have you ever been a victim of gender-based violence?”. Gender based violence is defined by Heise et al (2002) as an umbrella term which encompasses many different forms of harm. Sexual coercion and abuse are included within the term gender-based violence and are noted to have adverse consequences on a person’s health. However, using this term as an entry to conversations around consent may not be the most coherent use of language. As “gender-based violence” is an all-encompassing term which refers to many different forms of violence, it would not open up a conversation specifically around consent. Although it is a potentially beneficial term to use when looking at various forms of harm towards a service-user, as stated by Lily, it could hinder or distract service users from the topic of consent as they are thinking about the different elements of gender-based violence. However, in order for any opening of discussions around consent, or any distractions, to take place would require service users to understand the term “gender-based violence” and what it means. This is a subsequent critique of the use of the “gender-based violence” term when trying to open conversations about consent, that service-users may not have this level of understanding. Krug (2008) examines the use of language within healthcare and the way that it is easy for providers to use terminology which is grounded within their work towards service-users subconsciously. Krug also

stated that when communicating with service users, if you do not “speak their language, they won’t hear you”. This idea is supported by Partida (2012) who emphasises the importance of shared language between providers and receivers within health provision. Furthermore, effective communication is described as a “marker of good health-care quality” (2012:19) and key to ensuring understanding and providing treatment. Relating this to complex concepts such as gender-based violence being used in sexual health practice, it could put up barriers between service-users and any disclosures of non-consensual sex.

5.1.3 Reflective Discussions

Sexual health providers stated that they felt a duty of care to make sure that the sexual interaction that users were experiencing was consensual. However, providers also discussed the tensions between having this responsibility and respecting the privacy of the service user (see 4.2.2). In order to manage these tensions and to successfully facilitate conversations surrounding consent with service users, it is important that providers ensure that the service users feel in control of any discussions that are being had around their sexual activity. Paul and Tim discussed the use of reflective language when facilitating conversations around consent, as to make sure that the service user feels that they are in control of the discussion. Moreover, using the language that participants use, whether that be matching the terms or phrases that they use, back to them can enable providers to facilitate the topics that they want to, without pushing the service-user.

As discussed previously, it is important that providers and service-users are “speaking the same language” (Krug, 2008: 19) when having discussions around the individual’s health. As consent draws upon the emotional aspects of sexual health, it is also important that this is done in a sensitive manner, and that service users are not feeling pushed to disclose things that they don’t wish to. Third sector providers reflected on the use of motivational interviewing as a tool to understanding the way that consent occurs in a service users’ sexual interaction. Motivation interviewing refers to the “communication style that uses specific techniques and strategies such as reflective listening” in order to allow an individual to process what they are saying and elicit change (Resnicow & McMaster, 2012:1). Providers discussed the fact that motivational interviewing

allowed conversations to be opened up using the individuals' own language and disclosures back to them to make them reflect upon what they were saying. Within this research, it is clear that service-users do not understand the complex nature of consent (see 4.3.2) and within their experiences may fail to highlight when their consent has been breached. Therefore, motivational interview training could be a useful method to highlight any concerns that providers have with the context of the sex which has occurred. If a service-user discloses the context of the sexual interaction and the provider believes that the consent was questionable, by repeating this back to the service user in their own words, providers are still maintaining the professional boundaries whilst also facilitating important conversations. Motivational interviewing is a method which results in long-term behavioural change within health (Resnicow & McMaster, 2012) and does so in a way where service users are autonomously motivated. This method would allow providers, across sectors, to open up discussions surrounding consent but also facilitate change in how service users view the sex that they are having. If a change in the way service-users takes place, then appropriate support can be given where consent has been breached in their experiences.

5.2 Partnership Working

It was found that providers focus on and are specialised in certain aspects of sexual health and this differs on an individual basis (4.1.1). If the strengths of individual providers, across sexual health and across sectors, are brought together to work together then it would provide a better standard for service-users. Regarding conversations which take place surrounding consent, it is important that should disclosures of non-consensual sex take place, support must be in place. Partnership working and resource sharing is the most beneficial way to do this and, again, relates to the way that the Scottish Government wishes for sexual health services to be meeting the outcomes of the SHBBV framework.

