BLACK CARIBBEAN MEN, SEXUAL HEALTH DECISIONS AND SILENCES

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CONTENTS

ABSTRACT

Sexual health behaviour and the choices people make are influenced by whole range of factors including, social grouping, education, peer pressure and access to services/information. Reports on the health of the public in Britain have shown that sexual ill health is unequally distributed across society (Department of Health 2001; Royal College of Nursing 2001). People from socially disadvantaged and marginalised groups experience the highest levels of sexually related illness.

Quantitative studies form the main pool of information available in relation to sexual health and risk. They have demonstrated that in some areas of the country the infection rates for STIs are up to twelve times higher in men from black Caribbean communities (Fenton, Johnson et al. 1997; Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997). At present there is very little published qualitative information on the factors affecting sexual health decisions, particularly in relation to black Caribbean communities.

This research study focuses on black Caribbean men. A qualitative approach is used to identify and explore the key factors influencing the health decisions and risk activities of black Caribbean men in relation to sexual health. Social construction theory provides the theoretical underpinning for this study alongside aspects of feminism, criticalist and ethnicities based approaches. The stereotype of black Caribbean men as sexually insatiable and irresponsible emerged as a key feature of the social scripts associated with their sexual behaviour. The themes 'The nature of the stereotype', 'Living with the stereotype' and 'Hearing the silences' discussed in the data chapters explore the impact of the stereotype on the sexual health decisions of black Caribbean men. The experiences highlighted through the themes expose the importance of the political, social and personal context associated with specific sexual scripts on the sexual health decisions of black Caribbean men. Of key importance in these socially determined scripts are the screaming silences contained within them. The findings are reviewed in the light of current sexual health policies to consider how sexual health services and professionals can best provide for the sexual health care needs of black Caribbean men.

The thesis adds to current knowledge in sexual health and ethnicities in concluding that the sexual health decisions of black Caribbean men take place in the context of the real

or imagined expectations that society has of them. Individuals sexual decisions therefore occur in light of shared and personal appraisal of socially determined relevant issues. This forms the context in which sexual scripts are given meaning and sexual decisions take place. The study compliments the established pool of quantitative data available linking issues of sexual health and ethnicity in Britain. The findings presented within the thesis reveal a range of issues to initiate further qualitative research in the area and provides a lead for British based thinking on adult sexual health decisions and ethnicity.

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TRANSCRIPT CODES

Italics are used for tape recorded interview and focus group material

Each participant is given a pseudonym to protect anonymity and code representing the focus group attended.

BAC = black Caribbean male

SHP = Sexual health professional

P = Partner of black Caribbean male

BW = black Caribbean woman

When extracts of conversations are presented LSG = researcher

All tape recorded material are verbatim transcripts

Words in [ ] are additional information to clarify the context and/or meaning

... ..words, phrases or sentences of the extract omitted

Data have been edited to preserve the anonymity of participants or organisations.

GLOSSARY OF TERMS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
HAART	Highly Active Anti-Retroviral Therapy
GUM	Genito-Urinary Medicine
NSSHH	National Strategy for Sexual Health and HIV
DoH	Department of Health
STI	Sexually Transmitted Infections
'Lay'	Member of general public not recruited to study because of expert knowledge or experience in sexual health.
'Professional'	Member of professional, statutory or voluntary organisation included in study because of expert knowledge or experience in sexual health.

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INTRODUCTION

In 1992 the government document 'The Health of the Nation' identified HIV/AIDS and sexual health as one of five key areas for the improvement of the public's health by the millennium (Department of Health 1992). These early attempts by the government to highlight sexual health as an issue for public concern have been advanced in subsequent years through introduction of a range of strategies designed to improve the sexual health of the general public (Department of Health 1997; Royal College of Nursing 2000; Department of Health 2001; Royal College of Nursing 2001).

The number of casual sexual partners, rates of unwanted pregnancy, sexually transmitted infections and HIV infection in society are commonly used in public health to reflect the levels of sexual health of members of social groups and the nation as a whole. The National Survey of Sexual Attitudes and Lifestyles conducted in 2000 revealed that despite the increased use of condoms in the ten years since the last survey, the overall figures for people having two or more sexual partners in the past year coupled with inconsistent condom use in the past 4 weeks rose by 13.6% to 15.4% in men and 7.1% to 10.1% in women between 1999-2000 (House of commons 2003). The UK currently has the highest rates of teenage pregnancies in Western Europe with over half the under 16 conceptions ending in termination of pregnancy (Department of Health 2001). The number of visits to genitor-urinary clinics for treatment of sexually transmitted diseases has doubled over the period 1999-2001 with the infection rates for Chlamydia and gonorrhoea showing a continued rise of about 21% in the general population (PHLS 2000). While the number of HIV related deaths has been reduced through the introduction of highly active anti-retroviral therapy (HAART), the number of newly diagnosed cases of HIV infection in 2000 was the highest recorded since HIV testing began in 1985 (PHLS 2001). Concern expressed by the government, health and care service providers about the health,

social and economic consequences of sexual ill health in Britain has spurred moves to improve this aspect of the nations' health (Green and Tones 2000; Department of Health 2003).

The impact of sexual ill health encompasses more than the quantifiable large scale consequences for a society. At an individual level sexual health affects a person's physical and psychological well being and is a key part of some of the most important personal relationships in their lives (Department of Health 2001). Promoting, maintaining and maximising the sexual health of individuals and groups are therefore important components in quality of life. Sexual health and associated decisions about sexual activity and self expression are influenced by a range of factors including, social grouping, education, peer pressure and access to services/information (Aggleton and Tyrer 1994; Ford and Norris 1996; Harding 1998).

Researchers in sexual health have highlighted that as for other areas of health the health risks for sexually transmitted infections are not equally distributed across the population in the Britain (Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997). These studies reported that infection rates for the sexually transmitted infections (STIs) Gonorrhoea and Chlamydia were up to 12 times higher in men from Black Caribbean communities. The National Strategy for Sexual Health and HIV (NSSHH) published in July 2001 (Department of Health 2001) was developed in consultation with sexual health professionals from education, health. It also highlighted that sexual ill health was more likely to be located among young people, members of minority ethnic communities and other socially excluded groups (Department of Health 2001; Department of Health 2003). In the NSSHH, the British Government expressed concern about the continued rise in sexually transmitted infection among minority groups and other socially excluded populations and stressed the need to improve the sexual health of the general population and minority groups in particular.

My previous experience as an outreach worker/nurse working with Black and minority ethnic communities around HIV and sexual health in the early 1990s made

me aware that the sexual activities of black Caribbean men were no different than that of men from other ethnic groups. The significant differences noted in the infection rates for STIs across ethnic groups raises questions as to why men of black Caribbean communities were overrepresented in the reported data. Reviewing the literature prior to beginning this study revealed relatively little information discussing the 'why' and 'how' questions concerning the high levels of sexually transmitted infections amongst Britain's black Caribbean male population (De Cock and Low 1997; Valdiserri 2002). This highlighted a need to explore how personal decisions about sexual activity or expression made by black Caribbean men evolved into the outcomes reflected in the rates of sexually transmitted infection.

In studies identifying the high rates of sexually transmitted infections in black Caribbean men, (see Geringer, Marks et al. 1993; Ford and Norris 1996; Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997), researchers stressed the need to increase the evidence base identifying the underlying factors and experiences influencing the sexual health of minority ethnic groups. Investigation of these issues is to some degree compounded by a variety of issues pertinent to both researching sexual health in general and the focussing of such research on the experiences of black Caribbean men. The politically and socially sensitive nature of the subjects, ethnicity and sexual health which lie at the heart of investigation into black Caribbean men and their sexual health have historically influenced the types of research that have been conducted in these areas and the willingness of researchers to select these as subjects of study. Attempts to conduct a national survey on sexual attitudes and lifestyles in Britain in the early 1980s for example were blocked by the government of the time as this was deemed inappropriate use of public funds and politically problematic (Adams 2000).

In relation to research into ethnicity and health efforts have been made in nursing and other care professions into exploring the links between ethnicity and health. Ethnicity and other socially related categories such as gender, class and socioeconomic group have long been recognised as a key influencing factor on health, access to services

and susceptibility to illness (Department of Health 1997). However, with the exception of extensive research work on HIV/AIDS as a very specific disease phenomenon research into ethnicity and health has not routinely focussed on sexual health. Some of the reasons for this lack of focus will be explored in the literature review chapter but the issue is highlighted here as a prerequisite to the dearth of information available on sexual health as distinct from specific sexually related illnesses. The sensitivities around researching sex and health have lead to a situation where the research base for the subject of sexual health in the Britain is fragmented and the evidence base for developing strategies for working with minority ethnic groups is particularly scarce (Adler 1997; Guthrie 1999).

Attempts to investigate the sexual health decisions of minority ethnic communities in Britain is further complicated by the fact that much of the qualitative research in this area has been conducted outside Britain which raises questions of transferability and relevance to a British context (Holtzman, Bland et al. 2001; Kempadoo 2001). The rationale for this study is based on the suggestion by researchers in sexual health that more research evidence is needed to understand why particular groups in Britain appear to be at higher risk of sexually transmitted infections in order to improve the sexual health of specific social groups (Nicoll 1997; PHLS 2000; Valdiserri 2002). Without a detailed evidence base to refer to sexual health professionals' and sexual service providers' efforts to develop the range of health care practices required to implement the priorities set out in the HIV and sexual health strategy will remain hampered.

The aims of this study are to identify the key factors influencing the sexual health decisions of Black Caribbean men and explore how these factors may impact on their sexual health seeking and risk taking behaviours.

The aims will be fulfilled by completing the following objectives

- To identify the key factors influencing the sexual health decisions of black Caribbean men.
- To explore how the identified factors are believed to impact on the sexual health decisions of black Caribbean men in terms of their sexual health seeking and risk taking behaviours.
- To consider the possible consequences and challenges of the factors identified for sexual health professionals seeking to provide sexual health care for black Caribbean men.

Chapter one begins by setting out the context in which this study takes place. In doing so it introduces the concept of screaming silences which underpins the study. Screaming silences is the term used to epitomise areas of research and experience which are at best under-researched and require more development, or are at worst historically and/or politically undervalued, absent or invisible. Chapter two explores the literature relating to sexual health, decisions and risk. It explores the relationship of these issues with the sexual activity of black Caribbean men in particular. The methodological approaches underpinning this study are presented in chapter three. The methodological chapter also provides details of the process by which the research was conducted and the data handling procedures. The findings from the data collection phase are presented in chapters' four to six. These three data chapters are entitled 'The nature of the stereotype', 'Living with the stereotype' and 'Hearing the silences' to reflect the main themes emerging from analysis of the findings. Chapter seven is the final chapter in the study in which the implications of the findings for sexual health research, education and practice are discussed.

CHAPTER ONE

SETTING THE CONTEXT

Introduction

This chapter will introduce the reader to the context in which this research study into black Caribbean men and sexual health decisions takes place by presenting the conceptual and practical grounding for my study. The context in which the study takes place is presented at the outset to clarify some of the experiences and assumptions which influence the study so that the reader may make sense of the processes and decisions which follow.

Setting out the factors influencing this research very early on in the study is used as a strategy to promote transparency in this study. Avis (1998) speaks of the need for transparency in research to enable the researcher's interpretation of evidence to be examined, checked and critiqued so that the validity of the research may be assessed. However, it must also be recognised that in all research studies the need for transparency must be balanced with an awareness of the possible effects on all those involved. This study like many others is rooted in personal experience of the researcher and participants. It involves investigation of the sensitive issues of ethnicity, sexual activity and gender in a relatively unexplored area of study. These issues have a long history of association with negative experiences for black Caribbean people who are at the centre of this study. As a result the information discussed in fulfilling the need for transparency could elicit adverse reactions from or consequences for the black Caribbean communities involved. Presenting the context of the study is an attempt to facilitate the readers understanding of the research environment which impacts on the focus, process and purpose of the study in order

to minimise the possibility of the study inadvertently having a negative impact on the black Caribbean communities involved.

This chapter is divided into three sections. The first section of this chapter outlines the wider context to conducting this research by discussing race, ethnicities and gender as they relate to this study into sexual health and the context with which the terms 'black' and 'minority ethnic' are used in this study. The specific aspects of my practical experiences of working with black Caribbean men on issues of sexual health and the related epidemiological data which initiated my interest in this area are outlined in section two. The third section of the chapter introduces the notion of screaming silences which is derived out of the contextual issues presented in the preceding sections and used as a framework for the study as a whole.

1.1: Race, ethnicities and gender

Race and ethnicity are complex terms that have been, and continue to be used to denote characteristics of people in society (Bhopal 1997). Their complexity lies in the lack of consensus as to their definitions and in the often confused or contradictory ways in which they have been used to include some and exclude others from society. Writing and speaking about ethnicity and race is preceded by a long history of concentrating on specific aspects of an individual culture, ethnicity or ancestral origin and using this as a basis to constrain the identity of minority communities and the individuals who comprise them within three to five bounded categories (Ahmad 1993). Historically much of this categorisation has been imposed by people belonging to groups who themselves have not been constrained by such categories. These categories have then been used to establish grounds for inequality and maintain the status quo.

The outcome of this approach in relation to nursing research, policy development and practice in health is that minority ethnic populations have been routinely homogenised within racial stereotypes. This homogenisation has been criticised for

taking little or no account of the effects of other socially determined factors such as gender, occupation or socioeconomic group in their lives (Balsa and McGuire 2002). Nursing researchers in particular are being encouraged to employ a much more critical and reflexive approach to ethnicity and race centred research in order to enable them to review their own approaches to the health needs of minority ethnic groups more effectively (Culley and Dyson 2001).

The labelling of minority ethnic people within categories that differentiate them from majority populations but not from each other in this way is not exclusive to issues of academic research, but is within the lived experience of many people who are members of minority ethnic groups. In my experience this meant that from an early age, being of West Indian origin in the Midlands area of Britain meant being Jamaican. Dominica, the island of my ancestors differs from Jamaica and many of the other islands of the West Indies in relation to language, dominant religions, climate and major economies. Thus I, while sharing with other West Indians the common experience of being black in Britain, am in many ways culturally and ethnically dissimilar to Jamaicans who comprise the largest group of West Indians in the Midlands. In this study the approach to the research and perspective of myself as researcher is conceptually, experientially and overtly that of a black Caribbean person living through and with this history. The complex situation in which this section on race, ethnicity and gender is written is acknowledged as a continuous and influencing factor underpinning this study.

The origins of 'race' as a term are disputed but it is believed to be a much older term than ethnicity (Sollars 1996). In the United States race identity was initially associated with phenotypical characteristics and races were deemed to be distinguishable on physical grounds (Woodward 1999). Thus from the outset race was presented as an objective term associated with physical and fixed characteristics. The linking of the term race to notions of fixed, differentiated and identifiable traits underlines the traditional ways in which race is understood and was used to justify the difference

and superiority of one 'race' of people from another (hooks 1992; Estes 2000). The value of using this essentialist or fixed notion of race to identify specific groups in society has been discredited particularly in the sociological literature on many fronts and it is not the intention to repeat them here (see Rose et al 1984, Barot 1996 and Whitehead 2000).

Many of the criticisms directed at this traditional approach to race focus on the fact that many of the categories used to determine racial identity were less self-evident and objective than was claimed. While appearing to be based on fixed and objective measures, the characteristics such as skin colour or country of origin depend on both internal and external definitions, which in turn are not fixed or self-evident but determined by degrees of interpretation which vary between people, societies and over time (Bhabha 1997; Brah, Hickman et al. 1999). Race as a descriptive term has been further discredited due to its association with racism and the persecution and victimisation of people that occurred (and continues to do so) in Britain and elsewhere on the grounds of racial identity or categorisation (Skellington 1996). This culminated in the coupling of the term race with degree of negativity that has been difficult to overcome and to some extent the exploration of race as a concept, still remains shackled to and substituted for racism and oppression in the minds of the general public (Afshar and Maynard 2000).

The negative connotations and inadequacies associated with the use of the term 'race' as an effective way of identifying groups in society resulted in people in both academic and social spheres avoiding use of the word and seeking out other ways of locating individuals. During this period of time ethnicity emerged as less rigid way of describing social groups. The term ethnicity is closely linked to the Greek noun *ethnos* from which it is derived. This word was used to refer to people in general but also to 'others' who were different from the self (Sollars 1996). The literary origins of term ethnicity are non-specific about the nature of 'others' and give no indication as to the traits associated with particular groups or the identity. This would seem to invite the

development of concepts of ethnicity that exclude no one and make no attempt to determine absolutely who or what is included in the term.

However in practice there have been various attempts to define ethnicity by setting boundaries to contain it which have then been applied to limit its association to specific groups (Pickering 2001). In relation to health and nursing care in Britain the term ethnicity has regularly been used with these connotations resulting in the selective application of the term to black and minority ethnic populations to the exclusion of people from white communities. Definitions of ethnicity used in health and social care settings attempted to incorporate the value of cultural difference and diversity missing from race based approaches. However, this was often carried out uncritically with little reference to the political and social constraints which affected people's experiences (Ahmad and Atkin 1997). This approach to ethnicity has been criticised as leading to a focussing on ethnicity to the exclusion of other social factors as a central cause of the health and care needs of people from minority ethnic groups (Afshar and Maynard 2000; Balsa and McGuire 2002; Karlsen and Nazroo 2002). In doing so this approach denies a full exploration of the positive and challenging aspects of ethnic identity and health that are equally part of minority ethnic people's experiences.

Attempts to define race and ethnicity, whether based on a particular physical trait, belonging to a defined social group or another pre-defined characteristic have resulted in benefits and liabilities which have been inconsistent over time, between and within social groups. This suggests that race, ethnicity and identity are more closely determined on the basis of culturally, historically and politically derived perceptions of a society rather than on 'objective' facts. If this is the case, then there is a need to know much more than 'who' is denoted by racial or ethnic categories but focus on how, why and with what effects this categorisation takes place.

In recent years ethnicity in particular has been explored much less as an issue in itself but increasingly and extensively reviewed and explored in relation to other concepts

such as class, gender and identity. Education and social sciences research over the years have widened the discussion of race and ethnicity beyond the boundaries of categorisation. Research is evident that has investigated, debated and explored the impact of race and ethnicity on a range of issues including feminist thought (Bryant, Dadzie et al. 1985; Carby 1997), education achievement (Sewell 1995) and youth culture (Richeson and Pollydore 2002). As a result of this race and ethnicity have been extensively identified alongside several characteristics, such as class and gender for example, which modify and are modified by society (Bhopal 1998; Afshar and Maynard 2000). This broader revised focus has moved debates particularly in the social sciences, beyond the question of terminology or difficulties associated with definition into contemplation of the theoretical and experiential nature of these concepts and their effects. The long history in these disciplines of engaging in debates which recognise and appreciate the differences in experience brought about by the effects of society on individuals and groups underpins the fluidity inherent in this anti-essentialist view of race and ethnicity. An anti-essentialist approach allows an understanding of race and ethnicity to emerge where their 'definitions' are identified as being contextual and forever changing (Robinson 1998).

This has enabled the discussion in the social sciences to move beyond exploration of race and ethnicity as concepts in themselves or attempts to define them absolutely. Instead current thinking accepts there are not one but many racisms and ethnicities existing at an individual, group and societal level (Mac an Ghaill 1999). The acceptance of multiple racisms and ethnicities have been identified with post-structuralist approaches which accept that there are many different experiences and viewpoints in understanding the world (May and Williams 1998; Mulholland and Dyson 2001). This is the approach that I will take in this study.

Incorporating multiple views of the world allow for alternative or even simultaneous aspects of ethnicity to emerge in a society or be located in individual experience and identity. As part of this fluid and changeable view of ethnicities and racisms different

aspects of these experiences relating to an individuals identity may become more prominent or pertinent depending on the context (Weekes 1997; Brah, Hickman et al. 1999). For example, in my experience ethnic identity comprises a combination of my phenotypical characteristics, cultural, racial and social situation. I am thus seen by others and myself as simultaneously or consecutively as black Caribbean, West Indian or Dominican, a community member, professional but always female.

