Sexual & Reproductive Healthcare 17 (2018) 26–30

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

‘Do you know how to use a condom?’ – UK nurse practitioners’ conversation about men and family planning

A.D. Wilson

School of Social Sciences, Leeds Beckett University, Calverley Building, Room 411, Leeds LS1 3HE, England, United Kingdom

ARTICLE INFO

Keywords:
Men’s health
Culture
Condoms
Education
Nurse-patient relationship

ABSTRACT

Introduction: Health professionals have been identified as central to encouraging men to take an active part in family planning. The aim of this article is to understand nurse practitioners’ conversations about men as family planning patients.

Methods: One-to-one, semi-structured interviews were conducted with five nurse practitioners. Nurses interviewed worked in a northern UK student medical practice serving over 34,000 students with a diverse range of ages and demographic backgrounds (both home and overseas students). The research method was qualitative using discourse analysis.

Results: After completing the analysis, two discourses emerged. Discourse one, family planning services are culturally female centric, and discourse two, condom use by male family planning patients is problematic.

Discussion: Implications for how nurse practitioners can continue to play an important part when providing care to male family planning patients is discussed, specifically in relation to culture and condom efficacy.

Introduction

Nurses are considered important to patient care, particularly to inform the reproductive life plan of individuals [1]. In the United Kingdom (UK) due to restructuring of the National Health System (NHS) nurses’ responsibilities have increased to include consultations for family planning [2]. The UK lacks a national curriculum for nurses in sexual and reproductive health (SRH) despite research to suggest there are benefits to a national curriculum (e.g. an increased level of patient knowledge) [3]. The number of UK health professionals specifically trained to provide SRH care is low [4] and services report difficulty recruiting SRH educated nurses [5]. Regardless of the external strains on delivering SRH care, researchers in critical men’s studies have identified that health professionals are central to encouraging men to take an active part in family planning. Nursing and other disciplines have been championed to work together to expand the limited research on men in the procreative realm [6].

There are some concerns to including men in reproductive decisions, particularly the potential impact including men may have over women’s power and autonomy. Irrespective of these concerns, men are already involved as part of women’s reproductive decisions. Research exploring men’s role in family planning could be used to inform the manner in which men could positively be incorporated to improve women’s reproductive health [7]. Research on men’s engagement in pregnancy suggests men can improve maternal health, with further research needed to include all areas of pregnancy (e.g. preconception). Healthcare professionals play a primary role in strengthening or reducing men’s role, providing them a unique opportunity to directly influence men’s engagement [8]. Reproductive health psychologists are increasingly aware there are also social and cultural influences behind men’s reproductive decisions. For example, men with more egalitarian attitudes and beliefs have a more positive effect on women’s reproductive health [9]. Currently little is known about the practices that occur during UK nurses’ consultations with male family planning patients and how these consultations may influence men’s engagement in family planning. This study aims to further understand these practices through conversations with nurses about their male family planning patients. The research question asks how do nurses’ construct men as family planning patients?

Methods

The medical practice had over 34,000 student patients primarily between the ages of 18–25, with overseas patients (international students) described by the nurses as older (30 and above). The nurses provided primary family planning care to male patients (e.g. condoms, advice), male patients were only referred to see the General Practitioner (GP) if they presented with painful urination. Interviews were between 20 and 35 min, lasting on average 30 min. A semi-structured interview schedule was created to allow for flexibility. Five semi-structured

E-mail address: a.d_wilson@yahoo.co.uk.

https://doi.org/10.1016/j.srhc.2018.05.005
Received 21 March 2017; Received in revised form 21 May 2018; Accepted 25 May 2018

Table 1
Nurse practitioner demographics.

Pseudonym	Training	Sex	Ethnicity
Nurse 1	7 years in practice	Female	White British
Nurse 2	17 years in practice	Female	White British
Nurse 3	30 years in practice, previously working with a men's health specialist	Female	White British
Nurse 4	48 years in practice, previously working as a midwife for 10 years before returning to general practice as a nurse	Female	White British
Nurse 5	9 years in practice	Female	White British

interviews were completed with practitioners during their scheduled lunch breaks at work. The interviews occurred in a private area or a semi-private location where nurses could feel free to express themselves without worrying about what other employees or managers may think. The nurses had various levels of professional experience. Regardless of total length of time in practice, the nurses had worked at the current medical practice for roughly 6–8 years. Prior to interviews, University ethical approval was obtained and the ethical considerations were made in reference to the British Psychological Society (BPS) guidelines for human participants [10]. Written permission to interview nurses was provided by the medical practice, with consent forms received by each nurse who participated. Anonymity was assured through creating a numerical assignment to each nurse (e.g. Nurse 1, Nurse 2). A table of the participants is as follows (see Table 1):