5.2.1 Across Job Roles

Sexual health can be understood as three aspects; physical, emotional and social and the focus and prioritisation of these aspects is different depending on the responsibilities of the role (4.1.1). In order for the service provided to encompass

all aspects and to optimise the access that service-users receive, it is beneficial for clinical and social roles to work collaboratively. This would mean that clinical roles such as doctors and nurses would work in conjunction with those who have more social-centred focusses such as youth workers, health-advisors and support workers.

Partnership working within healthcare seeks to focus on prevention, intervention and social improvement (Sauvage & Ahluwalia, 2016) of a shared interest. This type of collaboration could be carried out by distributing resources, lending expertise and sharing power. Whilst this type of partnership working was present within the NHS and third sector organisations, it was also discussed by providers that there were many areas where it was not taking place. Sauvage & Ahluwalia (2016:52) discuss the “universal anxiety” felt by health-care professionals who strive to work collaboratively with others in order to provide high quality care. They understood the financial cuts and pressures resulting from austerity, means that standardised approaches to healthcare are being reintroduced in order to enhance productivity. Providers echoed these ideas with those, particularly in the NHS, commenting on the way that resources and hours of health-care professionals are being limited. In addition, it was noted that it was the social roles, such as youth workers and support workers, which were lacking within the service rather than the clinical staff. Clinical staff within the study were forthcoming about the importance that they felt youth workers brought to the service, particularly when discussing consent to service users. In addition to this, every clinical member of staff interviewed commented on the benefits that more youth workers would bring to the service in order to assist with the emotional and social aspects of sexual health. With the NHS, as an institution, not hiring these types of roles, it supports the claim that the NHS focus is on the physical health of the service-users. In order for consent to be focussed on, it is important that roles within the service are working together to make sure that the emotional and social aspects of care are being prioritised just as the physical aspects are.

5.2.2 Across Sectors

The SHBBV framework places importance on people-centred principles within sexual health to ensure every individuals’ needs are being met and supported.

The framework further dictates that in order for this to be achieved a cross-sector and inter-agency approach should be encouraged. Glasby et al (2011:1) states that “any holistic response to health needs will have to link to and be co-ordinated with the responses of other agencies if it is to be successful” as people do not simply adjust their lives to suit the health provision available. Therefore, in order to facilitate conversations surrounding consent with health-care providers, it is important that work is being carried out in collaboration with other sectors.

5.2.2.1 NHS & Third Sector

Both NHS and third sector providers believe that by interacting with each other, pooling resources and sharing expertise, that the quality of care is improved. While this can refer to better facilitating conversations around consent, it also applies when looking at the support available to those who need it. As discussed previously, it is important for all aspects of sexual health to be available to service-users and due to the differing focus and prioritisation of each service, this may require cross sector collaboration to take place.

Cross-sector collaboration is encouraged throughout the SHBBV framework in order to provide a well-rounded service to those seeking it. It is stated by Shaw et al (2006) as being key to enhancing the delivery across health-care services generally but can also be applied specifically to sexual health as a field. The prioritisation of certain aspects of sexual health depending on the provider’s role, profession and sector can mean that the emotional support required by service-users is not being provided, particularly due to the increasing pressures within the NHS. In order to combat this, it is important that third sector organisations can provide the emotional support and that NHS staff have the knowledge on where to direct people to get additional support. As NHS providers do not always have the tools at hand, with Mark saying “you almost with you could be like okay here is the councillor next door to help you with that”, it is important that an open line of communication is created to ensure that the service-users are being signposted appropriately. In addition to providing the necessary support, open communication across sectors can provide sexual health professionals with confidence to open up the conversations surrounding consent. For example, if an NHS provider had hesitation about discussing consent with a service-user, due

to not knowing where to send them should they disclose something, this hesitation would be eradicated. Partnership working can also be beneficial in the form of sharing resources and tools, particularly when there is a shared interest or goal (Boydell & Rugkasa, 2007). For example, providers in the third sector discussed the freedom that they had on their organisations' social media accounts to promote and campaign areas of their work. Tim discussed the ways that this was in comparison to the NHS which has procedures and "red-tape" and that through working closely together it was possible for his organisation to put out messages that they knew would support the work carried out by the NHS. For this type of collaboration to take place, it is again important that clear and open communication is taking place between the NHS and third sector organisations, which is arguably the most difficult element of establishing and maintaining cross-sector partnerships (Taylor-Robinson et al, 2012).