These aspects are not contradictory in themselves but are components of the unified whole that is the black and minority ethnic individual.

In relation to this study then, I resist attempts to define or determine the nature of the relationship between race and ethnicity absolutely. Instead a more pragmatic view will be adopted which incorporates an acceptance of variety and diversity in the ways race and ethnicity are experienced. Exploring the sexual health decisions of black Caribbean men from this standpoint will enable me to conduct this study from my own situated position which is recognised as being neither objective nor unique but will provide one of many possible interpretations.

In research in sexual health however, race and ethnicity have received comparatively less attention that in the social sciences or education. Unlike these academic disciplines where studies have been conducted to provide an insight into the black and minority ethnic experiences in Britain, sexual health experiences and expectation still remains relatively unexplored within these communities outside epidemiology (Bhopal 1997). Some of the reasons for this will be discussed later in this chapter. Failure to establish a range of other types of study alongside the epidemiological approaches has resulted in research detailing the sexual health experiences of the black British population concentrating almost exclusively on incidence and prevalence of sexually related disease across racial groups (Adler 1997; De Cock and Low 1997). As a result the wider health implications resulting from the interplay of ethnicity, class or gender on sexual health have received little attention. Health service providers and nurse researchers have been accused of being particularly reluctant in adopting a

critical approach to the needs of black and minority ethnic clients particularly in acknowledging the effects of race and racism on the health and life chances of black and minority ethnic populations (Culley 1996; Gerrish, Husband et al. 1996; Balsa and McGuire 2002).

The lack of sexual health research into the experiences impacting on the health chances of the black populations occurs within a wider sphere where in terms of gender and sexual health, exploration of women's health, rather than men's health is the norm (Williamson and Robinson 1999; Watson 2000). In addition, men's health issues, like those of black and minority ethnic populations have been characterised by reporting of statistics outlining mortality and morbidity with little exploration as to the cause of effects of these on life experiences (Luck, Bamford et al. 2000). This issue is explored further in the literature review chapter. However, in relation to sexual health, the high rates of sexually transmitted infections recorded in men from all ethnic groups in comparison to women has highlighted the need to recognise men's sexual health as an area of concern relating to the public's health (Department of Health 1999; Department of Health 2001).

Epidemiological studies alone are inadequate in providing an indication of why sexual illness varies between social groups or how the socialisation process affects our beliefs about health and behaviour (Pitts 1996). Researchers on men's health have called for a need to look beyond the statistics and explore the mechanisms and symbols which influence them, in this way we can gain a better understanding of men's health and illness (Sabo and Gordon 1995). Socio-cultural studies of men's sexual health need to be politicised in similar ways as issues concerning race and ethnicity in order that they may be better able to illustrate how social inequality affects health chances of individuals from different social groups. This need offers an ideal invitation to researchers to explore the interplay between social groupings and identities and men's health. It follows then that in order to fully understand the issues associated with black Caribbean men's sexual health illness the study needs to explore the social dimensions under which gender is constructed and how relates to ethnicity.

The possible variations in experiences arising out of the interplay between gender, racisms and ethnicities in society mean it is important that research set within these contexts makes explicit the ways in which the researcher identifies their research in relation to these concepts. To this end this first section of the chapter concludes by identifying how the terms 'black' and 'minority ethnic' are used throughout the study.

1.1.1:Use of the term 'black'

The term black is used in this study as a political term to identify peoples of African, African-Caribbean and South Asian origin. It is a term increasingly accepted by the members of the groups themselves as representing a unity of experience of racism, discrimination and prejudice amongst people whose skin colour is not white. It makes no claim to a homogeneous black identity and acknowledges the modifying effects of other socially determined factors such as gender, education and class on experiences. in doing so it embraces the diversity of black experience within and between black individuals and communities.

1.1.2:Use of the term 'minority ethnic'

There exists within Britain as in other parts of the world, a host of communities who by virtue of a difference in language, customs, and country of origin, religion, norms and values are different from the majority ethnic populations. While black communities may also be recognised as having minority ethnic identities many other communities are white or do not define themselves as black. In relation to health needs assessment, service planning and social provision however they also experience a degree of discrimination that is often hidden. These are the minority ethnic communities referred to in this study.

1.2: Practical influences

My interest in sexual health and ethnicity began in 1990 when I was employed as an outreach worker/nurse in Townsville the city in which this study takes place.

Townsville is a city in the midlands area of England. It has a population of 266,988 recorded in the 2001 census of which 15.1% define themselves as belonging to non-white minority ethnic groups (Key statistics for local authorities 2003). The percentage of residents identifying themselves as belonging to non-white groups in the 2001 census is higher than the national average of 9%. Black Caribbean residents including those of dual heritage make up 35.9% of the non-white minority ethnic residents in Townsville. In common with many areas of Britain the main source of migration by black Caribbean residents of Townsville to Britain was during the mass migration for employment in the 1950s and 1960s (Mac an Ghaill 1999).

My remit as nurse/outreach worker in the early 1990s was to work with black and minority ethnic communities on issues concerning Human Immunodeficiency Virus (HIV) awareness and harm reduction. At that time in the UK there were many local and national initiatives set up by the health and social care services to promote the safer sex message and provide accurate information concerning HIV infection, at a grassroots level. Much of the work undertaken occurred in direct response to the predicted worldwide HIV and AIDS pandemic (Bolton 1992).

One of the problems I faced in completing my duties in this post was that many members of the black and minority ethnic communities and the professionals working with them, appeared to believe that risk or relative safety from sexual infection was in part, determined by ethnic group (Serrant-Green 2001b). Discussions with clients and colleagues at the time, seemed to suggest that their perception of sexual risk taking and the decisions preceding sexual activity were clearly delineated on the grounds of ethnicity (Serrant-Green 2001b). Different levels of risk were attributed to members of particular ethnic groups. It appeared that the generally held belief was that black Caribbean men were less 'responsible' in their sexual behaviour than other male ethnic groups and more likely to put themselves and their partners at risk of contracting sexually transmitted infections (Serrant-Green 1999). This was usually communicated to me verbally and on investigation I was unable to find any empirical data exploring these views only epidemiological data,

indicating the high levels of HIV infection in Africa and parts of the United States of America (Gibbs 1988; Geringer, Marks et al. 1993).

Since commencing this research quantitative studies have been published which appear to support the belief that the high rates of STIs recorded in other countries are replicated in Britain. The infection rates for Gonorrhoea and Chlamydia in some cities in Britain are reported as being significantly higher in black Caribbean men than in any other ethnic group. A study by Low et al conducted in one London borough reported that the number of positive cases of gonorrhoea infection were 12 times higher in black minority ethnic attendees at the genito-urinary medicine (GUM) clinic than in their white counterparts (Low, Daker-White et al. 1997). Studies completed elsewhere have reported similarly high rates of infection in minority ethnic populations with the highest levels of infection detected in black Caribbean men (Lacey, Merrick et al. 1997; Fenton, Korovessis et al. 2001). The reports seemed to provide evidence to support the opinions and beliefs of the lay people and professionals I had worked with, almost a decade earlier. This led me to question whether the results were exclusive to the cities and populations studied. Did similar patterns of infection existed in Townsville? Were my experiences from earlier years co-incidental to the results being presented? In essence, did a difference in infection rates between ethnic groups really exist or were these reports just an (un) fortunate coincidence?

In order to answer these initial questions I conducted an exploratory study for the 1998 Mary Seacole Nursing Leadership award, funded by the Department of Health (DoH). The DoH study data was collected from January to December 1999 and mirrored, the approach taken by previous studies in investigating the infection rates for Gonorrhoea in attendees at the local GUM clinic by ethnic group. The full report of the study has been published elsewhere (Serrant-Green 1999), but it is outlined here as it provided the epidemiological data underpinning this subsequent study.

The exploratory study consisted of two phases. In phase one existing epidemiological data about the infection rates for gonorrhoea from Townsville and another city in the UK with a similar demographic profiles were collated. I compared the infection rates in male attendees at the local GUM clinic across the different ethnic groups over a six-year period preceding the exploratory study, from 1992-1997. The purpose of phase two of the study was to find out whether the opinions expressed by clients and colleagues in my past experience were still apparent and if so, identify any possible explanations of why. Phase two therefore consisted of a series of interviews and questionnaires in which the participants included members of the black communities, those working with them and sexual health professionals.

The epidemiological data obtained from the GUM clinic in Townsville detailed percentage positive cases of gonorrhoea infection by ethnic group i.e. they only reported cases in which the tests conducted detected the presence of the named infection. Prior to discussing the findings, it is important to note that a limitation of the data used in the study was that it was pre-existing data from the GUM services and was not collected specifically for the purposes of the exploratory study. However, as the purpose of the exploratory study was simply to illustrate any difference in infection rate between ethnic groups, the data was adequate for that purpose.

The data from the GUM clinic indicted there was a difference in the infection rates for gonorrhoea by ethnic group. The details of infection rates were reported by percentage number of cases in male clinic attendees i.e. the percentage of the total number of male attendees, belonging to that ethnic group, who were found to have the named infection. The tabulated results from Phase one of the exploratory study are shown below.

	1992	1993	1994	1995	1996
White	1.5%	0.9%	1.1%	1.2%	1.4%
black Caribbean	12.1%	11.9%	10.2%	14.8%	14.5%
Asian	3.1%	0.8%	3.2%	3.3%	3.7%
Other	3.0%	2.8%	9.3%	2.0%	8.1%

Table 1: Infection rates for Gonorrhoea in males in Townsville by ethnic group 1992-1996

The data collated from the GUM clinic seemed to support the previously reported data in that it indicated a higher incidence rate for sexually transmitted infection in black Caribbean men compared with other ethnic groups. It seemed that black Caribbean men were disproportionally more likely to be diagnosed with a sexually transmitted infection than other men in Townsville.

On completing the first phase of the exploratory study, I was aware that the data did little to reveal the factors affecting the infection rates for STIs and by inference the health choices and sexual health decisions of black Caribbean men. I completed the interviews and questionnaires comprising phase two of the exploratory study partly in order to attempt to gain more insight into these issues. The key issue for both black Caribbean men and sexual health professionals arising out of phase two seemed to be an awareness of the negative ways in which black Caribbean men were presented in relation to sexual health and a lack of any real idea of how to overcome this.

The confirmation of a discrepancy between the proportion of black Caribbean men in Townsville and the rates of gonorrhoea infection left a number of questions unanswered which formed the starting point for this study. Do the higher infection rates in Caribbean men simply reflect higher risk taking and less responsibility in sexual health decisions, or do they indicate a higher responsibility in relation to personal health by seeking advice? Do lay and professional perceptions of black

Caribbean men as high risk takers affect the way they are reacted to? How does this affect black Caribbean men's willingness to use sexual health services or the quality of the services they receive? In seeking to address some of these questions in this study a number of issues need to be taken into account. Many of these issues will be explored more fully or developed throughout this study however they are introduced here as they affect the context in which this research takes place.

One issue relates to the established use of epidemiological data and quantitative approaches in sexual health research particularly in a nursing context. With the exception of many excellent HIV/AIDS focussed studies, nursing as a discipline has not yet established a body of approaches to sexual health research and to date relies instead on epidemiological data collected through public health studies. Epidemiological research has been invaluable in bringing to the attention of health service providers, politicians and the general public the very real need to address the issue of sexual health and ill health in Britain. The use of quantitative methods of enquiry has become part of the established mode of research into sexual health and ethnicity in Britain mainly focussed within medicine and public health.

This study takes place at a time when sexual health and sexual activity are still inextricably tied up with morality and social expectations concerning what is appropriate and acceptable behaviour in society (Screen 1992). The use of surveys as the main form of enquiry into sexual health has become established for a variety of political and social reasons relating to the sensitive nature of the subject and reluctance on the part of governments to take political risks on this platform. The use of epidemiological approaches in studying sexual health may be seen as a way of facilitating the study of a sensitive subject by removing the need to ask probing or personal questions about an individual's sexual practices thereby reducing the threatening aspects of studying what are still deemed to be private issues. By confining research about sexual health and ethnicity into the more 'objective' scientific paradigm it is possible to avoid public discussion or exposure of an embarrassing and politically sensitive issue (Lee 1993).

The exposure of variations in sexual health across ethnic groups brings with it a challenge to understand why rates differ so significantly in particular groups. Nurses and other sexual health professionals need to understanding why these differences exist and the impact on the lives of black Caribbean men in order to provide care and advice to their clients. One of the issues which affect this is the tension between the factual risk data provided by epidemiological studies and the way people make sense of sexual activity. In sexual health decisions 'perceived risk' based on feelings, expectations and beliefs about individuals plays a part in determining actions. These aspects of making decisions about sexual activity are neither quantifiable nor measurable in any absolute sense. This means that the questions required to be answered by nurses and sexual health professionals cannot be addressed by quantitative data alone. What is required is that other methods of enquiry which face the social or political aspects of sexual health in particular groups are introduced into the discussion. In order to do this many areas of experience and knowledge not usually associated with a nursing approach to sexual health care need to be exposed.

In this study focussing on black Caribbean men issues pertaining to researching aspects ethnicity and gender have been highlighted as being of particular importance. These issues are associated with a host of sensitive and problematic concerns in themselves which have been extensively discussed and critiqued in the health and social care literature and as such are neither new nor unique to this study. However the traditional reliance on epidemiological studies mentioned earlier means few of the issues have been explored in relation to sexual health and nursing. The wider and study specific issues related to this study outlined so far were instrumental in eliciting what I felt as 'general unease' about the conducting this nursing research within a tradition where the interplay ethnicity, gender and sexual health remained relatively unexplored. In order to acknowledge and manage this 'unease' I formulated a conceptual viewpoint called 'screaming silences' which underpins this study.

1.3: Screaming silences

The approach underpinning this research study is based on a concept that I have named screaming silences. This final section of the chapter will begin by defining screaming silences as they are conceptualised in this study. It will then outline the nature of the screaming silences arising out of the wider and study specific contextual issues raised in the first two sections of this chapter. In doing so it will locate screaming silences as existing within the broader framework of theoretical and philosophical approaches which influence this research.

The term Screaming silences is used in this study to epitomise areas of research and experience which are at best under-researched and require more development, or are at worst historically and/or politically undervalued, absent or invisible.

Screaming silences is derived from anti-essentialist viewpoints similar to those discussed earlier in relation to racisms and ethnicities. These views accept that reality is neither objective, nor fixed rather the social world is constructed and determined by human beings in a particular society at a particular point in time (Williams and May 1996). As a result of the influence of an anti-essentialist approach individual or group interpretations of events and human experiences are valued in screaming silences as a key part of what people believe to be 'truth'. One of the important points arising out of this in relation to screaming silences is that ultimately screaming silences are situated in the subjective experience of the listener and the context in which their experiences occur.

The listener is the person who identifies, prioritises and responds to a particular screaming silence. Variations in experiences occurring between individuals and within the contextual experiences of the same individual produce differences in terms of which screaming silences are 'heard' but also the importance placed on the silence and the impact it has. The screaming silences identified in this research are located by me as researcher and primary listener. An anti-essentialist approach to research

recognises that research does not take place in isolation from the reset of society and researchers are no different to anyone else in being influenced by their experiences of being socialised into particular beliefs about the world and individuals in it (Stanfield and Dennis 1993; Hammersley and Gomm 1997). The screaming silences explored here are therefore declared at the outset as being a product of my own subjective viewpoints as a black Caribbean female academic and the experiences of conducting this study. The importance of these to the study will be commented on later in this section and more fully explored in the methodology chapter.

Screaming silences, like many aspects of any society are a product of the time spaces they occupy and the way in which the effects of power and inequality are experienced by an individual in a particular timeframe. Screaming silences may therefore be derived from, or focus on the ways in which power is used to determine an arbitrary norm at a particular historical and political point in a society. For example, the historical and political positioning of academic research has been highlighted in the literature as overtly male, white and heterosexual (Valentine 1998; Seibold 2000). This has resulted from a range of issues relating to a longstanding history of gender and race inequality in Britain and reflects the sanctioning of education and scientific 'work' in the past as a white, male privilege (Hammersley 1995; Afshar and Maynard 2000).

The historical and political domination of research from this perspective has influenced not only the interpretation of research but also the type of research projects conducted and funded in the public arena hence an arbitrary norm has been established (Millen 1997; Pilcher 2001). This has resulted in a situation where 'gaps' exist in the terms of the range of approaches, experiences and viewpoints presented by those undertaking or taking part in research and in the type of studies conducted in academic and research terms (Hammersley 1995; Mason 2002). Screaming silences are located in these gaps and closely associated with some of the issues arsing out of these wider debates.

In occupying these research 'gaps' Screaming silences can be associated with what some have identified as marginal discourses (Foucault 1972; Ifekwunigwe 1997; Afshar and Maynard 2000). Marginal discourses are related to mainstream discourses in that they fulfil the same basic function in that they identify bodies of knowledge, beliefs or assumptions about the world we inhabit and ourselves as human beings (Sawicki 1991). However, the marginal nature of these discourses is exemplified by the fact that they are the positional 'other' to an arbitrary norm. As 'other' they are often positioned low down in the official hierarchies of a society where power is located and may even be presented as being far removed from the lived experiences of people within a given society (hooks 1992; Hammersley 1995). As such research focussing or arising out of these less valued views of society may be taken less seriously or deemed inadequate.

In this research marginal discourses are located though the central role played by experiences of racisms and ethnicities on the sexual health decsions of black Caribbean men. Screaming silences recognises the marginal nature of some of the viewpoints in this research and provides a framework in which they may be valued, explored and critiqued in this study. This aligns this research based on screaming silences with philosophical approaches which recognise that all aspects of life, even scientific discoveries are influenced by a range of factors including human beliefs, social change and politics (Hollis 1994). At the core of research embodying this philosophy such as feminist, ethnicities and criticalist based approaches lies a belief that any interpretation of the world, whether presented in the guise of formal, written scientific research or in verbal reports of lived experience is always subjective and carried out from a particular political and social viewpoint. It therefore follows that far from there being a single 'truth' waiting to be discovered, the world perspectives are believed to be multidimensional in nature, consisting of many realities or 'truths' (May and Williams 1998).

The purpose of research conducted from within a multidimensional approach to reality is to understand and describe events that occur but at all times seek to gain a

clearer appreciation of the meanings ascribed to the event by the individual (Denzin and Lincoln 1998). An appreciation of the inequality inherent in society and the impact this has on people's experiences means that in order to understand and make sense of the screaming silences that impact on specific experiences and activities it is therefore important to consider the wider social as well as individual context in which decisions take place. The incorporation of screaming silences into this framework opens up opportunities in this study to enable a contextualised, situated exploration of sexual health decisions by black Caribbean men to take place which values personal experiences alongside established theoretical debates.

Maintaining personal experiences as a central component of this research is facilitated by the anti-essentialist roots of screaming silences. It also draws on feminist, ethnicities based and criticalist viewpoints where personal experience is critical to strategies to free research from rigid adherence to traditional or dominant discourses (Solorzano 1998; Seibold 2000). As with the nature of race and ethnicity discussed earlier, there are many feminisms, ethnicities and criticalist approaches. The aspects of the approaches particularly pertinent to this study will be discussed in more detail in the methodology chapter. However, in general these approaches have several characteristics in common which support the concept of screaming silences as presented in this study.