The interviews were analyzed using a method of discourse analysis from Willot and Griffin [11] and Gough [12] (see Wilson et al. [13]). Discourse analysis has been used in critical health research with nurses to understand how language informs nursing practice [14]. To conduct the analysis the transcripts were divided into sections and numbered sequentially (e.g. the first interview transcript labelled section one). Once the transcripts were divided into sections, the sections were coded line-by-line for themes. Upon completing the coding of the first section, the themes identified were collapsed to create revised super-ordinate categories. Lines were re-coded as necessary before identifying themes in the subsequent sections. New themes were added as they emerged in each section and the themes continued to be revised within each transcript until they were finalised. Once finalised, the ways in which the themes were talked about were identified. The talk was then analysed for recurring patterns of discourse. From the analysis two discourses emerged: Discourse 1- family planning services are culturally female centric, and, Discourse 2- condom use by male family planning patients is problematic. The data was triangulated using multiple researchers; investigator triangulation includes two or more researchers during analysis [15] to reduce bias, increase internal validity, and increase reliability [16]. It is a common practice in psychology [17] and has been used in discursive research [18]. Investigator triangulation involved the author and two academic researchers agreeing the themes, talk, and discourses that emerged from the analysis of the transcripts. Reflective memos were also created by the author and shared with the same two researchers to identify potential bias within the analysis.

Results

The results section is presented in two parts, one for each discourse. Within each part, quotes are presented and the talk that constructed the discourse is discussed. The quotes presented best represented the dominant themes that formed the relevant discourses from analysis.

Discourse 1 – family planning services are culturally female centric

Male patients' were largely absent in the medical practice. However, nurses explained some men attended consultations as part of a couple:

Interviewer: Have you had any male family planning patients?

Nurse 2: I don't recall any men coming in on their own, for family planning. I have had the odd chap that's usually for like, um, sometimes they come in asking for Chlamydia screening, um, which I am always surprised about. They obviously don't know they can get it at reception, cause I don't know why they would want to put themselves through that, but that's fine. Um and it's, some of them are quite confident, quiet outgoing with it and then they tend to ask for condoms then so that's a positive I suppose. I don't recall ever having somebody that has come in for something totally unrelated asking anything with regards to family planning and contraception. So the main thing I would say is probably that we get partners coming with their girlfriend or with their wife. Um it happens a lot with the international students because a lot of the time the wives don't speak English or their English isn't very good so they HAVE to come with them to ACT as translator. But often you do get a girl that is coming in for emergency contraception, often she will DRAG the boyfriend with her, and say well this is your fault, so you know if I have to go your coming with me. I had a couple of guys that have seemed very interested and I suppose actually thinking about it I'm suspicious about that. Which, I shouldn't have been, but because it isn't normal I'm thinking why are you so bothered, why are you so interested. I wonder if it's a bit of a control thing or, but actually no they are probably just you know just don't want their girlfriend to be pregnant and because you know it effects them, well almost as much. But yeah I think because it doesn't happen often, it flags it up in your brain and you think why are you so interested in this? They [male patients] seem to be more interested when the woman is having like a coil fitted. Um, and I don't know if it's because they think it's going to affect them because some men have said that they can feel the strings during intercourse, so I don't know if that's the case or I don't know if in some cultures. Maybe it's to make sure she definitely has contraception, where she might say oh I got a coil and how would he check that. He can check that she is taking pills, or you know, so I don't know what the reasons behind that is, but that is what I've noticed. But yeah, you don't often get men coming in; they don't want to talk to you about sex really.

Nurse 2 did not see male patients for family planning, stating 'I don't recall' twice. Male patients only presented if there was a problem like sexually transmitted infections (STIs). Nurse 2's talk was ambivalent towards male STI patients; she 'supposes' it is 'positive' that some ask for condoms. Nurse 2 positioned male patients as accessories- it is likely that female patients had to 'DRAG' male partners, using a loud tone for emphasis. International partners attended more frequently because they had no choice; 'they HAVE to come with them to ACT as translator' for their wives (again using a loud tone for emphasis). Nurse 2 further positioned male partners as potentially coercive; her talk suggests it is 'suspicious' or not 'normal' to be 'bothered' and 'so interested' in their partners' contraception. Her dubious tone continued, they 'probably' want to prevent pregnancy, but pregnancy does not affect them 'as much'. Instead, she felt they attended because they were concerned with their own sexual pleasure- with a coil they may 'feel the strings during intercourse', or because they want to 'check' their partner has received contraception. Nurse 2 highlighted it was difficult to engage male patients in general because 'they don't want to talk to you about sex really', framing them as disengaged.

The nurses believed the absence of male family planning patients was due to UK culture, justifying male patients' absence. In response, nurses suggested that male spheres might be more appropriate places to engage men:

Interviewer: So what do you think is the biggest barrier to men coming in to say a medical practice and talking about family planning?

Nurse 4: Um, I think, the biggest barrier is men themselves, I don't think we put up barriers here necessarily, I think it is men themselves, there, the attitude that it's not their role, it's you know, the