Despite both NHS and third sector providers stating the value of partnership working, it is necessary that open communication takes place in order for both parties to benefit from the pairing. Third sector providers were aware of the services provided by the NHS, arguably because the NHS is a traditional and long-standing institution, whereas NHS providers felt they needed more guidance to provide the best quality of care. NHS providers were equipped with some "go-to" third sector organisations, such as Waverly Care, STAR Project and Rape Crisis to refer people onto. However, they vocalised that the increasing cuts and staff shortages behind the scenes of third sector organisations meant it was hard to keep up to date on who was most appropriate to help. Furthermore, they expressed that they would benefit from communicating with new third sector organisations currently emerging, and that they believed this could improve the overall sexual health practice. Therefore, highlighting the importance of communication in order to make partnership working successful and for the benefits of the relationship to be optimised.

5.2.2.2 Sexual Health & Education

Partnership working can allow a line of communication across sectors, but it can also allow a method of communication to potential service-users (Taylor-Robinson et al, 2012). As discussed in 4.3.1, consent is a difficult concept to

understand, and failure to do so impacts the types of conversations which are had in sexual health service. By establishing relationships with education outlets, this would allow service-users to understand more about the services available and also to learn about complex concepts which are difficult to understand. Throughout the interviews, providers in both sectors reflected on the importance that education had in informing service-users about consent as a concept before they are sexually active. As the age in which people initiate first sexual contact is becoming younger (Lewis et al, 2017), it is important that these discussions take place at an appropriate level and with good quality content. Through partnership working and active communication, sexual health providers and educators would be able to provide content direct to the target demographic. This would also enable educators to feel confident in providing the information as they would have an opportunity to ask questions and ensure that the content is current and accurate. In order for beneficial conversations around consent to be had it is evident that service-users must understand the concepts before they enter a consultation. Furthermore, it is apparent that education either through sex education in schools; parental guidance; or media outlets is necessary to achieving this outcome.

5.3 Understanding Consent

In order to have conversations surrounding consent, providers and service-users must understand the concept of consent and its complexities. This will enable service-users to have access to the types of conversations around consent which are being had in sexual health provision. In addition to this access, with better knowledge surrounding consent it will allow individuals to have safer and more comfortable sex.

5.3.1 Improving Knowledge of Consent

The best way to improve knowledge surrounding consent is to educate potential service-users on the concept of consent and the elements related to it. While this could be done through parental guidance and media outlets, it is important that core knowledge is being provided in schools. As school education is a requirement in Scotland, by providing knowledge around consent consistently

throughout sex education, it acts as a good access point to the target demographic. Furthermore, due to the variable nature of family and media education, it is important that sex education in schools provides at least a foundational level of knowledge to everyone who attends. By educating about consent in schools it would be possible for all individuals to have the same level of knowledge before forming sexual relationships. Sex education programmes must include consent as a core part of the content and placing emphasis on the complexities which must be considered across the board. Users must be able to understand that the many elements of consent which exist (see 4.3.1) and understand that it is more complex than the yes/no narrative which is traditionally presented. Sex education could benefit from including all aspects of sexual health in its content. Therefore, teaching and consideration of physical, emotional and social elements of sexual health will allow an opportunity for consent to be discussed and taught. As individuals understand the different elements of consent, they will be able to reflect on these and ensure that they are comfortable in proceeding with any sexual interaction. Without considering, or having the capacity to consider these complexities, it could be argued that the interaction is not deemed consensual.

The perceptions of consent will change as the “yes”/“no” narrative begins to be challenged. As discussed in section 2.2.4, discussions around consent have been framed around whether an individual says “yes” or “no” to sexual contact, without considering any potential negotiation which takes place or external factors which influence. As other aspects of consent are being examined, and the complexities are being considered, this will change the way individuals look at consent within sexual interaction. However, in order for these topics to be discussed they must be accessible to individuals meaning that they must first be taught across the board, but also taught to people in an appropriate way.