One aspect of these approaches is that they articulate the importance of personal experiences as a central tool in social analysis and theory building (Olesen 1998; Ribbens and Edwards 1998). In centralising personal experience in their discussions, these approaches highlight diverse experiences in society and relate them to the effects of living in an inequitable society rather than presenting them simply as matters of personal choice. Proceeding beyond disclosure is an important aspect of research conducted from these perspectives. The influence of critical perspectives on society and experience inherent in these approaches suggests that research that simply describes experiences provides insufficient information for it to be fully judged (Scott 1991). These perspectives therefore encourage any examination of issues related to human experience to occur within theoretical, political or action focussed frameworks

while appreciating the variety and diversity of human experience. The general beliefs underlying these approaches are summed up by Scott (1991) who said:

> 'Experience is at once always already an interpretation and in need of interpretation'
>
> (Scott 1991. p 779)

Positioning experiences which are personal and to a degree subjective at the centre of the concept of screaming silences does not imply that agreement on the nature of some screaming silences do not exist. Common experiences and the effects of inequality on particular groups may produce situations in which members of different social groups are aware of the same screaming silences even though they may have differing experiences of their effect. For example, the issue of homogeneity highlighted in section one of this chapter is evidenced in more than just discussions of race and ethnicity. Evidence of this is available in the vast amount of literature discussing similarities and differences in the political and historical experiences that have existed (and continue to do so) in a range of spheres including women's lives, heterosexism and racism (Christian 1989; Brah 1996; Ribbens and Edwards 1998; Balsa and McGuire 2002; Gill and Maclean 2002). In each of these cases, while the individual nature of the experiences and silences encapsulated by societies homogeneous approach to people's lives varies, a common experience of living with inequality lies at the core. Women, members of minority ethnic communities and gay/lesbian researchers in particular have worked to redress the balance however, research focussing on these marginal experiences remain in the minority.

The issues outlined above are all pertinent to this study and provide some insight into my approach to this research. However an individual's interpretation of any interaction or appraisal of a situation also results from complex responses to their historical positioning as individuals and group members in society as well as their immediate experiences (May and Williams 1998; Pratto and Espinoza 2001). Any exploration into screaming silences therefore needs to be concerned with much more

than just the recent experiences and conscious thought processes associated with the actions or reactions of an individual. Sexual health research in Britain has presented black experiences as overtly negative portraying only the problematic aspects of the relationship between sexual health and ethnicity through the common reliance on epidemiological data alone (Adler 1997). Recognising the screaming silences left by this history encourages exploration of the reasons for the high rates of STI among black Caribbean men and supports the investigation of the more positive aspects of their sexual health experiences.

The application of feminist, ethnicities and criticalist based approaches to this study does not mean a rejection of the traditional epidemiological approaches to studying sexual health. Instead epidemiological studies are recognised as being one of many ways of researching the subject. Researching sexual health from these perspectives involves engaging with past debates and research around sexual health, ethnicity and gender in order to evaluate the experiences of black Caribbean men in Townsville. This allows a greater degree of discussion or exploration of the impact of historical and social views of sexual health and activity on the decisions of black Caribbean men.

The anti-essentialist approaches associated with screaming silences suggests that research which seeks to reflect, examine and explore human experiences cannot avoid the influences of power and the associated screaming silences on it or existing as part of it. Historically and politically the affects and effects of power and inequality within society have resulted in situations where inequality and power are part of all human experience to varying degrees affecting how the world is seen and experienced (Abrams and Hogg 1999). When viewed in relation to these wider discourses, screaming silences can be seen to be part of a range of established approaches which seek to incorporate alternative viewpoints and value individual experiences as part of strategies to gain understanding of the world.

Screaming silences as a concept is therefore used to broaden the picture of how beliefs, values and expectations impact on this research at a number of levels. Screaming silences may be heard in this research through the perspective of the researcher (black Caribbean woman), the subject of the research (sexual health) or the participants at the centre of this study (black Caribbean men). However, in exposing that which is hidden, under-researched and invisible in this research, the screaming silences themselves are presented from a situated viewpoint which produces silences of their own.

For example if the domination of research from the white, heterosexual, male perspective highlighted earlier is taking as an arbitrary norm, then every researcher is to some extent 'placed' prior to a study being undertaken as either typical or atypical of the traditional academic researcher (Johnson-Bailey 1999; Johnson, Long et al. 2001). This research explicitly conducted from a non-white, female perspective for example denotes an approach to researching sexual health which is atypical. My research therefore includes silences associated with power and marginal discourses which impact on the study in a general sense but also on the social interaction between me as a black Caribbean female academic and the study participants.

My approach to this research recognises that exposing and exploring the silences associated with this research from my own perspective will not bring an end to the screaming silences around black Caribbean men and sexual decisions. For a variety of reasons including the nature of society at the time this research is conducted, my choices of how to present myself as researcher and the ability of participants to selectively disclose information about their experiences not all the screaming silences already in existence will be exposed. However, engaging in research into the screaming silences around black Caribbean men and sexual health decisions is essential if the discussion is to be moved forward.

The necessity of exploring these issues and the contexts within which they occur from my own situated perspective as a member of the black Caribbean community in

Townsville, are aptly described by the comments of Sawicki (1991) and Lorde (1984) who on speaking about the hidden aspects of women's lives said:

> 'If we are not the ones to give voice to them, then history suggests that they will continue to be either misnamed and distorted or simply reduced to silence'
>
> (Sawicki 1991. p32)

and

> 'It is not difference which immobilises us but silence. And there are so many silences to be broken'
>
> (Lorde 1984. p4)

This research study is conducted with open recognition of the silences inherent in it, those it challenges and the fact that others will remain or be created as a result of it. I will explore the screaming silences specifically relating to the perspective of the researcher in the methodology chapter. Those silences relating to the research subject and black Caribbean men as participants will be introduced in the literature chapter which follows.

Chapter summary

This study and the approaches taken to it initially arose from my experiences of working with black and minority ethnic communities in the area of sexual health promotion in the early 1990's. It is conducted from a philosophical perspective which sees human experience as multidimensional and existing in a dynamic relationship with past and present viewpoints. The framework underpinning this research is called screaming silences. The term is used to epitomise areas of research and experience which are at best under-researched and require more development, or are at worst historically and/or politically undervalued, absent or invisible.

The feminist, ethnicities based and criticalist approaches underpinning this framework recognises viewpoints in society as ambiguous and changeable, determined to a greater or lesser extent by the effects of power and inequality at an individual and societal level. These approaches therefore highlight the importance of exploring the context in which research takes place and experiences occur in society in order to promote understanding of the world. Exploring the impact of ethnicity and lived experience on the sexual health decision making of black Caribbean men from my own situated position utilising this framework will be used to promote transparency in the study and gain a better understanding of the broad and specific contexts in which sexual decisions are made.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents the current literature providing a framework for this study. It explores sexual health as a concept and the approach taken to it in this study. The need to increase the scope of the knowledge base on the sexual health of men, particularly black and minority ethnic men is discussed as a key issue in strategic planning on public health. In response to the conceptual approach discussed in the last chapter, the screaming silences around sexual health in general and men's sexual health in particular will be identified. In doing so, the reasons for placing black Caribbean men at the centre of this study will be made clear.

The information presented in this chapter is the result of literature searches conducted using BIDS database, DoH information base and World Wide Web as well as the University of Nottingham Information Services libraries. Key words used to initiate searches were 'sexual health', 'sexually transmitted infection', 'men's health' and 'health and risk'.

The literature chapter is divided into three sections. Section 2.1 will introduce sexual health, issues relating to men's sexual health and identify how sexual health is defined in this study. Section 2.2 will explore the relationship between sexual health and risk. In section 2.3 the positioning of black Caribbean men in relation to sexual health decision making and risk will be introduced. The chapter will conclude by locating this study within the current research on sexual health.

2.1: Sexual health and the male

This section of the literature review will consider some of the ways in which sexual health has been defined in society. It identifies how sexual health in relation to men, compared to that of women has received little attention from health researchers, policy makers and health service providers. The consequences of this for sexual health practice and need to redress this balance and focus equally on men's sexual health are explored.

2.1.1: Sexual health

The increasing interest in sexual health in nursing and other health care professions sexual health over the past few decades has occurred in conjunction with wider changes amongst these disciplines to focus on prevention of ill health and promotion of healthy lifestyles (Clifford 1998; Crepaz and Marks 2002). Since the emergence of HIV and AIDS in the last century, issues such as sexual health and the need to provide for what were previously viewed as private issues between individuals, have entered the public sphere (Aggleton and Tyrer 1994; Beacham 1995; Royal College of Nursing 2000). Sexual health is in general no longer simply a matter of a physical act with consequences for an individual but is recognised by the government, health and social care providers, as an area of health need requiring planning, assessing and services to support it (Department of Health 2001; Fenton and Wellings 2001).

However, the apparent recognition of a need to address sexual health issues at an individual and strategic level is juxtaposed by the silences that have developed around sexual health as a subject in itself and the way it has been addressed within a nursing and health care context. Discussions of sexual health as an area of need in nursing and the health care strategies used to promote it have been built around a very narrow

view of what constitutes sexual health. This view had at its core an implicit assumption that the nature of sexual health was primarily concerned with physiological functioning (Wilson and McAndrews 2000). In this context a tradition of sexual health work developed in nursing where it was more likely to be associated with reproductive function, the investigation and treatment of sexually transmitted infections and the prevention of unplanned pregnancy (Goldsmith 1992; Stedman and Elsteen 1995; Koshiti-Richmond 1996). As a result this research occurs against a historical legacy of relatively little discussion in nursing spheres about possible variation in people's understanding of sexual health and the consequences of this for patient populations. This occurred has occurred despite the fact that as far back as 1975 the World Health Organisation urged health care professionals to widen their views on sexual health away from pure epidemiology and sexual intercourse towards a more positive and holistic approach. They called for:

> 'The integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love'
>
> (World Health Organisation 1975)

In contrast to the situation in nursing, the social sciences, particularly areas such as gender and cultural studies has produced a vast array of literature investigating and discussing a wide variety of issues relating to sexual health including sexuality, self identity and social stigma. However in ways similar to the situation related to ethnicity discussed previously, few studies nursing or health focussed studies incorporated a person-centred approach to sexual health. Up until the 1980s at least most continued with the push to 'measure' sexual health in terms of infection and pregnancy. In this environment little consideration was given to the wider components of sexual health and the possibility of variation in the associated sexual decision making of different groups in society (Green and Tones 2000). As a consequence, with the exception of HIV/AIDS, which will be commented on later, discussing 'sexual health' is to a great

extent actually synonymous with 'sexual ill health' and disease with epidemiological studies forming the main and often only source of research data.

The majority of the research conducted under this restricted interpretation of sexual health centred on medical treatments for specific diseases such as STIs or took the form of large surveys conducted by public health departments. The contribution of nursing as a profession to this challenging area of health was conspicuous by its absence. The reasons for the lack of information or investigation into the nature and consequences of sexual health from a nursing perspective are complex. Some of the possible influencing factors relate to wider social attitudes to sexual health as an issue in itself while others are specifically associated with the response of nursing as a profession to sexual health as an area of health care.

Research into sexual health is impeded by a variety of issues related to the nature of the sex and sexual expression in society (Wilson and McAndrews 2000). Sexual health has throughout history been inextricably associated with social taboo, privacy and blame. Long before the onset of HIV/AIDS, sexual practices had been colonised by concerns about immorality and fears about the consequences of moral decline in the political, public and private sphere (de Beauviour 1984; Lancaster and di Leonardo 1997). The Victorian purity movement for example, with its well rehearsed warnings against sex outside marriage, masturbation and homosexuality has been well documented (Caplan 1987; Bhabha 1992; Master, Johnson et al. 1995; Lancaster and di Leonardo 1997). Social action and sanctioning at the time served to perpetuate feelings of guilt and sin around any sexual expression outside the sanitised arena of marriage and procreation as a result of this and many other examples sexual health has regularly been subjected to degrees of silence over the years which have been difficult to overcome. This has contributed to the current situation where health researchers seeking to expand the pool of knowledge about the nature of human sexual decision making have been hindered by the fact that the subject itself is still perceived as being 'not nice', too sensitive for objective research or unlikely to provide truthful responses (Pitts 1996).

In the 1980s the emergence of AIDS and HIV as life threatening conditions had a far-reaching impact on the need to discuss sexual activity and risk taking (Adler 1997). As a result of the devastating effects of HIV/AIDS experienced worldwide, sexual health issues were openly discussed beyond the parameters of epidemiology. Efforts were made to explore the causes, consequences and affects of sexual illness on an individual and societal level (Health Education Authority 1994). Nursing practice and research equally responded to the challenges arising from HIV/AIDS recognising the consequences for patient care, infection control and professional health and safety amongst other issues (Wilson and McAndrews 2000). However, while the emergence and world wide recognition of the seriousness of HIV/AIDS was both effective and invaluable in bringing into the public arena the importance of research and discussion into sexual health, the success of the efforts made in HIV/AIDS reveal other silences.

The political climate in the face of the widespread hysteria around HIV in the early 1980s played a central role in the disease becoming established in the minds of the public as being far removed from the experiences of the white, male, heterosexual norm (Hart and Boulton 1995). As a result gay men, black people, prostitutes and groups marginalised as 'other' were identified as the primary cause of HIV infection and harbourers of the disease (Department of Health 1993; Harding 1998; Green and Tones 2000). Despite the progressive move towards wider consideration of sexual health called for by WHO in the 1970s, the effect of political attempts to manage the fear surrounding HIV/AIDS by controlling sexual practices in the social and private spheres, resulted in a re-focussing on 'illness' as a consequence of poor sexual practices. The possibility of any other causative or influencing contextual factors on sexual ill health were lost in the impetus by politicians and media sources to create and recreate the divisions between 'us' and 'them' through the HIV tragedy. 'Good' sex and health being again associated with morality and reunited with stoic versions of romantic love and duty (Royal College of General Practitioners 1981; Sabo and Gordon 1995; Robinson 1999). Once historical parameters of good versus bad were

erected around sexual behaviour and reinforced by the scientific 'proof' provided by HIV research. Llifestyles which did not conform to the ideal were labelled 'unhealthy'. The effects of this labelling on individuals belonging to these marginalised groups has been highlighted in the literature particularly in relation to the effects on African populations and Gay communities (Hart and Boulton 1995; Treicher 1999; Valdiserri 2002). However, with the emphasis of sexual health work once again placed on prevention of the negative consequences of illness rather than promotion of health in any positive sense, what began as a public relations or harm reduction exercise at parliamentary level also helped to confine the exploration of sexual health in its broadest sense in another.

The widespread and firm association of sexual health with HIV/AIDS has also to some extent developed into a belief that research into sexual health means HIV/AIDS research. Evidence of this was found in conducting the searches for this literature review by the plethora of research topics, funding and policies related specifically to HIV/AIDS research world-wide which presented under the general title sexual health. HIV/AIDS research is very well developed in both breadth and depth, receiving relatively large amounts of funding compared to other areas of sexual health from both private companies and public bodies (Department of Health 2001). The initial ring fencing of monies for research and development in this area and the efforts made by voluntary agencies in highlighting the effects of HIV related illness means there exists a large amount of both qualitative and quantitative studies relating specifically to HIV/AIDS (Treicher 1999; Donenberg, Emerson et al. 2001; Holtzman, Bland et al. 2001; Johnson, Mercer et al. 2001). While it can be argued that the HIV pandemic was, and still is, of major concern to all countries of the world, in Britain the concentration of sexual health research, funding and policies in this area has had negative consequences for sexual health research and policy development in general.

In Britain comparatively little funding or research attention in health has been paid to the sexual decision making process and the preceding factors influencing patterns of

sexual activity outside the parameters of HIV infection (Adams 2000). Research into sexual health in Britain in particular has furthermore focussed almost exclusively on minimising the effects of what are identified as poor sexual choices with little consideration of how or why those choices take place. It could be argued that these things have been studied in relation to HIV and the results could be applied more generally to other sexual health situations (Cantana, Kegeles et al. 1990; Aggleton, O'Reilly et al. 1994; Crepaz and Marks 2002). However it cannot be assumed that the same decision making processes take place when the risks are not perceived to be life threatening.

Research evidence from more established areas where the risk of death is well known as an outcome of particular health choices such as smoking suggest that beliefs about actual risk of death acts as a modifying factor to behaviour (Woodland and Hunt 1994). This introduces the idea of perceived risk as existing alongside real risk in health decisions. Issues relating to risk will be explored in the next section. However, in relation to the studies on STIs which initiated this research a tension is set up between actual risk as measured by quantitative methods and perceived risk as evaluated by individuals making choices about their sexual health. The relative lack of empirical evidence in sexual health in general accounting for the gap between these two forms of risk serves to perpetuate the problem. Despite the wealth of HIV/AIDS information available the generalisability of the information to sexual health in general arising out of many of the existing studies remains relatively unknown. Indeed with the removal of the 'ring fence' around even HIV/AIDS research funding in the last few years and confirmed state allocations from central government running out in 2003 (House of commons 2003), the likelihood is that the ability to pursue answers to even pre-existing questions about sexual health and decisions will be hampered in future.

Since the early 1990s attempts have been made by some sexual health researchers and practitioners to provide a more holistic view of sexual health. There has been increasing recognition that simply recording infection rates and the numbers of

unintended pregnancy was insufficient to bring about any change in the continued rise in sexually transmitted infections (Bolton 1992; Hart and Boulton 1995; Taylor 1995; Adler 1997). The issues raised by the World Health Organisation almost 20 years earlier had begun to be more widely and overtly promoted among sexual health specialists. To define sexual health solely in terms of a physical act or as a problematic activity is increasingly seen as denying the life enhancing and positive aspects of sexual expression (Pitts 1996; Williamson and Robinson 1999). Attempts to define sexual health in nursing have therefore moved to incorporate a more holistic view of this concept rather than to try to confine it to a list of physical acts and their consequences. Such attempts do not remove, negate or minimise the importance of the physical aspects of sex, but seek to incorporate self-identity, emotional well-being and the ability to develop mutually satisfying relationships alongside physical expression as essential parts of any definition (Harding 1998; Green and Tones 2000; Royal College of Nursing 2000).

In nursing attempts to incorporate a multidimensional view of sexual health to practice is problematic. Sexual health nursing as a distinct area of practice does not really exist. Nursing practice in sexual health is identified as covering a wide range of areas including family planning, GUM services, HIV/AIDS care. On closer inspection the scope of nursing care in this areas remain shackled to the stigmatised and fixed approaches to sexual health in the past. In practice the multidimensional approach to sexual health does not exist on a large scale. Sexual health education is not a compulsory part of nurse training and there are no standards relating to it on the core curriculum. The holistic approach to sexual health being encouraged through nursing research therefore effectively exists as a type of 'theoretical holism' which does not translate into practice. Sexual health nursing continues to reflect a physiological focus with little or no general consideration given to the psychosexual aspects of care (Clifford 1998). Research suggests that nurses themselves find it hard to overcome their personal aversions to particular sexual practices or aspects of patient's sexuality and receive little or no training as to how to manage this, and this has a knock on effect on the care they provide (Hayter 1996).

Difficulties in delivering a holistic service are not confined to the individual nurse. Nursing contribution to sexual health care occurs within a context where sexual health services themselves are fragmented (Department of Health 2001). Sexual health care is thus delivered in a piecemeal fashion with each service providing a portion of the care required without any real consideration of the whole. The provision of a fragmented health care service is not unique to sexual health or nursing, however, in sexual health the situation is compounded by the fact that many sexual health services and practitioners are unaware of whether or which other complimentary services are available (Department of Health 2003). As a result patients are often left to search out and pursue additional services for themselves and so the quality of sexual health care varies immensely.

The tensions existing between the theories of sexual health, the realities of nursing practice and the patients experience make it difficult to select an effective definition of sexual health to use in this study. The World Health Organisation (WHO) have acknowledged the difficulties in specifying the nature of sexual health, and suggest that accepting the multifaceted nature of sexual health, means that a single definition of a sexually healthy individual cannot exist (World Health Organisation 1986).
As a result sexual health will not be defined absolutely in this study but will be seen as revolving around three broad concepts

- The absence or avoidance of STIs and disorders affecting reproduction
- The control of fertility and avoidance of unwanted pregnancy
- Sexual expression and enjoyment without exploitation, oppression or abuse.

(Goldsmith, 1992. p121)

While Goldsmith's categorisation on sexual health is useful, it fails to adequately incorporate a number of key components which are important to this study. The first issue is that of responsibility. Sexual decisions incorporate a degree of responsibility for both the self and others who are affected in a sexual relationship. The third area

of Goldsmith's categorisation indirectly refers to this when it talks of the need to avoid exploitation or oppression. However, this point needs to be incorporated much more explicitly to be of use to sexual health practice. Hendriks (1992) for example includes in his definition of sexual health a view that it contributes to

> 'The fulfilment of individual sexuality enabling a person to share this with consenting others without jeopardising the health and well-being of other persons'
>
> (Hendriks 1992)

Hendriks suggests that responsibility in personal sexual expression ultimately translates into responsibility for the community as a whole since the consequences impact at both an individual and societal level (Hendriks 1992). Practical examples of Hendriks' comments are reflected in the published epidemiological research indicating the social and individual health costs of high pregnancy rates and consequences of untreated STIs (Department of Health 2001; DiClemente, Wingwood et al. 2002). In these cases the impact of sexual decisions for the individual also has consequences for health and social care services due to the scale of the associated needs.