5.3.3 Appropriate Delivery

When teaching about the complexities of consent it is important that the delivery is carried out in an appropriately in order for the information to be as accessible as possible. Providers reflected upon the role of sex education in informing individuals about the concept of consent, and furthermore stated that while it is

paramount that consent is included in content, as with all aspects of education, it must be age appropriate. Providers across sectors felt that consent could be discussed at an age-appropriate level by removing the sexual context for those at a young age. Then, as individuals progressed through the education system, the knowledge would be specific to sexual interaction. By looking at the different contexts in which consent is required, it supports the claims of providers who believe that consent should be taught as a life skill. As individuals obtain this life skill it will allow them to form their own self-esteem and confidence in order to make informed and comfortable choices. By refraining from explaining consent specifically within a sexual context initially, it will allow people to have a foundational understanding of the concept before they begin to form relationships. Understanding the complex nature of consent, and having it delivered to individuals in a way that is informative and accessible will lead to better communication around consent both at the learning stage, and while forming relationships.

5.4 Chapter Summary

Recommendation 1 (5.1):

Conversations surrounding consent must be framed correctly.

Providers should have these conversations with all service-users; they must use appropriate language; and they must use methods such as motivational interview techniques to allow users to reflect on their own experiences.

Recommendation 2 (5.2):

Sexual health providers should work in partnership.

Providers should work together across roles and sectors to share expertise and resources to better facilitate conversations surrounding consent.

Recommendation 3 (5.3):

Service-users must have better understandings of consent as a concept.

In order for beneficial conversations to be had with service-users surrounding consent, a level of knowledge must be achieved. By delivering this knowledge appropriately this will allow conversations to be accessible both inside and outside sexual health provision.

This chapter recommends how to better facilitate conversations surrounding consent relating back to the findings of chapter 4 and the opinions of service providers within sexual health. With the renewal of the SHBBV framework, it is important to reflect on the research conducted in order to answer the research question but also formulate recommendations which could be fed into policy and practice. Throughout this project a realist perspective has been employed in order to evaluate sexual health provision in regards to how conversations surrounding consent are facilitated. By doing this, the recommendations listed in this chapter examine what works; for whom; and in what circumstances. If adopted, these recommendations would contribute towards achieving outcome 4 of the SHBBV framework as they aim to better facilitate conversations across sexual health sectors but also improve the accessibility to these conversations in wider society.

6.0 Concluding Remarks

6.1 Future Research

With the renewal of the SHBBV framework approaching in 2020, further exploration into the progress of all outcomes would be useful. Due to the difficulties in measuring outcomes 4 and 5, research conducted will have to be done so qualitatively and with a people-centred approach. The research in this study was conducted in partnership with NHS Lothian and as a result the area of investigation was mainly focussed there. Further research could include widening the scope of provision to include services across Scotland in order to examine the way in which outcome is being met across the country. In addition, it could also be beneficial to incorporate health-care staff, who do not identify as solely sexual health staff, into the examination to monitor how they discuss consent with their service-users. For example, general practitioners and clinic nurses who will carry out sexual health duties in a different context.

Further research could also examine the understandings of individuals or service-users have on sexual consent and whether they understand the complexities of consent. This would enable researchers to understand if consent is being framed within a simplistic “yes”/”no” narrative and what can be done to potentially change this. Consulting service-users would also offer a new perspective to the realist approach used in this project and would allow for a well-rounded evaluation to be undertaken. This would lead to more recommendations as to how to better facilitate conversations around consent and in a context which works for many people. As the SHBBV framework’s outcome 4 sets out to make sexual relationships free from harm and coercion, it would be interesting to investigate whether the aims of the sexual health providers and the wants of the service-users correlate.

6.2 Conclusion

The complex nature of consent has an impact on the conversations that are being had regarding sexual interaction. As such, these complexities must be examined

in order to feed back into sexual health policy and practice and keep sexual interaction safe, pleasurable and consensual. Furthermore, these complexities must be reflected upon by providers as they carry out the fulfilments of their role and cater to the needs of their service-users. The research conducted in this thesis was carried out in order to evaluate the extent to which consent was discussed within sexual health provision. Outcome 4 of the Sexual Health and Blood Borne Virus framework states that all sexual relationships should be safe and free from coercion. It is sexual health providers who have the role of meeting this outcome and ensuring that these conversations are accessible across the board and in every context. While it was found that there are many other remits within each role as a provider, it is important that conversations surrounding consent should be considered and implemented. This study has built upon discussions surrounding consent in the public forum which frame a simplistic “yes”/“no” narrative. By highlighting the complexities of consent as a concept, then better conversations about consent will be had within the sexual health services. Furthermore, this will allow service-users to open up about their experiences in order to receive the best support should they need it, and learn about the role that consent takes in sexual interaction. Thus, meeting the requirements set out in outcome 4 of the SHBBV framework. Going forward, it is important that the structures in society inform, help and support those in our communities, to ensure that every sexual relationship has consent at the core of its nature. As such, this thesis has concluded by proposing three recommendations which are linked to the findings of this research and the expertise of the providers. If implemented, these recommendations could better facilitate conversations surrounding consent by allowing conversations to be accessible; by setting up good working relationships; and by educating on the complex nature of consent.

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8.0 Appendices

Appendix A: Edinburgh Napier University Ethical Approval



Edinburgh Napier University
School of Applied Sciences
9 Sighthill Court
Edinburgh
EH11 4BN

19th December 2018

Dear Sir/Madam

Application for Ethical Approval

Victoria Jones – Do health providers feel equipped to facilitate conversations about consent and healthy relationships?

Reference: SAS0053

Further to the application for ethical approval to undertake a research study from above named Staff member of Edinburgh Napier University School of Sciences, I can confirm that this has been granted and they are now approved to proceed with their project.

Yours sincerely,



Dr. Rory MacLean
Convenor
SAS Research Integrity Committee

Appendix B: NHS Access Permission

NHS Lothian –
University Hospitals Division

27 February 2019

NHS
Lothian

Research &
Development

Room E1.16
The Queen's Medical
Research Institute
47 Little France Crescent
Edinburgh
EH16 4TJ
Tel 0131 242 3330

Dear Miss Jones

Letter of Clinical Research Access – only valid until 11 May 2019 for study number 2018/0295 entitled 'Do health providers working in sexual health feel equipped to facilitate conversation on consent and healthy relationships?'

The UK Policy Framework for Health and Social Care Research outlines the responsibilities of researchers who undertake research in a clinical setting. The framework has been compiled by the Scottish Executive Health Department to ensure all research meets high scientific and ethical standards.

This Letter of Clinical Research Access defines the requirements of Lothian Health Board (the "Board"), subject to which, you are granted rights of Clinical Research Access to carry out Approved Research in the course of your current programme of study at the Edinburgh Napier University.

On signature of this letter, subject to the Board undertaking appropriate Disclosure Scotland checks, you will be granted the right of Clinical Research Access which will continue, until such time as permission is withdrawn by the Board, in the circumstances mentioned in the next paragraph, or such time as you cease to be involved in Approved Research activity or your current study programme mentioned above.

In the event that you are in material breach of the requirements regarding Clinical Research Access as set out in this letter, or the Board considers that it is in the best interests of its patients, then in either circumstance the Board may withdraw Clinical Research Access with immediate effect by giving you written notice of this.

1. **Definitions**

"Approved Research"	means research which has not only been approved by Edinburgh Napier University, but has also received the approval of Lothian Health Board i.e. R & C Management approval, the necessary ethical approval and any further statutory approvals.
"Confidential Information"	includes all information which has been specifically designated as confidential by the Board and any information which relates to the commercial and financial activities of the

Appendix C: Interview Schedule

Edinburgh Napier
UNIVERSITY

Interview Schedule

Introduction

Just some introductions. I am Victoria. I am looking at finding out a bit more about the conversations around consent and healthy relationships that you have with your service-users around the Lothian are whether that be in the NHS or third sector organisations.

The research question today is "Are those working within sexual health services equipped to facilitate conversations around sexual consent?"

My background is in sociology, I am not really too clued up on the clinical and medical side of sexual health so bear with me if I ask you to further explain terminology that you may use throughout this interview.

The type of things we are going to be talking about is the work that you do; the extent to which you discuss consent and healthy relationships; what you think about these conversations being incorporated into your work.

I am going to ask you to keep your identifiable features and the identifiable features of others to a minimum. If you do provide identifiable features, these will be omitted from the transcript.

If you see me looking at my phone or the recording it is just to make sure we are keeping to time. And if you see me scribbling down anything it is just as I think of different things I want to ask you later on. So don't think I'm being rude, I am still listening.