The linking of sexual health to the community highlights the importance of the social aspects of sexual health. Adopting the broad approach to sexual health outlined above in this study sees sexual health as involving much more than simply personal responsibility and includes the recognition that sexual health, particularly those aspects related to self-esteem and self-identity are not developed in isolation (Screen 1992). Helman (1990) said that sexual health, and the choice people make are influenced by their values, beliefs and concepts of self. As such, sexual health can be seen to reflect a person's experiences of socialisation and our environment.

This multidimensional view of sexual health allows research into the area to consider the possibility that individuals and groups may have different ideas about the nature

of sexual health, as a result of their differing life experiences and viewpoints. Green and Tones (2000) comment that sex and sexual activity, have always been regulated by religion, state law or social pressure. As such it is difficult to discuss sexual health in isolation from individual life experiences. Like other aspects of life, once human experience and viewpoints are included, sexual health cannot be discussed, evaluated or provided for in a political and cultural vacuum (Helman 1990; Hendriks 1992; Green and Tones 2000).

In this study the need to include a cultural and political understanding of the influences on the sexual health decisions of an individual or group is of central concern as it forms part of the context in which sexual decisions occur. Without such an approach to this research it will be impossible to provide any further insight or indication as to why black Caribbean men consistently appear at disproportionately higher risk of STIs (Adler 1997). Existing epidemiological data has been shown to be inadequate by itself to explain why infection rates in this group remain high. A contextual approach to the subject of black Caribbean men and sexual decisions is therefore necessary. This is required from both a theoretical perspective in relation to this study and for the development of strategies and services to bring about a reduction in the rates of sexually acquired infections in this social group.

In adopting a broader perspective on the relationship between sexual health, decisions and ethnicity, this study will work towards fulfilling some of the requirements of the National Strategy for Sexual Health and HIV (NSSHH), which calls for researchers to work to increase the British evidence base for provision of sexual health services and policy development (Department of Health 2001). The NSSHH identified research into sexual health as a basic requirement in initiating the strategies needed to assist sexual health services in bringing about changes in the sexual health profiles of populations at higher risk of infection. Particular emphasis is placed in the NSSHH on research to facilitate understanding of

- The sexual networks, health seeking behaviour and risk behaviour of targeted groups.
- The impact on ethnicity, deprivation and other socio-economic factors on sexual health

(p45)

Many of the points raised in this literature review highlight the importance of understanding some of the wider social factors affecting behaviour and beliefs in relation to sex and sexual expression and how they may impact on life choices and health. It is particularly important to identify the ways in which beliefs about sexual expression relate to both health decisions and individual perception of risk.

The importance of the broader context in which sexual decisions take place to this study is influenced by the conceptual approach to include the practical and real life situations in which decisions occur. One of the issues pertaining to sexual health is the fact that individual knowledge and public belief systems often vary from what is scientifically proven or established through academic investigation. In all aspects of health care practice both professional and lay definitions of health exist (McGee 1992; Valkimaki, Suominen et al. 1998). These are not necessarily distinct or wholly separate from each other, but may be confused, conflict or a cause of misunderstanding. Sexual health, like other aspects of health is open to interpretation and may be related to more general views about what it means to be healthy (Wilson, Uuskula et al. 2001). Therefore despite the welcome changes made in academic and professional circles to see sexual health as a holistic and changeable concept very little may have changed in the mind of the general public or sexual health professionals. Projects investigating sexual health issues among lay people and health care professionals, for example, have identified that individuals continue to associate sexual health solely with simply sexual intercourse and its consequences (Screen 1992; Rosenthal and Moore 1994; Johnson, Mercer et al. 2001).

In order to account for the range of issues described above, sexual health in this study is taken be a complex issue comprising the somatic, emotional, intellectual and social aspects of an individual (Lewis and Bor 1994). Sexual health is accepted as being achieved when these characteristics positively interact (World Health Organisation 1986). As a concept there are many issues and experiences that are shared between human beings. However, the social influences on such things as sexual expression or acceptable sexual practices mean sexual health must also be recognised as a concept which changes over time both between groups and for individuals throughout the life span (Ewes and Simnett 1993).

In order to be able to research aspects of sexual health in detail using a contextual approach, it is important to narrow down the scope of the research to a specific group. The next section of the literature review will explore issues relating to the sexual health of men as the social group forming the broad focus of this study.

2.1.2: Men and sexual health

The previous section highlighted some of the ways in which much of the British based research evidence on sexual health was unequally distributed in favour studies into of HIV/AIDS. However review of the information published on general sexual health subjects also reveals another area of concern, that of gender inequality. The issue of gender bias in sexual health research and information production reveals that the male as subject of research studies is relatively absent. Until the early 1990s comparatively little had been published in relation to men's sexual health and the need to provide appropriate male-centred services (Sabo and Gordon 1995; Watson 2000). Until that time in Britain the views, needs and voices of men as gendered subjects in sexual health were conspicuous by their absence. In general, research into sexual health and gender meant researching women's health (Fareed 1994).

The roots of the disparity between the association of men and women with sexual health are longstanding. To some extent they may be explained by considering the

historical and political contexts in which sexual health takes place. Historically the sanctioning of sexual practices, behaviour and sexuality in the Britain has traditionally been closely associated with control of the sexual expression of women (Lancaster and di Leonardo 1997). Attempts to control the sexual activities of the public were to a great extent, centred on the sanctioning of female sexual behaviour through public pressure, policy and criminal law. Much has been written illustrating the ways in which British society worked to criminalise or pathologise female sexual expression to a greater extent than male sexual practices (Screen 1992; Master, Johnson et al. 1995; Parker and Aggleton 1999; Wilson and McAndrews 2000).

At a time when medicine was perhaps one of the great controlling factors in British society, the pathologising of female sexual practice meant it could be opened up to scrutiny by the medical profession and society as a whole in an attempt to control it (Lancaster and di Leonardo 1997). While the methods used to control sexual expression in women where at times abhorrent and damaging, the push to control women's sexual practices worked to cement the belief that any association between gender and sexual health, concerned women's health (Verbrugge 1985; Williamson and Robinson 1999). The continuation of sexual health promotion approaches based on these beliefs, even into this century is partly responsible for the situation today. To some extent therefore men are not readily identified as subjects of research into sexual health because historically and politically their behaviour has not been pathologised.

The issue of inequality relating to the relationships between men, women and sexual health go beyond simply the frequency of the associations. In criticising the poor levels of provision of information and lack of support for men's sexual health issues, men's health organisations have also commented on the restrictive approach taken by researchers and service providers to the sexual health needs of men (Brown and Lunt 1992; Ions 2000). In conjunction with the lack of research studies into men's sexual

health a wider variety of approaches is taken in relation to the sexual health of women (Watson 2000). Female centred studies in sexual health vary from pure information giving to more general exploration of the psychosocial issues related to the subject and how to seek further support and help. In contrast the resources specifically produced for men are identified as invariably physiologically based, and unlike those for women less likely to incorporate a multi-dimensional approach (Luck, Bamford et al. 2000). In relation to sexual health practice therefore even when men's issues are considered this frequently incorporates the physical aspects of sexual expression, with little or no consideration given to the psychological and social impact of these conditions on men's lives (Williamson and Robinson 1999).

The recent notable exception to this is the attention given to male erectile dysfunction following the launch of sildenafil citrate (Viagra) onto the UK market in September 1998. While in one sense erectile dysfunction did focus on the usual physical aspects of male sexual functioning the launch of viagra was significant because it not only signalled a change by primarily highlighting men's sexual health but appeared to initiate open discussion of the psychosocial impact of poor sexual health on men. However, like HIV consideration of the contexts in which the benefits of Viagra to the discussion of men's sexual health issues occur contain cautionary notes. Viagra and the possible benefits for men's sexual health emerged as a bi-product of treatment for hypertension for which it was originally designed (Shakir, Wilton et al. 2001). While the discovery of additional benefits of a drug for other conditions is not unique the mass publicity given to viagra led to increased demands for the product (Kaye and Jick 2003). The historical lack of information about men's health in which this took place makes it difficult to surmise whether this increased demand was the result of a hidden problem or the publicity surrounding the 'miracle' effects of the drug. In either case the links between a notable increase in the diagnosis of erectile dysfunction, the restrictions placed on its distribution by the government and the large revenues generated for the drug company producing it have

since been subjects of continuing debate in political, medical and media circles (Ralph and McNicholas 2000). The silences encased within the debates include the way in which political and social reactions to this drug has progressively equated it with men's sexual health and in doing so refocused the male sexual health agenda around physical prowess. It is also interesting to consider how far the financial and political rewards associated with viagra for men have influenced moves in early 2000 to identify female sexual dysfunction as a condition at a time when permission to launch a version of the drug for women in Britain is being sought.

The disparity in the availability of information and research between men and women within a wider health context is not exclusive to issues of sexual health but is part of a general trend. Researchers into men's health and support groups argue that men's health in general is an area of unmet need that has dire consequences on the quality and quantity of life of the modern man (O'Dowd and Jewell 1998; Lee and Owens 2002). Medical sociologists and health professionals have begun to highlight the discrepancy between the health education and information produced for men compared to women. They comment for example that despite an increase in the application of initiatives to improve health across the population in Britain, middle aged men are rarely receiving any preventative health care (Robertson 1995). This is reinforced by other researchers who point out that unlike women's health and strategies aimed at the public in general, provision for men's health has not progressed sufficiently from the treatment of ill-health models of the past (Sabo and Gordon 1995; O'Dowd and Jewell 1998; Williamson and Robinson 1999).

The implications of the hidden aspects of male sexual health and the lack of reaction to it as an area of health need must be appraised in the light of the gender bias in society. The marginalised positioning of men as subjects of sexual health research is strange because in British society, men and white men in particular have been centralised as the norm. However, as discussed earlier, in sexual health the positions

in relation to gender are reversed with women's sexual health occupying the 'dominant' position. While on the one hand the silence denoted by men and sexual health as a subject may be a reflection of inequality in a society that overtly and covertly identifies male sexual expression as unproblematic, the outcomes are not necessarily beneficial to the sexual health of men (Lee and Owens 2002).

In identifying male heterosexual activity as normal, society and history has worked to silence the needs associated with it. The consequences for heterosexual men is reflected in their relative absence from research into sexual health, particularly that concerning preventative health and community based support (Luck, Bamford et al. 2000). The magnitude of the silences brought about by this situation increase when consideration is given to the types of sexual health information produced on HIV prevention since the advent of AIDS. The sexual health information provided exclusively for males in relation to HIV prevention and promotion of safer sex practices is predominantly geared to the needs of gay and bisexual men (Treicher 1999). Here too the label of normality impressed upon heterosexual male sexuality works to render it absent from the main focus of research on sexual health in Britain. This is a matter of grave concern since reports indicate that heterosexual transmission rates for HIV in the new millennium are now rising at a faster rate than that of homosexual transmission (Department of Health 2001). Despite this, it seems that sexual health and its consequences are still being identified by politicians, health information and service providers as predominantly an issue for men who have sex with men, rather than the exclusively heterosexual male.

The above discussion illustrates how the historical and political contexts in which the emerging sexual health issues are determined is less likely to identify men and heterosexual men in particular as the target group. In the light of this it is pertinent to consider whether women have a greater need for preventative sexual health information and services than their male counterparts. This was tested out prior to determining the study questions by considering whether women were at greater risk

of sexually related illness as indicated by a number of health related factors including incidence rates for sexually transmitted infections and male participation in potentially risky activity.

The consequences of unprotected sex have are well documented. These include the increased HIV transmission risk, and the associated reduction in the life expectancy of both partners as well as the possibility of STI transmission affecting quality of life and fertility (HEA 1994, Adler 1997, Buve *et al* 1993). In research conducted at various genito-urinary medicine (GUM) clinics across Britain, men in all ethnic groups are consistently reported to have a higher incidence of diagnosed STI than women from the same groups(Fenton, Korovessis et al. 2001; Hughes, Brady et al. 2001). Studies from outside Britain also show a similar pattern of infection along gender lines and support the suggestion that greater sexual risk among men may be a worldwide issue rather than simply an isolated issue in Britain (Ford and Norris 1996; Donenberg, Emerson et al. 2001). The consistency of the disparity in infection rates across socioeconomic groupings, ethnicities and even geographical boundaries raises the question why.

Health and life chances are affected by a whole host of issues spanning the socio-economic, genetic and contextual situation of the individual as well as their perception of the risks associated with a particular activity (Conner and Norman 1998; Fonck, Mwai et al. 2002). However although there are varying views as to its effectiveness it is also accepted that the level of knowledge an individual has concerning the risks involved in a particular activity plays some part in their decision to continue or change potentially risky behaviours (Lupton 1999). Despite the high rates in STI in men however there are relatively few men-only or male focussed sexual health centres in Britain (Brown and Lunt 1992). Outside GUM clinics, sexual health services in Britain are focus on family planning, local health centres and

maternity services developing and sustaining a continuous link with women throughout their reproductive life (Davidson and Lloyd 2001). In contrast men's sexual health provision by statutory health services, where it exists takes place 'after the fact' in treating sexual infection or urological disorders. Prevention or proactive promotion of men's sexual health in general occurs as an additional concern to women's health particularly in relation to fertility and family planning.

In relation to sexual health, as elsewhere health education approaches are based on a view that lack of information reduces the individual's ability to exercise free will in making an informed choice within the contexts of their individual situation (Woodland and Hunt 1994). This view is challenged by research which demonstrates that despite information about sexual risk reduction being widely available since the 1980s, STI infection rates continue to rise (Adler 1997). The ineffectiveness of relying on information alone to bring about improvements in health is highlighted by a range of researchers who point to the need to consider the wider contexts in which health is maintained and any information provided is interpreted (Gillies 1998; Lomas 1998). When this information is coupled with the lack of a broad sexual health focus on men in the practice arena, the higher rates of sexual ill health in males is not surprising.

In some cases the high incidence rates of sexually related disorders amongst men could be considered to be associated with the social aspects of the male experience in society. Sabo and Gordon (1995) reported that the leading causes of death in males were as a result of their behaviours. They identified that masculinity was a defining factor in considering risk and men's health and also acted as a barrier to men developing a consciousness or seeking help in relation to their health. The socialising of British men into a society which prescribes that men are strong, unemotional and

unconcerned with family life, may therefore encourage individual behaviours which compromise men's sexual health.

In general health data, men have been reported as being more likely to delay in seeking medical advice when they are ill (Platzer 1988; Royal College of Nursing 1995) and often denying their symptoms (Watson 2000). It has also been shown that men have a greater tendency to participate in activities which present risks to their health, such as excessive alcohol and tobacco consumption (Williamson 1995, Platzer 1988, Luck 2000), have an unhealthy diet (Fareed 1994), and follow a sedentary lifestyle (Watson 2000). The higher incidence of alcohol and drug use in men (Robertson 1995), may be considered as adding to the potential sexual health risks when viewed alongside reports which indicate that use of alcohol has an un-inhibiting affect on sexual behaviour (Geringer, Marks et al. 1993; Aggleton, O'Reilly et al. 1994; Ford, Sohn et al. 2002). This is reflected in the higher incidence of reported unsafe sexual practices under the influence of alcohol and other drugs (HEA 1994).

The majority of sex related health issues are preventable and easily managed or treated if detected early (Wilson and McAndrews 2000). Historically based, stereotypical views of masculinity and sexual health in Britain however which reinforce an engendered belief that sexual illness is associated with 'women's problems' are unlikely to encourage men to adopt a proactive approach to their sexual health. This may go some way to explaining the low use of prevention advice services by men and their higher risk of many preventable diseases (Mac an Ghaill 1994; Luck, Bamford et al. 2000). In order to begin to bring about a behavioural or attitudinal change in relation to sexual health what must be determined are the factors which impact on or influence the sexual health decisions of men in particular situations.

Many of the studies highlighted above provide important quantitative data to illustrate the need to include men as well as women in strategies to improve the sexual health of the public. However, without greater insight into how and why men are at risk with regard to their sexual health, it is impossible to determine what form any action should take and whether it is achievable. In order to do this in this study, what is required is a gendered approach to research into men's sexual health. This means attempting to identify and understand the factors influencing the sexual health seeking and risk taking activities of men in the context of their life experiences and socio-cultural positioning. Men's sexual health and decisions about their health related activities can be therefore be appraised in the light of their particular social, cultural and individual experiences.

The relative lack of knowledge about the multidimensional nature of male sexual health and sexual expression hampers the development of any services or initiatives to address the challenges posed by men's sexual health (Petersen 1998). In order to progress the work into men's sexual health it is desirable to produce research aimed at more than monitoring the physical consequences of male sexual practices (Harrison and Dignan 1999; Ions 2000; Lee and Owens 2002). The magnitude of the silences around men's sexual health produced as a result of the lack of qualitative research in this area calls for studies that acknowledge the physical basis of male sexual expression but not be constrained or defined by it. Research must therefore incorporate the psychological, social and cultural aspects of men's sexual health in order to produce the information sources for the development of further research and health promotion strategies (O'Dowd and Jewell 1998).

2.2: Sexual health, decisions and risk

The literature review so far has highlighted a wide range of issues relating to sexual health as a concept. This section of the literature review takes up the challenge set out at the end of section one to provide a contextualised view of men's sexual health by focussing on the practices and decisions associated with it. In this study sexual health decisions are viewed as an aspect of normal human experience where beliefs and assumptions underlying decisions are developed through established mechanisms of socialisation (Aggleton and Tyrer 1994). Sexual health decisions and the factors believed to influence them will therefore be discussed in this chapter within the general frameworks of health related behaviours.

In discussing some of the decision to place men at the centre of this study each of the issues raised has a direct or indirect association with one of the predominant concepts in relation to health decisions in general and sexual health decision making in particular, that is the notion of risk. Risk is a key contextualising factor in discussion of sexual health. Following the discussion of sexual health and health behaviour, the close association between risk, health decisions and sexual health will be explored. This will provide the basis for the final section of the literature review by identifying the ways in which the association of sexual health decisions and risk with sin, blame and responsibility have impacted on the sexual health chances of specific groups in society.

This second section of the literature review discusses three issues

- Health behaviour and sexual health
- The notion of risk
- Risk, sexual health and decisions

2.2.1: Health behaviour and sexual health

Health and ill health in society today have been revealed so far in this chapter as often being perceived as resulting from lifestyle choices made by the individual. These lifestyle choices and the actions taken as a result are collectively studied as health behaviours. Health behaviours are related to the health status of an individual in that they may have either a positive, enhancing influence on health or result in negative, health impairing consequences (Ogden 1996). Health behaviours may take the form of either specific health related activities undertaken by an individual, such as the decision to give up smoking and take regular exercise, or their general approach to life such as avoiding undue stress and maintaining support networks.

The interest in health behaviours in society has been said by researchers to be based on two basic assumptions. The first is the belief that a great deal of illness today is the result of particular behaviour patterns, the second assumption is that these behaviours are modifiable (Niven 2000; Crepaz and Marks 2002). Both assumptions accept to varying degrees that health behaviours associated with them are influenced by the social structuring of society in which the behaviours take place and by personal responsibility for health living decisions. Health promotion and education approaches today are often based within frameworks that incorporate these two assumptions in relation to some aspects of health. Many of the health promotion strategies used to prevent ill health arising out of these approaches aim to increase an individual's awareness of the consequences associated with certain behaviours.