Do you have any questions about what I have just said or what is set out in the participant information sheet?

Section 1: Definitions

How would you define sexual health? What does this term mean to you?

How would you define consent? What does this term mean to you?

Then provide definitions for clarity:

"Sexual health is the specialized area of medical practice concerned with sexual relations, including freedom from sexually transmitted infections, unplanned pregnancy, emotional and physical discomfort associated with sexuality."

"Consent is defined as the permission given by one party to allow certain actions to take place. That permission must be governed by all parties in order for the interaction to consider consensual."

Section 2: The participant's role within sexual health

What is your role within the sexual health?

Past experience in sexual health?

Do you work within a department/ organisation?

How much of your work is spent interacting with service users?

Can you tell me a bit about that interaction (sex/ age/ case load/ formality/time with client, etc)?

Section 2: Interaction with Service-users

Do you discuss consent and healthy relationships with the service users that you interact with? In what sense do you discuss this?

If yes, how does this usually take place?

What would happen should someone disclose that they have experienced non-consensual sex?

Do you find it hard to find the balance in your role of remaining non-judgmental/ not prying too much but maintaining the duty of care?

Vignette: “If a service user came in and discussed that they had had a consensual experience of sex but during it, the partner had removed the condom without them knowing until afterwards. They didn’t seem to be bothered or understand the implications of what had happened, mentioning it to you only in passing. How would you proceed with this consultation?”

Section 3: Working Environment

In an operational sense, do you discuss consent & healthy relationships as a concept with your colleagues?

In an operational sense, do you discuss consent & healthy relationships as a concept with your superiors?

Do you feel supported enough by your work to have these types of conversations with service users (training/ resources/ advice)?

How important do you think the relationship is between the clinical side of care and the social side of care?

Section 4: Going forward

Do you feel the role of the media (social media/ tv/ film/ porn) affects the conversations that are being had about consent and relationships. Both in your work and generally?

Do you feel the role of sex education affects the conversations that are being had about consent and relationships. Both in your work and generally?

How do you feel that consent and relationships could be better discussed in sexual health/ where do you think that the responsibility lies with having these discussions?

(If they believe it to be their responsibility) How could you personally feel better supported to have these conversations within your role?

Explain to the participant that there are no more questions. However, this is a time to give them space to say anything that I did not ask that they think is relevant. Or that there wasn’t the opportunity to discuss.

Appendix D: Recruitment Poster

Research Participants Needed

"Are those working within sexual health services equipped to facilitate discussions around sexual consent?"

Do you work in SEXUAL HEALTH provision?

If yes, we invite you to participate in interviews with our research team as we aim to understand if consent is a topic discussed within sexual health provision.

We are looking for people who work across different sexual health services to voice their opinions on the way their sexual health programme works; and how they feel about discussing consent with a service user.

If interested, please contact Victoria Jones from Edinburgh Napier University at Victoria.jones@napier.ac.uk

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Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk	Victoria Jones: Research Student Edinburgh Napier University Victoria.jones@napier.ac.uk
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Appendix E: Participant Information Sheets

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Participant Information Sheet: Interviews

Exploring Sexual Health Provision: Conversations Surrounding Consent.

Introduction

My name is Victoria Jones and as part of my Masters thesis at Edinburgh Napier University, I plan to research how sexual health service providers feel is the best way to facilitate conversations around sexual consent. My interest in the subject matter stems from the topic of sexual consent, which is an important narrative in our society currently. My university email address should you wish to know more about the project or anything stated in this document is Victoria.jones@napier.ac.uk.

What is the purpose of this investigation?

The overarching aim of my study is to explore sexual health provision in the Lothian area, focussing on whether discussions on respect and consent are taking place during consultations between providers and service-users, and what could potentially improve those conversations.

I will be asking you to think about the following topics:

- Sexual health services in Scotland and how these services are currently operating;
- Your role as a sexual health provider;
- The extent to which these initiatives are discussing consent;
- What you, as a sexual health provider, feel that should be done to further conversations;

Why have I been invited to take part?

You have been invited to take part as I would like to hear from sexual health providers who are the first point of call to the service users. Your opinions would offer valuable contributions to my research as it is based on knowledge and experience of the very initiatives I am exploring.

Do I have to take part?

No. It is up to you to decide whether to take part in the research. If you decide to take part, you can change your mind at any point. You will be asked to sign a consent form if you decide to take part. You will be given a copy of the form, and you may also keep this information sheet.

What will happen if I take part?

If you decide to take part, I will contact you to arrange an interview. This will take place at your convenience and will last around 45 minutes. The agenda will be flexible, so that you can talk about the issues that you think are important. The interviews will be recorded, transcribed and then analysed by the research team.

Will everything I say be kept private?

The interview transcript will be kept confidential. You can say as little or as much as you wish. In the transcript, your name as well as anyone you mention will be changed, so that you will not be identifiable. The transcript will be kept in a secure place. In very rare cases, something may be said that the researcher is not allowed to keep confidential, for example if someone says something about a crime or potential harm to an individual. If this happens, the researcher must report the disclosure to the appropriate agency to ensure everyone's safety. It is very unlikely that this will happen in these interviews.

What happens to the information in the project?

Personal details (contact details only), recordings, and transcripts will be kept on a password protected computer and deleted as soon as they are no longer needed. For example, when the transcripts have been written up, the recordings will be deleted. Upon the writing of the report, anonymised quotes and pseudonyms will be used to keep your identity private. Edinburgh Napier University is registered with the Information Commissioner's Office who implements GDPR. All personal data on participants will be processed in accordance with the provisions of GDPR.

The use of this data is primarily to submit a student master thesis and as such, data will be destroyed after the examination period. However, if a research finding is substantiated; in such cases, in accordance with the University Research Data Management policy, anonymised data will be retained for at least 10 years.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher who will try to answer your questions. You can also speak to Dr Eric Chen & Yvonne Kerr at Chalmers, my director of studies, Dr Sally Brown, or to an independent advisor, Dr Rory Maclean ([REDACTED]). If you decide to withdraw from the study at any point, any data which we have already collected from you will remain in the study. No further data will be collected.

What happens next?

If you do not wish to be involved, I thank you for your time reading this.

If you are interested in being involved I sincerely thank you. Please get in touch with me via victoria.jones@napier.ac.uk to arrange an interview at your convenience.

Researcher contact details:

Victoria Jones

Master of Research: Applied Sciences



This investigation was granted ethical approval by School of Applied Sciences at Edinburgh Napier University. If you have any questions/concerns, during or after the investigation, please contact my director of studies:

Dr Sally Brown



Appendix F: Data Information Sheet

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Data Information Sheet

Edinburgh Napier University is the sponsor for this study based in Edinburgh, Scotland. We will be using information that you provide us with, in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Edinburgh Napier University will keep identifiable information about you until the final report has been assessed. However, should the final report be published, your data will be held for 10 years by Edinburgh Napier after the study has finished.

Your rights to access change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting one of the research team listed on the bottom of the participant information sheet.

Data Usage Procedures:

Your personal data will be obtained from you directly for the primary purpose of research. The data will be collected during the interviews as you verbally communicate your responses.

Edinburgh Napier University will keep your name, contact details and other identifiers confidential and will not pass this information to any external organisations.

Edinburgh Napier University will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Edinburgh Napier University and regulatory organisations may look at the data provided to check the accuracy of the research study. In this instance, said organisations will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Edinburgh Napier University will keep the information about you from this study for 10 years after the study has finished.

Where data is intended to or likely to be used for future research:

When you agree to take part in a research study, the information you give may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the “UK Policy Framework for Health and Social Care Research”.

The information used in the final report will not identify you and will not be combined with other information in a way that could identify you. The information will be used only for the purpose of health and care research, and cannot be used to contact you or to affect your work. It will not be used to make decisions about future services available to you, such as insurance.

Appendix G: Consent Form

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Consent Form: Interview

I confirm that I have read and understood the participation information sheet dated xx/xx/2018 for the above study. I have had time to think about the information provided, ask questions, and have had any questions answered.	
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I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason.	
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I agree that if I withdraw from the study, any data that has been collected from me up to that point will be kept and may be used in reports and publications, but no further information will be collected.	
--	--

I understand that if something is said that raises a concern about workplace practices, for example bad practice or breach of professional guidelines, then this information must be passed on to the relevant authority.	
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I agree to protect the anonymity myself, my colleagues and my service users to the best of my ability.	
--	--

I understand data will be destroyed after the examination period, unless they substantiate a research finding; in such cases, in accordance with the University Research Data Management policy, anonymised data will be retained for at least 10 years.	
I agree to anonymised quotes being used in reports and publications.	
I consent to this interview being audio-recorded.	
I agree to participate in this study.	