Increasing knowledge in relation to a particular behaviour is commonly used as the main strategy for raising awareness. It assumes that if individuals are made aware of the facts concerning the impact of particular activities on health, they will make the rational choice to change their behaviour and thereby reduce the health risks to themselves and others (Niven 2000). A range of researchers and health care practitioners have criticised this approach to improving health for its emphasis on

'individual choice' without sufficient recourse to social and political factors. Gillies (1998) for example, suggests that the behaviour of no more than one in for people is changed by receipt of information alone. Despite the fact that information giving alone has been challenged as ineffectual in bringing about behavioural change, this approach to health promotion persists, particularly in relation to sexual health.

Research into health behaviour has developed alongside the shift in emphasis from one in which ill heath is believed to result from 'bad luck' or is inevitable, to an acceptance that ill health is both predictable and avoidable (Conner and Norman 1998). The implications of this approach are that an expectation is set that individuals have the ability to increase their own health chances by reducing their health limiting activities and increasing their health enhancing ones (Ogden 1996; Fonck, Mwai et al 2002; Robin, Brener et al. 2002)

Much of the research around health behaviour has occurred in the field of health psychology. There is a vast amount of literature investigating the nature of health behaviours adopted by individuals and the factors underpinning their decisions. A range of models have been put forward to describe and explain the decision making process that occurs (see (Woodland and Hunt 1994; Ogden 1996; Conner and Norman 1998; Niven 2000; Lee and Owens 2002). While these models provide differing views on the process of health decision making, they agree that in general the factors impacting on health decisions arise from two sources

- Factors specific to the individual such as socio-demographic situation, ethnicity, culture and personal attitudes to health
- Factors extrinsic to the individual, arising out of incentives to change health decisions (such as free condoms to promote safer sex) or legislative restrictions (for example, making seatbelts compulsory)

(Conner and Norman 1998)

Since the extrinsic factors are in general out of the control of the individual, much of the research into health decisions has centred on the specific factors affecting personal decisions (Figlio 1989; Santelli, Lowry et al. 2000; Donenberg, Emerson et al. 2001; Ford, Sohn et al. 2002). Qualitative research in this area has focussed on a wide range of determinants of health behaviour including

(a) The accessibility of health care services (Brown and Lunt 1992; Allen 1998).
(b) Attitudes to health care (Williamson 1995).
(c) Perception of disease threat (Lawson 1998).
(d) Knowledge of disease (Wynne 1996).
(e) Social network characteristics (Rothenberg 2001).
(f) Demographic factors (Santelli, Lowry et al. 2000).

The majority of these determinants relate to the knowledge, beliefs and attitudes of individuals to health, behaviour and illness prevention. These have been collectively characterised by researchers and health psychologists as social cognition factors (Ogden 1996; Conner and Norman 1998).

Social cognition factors have been defined by Conner and Norman (1998) as enduring parts of an individual which shape their behaviour and are learned through socialisation (p.5). As socially acquired characteristics health behaviours cannot be considered to be unchanging and universal between or within social groups. Group variations in attitude to particular health behaviours may be influenced by the cultural norms and values of the group as well as their social positioning and experiences of living in society (Helman 1990; Fiske and Taylor 1991; Donald and Rattansi 1992; Ahmad 1993). Social groups are not homogenous in themselves, variations in the impact, importance and application of health behaviours exist between individuals from the same social groups. Acknowledging this will be an important factor in this research that focuses on an identified section of the black Caribbean community in Townsville if the multidimensional approach to the context of sexual decisions expressed at the outset of this study is to be maintained. Variations in the experiences, perceptions and beliefs of individuals in Townsville will result in

individual differences in terms of the likelihood of adopting a particular approach to health which will need to be explored.

Differences in the way individuals make sense of social situations and interactions are not restricted to making in health decisions (Ogden 1996). Social cognition is an integral part of social behaviour and is a function of an individual's perception of reality rather than simply an objective description of the environment or situation (Fiske and Taylor 1991; Niven 2000; Fonck, Mwai et al. 2002). The notion that social cognition involves a degree of individual determination of reality, introduces degrees of uncertainty into making of health decisions. In order to manage any exploration of the variety of influences on health decisions or health chances, research must be focussed on a particular subject and social context. This study focuses on sexual health. Sexual health was identified earlier in this chapter as complex and changeable, incorporating various aspects of an individual's self and social identity. As such views on how or when it is achieved may vary between individuals in the same way as views about health in general (Woodland and Hunt 1994; Valkimaki, Suominen et al. 1998; Wilson and McAndrews 2000).

The variable nature of a person's perception of a situation or event renders decisions open to a range of influences and susceptible to change. This suggests that it is possible to alter beliefs, attitudes and approaches to sexual health in order to bring about improvements in the health of individuals or groups. As identified earlier in this chapter however, researchers utilising these approaches to health behaviour argue that in order to improve the health chances of individuals, more needs to be known about how and why individuals make choices about their health (Fiske and Taylor 1991).

2.2.2: Social construction theory and sexuality

One particular theoretical approach, which is useful in attempting to understanding human behaviour in general and sexuality in particular in this study, is social

construction theory. Social construction as a term has been used in many different ways by researchers and theorists. They differ in their views of which aspects of behaviour may be socially constructed or mediated for example, in relation to sexual health these may include such aspects as desire, object of desire or sexual activities. However, what approaches to social construction have in common is their attempts to problematise social construction as a term and the actions or behaviours associated with a particular issue. There is general agreement within these differently focussed explorations that social actions and decisions underpinning them are mediated by cultural and historical factors (Vance 1991). As a result they adopt a view that the same social actions may vary in social significance and their subjective meanings may change depending on how they are understood or defined in particular cultures or periods in history (Douglas 1992; Abrams and Hogg 1999).

The intellectual history of social construction theory is complex. It draws on many disciplines such as social interactionism, aspects of labelling theory, social history, and women's history amongst others. The introductory sections of this chapter have illustrated how much of the theoretical and practical study of sexuality and sexual health have come to locate it as a marginal area of study in comparison to other areas of health. This may have been influenced on a theoretical level by the fact that historically much of the anti-essentialist and cultural views developed in social construction theory stem from efforts of marginal groups in society.

Marginalised groups in the early 1970s provided much of the impetus for development of bodies of work on social construction and identity. Gay and feminist focussed research were some of the first examples of sustained study uniting aspects of social construction, sexuality and identity. Many of these early approaches centred around the salvaging and reviving of 'hidden' documents, narratives and life experiences of individuals and their communities (hooks 1982; Wilson 1983; Bryant, Dadzie et al. 1985). These texts contextualised sexuality by

reviewing its relationship with other aspects of social life at the time. Weeks (1977) for example drew on writings about homosexual roles and used this as a basis to distinguish between universal homosexual behaviours and homosexual identity which was recognised through this work as being culturally and historically specific. Feminist writers challenged the notion of normality as applied to gender and identity, and as a result avenues for the critique and challenge of the prevailing view that gender was biologically determined and linked to the physiological nature or reproductive role of the female evolved.

In general much of these early works challenged the dominant physiological focus on sexuality and identity of the time and the belief that sexuality was a specific, constant or unchangeable entity. Through these works increasing emphasis was placed on expanding the scope of questioning about nature and meaning attached to sexual conduct and social identity and the significance of different sexual acts for the people or communities involved (Vance 1991). The interplay between the individual sexual conduct and the sexual norms of society at a historical point in time were of particular interest and led to specific exploration of the role played by cultural and social determinants in individual and shared notions of sexuality.

Social construction theory applied to sexuality identifies sexual acts as being without universal meaning but as a basic component of a human being which may be shaped and influenced by culture, learning or experience (Gagnon and Simon 1973). Sexuality is thus expressed via certain behaviours and attitudes demonstrated on an individual level and witnessed in a society. In society culture works to encourage or discourage particular kinds of behaviour, sexual expression or relationships. Thus sexuality and how it is expressed is neither universal nor biologically determined but understood and explained from the view of the observer which is specific in both time and space (Green and Tones 2000). However, this construction of meaning related to sexuality does not only occur on an individual basis. As with other aspects of social behaviour cultures develop

their own ways of naming, categorising and labelling sexual acts and experiences to give them collective meaning and a socio-cultural level of understanding. Utilising a social construction approach therefore allows for sexual acts and sexual expression to be complex and variable both over time and across or within societies. Meanings may be shared at the level of the community or society but simultaneously varied at the individual's experiential level. It is the variations and distinctions that exist between the sexual (social) acts, identities and the communities involved in a society that form the basic focus of a social constructionist approach to sexuality.

In examining the shared or cultural aspects of the way sexuality expressed, understood and defined in a society, social construction theory also focuses on the way in which social structures work to reinforce particular aspects of human sexual activity. These include the formalised structures of education, law and politics and the major discourses formed through statutes and the application of sanctions, as well as the 'informal' norms and values of a society and the cultures that make it up (Adams 2000). The emphasis in relating sexuality to the structures in a particular society is move beyond simple identification of the acceptable or unacceptable components of sexuality. It also encourages exploration of how socially determined aspects of sexuality are learned. This includes understanding the relationship between the meanings given to sexuality and its expression at the level of the dominant and sub-cultures in a society and how they interact or change over time (Gagnon and Simon 1973).

Pitts (1996) discusses the need to know much more about sexual health and how it is negotiated, perceived and experienced. This calls for a continued broadening of the approaches to research in this area to run alongside the established quantitative approaches. Researchers undertaking epidemiological studies of STIs and teenage pregnancy, cite the lack of insight into reasons for the variations in infection/pregnancy rates between social groups as a limitation in their studies

(Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997; Stoner, Whittington et al. 2000; Sionean, DiClimente et al. 2001; Varghese, Maher et al. 2002). Qualitative research investigating the reasons for the variations in incidence rates detected in their studies is a prerequisite for development of strategies to improve the health of members of particular social groups. Sexual health research particularly that conducted from a nursing perspective may then move towards a more holistic view of the process of making sexual decisions and the consequences for health

The need to expand the range of information generated through sexual health research to include exploration of issues influencing sexual decisions has been a central part of government health initiatives since the 1990s (Department of Health 1999; Department of Health 2001). Policies such as The National Strategy for Sexual Health and HIV called for further investigation into the reasons for the high levels of sexual ill health in Britain. In addition the need to set up professional groups or committees to consider aspects of sexual health and decision making is highlighted (Royal College of Nursing 2000).

The relative paucity of evidence relating to these aspects of sexual health is compounded by the fragmented way in which sexual health services are organised in Britain. This creates a problem when trying to clarify even what is meant by sexual health decisions in order that the factors impacting the decisions of black Caribbean men may be explored in this study. Viewing sexual health decisions as a specific aspect of health decisions in general is useful in providing a framework for determining the initial standpoint in this research. Sexual health decisions are identified in this study as encompassing the lifestyle choices of an individual and the actions taken as a result of these choices which impact on their sexual health.

One of the key issues in social construction which facilitates the exploration of sexuality and associated behaviours alongside individual lifestyles is an insistence that sexuality be understood as the outcome of the normal but complex process of

psychosocial development (Gagnon and Simon 1973). As such, sexuality is very much part of continuous, normal human development and adjustment in society which may change as a result of external and internal influences such as age, accident, misunderstandings or loss of self esteem. Seeing sexuality as a particular aspect of social learning means that it cannot be taken to be uniform either across cultures or within individuals. This means that to explore it effectively, a strategy for making sense of it at a particular point in time, in relation to specific individuals or groups is required.

Gagnon's concept social scripting or 'scripts' provides a useful vehicle for exploring these issues in this study. Gagnon (1990) describes scripts as cognitive schemas existing in all aspects of society as part of the social structure (Gagnon 1990). Scripts act as a sort of template for activities and interactions involving individuals in a social setting. They assist those involved to recognise and define a situation, the actors involved, and plot the behaviour that elicits a particular response or outcome (Gagnon and Simon 1973). Within a social constructionist framework human participation in scripts are more than just a reactive response to a set of stimuli but actively organise and process the components of an interaction into an appropriate script to elicit a particular response. People are therefore active participants and modellers of social scripts.

Gagnon suggests that the social scripts for sexual behaviour are largely missing from research writings and this may explain why there is an over reliance on physiological explanations and focussing on sexuality (Gagnon 1990). In sexual interactions, scripts assist the participants in both recognising a situation as potentially sexual, negotiating and organising the sequence of sexual acts and setting limits on sexual responses. In a sense this introduces the negotiated aspects of social interaction into readings of sexual encounters. Thus sexual situation arise through a process of recognised and negotiated responses in a particular context,

rather than because of the inherent 'sexual' nature of the particular aspects that comprise it.

Sexual scripts as part of the social processes are learned during the continuous process of development. They connect physical feelings and emotions with sexual activities and sexual conduct. To a degree they determine behaviour in that they pre-exist judgments and decisions about what ought to be done is done in a particular sexual situation, with a particular person at a particular time (Gagnon and Simon 1973). The social institutions of a society are also recognised as reinforcing and embedding certain sexual scripts in the same value laden way as other norms and values about gender, class and ethnicity. Thus in learning the sexual scripts people are also made aware of the consequences (good or bad) of particular sexual choices.

It is the close association between sexual and non-sexual situations in influencing sexual experiences and activity that allows for the variations or similarities in sexuality, sexual expression and sexual interactions at the level of individual or social life. They therefore provide guidance in a particular society about what is or isn't a sexual situation and denote the actions, motives and responses deemed appropriate as a result. Researchers interested in the social scripting of sexuality suggest that it is important to identify how the facts and meanings associated with a script are integrated and organised within the script itself as well as the particular society in which it exists (Gagnon 1990; Parker and Aggleton 1999).

While Gagnon's perspective sees all behaviour, including sexuality as scripted, it also accepts that cultural or social scripts alone are rarely direct predictors of actual behaviour (Gagnon and Simon 1973). Instead they are commonly amended by the individuals involved to fulfil the requirements of a particular circumstance or achieve a desired result. Amendments may be minor or major and occur as a result of reference to previously scripted knowledge and experiences. Irrespective

of the degree of amendment made, this in turn will go on to influence the scripts which may impact on future sexual behaviours and social choices. The greater the amount of disparity between the socially expected outcome and the individuals own experiences/desires the greater the demand placed on the individual to amend or to actively determine the appropriate action.

As a socially determined aspect of human development, lifestyle choices and actions taken in relation to sexual health may be particular, but not exclusive to an individual or group. Social construction theory therefore provides a useful starting point to explore some of the unanswered questions and silences about black Caribbean men and sexual behaviour. By placing emphasis on sexuality as a socially constructed aspect of human experience, sexuality can be explored within and alongside other non-sexual aspects of experience. This may help to broaden the scope for understanding or explaining incongruence between sexual behaviour, social behaviour and self definition (Abrams and Hogg 1999; Adams 2000). In addition it becomes possible to question not only how ideas of sexual identity and appropriate activity are formed, but how their meanings are changed or affected by the self and wider society.

Incorporating a scripting perspective to support exploration of the sexual behaviour and decisions of black Caribbean men in this study will allow issues concerning what participants think, do and are affected by the socio-cultural context in which decisions take place to be explored. At a cultural level it will allow the norms and values associated with sexuality in general and the experiences of black Caribbean men in particular to be viewed as socially determined aspects of experience and development with negative and positive consequences. In this way the sexual health decisions of black Caribbean men can be viewed as more than simply individual behaviours but as a complex process of events governed by the interactions between the scripted sexual cultures

comprising British society and the sexual and non-sexual experiences of the participants.

In relation to health decisions in general and sexual health in particular, the importance of an event, situation or experience and the impact this has on an individual's decision making is often associated with the perception of risk. In order to make sense of the way in which the sexual health decisions of an individual or specific group may vary, it is therefore useful to first explore the notion of risk as it relates to sexual health and decisions.

2.2.3: The notion of risk

a) The nature of risk

In its most pure sense, risk relates to mathematical probability and encompasses the possibility of an event having both positive and negative outcomes (Lupton 1999). It originally excluded any notion of human 'fault' or responsibility and was related to aspects of life that humans were unable to control but could estimate the likelihood that an event may occur and take steps to manage its effects (Ogden 1996). Risk was therefore related to 'chance' where the possible outcomes may be good or bad for the individual.

Over time the context in which the word 'risk' is used has changed and the meaning applied to it now includes a wider range of situations than simply mathematical probability. Risk has been said to be affected by both genetic or biological factors (nature) and social or environmental factors (nurture) (Ewald 1991; Cockerham 1995). Nowadays risk is still taken to refer to possible consequences of action for the individual, but is more likely to be linked with danger or have negative connotations, use of the term in relation to positive outcomes is less common (Niven 2000).

Changes in the way risk is applied and defined in relation to health have emerged within a developing social and political context that mirrors the changing nature of disease in society. These changes are reflected in the fact that the major threats to health and psychological well-being today are likely to be seen as a consequence of unhealthy lifestyles and high risk activities rather than from external, uncontrollable forces (fate). One of the most significant contributions to understanding this change in the nature of risk in the 20th century has been that of German sociologist Ulrich Beck. His seminal work 'Risk Society' identifies and explores the ways in which risks themselves and their implications have changed through the ever increasing rise in globalisation and technological development (Beck 1992). Beck sees risk as part of the normal fabric of life in the 1990s which are more openly debated and discussed; as a consequence people are more aware of risk in their everyday lives.

This view of risk as an inevitable part of life negates the need to question in practical terms whether risks really exist. However what still needs to be clarified from the earlier discussion about the sanctioning of sexual activity (see chapter one 'setting the context') is whether there is a difference between a risk itself and the perception of it. If Beck's view of risk as a normal part of life is accepted then in practical terms risks must be 'known' to individuals. Lay definitions of risk commonly equate it with threat, danger, harm or hazard for the individual, either in terms of the outcome of the risk or the action involved in taking a risk (Wynne 1996). Judgements are therefore an inherent part of understanding and reacting to risk on a daily basis. Whether the judgement is based on a perceived or 'real' threat which is either possible or probable is immaterial, in ether case a reaction is provoked in the individual. The question of the difference of perception versus reality of risk in practice therefore becomes less important. This pragmatic view of risk contrasts with the general approach taken in relation to health.

Risk is used in health promotion and harm reduction strategies to help individuals make decisions about life and health, suggesting that they must first be made aware of the risks that may impact on their health prior to making decisions about them. The

underlying assumption here is that individuals are unaware of health risks they face and the role of health promotion is to provide information about the predictable and avoidable risks associated with an activity (Ogden 1996). This contextualises risk related to health and prevention of illness as inextricably linked to individual lifestyle choices, which could have a negative impact on health that is predictable (Wilson and McAndrews 2000).

The association of risk with predictability in discussions about health and lifestyles has often lead to the subsequent use of epidemiological studies as vehicles for demonstrating the accuracy of predictions (Ford and Norris 1996; Fenton, Korovessis et al. 2001; Katz, Fortenberry et al. 2001). Quantitative approaches to risk involve use of statistical calculations to illustrate whether health, ill health and life expectancy is affected by the decisions people make about their lives. The link with predictability introduces the idea that it is possible to adopt a completely scientific approach to determining what is risky and suggests that this is the result of a degree of precise calculation and study (Douglas 1992).

Epidemiological studies often consider the ratio of the incidence of a health issue in a particular sample and compare this to its prevalence in the population. Calculations are then made to identify the relative risk of contracting the disorder or undertaking risky behaviours for individuals from different groups (Lupton 1995). Following these calculations and predictions, attempts are then made to explain and identify the factors that predispose to the disorder or the situations in which risks are taken. Thus an epidemiological approach appears to allow scientific and objective judgements to be made as to which behaviours are considered risky and who is at risk (Douglas 1992).

As a result of these predictions governments, policy makers and service providers set targets for improvements in health which are indicated by a reduction in the

incidence rate (Royal College of General Practitioners 1981; Department of Health 1999; Department of Health 2001). These targets for health improvement based on the outcomes of prior statistical predictions may be narrowed in focus and relate to identified risk factors and specific 'target' groups. Targeting is based on the assumption that the advice, services and information indicating ways of reducing risk if effectively applied will be taken on board by the target group, and the disorder will eventually be eradiated from society (Woodland and Hunt 1994). The role of epidemiology in relation to risk therefore concentrates on the generation of statistical data, in order that risk may be quantified and possibly managed. However, targeting as a response to high levels of risk in particular groups encases silences about the way risks are identified in a political and social context. Use of science as a basis for determining risk suggests that a scientific approach is essential in order for a risk to be identified. Beck in fact suggests that what he calls natural-scientific objectionism is required for risks to be perceived at all in the 20th century (Beck 1992). Although this appears to have some relation to the national approach to sexual health issues in Britain, evidence in other parts of the world suggests this claim does not really equate to local or personal acknowledgement of sexual risk. For example the risks associated with HIV were apparent to the Gay communities long before scientific measures 'named' the disease and legitimised the need to act (Shilts 1988).