Name: _____

Signature: _____

Researcher Signature: _____

Date: ____/____/____

Appendix H: Service Overview Resources

[as of December 2018]

Sandyford Sexual Health Website:

<https://www.sandyford.org/sexual-health-services/>

NHS Lothian Sexual Health:

<https://www.lothiansexualhealth.scot.nhs.uk/Pages/default.aspx>

SHBBV Framework:

<https://www.gov.scot/publications/sexual-health-blood-borne-virus-framework-2015-2020-update/>

Appendix I: Service Overview

Glasgow: Sandyford Clinic	Lothian: Chalmers Clinic	Lothian: Additional Services
<u>Testing:</u> <ul style="list-style-type: none"> - Self-testing - Test Clinics - No- talk testing 	<u>Testing:</u> <ul style="list-style-type: none"> - STI testing and treatment - HIV including Post Exposure Prophylaxis (PEP)** - Pregnancy Testing 	<u>Sexual Health Clinics:</u> <ul style="list-style-type: none"> - Bathgate - Dalkeith - Pennywell - Leith - Howden - Sighthill - Westerhailes - Whitburn - Craigmillar - Tranent

<u>Contraception:</u> <ul style="list-style-type: none"> - C-card Condom Access - Consultation & Prescription - Vasectomy - Coil Insertion - Emergency Contraception 	<u>Contraception:</u> <ul style="list-style-type: none"> - Advice and supplies - Emergency contraception - C-card Condom Access - Vasectomy - Clinical Trials 	
<u>MSM Clinics</u> <ul style="list-style-type: none"> - <u>Testing</u> - <u>PrEP</u> 	<u>MSM Clinics</u> <ul style="list-style-type: none"> - <u>Testing</u> - <u>PrEP</u> 	<u>ROAM M-Test:</u> <ul style="list-style-type: none"> - Gay, Bi-sexual Men and Men who have Sex with Men over the age of 16
<u>G3 Priority Clinic</u> For People Who Sell or Exchange Sex		<u>Spittal Street</u> Commercial Sex Women's clinic
<u>Termination of Pregnancy:</u> <ul style="list-style-type: none"> - Discussion of Options - Abortion Clinic 	<u>Termination of Pregnancy:</u> <ul style="list-style-type: none"> - Referral - Consultation - Abortion Clinic 	
<u>Sexual Assault:</u> <ul style="list-style-type: none"> - Referral to counselling (Archway Service) - My Body Back (Cervical Screening) 	<u>Sexual Assault:</u> <ul style="list-style-type: none"> - Support 	
<u>Young People Clinic</u>	<u>Young People Clinic</u>	
<u>Female Clinics:</u> <ul style="list-style-type: none"> - Gynaecology - Menopause Clinics 	<u>Female Clinics:</u> <ul style="list-style-type: none"> - Community gynaecology - Menopause - Premenstrual Issues - Colposcopy 	
<u>Sexual Problems Service</u>	<u>Sexual Problems Service</u>	
<u>Gender Clinics:</u> <ul style="list-style-type: none"> - Gender Identity Services - Young People Gender Identity Services 	<u>Gender Identity Clinic</u>	

<u>People Who Need Extra Support</u> - Inclusion Support Team			
Appendix J: Descriptive Labels (Coding)			
<ul style="list-style-type: none"> • Adapting/ Flexibility • Alcohol • Age • Child Protection • Clinical • Complexity • Confidence • Conflicts • Disclosure/ Confiding • Duty (of care) • Fear • Filtering • Gender • Interaction • Judgement • Knowledge • Media • Language • Legality • LGBT • Partnership Working • Preparation • Pressures • Procedure • Requirements • Role • Referral/ Referring • Rapport • Relationships • Self-worth/ • Sex Education • Social • Support • “Tells” • Time • Tools & Resources • Withdrawal of Consent • Young People 			