In contrast to the epidemiological approach outlined above, social science based definition of risk while recognising the importance of science and calculation to the overall debates on risk, do not accept scientific methods as the whole or most important aspects (Franklin 1998; Giddens 1998). Beck for example defines risk as:

> 'Social constructs which are strategically defined, covered up or dramatised in the public sphere with the help of scientific material supplied for the purpose'
>
> (Beck 1996)

Although Beck is referring here to ecological risks brought about by scientific interventions when offering this definition, it raises some interesting issues for considering sexual health.

As demonstrated above, epidemiological data used to determine risk in relation to STIs often precede changes in statute to sexual health. At the same time these changes often conceal silences in the selective way messages that risks related to particular groups and sexual activities are highlighted e.g. linking minority ethnic people with risky activity or concerns about rising rates in unwanted teenage pregnancy and links with abortion. Within these two examples data is used to support the 'concerns' of statutory bodies with little contextual information given to encourage any other reading of the data such as the extent to which unwanted pregnancies exist in adult groups or the nature of the communities covered by the term black minority ethnic. While these omissions are not sufficient in themselves to claim that the purpose of the data was to 'cover-up or dramatise' the risks as in Beck's definition, the disembodied presentation of the risk to particular marginalised groups allows this to happen.

The continued use of epidemiological studies in health to predict risk is based on an assumption that there is a linear relationship between the amount of information a person has on a subject and health behaviour (Conner and Norman 1998). Risks to health can therefore be minimised by making rational choices based on the facts. In each case the rational choice is determined by the logical interpretation of the facts. Interpretation involves individual assessment of the risks related to a particular activity based on what is either socially acceptable to the group to which the individual belongs, or proven by 'experts' to be best for the individual (Douglas 1992; Crepaz and Marks 2002; Kemshall 2002).

Social scientists suggest that any pronouncements about risk must be recognised as given from a particular perspective (Adams 2000; Aral 2002). Socio-cultural

perspectives on risk emphasise the importance of recognising the contexts in which risk is identified, understood and negotiated (Lupton 1999). From a social construction perspective, society both creates and reflects the risks it contains. In a sense something becomes a risk in a society because it is labelled as such and is reinforced by individual, social and cultural actions (Ewald 1991). Social constructionists argue to differing degrees that risk is therefore never fully objective but must be viewed within the belief system in which it exists and is created. To a greater or lesser extent therefore risks as parts of social life and human experience can only be assessed, identified and understood from situated positions in society. Science as a discipline is not immune to this. It has its own belief systems which are played out in a particular social context which itself is not objective. The situated view of science raises questions about the rational, logical and useful nature of the health risks identified by experts using this method.

Individual situated interpretation of the facts in prediction of risk introduces a degree of uncertainty and variation in the possible outcomes that makes it difficult to sustain a linear cause-effect between the assessment of risk taking and possible negative outcomes (Figlio 1989). Outside the world of the laboratory or the tables of statistical significance lie the realities of people's lives. In this reality risk appears less certain, more fluid and retains a degree of unpredictability not reported in scientific data. In particular when we move from theory to practice, measures of quantitative risk do not always translate. For example, not all smokers develop lung cancer and not all people engaging in unsafe sex contract HIV.

The social constructionist approaches underpinning this study mean that identification and understanding of risk in the real world is recognised as occurring within a particular social and historical context. This takes into account beliefs about the way in which life 'should' be lived within a particular timeframe (Woodland and Hunt 1994; Spencer 2001). Knowledge and awareness of these risks and the consequences for health help people to make decisions about how to live their lives and so reflect their attitudes and approaches to aspects of their personal and social

life (Kemshall 2002; Lee and Owens 2002). People do not make judgements of risk to themselves simply as a reaction to the amount of professionally produced information available to them. Similarly assessments of risk are not made in isolation from the other aspects of a person's life and experiences (Ogden 1996). Instead an individual's risk in relation to a particular disease is affected by a host of social, cultural and psychological influences suggesting that health behaviour is more than just a matter of unbiased, objective choice (Cantana, Kegeles et al. 1990; Cockerham 1995; Lupton 1999). Social science researchers suggest said that people use a culturally relative approach to make a critical assessment of the information they have been given in relation to risk (Lupton 1999; Kemshall 2002). A culturally relative approach takes into account the personal and social situation of an individual in time, experience and context. In this approach, scientific data forms part of the information available to the individual. This information is then 'processed' and evaluated in the light of their experience and particular social situation in order to weigh up the 'real' risks to themselves.

In an attempt to make sense of variations in the experiences of individuals and the patterns of health in society studies of risk have expanded to include consideration of whether we are all at equal risk of ill-health. This has resulted in investigation of the social and environmental determinants of health to a greater extent. Information is gathered to indicate the socioeconomic environment of those perceived to be at high-risk. The most popular variables considered include age, sex, race and socio-economic status.

The inclusion of more than pure incidence rates in calculations of risk allows us to move from the view that health behaviour is simply a matter of individual choice, to an acceptance of the notion of healthy lifestyles. Healthy lifestyles refers to the pattern of voluntary health behaviour based on choices from the options available to individuals according to their life situations (Cockerham 1995). One of the key aspects of this approach is that risks exist for everyone to some degree but not all people experience the same degree of risk. This challenges the cost-benefit approach

to assessment of risk which ignores the impact of power relations in society and attempts to present individuals as equally able to assess and resist risk (Lupton 1999).

The relative positions of individuals and groups in society influence all aspects of their lives including their health (Department of Health 1992; Davidson and Lloyd 2001; Macbeth and Shetty 2001). Variations in the gender, ethnicity and socio-economic status have long been identified as influencing the power positions within and between social groups. Thus the social and environmental situation of the individual, their cultural beliefs, norms and values can affect their chances of experiencing illness and disability. At the same time, these also determine their prospects of preventing disease and maintaining their health:

> 'Poverty attracts an unfortunate abundance of risks. By contrast, the wealthy (in income, power or education), can purchase safety and freedom from risk.'
>
> (Beck 1992, p.35)

The white paper, *Saving Lives: Our healthier Nation* (Department of Health 1999) takes up the points made by Beck and others in noting that society and the individual are interdependent with respect to health. Each individual has some choice (however limited) but their range of choices available may be constrained by society and their position within it. The role of the government and other statutory bodies is seen as ensuring the public have adequate information on the risks involved in particular choices. However, there is also recognition that changing people's attitudes to health concerns much more than providing information. It is suggested that alongside the information should be strategies that attempt to reduce the social and environmental inequalities between groups so that all have an equal opportunity to apply the available information and to make the appropriate choices (Ahmad and Atkin 1997; Balsa and McGuire 2002).

Highlighting the importance of accounting for variations in susceptibility to risk and ability to protect the self from harm appears very altruistic. Access to information identifying those most at risk would enable strategies to be targeted in the right paces to benefit those less able to protect themselves (Kemshall 2002). However, as a socially determined aspect of behaviour readings of risk must take into account the impact of the social and shared aspects of experience on perception of risk.

b) Communal notions of risk

Health behaviour has been identified in this chapter as a socially mediated activity which may be greatly influenced by other culturally predetermined issues such as beliefs, values and expectations (Woodland and Hunt 1994). Reviewing health decisions alongside other influences on behaviour reveals further contradictions to the presentation of risk judgements as objectively managed by individuals based on their awareness of scientific (trustworthy) facts. One such contradiction arises from the social aspects of decision making. Social and cultural identity helps people to develop a communal as well as individual notion of risk (Wynne 1996).

While individuals may experience the world as if it is composed of objective, pre-existing realities, most of these realities involve the reproduction of meaning and knowledge via social interaction, socialisation and thus rely on shared understandings and definitions of a situation (Douglas 1992). The process of identifying something as risky is itself therefore not simply determined by an individual's own experiences but also by the experiences of others. Within a community, shared, accumulated experiences are used to determine which risks may be most probable, harmful and preventable (Hart and Boulton 1995; Kempadoo 2001). Thus social scripts governing the way risks are recognised and the potential effects they are believed to have on the individual and group are pre-existing, created and reinforced in the social sphere. Through this mechanism a culture of shared understandings and constant change is embedded into communal notions of risk.

Gagnon's work on scripting emphasises that particular social scripts exist in a society because they are useful to the society and its members at a specific pointing time (Gagnon 1990). This raises the question as to how and why are communal notions of risk useful and what role do they play in society.

Communal notions of risk may be used as a means of maintaining social cohesion and order. Mary Douglas in her works on risk and culture identifies the ways in which communal notions of risk are useful in society as a strategy for recognising or dealing with otherness and danger (Douglas 1992). Risks are selected and named in a society based on the shared values and customs of the time. In a communal sense risks identify the boundaries of norms and values of a society. Outside this boundary risks exist as social taboos which threaten to destabilise communities or cultures in a society by challenging the status quo. The threats posed by a risk are therefore not inherent in the actions themselves but may be judged as such depending on the degree to which they may challenge the established norms and cultural values of a community at a particular point in time (Hilgartner 1992).

A community uses its shared accumulated experiences to determine not only the nature of risks but which are most probable, most harmful and most preventable. On the basis of this sanctions or warnings may be incorporated into society at the level of the individual, community or society as a whole in order to minimise and negate the effects of risks deemed the most destructive. Thus a hierarchy of risk is developed in a particular society in which different consequences of taking part or experiencing the effects of risk are graded from grave to trivial.

In identifying the nature of risks and the threats they pose to a society, communal notions of risk also identify perpetrators of risk as 'polluting people' who act as potential threats to society due to their close association with risk (Douglas and Wildavsky 1982) . Perpetrators of risky behaviours and actions are identified in

communal understandings of risk as being bad for society because they weaken cultural norms by committing the 'sin' of risky behaviour and also put others (community) in danger by doing so (Hilgartner 1992). Societies and communities devise formal and informal ways of dealing with them as initiators of risky activities in order to conserve the established boundaries.

Discussions of the communal aspects of risk so far have identified its usefulness in identifying and maintaining boundaries of behaviour in a society. However, some researchers have highlighted that communal notions of risk may also be used as a cultural and political tool to organise, regulate and monitor particular social groups and individuals (Rowbottom and Colquhoun 1993; Hart and Boulton 1995; Green and Tones 2000; Kemshall 2002).

Risk is politicised through its association with responsibility, accountability and blame (Ogden 1996; Lupton 1999). As such it may be used as a political weapon against particular sections of the community, to attribute blame for the dangers posed to the rest of society. This aspect of risk is selectively applied both in terms of the focus of the risk and the direction in which it is applied (Lupton 1995). This has been witnessed in may spheres including the risk-groups of early HIV campaigns (Department of Health 1993; Adler 1997)and the association of black Caribbean youths with risk of violence to others (Sewell 1995; Estes 2000) .

Through the political and cultural sanctions resulting from this aspect of risk, individuals, groups or particular activities may be constrained or marginalised. Boundaries are set up between 'us' as potential victims and 'them' (people) or 'it' (activity) as perpetrators of danger (Hart and Boulton 1995). These boundaries often determine and control our reactions to others or particular practices in the form of socially derived, culturally specific taboos and stereotypes of particular groups or types of behaviour. Risk taking in this context therefore means to transgress the

orders of a community, to break a taboo, cross a boundary or commit a sin (Lupton 1999).

Perpetrators may be social groups, organisations and individuals often culturally placed at the margins of society as acting other or outsiders to the shared cultural norms. Risk is thus epitomised as a social tool for maintaining socially determined boundaries between the self and other, to deal with social deviance and to achieve social order (Douglas 1985).

Communal notions of risk as part of the social scripting of behaviour take into account a mutual sense of obligation and expectation which is present in all aspects of social life. As a result decisions about individual risk taking may include an appraisal of the possible impact of a personal judgement on family, friends or even the community as a whole (Niven 2000). The relationships between risk, obligation and expectation are in turn influenced by other social distinctions and attributes which shape interactions and limit experiences with others such as ethnicity, gender and social class (Kemshall 2002). The combination of these sources of information and experience results in a culturally determined and context bound 'scale of risk' against which individual perception of the consequences of risk taking in a given situation can be considered (Macgill 1989; Rothenberg 2001). As a result people, communities and organisations may have differing views of risk even within the shared notions of communal risk. For example, the professional calculation that living in an inner city area is risky (based on high crime and deprivation rates), may contrast sharply with the sense of security and community felt by people who live there (Sewell 1995). The difference in outcome from the appraisal of risk in this example is understandable when viewed from the perspective of those making the judgement in each case. Higher rates of crime and deprivation may exist in inner cites and be related to feelings of insecurity and danger felt by the general public. Conversely, for people

living in the inner city, adversity may bring a shared sense of belonging and community support based on a need to survive in situations of relative deprivation.

Individual and communal appraisal of risk is further complicated by the fact that judgements are based the source of the information as well as the facts themselves and individual/communal experiences of them. The experience and perception an individual or groups have of the professional, organisation or policy makers providing the expert advice and information are therefore further influencing factors in decision-making (Macgill 1989; Hendriks 1992). Beck suggests that lay people are often sceptical about official pronouncements from scientific sources because they now recognise that science has itself created many of the problems they face and makes pronouncements about risk which are incomplete or contradicting (Beck 1996). The result is what Beck calls a definitional struggle about risk between the producers of the definition (experts) and the consumers of the definition (lay people).

If the source of the information is perceived by lay people to be biased, inappropriate or simply wrong, they may resist or challenge the expert advice presented. In sexual health for example, the early days of HIV and AIDS saw moves to equate high risk of infection with African people irrespective of their sexual practices (Caplan 1987; Green and Tones 2000). As a result researchers and sexual health workers subsequently reported some resistance and opposition from some black and minority ethnic groups to prevention strategies based on a mistrust of the politics behind targeting initiatives (Serrant-Green 1999; Fonck, Mwai et al. 2002; Valdiserri 2002).

Individual assessment of risk may therefore include the making of a truth judgement about both the information received and the source of that information. The result of this judgement may be a conscious choice to ignore or avoid the advice of experts. In this case, the decision to take a risk or reject risk avoiding practices is based on personal preference or a positive decision rather than ignorance or lack of information as suggested by quantitative approaches to explaining risk behaviour

(Wynne 1996). Giddens places greater emphasis than Beck on the role of trust in making decisions about risk. He claims that trust pre-supposes an awareness of risk and contributes to the individual's calculation of how to minimise danger and reach a level of acceptable risk (Giddens 1994). In making a judgment and calculating risks, individuals use communal notions, mass media, conversation with other as well as expert knowledges as legitimate sources of information. Making a truth judgement about risk at the level of the individual therefore incorporates a move away from objective judgements based on processing of information in any logical sense to deciding between what Giddens (1994) calls 'scenarios of risk' with varying degrees of plausibility.

The final issue of concern in this exploration of risk relates back to the opening discussion in which the consequences of risk were presented as being predominantly negative. It is easy to find examples from both research and practice of how and why risk is generally perceived in this way (Lawson 1998; Johnson, Mercer et al. 2001; Katz, Fortenberry et al. 2001). However this perspective on risk fails to incorporate the possibility that risks are taken because of the pleasure and enjoyment gained from undertaking the risk, rather than any disregard or ignorance of the consequences. Risky behaviour in this context is a preference and may in fact be actively sought out by an individual.

Risk can therefore be seen as a site of tension. Risk taking epitomises many aspects of life which are simultaneously revolting and attractive to us as human beings. To take a risk is seen at best to be careless or irresponsible and at worst, evidence of deviance (Aggleton, O'Reilly et al. 1994; Hughes, Brady et al. 2001). Alongside the negative connotations of risk exists a counter view in which risk taking is based on a need to escape from the regulation, control and order of everyday life (Lupton 1995). This perspective brings about a need to transgress, challenge the boundaries or push the self to the limit. The pleasure arising out of the risk activity may stem from the activity itself, for example in dangerous sports such as sky diving and pot-holing, or

linked to the association of the activity with fear, guilt or anxiety such as illicit sex or stealing.

This section of the literature review has explored the wide range of situations in which risk may be perceived and identified. The key issue in these discussions is that risk in society is multifaceted and changeable. It is identified and acted on by individuals and groups in relation to a particular context and with reference to their specific experiences and perspectives on how life (and behaviour) should be conducted. In order to investigate the impact of risk on sexual health decision making in more depth it is necessary to contextualise it in relation to this specific aspect of health.

2.2.4: Risk, sexual health and decisions

Earlier in this chapter health behaviour was identified as incorporating the health choices of an individual and the actions taken as a consequence of the choices made. Risk has been identified as a key component of decision-making in relation to health in general. The health decision-making of individuals or groups and the reactions of society to them are to some degree dependant on how risk is perceived (Douglas 1992; Beier, Rosenfeld et al. 2000). Some of the risks that receive the most attention in society today are often associated with moral principles. In discussing these challenges to morality, the danger posed by the risks is often presented using moral, cultural and political reference points.

As an aspect of health behaviour, sexual health has been associated with risk taking through discussions about the impact of declining morality and social taboos in society at a variety of points throughout history (Screen 1992; Lancaster and di Leonardo 1997). In order to begin to make sense of how this association between sex, decision making and risk impacts on the sexual decisions of individuals and

groups, it is first necessary to be more specific about what is meant by sexual health decisions.

Earlier in this chapter, sexual health was identified as just one aspect of health behaviour. Using the definition of health behaviour cited earlier, sexual health decisions were identified as encompassing the actions and choices made by an individual which may have an impact on their sexual health. More specifically sexual health decisions in this study incorporate sexual health seeking or risk taking activities. In this context, health seeking refers to either the positive decisions taken to reduce the risk of sexually transmitted infections (STIs) and pregnancy, or action to obtain treatment or expert advice for family planning and other sexual health concerns. Risk taking includes any activity that may result in STIs or unplanned pregnancy.

In the exploration of risk and health behaviour in this chapter, perception of risk was identified as a key aspect in individual's decisions about health. The discussion identified a variety of aspects of risk which could impact on a person's perception or appraisal of a situation or context as 'risky'. The remainder of this section of the literature review will use these aspects of risk as a basis for exploring how risk and sexual health decisions are associated in society. The list above incorporates a wide range of highly interrelated issues. These have been arranged into the following three themes to aid the management and structuring of this discussion

a) Risk as a negative concept
b) Risk as a 'lifestyle choice'
c) Communal notions of risk

These themes will be discussed in the remainder of this section using examples from sexual health research and practice to illustrate the relationship between society's expectations in relation to sexual health and links with notions of risk and sexual decisions.

a) Risk as a negative concept

The discussion of risk as a concept began by noting the way in which the view of risk has changed over time to incorporate less of a notion of 'chance' and more frequently the idea of threat or danger with negative consequences (Lupton 1999). Sexual risk taking has long been associated with negative connotations relating to health and decisions. The first section of this literature review cited many examples of how sexual practices and sexual health are more likely to be identified in research and literature in relation to ill health (Treicher 1999; Lamp 2000; Wilson and McAndrews 2000). The earlier sections of this chapter identified how the wholly negative focus often applied to risk has been widely criticised by social scientists and those opposed to some structured approaches to health education (Franklin 1998). Despite this opposition however in sexual health in particular the negative aspects of risk persist and the corresponding positive aspects are proving difficult to introduce.

The way in which sexual risk taking is publicised and illustrated acts as a good example of the negative promotion of risk as a concept in a number of ways. Firstly, in sexual health, statistics indicating incidence rates for sexually transmitted infections and diseases of the reproductive tract are widely used in public health, medicine and allied professions to 'prove' the reality of the consequences of poor sexual choices (Hart and Boulton 1995). These statistics are important in building a perception of sex as a risk activity. This is achieved by providing a 'factual' picture of the prevalence of a particular disease in society and because of the nature of the information reported. For example statistics reflecting the numbers of successful, planned pregnancies, uninfected users of genitourinary medicine clinics or regular condom users are either unlikely to be systematically recorded or not reported under 'risk' data. The result is that the negative message of risk is reinforced both by the figures quantifying the problem and the nature of the issues reported.

The reinforcement of risk as a negative concept in sexual health decisions is not only confined to the use of quantitative approaches. Qualitative approaches to presenting risks have often used the statistics as a starting point or evidence base to identify or discuss issues of blame and responsibility (Hayter 1996). Blame and responsibility are identified as key underpinning factors in debates of risk. The management of risky behaviour in society and protection of the self often reinforces this association though identifying the source of the risk along with the strategies available to avoid or reduce its impact (Kemshall 2002). This is combined with efforts to ensure that individuals have some knowledge of both the negative consequences of their decisions for themselves (in terms of their individual health) and also the wider implications of their decisions on others (costs to their peers or society as a whole).

In sexual health this approach to management is reflected in public health campaigns highlighting the personal consequences of unprotected sex to teenagers such as unplanned pregnancy, low education achievement and loss of independence (Purves 1997; Spencer 2001). These exist alongside national strategies identifying the 'teenage pregnancy problem' and the cost borne by society to support pregnant teenagers through increased need for social support, reduction in working capacity and care of low birth weight infants (Department of Health 1999).

The impact of sexual risk taking on both individuals and society facilitates the introduction of concepts of blame and responsibility into discussion of sexual decision making. The potential for personal decisions to impact on everyone in society either directly or indirectly legitimates attempts to identify the perpetrators of sexual risk or hold people responsible for their decisions once the risks are known (Treicher 1999; Valdiserri 2002). Knowledge of the cause and impact of the risks associated with and activity brings with it responsibility to actively work to avoid or minimise risks to the self and others. This suggests that both personal and social responsibility should be of concern to individuals in reaching sexual decisions (Aggleton, O'Reilly et al. 1994). For example, once information exists concerning the possibility of sexual infection from unprotected sex, it is the responsibility of public

health services to publicise the information and that of individual citizen to act according to the advice given and use condoms. In either case, blame and responsibility are entwined in the messages establishing the negative connotations relating to the 'cost' of non-conformity for the individual or social group.

The association of risk with negative consequences was presented as existing in constant opposition to the pleasure incorporated in some risk activities. Healthy sexual activity was defined as incorporating positive aspects of self identity, self expression and concerned with the giving and receiving of pleasure (Beacham 1995). These components of human sexual expression bear little resemblance to the negative, life destroying dangers epitomised in the above discussions of risk.

Heterosexual sexual expression as a fulfilling, enjoyable activity is accepted as a normal, desired part of human experience. However, this view of sexual activities is usually retained outside the boundaries of risk discussion. Some researchers have suggested that for some people, risk taking in sexual practices represents pleasure seeking, the threat of being caught and the thrill of breaking a taboo (Bolton 1992; DiClimente, Wingood et al. 2001). From these perspectives it is the very risk involved in the activity itself, or in the context in which it takes place, that is actively sought out by individuals. In sexual decision-making, it may therefore be the thrill of illicit sex, of having unprotected sex or engaging in forbidden erotic activity that is the objective of the individual, and form part of the scenario discussed by Giddens (1994), on which judgements of whether to take a risk is made. If this is the case, then the negative messages of consequences to health or social status may have little impact in the individual, except to perhaps make the risk appear more, rather than less enticing.

The association of risk with negative consequences and the responsibility of individuals to avoid risks are therefore not unproblematically linked but add to the context in which sexual decisions occur. The tension between the pleasure-danger

aspects of sexual activity mean that reaching sexual decisions based on the scenarios of risk discussed earlier, is not always straight forward, logical and understandable.

b) Risk as a 'lifestyle choice'

In discussions of risk and health decisions the underlying theme related to individual choices. Issues of lifestyle are often centralised in attempts to identify who, what and why the risk of poor health occur in a specific population at a particular time (Fortenberry, Dennis et al. 2002). Once the risks related to an activity were known, publicised and accepted individuals would be expected to avoid and minimise their own risks through heeding expert advice by non-participation in risky activities.

If the links between risk, blame and responsibility outlined in the above section of this discussion are added to the issue of lifestyle choices, then failure to comply (or attempt to comply) by an individual could be identified as abnormal or deviant. Lupton (1997) talks about the way in which risks are associated with particular activities then used to control or monitor human activity in a particular society. Non-conformity is a threat to the status quo and could undermine the established rules and acceptable practices. So for example, the need to control fertility through use of contraception is identified as a mechanism by which the negative impact of multiple pregnancies on an individual and the socioeconomic costs of a spirally population on society may be avoided.

One of the underlying assumptions in the association of risk and lifestyle choices is that individuals choose to take risks (Douglas 1992). Therefore to some extent risk takers are to blame and can be held responsible for the consequences of their actions on themselves and society. The element of choice, once attached to notions of sexual risk can be used to explain, sanction and legitimise the blaming of particular groups for the consequences of their decisions. Thus gay men, prostitutes, Africans and drug users were epitomised as engaging in risky activities by choice and held responsible

for the emergence of HIV/AIDS, for threatening the lives of innocent victims such as haemophiliacs and anyone else infected who did not fit into these groups (Valdiserri 2002). These associations evolved and persist to some degree today despite published data indicating that the risks associated with contracting HIV are applicable to everyone (Susser, Desvarieux et al. 1998; Treicher 1999).

The persistence of the stereotypes of those identified as sexual risk takers can perhaps be more easily understood by considering what it is they have in common with each other rather than their specific differences to the majority population. Members of these groups are more likely to suffer from moral, social or political discrimination in an inequitable society (Valdiserri 2002). The social and individual pressures brought about by their positions in society have been shown to have a negative impact on their sexual health and life chances in general (Johnson, Mercer et al. 2001; Karlsen and Nazroo 2002). As members of marginalised groups they are less likely to be considered as part of 'normal' society, their association with the negative aspects of sexual risk is not unique but a reflection of their general positioning in society.

Reports by researchers in sexual health have highlighted the fact that the risk of sexual infection was not equally distributed across the population in the UK (Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997). These studies reported that infection rates for the sexually transmitted infections Gonorrhoea and Chlamydia were disproportionally higher in men from black Caribbean communities. The National Strategy for HIV and Sexual Health published in July 2001 (Department of Health 2001) highlighted the UK Government's concern about the continued rise in sexually transmitted infection among minority ethnic groups and other socially excluded populations. The National Strategy, which was developed in consultation with sexual health professionals from education, health and welfare stresses the need to improve the sexual health of the general population and minority ethnic groups in particular:

'Sexual ill-health is not equally distributed among the population.

> The highest burden is borne by women, gay men, teenagers, young aduls and black and minority ethnic groups.'
>
> (DOH 2001, p 9)

The tradition of quantitative research in sexual health has produced a relatively large amount of statistical data to support the points made in relation to social group membership and risk of sexually transmitted infections. However, the paucity of information available to indicate how and why being young, black, or female may influence sexual decisions disadvantages attempts to improve the sexual health chances of these sections of the community.

The National Strategy for HIV and Sexual Health reiterates the earlier concerns of researchers in sexual health in highlighting that the research base for sexual health in the UK is fragmented and an evidence base for developing strategies for working with marginalised groups is scarce. In studies identifying the high rates of sexually acquired infections in black Caribbean men for example (see Geringer, Marks et al. 1993; Ford and Norris 1996; Lacey, Merrick et al. 1997; Low, Daker-Whiteet al. 1997), researchers identify the need to increase the evidence base relating to factors affecting and influencing sexual health behaviour and decision making. In essence there is an increasing recognition that more information is needed exploring why particular groups appear to be at higher risk and to understand the factors influencing sexual risk taking or health seeking decisions.

c) Communal notions of risk

One aspect of life that has been explored in relation to its impact on perception of risk is experience. In the earlier discussion it was highlighted that individuals may develop or modify their perception of a situation as risky based on their personal experience and that of others. This introduced a communal aspect into decisions about the severity of the risk as well as the initial identification of an activity as risky.

Sexual risk taking and experience has been widely researched outside Britain. Research has for example explored the impact of peer pressure and previous experience on issues such as age of first intercourse, use of contraception and attitudes to fidelity (Holtzman, Bland et al. 2001; Ford, Sohn et al. 2002; Fortenberry, Dennis et al. 2002) These studies indicate that there is an association between sexual decision-making, group and personal experience. The social experiences of individuals as part of a recognised community has been shown to impact on the nature of the sexual risks they recognise, are exposed to and ultimately decide to take (Ford, Sohn et al. 2002). This suggests that studying communal experiences and their influences on sexual decisions could provide interesting opportunities to clarify the social processes involved in sexual decisions.

The application of a social constructionist approach to studying sexual risk taking encourages it to be seen as part of normal human development in a particular society. As such through a process of socialisations individuals become aware of the social and moral parameters of their particular belief systems. All knowledge about sexual risk is therefore bound to the socio-cultural contexts in which knowledge is generated (Douglas 1992). Within this normal developmental process what is measured, identified and managed as sexual risks are constituted via shared, culturally determined pre-existing knowledges and discourses (Lupton 1999). As a consequence of the continuous affirmation and re-definition of belief systems that takes place in society sexual expression, sexuality and the risks associated with them are created and sustained through this process.

This suggests that sexual risks are part of our world view which is formulated and reaffirmed continuously through social and cultural interactions in society. Social scripts exist for all interactions, not just sexual behaviour. Scripting in sexual health describes the ways in which shared meanings and beliefs concerning sexual actions or activities are assembled together in a particular context and labelled risky. The changing mature of societies and expectations mean that the perceptions and beliefs

governing a shared notion of risks are not universal in time between or within social groups.

Many of the debates about sexuality and sexual expression focus on questions of cultural representation, meaning or political positions bound up with communal notions or risk and appropriate behaviour (Gagnon and Simon 1973). Both sexual and non-sexual information is contained in sexual scripts, these help to identify and maintain shared notions of sexual behaviour from which judgments of sexual behaviour take place. For example the allocation of an age of consent to heterosexual sexual activity in a society enforced by law is reflects the shared cultural beliefs about responsibility, reproduction and childhood. Variations in beliefs about the relationships between these non-sexual aspects of life and sexual activity are reflected in the raising or lowering of that lower age limit in other societies.

The example given above also illustrates how communal notions of risk are used to set and maintain cultural boundaries around sexual behaviour. Whether in the guise of sanctions by law at one extreme such as clause 28, age of consent and directives for legal abortions or family and community disapproval at the other, communal notions serve to set the script of how, what and where sexuality should be expressed. The boundaries of behaviour are identified by the labelling of particular aspects of sexuality as taboo and sinful. The statutes and reactions that occur in a society to minimise the breaching of these boundaries se are reflective of the ways in which societies develop strategies to maintain order and deal with behaviour which does not conform to the established scripted beliefs about sexual behaviour.

It was previously stated that communal notions of risk are not fixed but relative judgements. Thus variations in the relative positions of members of a society also lead to potential anomalies and alternative viewpoints of risk. Many of these variations arise out of the interplay between other social aspects of identity such as ethnicity, gender or social class and the social scripts of a society (Gagnon 1990). These other aspects of identity carry with them alternative meanings of social obligation,

expectations and responsibility. In societies made up of very diverse communities such as Britain there are likely to be even greater incidences where differing experiences lead to points of tension within and between the minority communities that make up British society. These different approaches and beliefs may constitute different calculations of risk in around sexual expression and sexuality in general lead to the existence of alternative behavioural scripts in particular sections of society which over time come to affect the larger sexual and social scripts in which they play a part.

Risks and their identification on a communal scale not only establish boundaries for appropriate action but also are used politically to identify the perpetrators of sinful acts and attribute blame (Parker and Aggleton 1999). Blame and sin where identified earlier in the literature chapter as closely associated with sexuality and sexual behaviour. Threats to society and individual from uncontrolled sexual activity and inappropriate sexual expression have been recounted in scientific reports, research and mass media (Screen 1992).These again act as another vehicle by which the boundaries of a society in relation to sexuality are reinforced and sustained. In setting boundaries and identifying risks communal notions also include constructions of the nature of harm or danger associated with a particular individual, group or activity (Gagnon 1990). Some of the key issues in a social constructionist approach to sexuality and risk are why and how particular behaviours, individuals or activities come to be labelled as risky in a society? What role do shared notions of risk play in setting the sexual scripts which identify individuals, activities or objects as sources of sexual risk? and how are the identified risks politicised?

The picture that emerges from a communal approach to risk is that risk notions are not only derived from social positioning in society but help to locate a person in that society (Douglas 1992). This is important as a component of the individuals self-identity as part of a social group. Acceptance of a social constructionist approach in general and the impact of scripting of sexual behaviour in particular means that much

more needs to be learned about the sexual scripting of behaviour of particular social groups.

This section of the literature review has highlighted the diverse and often conflicting bases on which health seeking or risk taking decisions are made. Utilising the framework of risk and sexual decision making presented here section what emerges is a picture of sexual risks as a continuously shifting system of beliefs about sexuality occurring in response to changes in personal experience, local knowledge networks and expert information (Lupton 1999). Through these mechanisms judgements are made as to the appropriate action to be taken in a sexual situation and these decisions in turn may be repeated or rejected in future similar responses. The outcomes of these interactions is to remodel or reaffirm the wider social group position and social cohesion as well as provide individual rationale for action. Without an idea of the arena in which sexual decisions are occur which includes the associated scripts, it follows than that issues of risk and sexual choice pertaining to a specific community will remain difficult to address (Douglas 1985; Donenberg, Emerson et al. 2001). Despite the range of approaches taken to exploring sexual health, risks and experience in various countries (Parker 1991; Ford and Norris 1996; Katz, Fortenberry et al. 2001), similar opportunities for broadening the scope of research have not been taken up in Britain, particularly in ethnicity centred sexual health research. As a consequence little is known about the communal notions of sexual risk and the impact on behaviour in minority ethnic groups.

Social construction as an approach to studying sexuality across ethnic differences may provide a framework for mapping and exploring incongruence and similarities in sexual behaviour and self-definition in British society. This would mean incorporating the meaning of sex acts within and across ethnic groups in a society and how these are lived out in the experiences of individuals from particular sections of the community. The malleable nature of sexuality in a social context raises interesting questions about the similarities between minority groups and dominant cultures. Of particular interest is the role of socially constructed ideas of acceptable or

unacceptable sexualities influence individual and community group choice. A social constructionist approach to this question encourages choices made by individuals to be explored within the context of their particular minority ethnic groups. However, it also calls for adequate recognition to be given to the role of wider social structures in restricting or facilitating the choices available to different groups at a particular point in time.

The process of change in cultural meanings and importance placed on them must not be overlooked in any assessment of the social construction of sexuality in ethnic groups. How individuals bring about changes in the cultural meanings given to sexual activity and choices or the impact this has on erotic meanings in this particular time and space are also key issues. A way forward in this would be to initiate studies to explore the nature of the sexual scripts underpinning sexual decision making in specific ethnic minority groups. Mapping the similarities or differences in these ethnically specific scripts to the broader social scripting of sexual behaviour in Britain could then be initiated. This would provide an invaluable picture of the current landscape of sexual scripting in Britain to support and initiate further research into sexuality and ethnicity in Britain.

2. 3: black Caribbean men, stereotyping and sexual risk

Epidemiological studies published in Britain in the last two decades have indicated that sexual ill health is unequally distributed across the population. The statistics at least would seem to indicate that black Caribbean men take more sexual risks and are less responsible in their attitudes to sexual encounters. The exploratory study conducted prior to commencing this main study discussed in chapter one, indicated that both formally and informally black Caribbean men where perceived to be at highest risk of sexually transmitted infection and less likely to seek help relating to their sexual health (Serrant-Green 1999).

Nazroo (2001) in discussing the way in which health chances vary between ethnic groups urges people to look more critically at any data provided in order to determine the factors underpinning differences in health risk. The need to question statistics and seek out answers to the question, 'why?' in this study are to some extent based on an acceptance that exposure and experience of risk in society is inequitable. As such, there is a need to reveal the social and sexual triggers that make up the scripts underpinning the behaviour of black Caribbean men. Researchers in men's health comment that finding an answer to this question and indications of greater risk taking in particular social groups requires that the socio-cultural aspects of men's health be politicised. Research into men's sexual health should therefore aim to illustrate how social inequality affects health chances in the lives of different social groups (Gibbs 1988, Verbrugge 1985).

The disproportionate rates of sexually transmitted infection in black Caribbean men therefore raises particular questions in relation to their sexual decision making such as

- What is it about the experiences and positioning of black Caribbean men in British society that increases their risk of STI?
- How is the sexual behaviour of black Caribbean men politicised through social scripts and associated with sexual risk?
- Are the sexual decisions of black Caribbean men affected by the perception of them as sexually risky? And if so how?

The way a person views sex and associated health decisions does not occur in isolation from other events in society but develops alongside fluctuations in the political, economic and cultural environments (Lancaster and Di Leonardo 1997). An individual's interpretation of these fluctuations and the experiences arising out of them are in turn, affected by their personal situation for example in relation to gender, social grouping and ethnicity. The wide range of possible individual and

communal influences on sexual health decision making therefore means there is a need to focus a research project within the particular context of the group under study in order to explore the interplay of sexual and social scripting in any depth. In this research study this requires that a review of some of the social, ethnic and political contexts in which black Caribbean male sexual expression occurs is conducted.

The historical and political contexts of individual and group experiences in any socially determined situation are subject, place and time specific (Brah 1996). Therefore prior to any further discussion there must be some clarification of the nature of the group of black Caribbean men who are the subject of this study. In relation to this study the black Caribbean male relates to the British experience. There will be no distinction made between the black Caribbean man who is British by birth, naturalisation or residency. The reasons underpinning these decisions will be fully outlined in the methodology chapter but are highlighted here for clarity.

The way in which political and social issues become established and accepted in a society are as much a result of their placing in the historical experiences of social groups as in the present (Barker 2000). Hilgartner (1992) said more attention needed to be paid to the social construction of what he called the risk object, that is things, activities or situations to which harmful consequences are conceptually attached at a particular point in time (Hilgartner 1992). Stereotyping of particular groups or behaviours is one vehicle by which risk objects are identified in society. In order to understand some of the current possible influences on the sexual health decision making of black Caribbean men, it is therefore helpful to consider some of the historical origins of perceptions of stereotyping, ethnicity, and sexuality.

2.3.1 Stereotypes and stereotyping

The term 'stereotype' is originally a printing term for the text casts used to ensure consistency and accuracy in articles which required the repeated use of information (Pickering 2001). However, the term has become increasingly associated with a range of disciplines such as cultural studies, social psychology and has been adopted in everyday use to reflect how certain groups and individuals are perceived in society (Brah, Hickman et al. 1999; Barker 2000). The term stereotype is often used interchangeably with categories or types in the literature despite the fact that these terms have different meanings. While all these terms are believed to refer to socially determined classifications, in general stereotypes are distinguished from categories or types in that they attempt to portray restricted representations of people which reduce them to a set of exaggerated and usually negative characteristics (Bhabha 1992; Collins 1998; Balsa and McGuire 2002).

The key attributes usually associated with stereotypes include an assumption that they are fixed in nature and related to people who are different to the majority or a socially accepted 'norm' (Donald and Rattansi 1992; Gill and Maclean 2002). The strength of the stereotype lies in its ability to present what appears to be a realistic and trustworthy 'blueprint' for identifying particular groups and a sound basis for appraising their actions (Leyens, Yzerbyt et al. 1994).

Viewed in this way, stereotypes can be seen as linking to issues of representation and how individuals or groups are identified in society. In its broadest sense, representations involve questions of inclusion or exclusion (Pickering 2001). Representations are actioned through the process of stereotyping which involves appraisal of information about an individual or group and the making of a judgement as to whether or not they belong to a particular category by establishing boundaries of 'them' and 'us'. The negative connotations which often accompany the everyday association of a group or individual with a stereotype introduce the inference that 'difference' denotes inferiority (Schermerhorn 1978; Rassool 1999; Pratto and

Espinoza 2001). The association of negativity with a stereotype is commonly reported in the literature despite the fact that the origins of the stereotype identify both negative and positive connotations as possible outcomes. In the stereotype of black Caribbean men feelings of desire, fantasy or longing are elicited alongside the negativity and inferiority it is set up to represent (Leyens, Yzerbyt et al. 1994; Hinton 2000).

Stereotypes are recognised as reflecting the social context in which stereotyping occurs. The nature and use of stereotypes often encompass the power relations and norms of behaviour in a particular society (Shohat and Stam 1994; Mac an Ghaill 1999; Pilcher 2001). Stereotypes may therefore denote the power relations between social categories, such as ethnicity, age and gender, and particular personality traits and types of behaviour (Carby 1997; Bhopal 1998; Brah, Hickman et al. 1999). The individuals who are stereotyped as a result are often therefore the less powerful in a particular society and the traits associated with them are often percieved as least desirable by particular societies.

The issue of representation, inclusion and exclusion in stereotyping have been explored by writers from feminist; ethnicities based research and criticalist perspectives. The issue of power in society as experienced through the use of stereotypes has been extensively explored through their writings from the position of 'other' (Bryant, Dadzie et al. 1985; Callaghan 1998; Estes 2000; Diekman, Eagly et al 2002). As 'other' to the white, male able-bodied norm, authors who are women, black people and people with disabilities write about the theory and realities of living with stereotypes from a position of relative social exclusion (hooks 1992; Ifekwunigwe 1997; Johnson-Bailey 1999). Many of these writers began their criticisms of stereotyping by highlighting how their experiences have been omitted from discussions into the impact of the stereotype. In addition they point out that where it has been included, the vast majority of the literature on stereotyping appears to reflect third party observations of the impact of stereotyping by the powerful on the least powerful members of society and have been commented on in scientific terms

without reference to their own perspectives (Lawson 1998; Olesen 1998; Pilcher 2001).

Through the writings of feminist and ethnicities based researchers what emerges is that when stereotypes are viewed critically as they are used in society, stereotypes appear to be more fluid, contradictory and changeable than suggested by the definitions. This is evidenced both in their nature and the way they are applied in society (Rassool 1999; Tusting, Crawshaw et al. 2002; Vonk 2002). Far from acting as a fixed, 'blueprint' they are context bound, being subject to change in use and interpretation over time and according to social situation.

The contradictions inherent in stereotyping are clearly revealed through explorations of 'other'. Here the effect of the social scripting of stereotypes identifies them as associated with forbidden, undesirable or negative characteristics. The negativity embedded in the socially determined nature of stereotypes is aimed at silencing them to a degree so that they are retained as hidden aspects of society. At the same time however, this appears to have the opposite affect of drawing attention to it, making it a curiosity, an example of that which cannot be admitted or accepted as a legitimate part of ordered society (Stoler 1997; Wyer 1998; Lupton 1999). The silences in the stereotype demonstrate the dilemmas within itself and how it is applied in the lives of those identified by it. This illustrates that far from the linear, rational use of stereotypes suggested by the definition, stereotypes are neither applied logically nor guaranteed to be interpreted in a uniform manner (Thompson, Judd et al. 1999).

Recent writings on stereotypes and their effects on society have suggested that their continued use damages both those who are the objects of stereotyping and those who use it as a basis for action (Thompson, Judd et al. 1999; Pickering 2001). The damage is said to arise from the fact that the myths and assumptions inherent in stereotypes create barriers in social interactions and relations between the individuals involved. This contrasts with the approach of presenting stereotypes as scientific observations of behaviour without adequate reference to the social context.

This literature above suggests that stereotyping works to present stereotypes as apolitical, absolute and invariable as the text casts from which the term is derived. In practical application however, it appears that it becomes increasingly difficult to sustain these aspects of the definition. However, rather than rejecting the stereotype as unsustainable in the face of such contradiction, the response is often to readjust the stereotype or the justification of it in order to account for the anomaly (Leyens, Yzerbyt et al. 1994). This raises the question of why stereotypes are not rejected when they do not fit and suggests that stereotypes are used because they are useful in some way.

Various suggestions have been made as to the 'usefulness' or role played by stereotyping in society, which will help to inform the exploration of the impact of the sexual stereotyping of Black Caribbean men on the experiences of participants in the study. These include the setting up of boundaries or indicators of belonging as mentioned above, as a basic social reference point for determining behaviour (Valentine 1998), or as a mechanism of social control which perpetuates inequality and justifies unjust treatment, social exclusion and bigotry towards particular social groups (Thompson, Judd et al. 1999; Woodward 1999; Pratto and Espinoza 2001; Vonk 2002).

As a result of the changeable and fluid way in which they are used and understood, a range of definitions of stereotypes exist. It is therefore important to clarify at the outset the definition of stereotypes used in a particular research study. Stereotypes in the initial stages of this study are identified with what has been called the traditional or 'common sense' view of stereotypes (Leyens, Yzerbyt et al. 1994). Stereotypes were therefore defined as:

> 'Shared beliefs about personal attributes, usually personality traits, but often also the behaviours of a group of people.'
> (Leyens, Yzerbyt et al 1994. p.18)

The definition of stereotypes was selected because it reflected the way in which participants spoke about the stereotype of Black Caribbean men in terms of beliefs about particular aspects of their attitudes to sexual activity or their character. In this chapter and throughout the study a distinction is made between stereotypes as defined above and stereotyping which is the process by which they are applied and actioned in society. Stereotyping, as referred to in this study is defined as:

> 'An exaggerated belief associated with a category. Its function is to justify (rationalise) our conduct in relation to that category' (Allport 1954 p.191)

This definition of stereotyping was selected because it reflects quite accurately the distinctions made by participants between the role and effects of the practice of using stereotypes to explain actions and judgements relating to sexual decisions in particular.

2.3.2 Black Caribbean men and sexual stereotyping

It has already been demonstrated earlier in this chapter that black Caribbean men are reported as having poorer sexual health in Britain. Similar differences have been reported in studies in other parts of the world (Ellen, Kohn et al. 1995; DiClimente, Wingood et al. 2001; Fonck, Mwai et al. 2002). However the experiences of the black Caribbean male in the other countries have been formulated under different social, political and historical foundations and are based around different experiences. For example in Britain, black Caribbean men are relatively recent migrants and many of them may still be identified by others or identify themselves as Caribbean rather then British and thus reliving the impact of generational adjustment to settlement in another country (Mac an Ghaill 1999). In contrast black Caribbean men in the USA may be more likely to be identified as African-Americans with established links to slavery and African origin rather than the Caribbean islands (Brah, Hickman et al.

1999). These differences will impact on the roles played by the black Caribbean men in each society and may impact differently on their sexual health decision making.

The sexual health experience of black Caribbean men in Britain is relatively unexplored beyond the production of statistical calculations of risk and so provided the impetus for placing black British Caribbean men at the centre of this study. Stereotypes of black men's sexual behaviour are often centred on the African/Caribbean male. This group of black men are almost inextricably linked with the physical body, physical strength and phallocentrism (Westwood 1990; Screen 1992; Skellington 1996). Representations of the black male as the embodiment of uncontrollable sexual power and the perceived threat posed by the expression of his sexuality are well documented can be traced back to colonial times (Stoler 1997). The black Caribbean male of African origin has therefore been both exemplified and pathologised in historical literature the epitome of primitive sexual urges.

In relation to Britain the colonial legacy rhetoric around the perception of black African Caribbean males as a risk to the established (white) society led to the problematising of black male sexual expression. These men were epitomised as a threat based on their resistance to attempts by the authorities to control them and the belief that they had an innate inability to resist sexual urges (Estes 2000). In the culture of fear of attack or infiltration of white households that existed within the colonies at the time, this was translated into the belief that all black African Caribbean men were threatening as potential sexual or political aggressors and perpetrators of sexual risk.

The political reaction to this was to present white women as being under constant threat from what was labelled 'the black peril', which was identified as the risk of sexual assault of the white female by the black African Caribbean male (Stoler 1997). The personal and political backlash experienced by the black male as a consequence

of this was at best demeaning and at worst life threatening. Reports from Papua New Guinea, Rhodesia, Kenya and the Solomon Islands in the 1930's and 1940's speak of a range of punishments implemented to deal with the black peril including public floggings, citizens militias and exercising of the death penalty (Lancaster and Di Leonardo 1997). This historical stereotyping of the black male was to a degree a production and phenomenon of its time and must be contextualised as such. However elements of it in relation to sexual stereotyping of black Caribbean men has persisted through the last centuries and even today remains an enduring ingredient of discussions of race and sexual expression particularly in the popular media (Screen 1992).

The statutes associated with the identification of sexual assault and legitimising the methods used to deal with it where racially assigned. They were race specific in relation to the alleged perpetrator of the crime and the victim. Each case of sexual assault, rape or intimidation related only to the threat posed by criminal actions of a black African Caribbean male towards a white female. The same laws and consequences did not apply to the black African/Caribbean woman, sexually assaulted or raped by the white male (Stoler 1997).

The brief discussion in this section so far has introduced two factors, which are central to this study and to the issues concerning black men's sexual health behaviour.

- The belief, often unchallenged, that in relation to black men and sexual activities, the black male is often unquestionably believed to be the man of African/Caribbean decent.
- The stereotype, rooted in the colonial past of Britain that the black African/Caribbean male is by nature aggressive, uncontrollable and sexually insatiable.

The pooling of black Caribbean male sexual behaviour within these assumptions provides further illustration of the way in which the existence of diversity within marginalised groups is denied in society. Researchers from a range of perspectives including feminism, criticalist and ethnicity based research have challenged the tendency to try to manage the 'problem' of minority populations by attempting to represent them as a homogeneous group (hooks 1992; James and Busia 1993; Johnson-Bailey 1999; Hinton 2000). In relation to this study then, the characterisation of black Caribbean men as powerful, phallic and sexually uncontrollable is applied indiscriminately and universally experienced by black Caribbean males who may or may not conform to the behaviours associated with this identity, but are identified by it.

The image of black Caribbean men as sexual beings derived from colonial stereotypes could be viewed as an indicator of the effects of risk labelling in society. As such it exposes the psychological and social fear the label was designed to produce in white and black society, rather than an accurate reflection of the reality of black men's lives (Sewell 1995). Assumptions concerning the sexual expression of black Caribbean men, based on colonial images were and still are, used to demean and control black Caribbean men in British society. The continuing impact of the image of the black peril is borne out in the way in which it permeates perceptions of other aspects of black Caribbean male activity, not associated with sexual expression.

Education and social sciences research over the years have investigated, debated and explored issues of ethnicity and its impact on a range of issues including feminist thought, education achievement and youth culture (Segal 1990; Sewell 1995; Skellington 1996). The debates have developed in these areas to include black perspectives and experiences. Researchers have reported on the ways in which the persistent stereotypes of black Caribbean males as aggressive and uncontrollable are played out, not so much in terms of sexual stereotypes but in relation to violence,

crime and mental illness. The situation is further complicated by the incorporation of a stereotype of the matriarchal black female as head of the household and controller of the family domain (James and Busia 1993). The outcome of these stereotypes being established is that the black Caribbean male is portrayed as uncontrollable outside the home and having little or no power inside the home. Writers on race and ethnicity have identified these stereotypes as the weapons of fear being used to dis-empower and emasculate the black Caribbean male in society (Douglas 1992; Goldberg 1993; Estes 2000).

However, black Caribbean men have begun to challenge these stereotypes through community based work and academic pursuits by seeking to establish their own definition of sexual expression and masculinity separate from that of white men (Parker and Aggleton 1999). For black Caribbean men in Britain this process of determining self includes personal and group strategies to challenge the colonial stereotypes and the view of them as controlled by black women. This occurs alongside strategies to counteract the associated image of them portrayed in the media as young, working class, black and angry (Screen 1992). Thus while the number of black Caribbean men entering higher education remains relatively low compared to other minority ethnic groups and black women, increasing numbers are finding ways to provide well for their families and develop their own businesses despite the racism they experience.

The experiences of black Caribbean men in Britain challenges this research to try to conextualise the sexual health decision making of a diverse group of individuals in a situation where their experiences take place under the shadow of a stereotype which does not differentiate between them. These challenges are important in this study as they involve the re-working or reappraisal of the colonial stereotypes and the 'risky' labels attributed to them rather than a rejection of them. The need to review rather than reject the stereotype is a key issue in bringing about change in the way black

Caribbean male sexual expression is both perceived and epitomised. The visibility of black Caribbean male due to his phenotypical characteristics makes it impossible for any individual to separate themselves from being 'fixed' with the identity of colonialism or to protect them from the judgement of others based on that reference point (Rassool 1999). It is for this reason that the influence of stereotypes of black Caribbean men based on such arbitrary measures such as skin colour cannot be dismissed completely from this study but must be incorporated into a re-thinking of black Caribbean male sexual behaviour and experience.

Concluding summary

The range of issues discussed in this literature review highlight the importance of understanding some of the wider social factors affecting individual behaviour and beliefs in relation to sex and how these may impact on people's lives. It is particularly important to identify the basis on which sexual decision making occurs and how this relates to both sexual health practice and beliefs about risk. The consequences of poor sexual health for individuals and communities can have long-lasting effects and a serious impact on quality of life. Research has shown a clear relationship between sexual ill-health, poverty and social exclusion with significant variations in the quality of sexual health services across the UK (DOH 2001, Low et al 1997, Ford and Norris 1996).

The National Strategy for HIV and Sexual Health (NSHSH) published in July 2001 identified the need to raise standards of sexual health services in line with the principles of the NHS plan (p.3). One of the major problems faced by the sexual health workers and service providers is the fact that the evidence base for sexual health in the Britain is fragmented and relatively scarce (DOH 2001). Qualitative evidence to run alongside the quantitative data relating to the sexual health needs of black and minority ethnic groups is particularly difficult to find. In essence there is an

increasing recognition that more information is needed to address the silences left and created by the predominant focus on epidemiological data in sexual health. This involves exploring why particular groups appear to be at higher risk and to understand the factors influencing the sexual decisions that precede the risks quantified in statistical reports.

Social construct theory provides a useful framework for exploring the ways in which human interactions and experiences are created, sustained and influenced in society. Examining sexual behaviour from a scripting perspective utilising this approach facilitates the organisation and linking together of what people think, do and how they are affected by sexually related experiences through the particular social context in which they live (Douglas 1985). In recognising all human behaviour as scripted to some degree, it places sexuality and sexual expression within a framework of normal social interaction. Actions and reactions in a sexual context may therefore be explored and explained in reference to non-sexual activity and ways of coping.

Scripting perspective also accommodates individual and shared notions of risk in general and sexual risk in particular. Sexuality is therefore scripted beyond the individual's choices and instead are recognised as also evolving, existing and changing as a result of cultural and social structures which pre-exist the individual (Gagnon 1990). The communal and individual notions of risk and sexual behaviour revealed through scripting also encourages examination of the processes by which activities, individuals or social groups are identified as sexually risky and the vehicles by which this view is reinforced. This will be particularly useful in this study where issues of ethnicity, gender and stereotyping which are central to the daily experiences of individual black Caribbean men and the social networks to which they belong are recognised as central issues impacting on the sexual health experiences of the participants.

This qualitative study is underpinned by a social constructionist approach and differs from many others in that it places black Caribbean men at the centre of the research. It considers the gender issues from a male perspective in a climate where there is a relative lack of research on the needs of heterosexual men in relation to sexual health. In doing so the study also incorporates consideration of sexual health issues in a gender and ethnicity based context. Recognition of the diversity inherent in perceptions of risk and sexual decision making discussed throughout this chapter mean that the focus in this research is to explore and identify which factors are pertinent at this particular time in influencing the sexual decisions of black Caribbean men from a nursing perspective.

CHAPTER THREE

METHODOLOGY

Introduction

The purpose of this research study was to explore the key factors influencing the sexual health decisions of black Caribbean men from the perspective of black Caribbean men and other key players in their sexual health. Sexual health decisions were defined in the literature chapter as incorporating sexual health seeking or risk taking activities. In this context, health seeking referred to either positive actions taken to reduce the risk of sexually transmitted infections (STIs) and pregnancy, or to obtain treatment and expert advice for family planning and other sexual health concerns. Risk taking included any activity that may directly or indirectly have resulted in STIs or unplanned pregnancy for example decisions to have unprotected sex or failure to seek treatment for a suspected STI.

The research aims and objectives stated in the introduction were explored by considering the following questions

- How are black Caribbean men perceived in relation to sexual health decisions and risk taking?
- What are the key factors influencing the attitudes of black Caribbean men to sexual health and risk taking?
- Do the ways in which black Caribbean men are viewed in relation to sexual risk taking impact on their sexual health decisions?
- What role do 'key players' have in relation to black Caribbean men and their sexual decisions?

In seeking answers to these questions I intended to explore and illustrate the variety of ways in which black Caribbean men make sense of one aspect of their lives (sexual health) from their own perspective and that of significant others (key players).

This chapter is divided into three sections. The first section of this chapter will present the research design used in the study including details of the participants. The second section details the data collection and analysis procedures used in the study. The final section of the chapter discusses the ethical issues relating to this study.

3.1: Research design

3.1.1: Theoretical assumptions of the research design

Chapter one discussed the context in which this research takes place and in doing so introduced the concept of screaming silences as a key influence on this study. Screaming silences were identified in this research as linking the current study to the broader theoretical approaches underpinning it. These are aspects of feminism, criticalist and ethnicities based research.

The approaches underlying this research are based on anti-essentialist viewpoint which incorporate beliefs that reality is socially constructed and multidimensional in nature. A core aspect of feminist, ethnicities based and criticalist approaches is their open acknowledgement that the reality often accepted as representing the truth, is not only multiply constructed but that the dominant reality presented to us exists as a result of and within socially determined power relationships and hegemony (Mirza 1995; Ribbens and Edwards 1998; Solorzano 1998). Crotty (1998) reflects that the difference between studies based on non-critical and these criticalist-based approaches to understanding reality can be summarised as that between research that 'reads' social situations in terms of interactions and research that sees oppression and

conflict. This aspect of the theoretical approaches underpinning this study are aptly summed up by Anne Oakley in her statement 'a way of seeing is a way of not seeing' (Oakley 1981). This statement demonstrates the awareness in anti-essentialist approaches of the need to acknowledge and take account of alternative or additional realities existing alongside the one often presented in a particular society.

Recognising that socially constructed and mediated versions of truth exist and at the same time render others obscured from view or less credible unites the concept of screaming silences with feminism, ethnicities and criticalist viewpoints. The range of issues discussed in chapter one concerning the screaming silences associated with researching sexual health, ethnicities and male issues mean it is essential that theories underpinning this research facilitate and acknowledge exposure of hidden views in society.

The theoretical approaches underpinning this study differ in relation to the primary subjects used to illustrate their points for example focussing on the experiences of women, black and minority ethnic people and the impact of wider social structures such as class. Despite the specific differences brought about by the subjects of discussion there are many shared silences between them which are important to this research. The open acknowledgement of inequality in society resulting from the way power is distributed and applied in society is a key uniting aspect of these approaches. Research conducted from these perspectives seeks to do more than simply explain or understand reality out of the social context in which it exists. Instead each study sets out to challenge the established dominant realities of society in some way, a society which is accepted as being inequitable (Andersen 1993; Bhopal 1997; Johnson-Bailey 1999; Afshar and Maynard 2000; Blum, Beuring et al. 2000).

The recognition of the inequitable position of the oppressed and marginalised in society provides the basic critical framework for this study. The investigation of the ways in which ethnicities and gender inequality in Britain combine to produce the particular viewpoints about black Caribbean men and their sexual health is therefore

conducted within a theoretical framework which incorporates the effects of power and inequality on individuals and groups. These aspects are of particular importance in this study in considering how black Caribbean men are constructed by, and construct themselves in relation to their sexual experiences and perceptions of risk.

The existing social structures play a central role in the establishment and continuation of domination and inequity between and within socially determined groups (Rattansi and Westwood 1994; Griffiths and Troyna 1995; Brah, Hickman et al. 1999). The effects of this are to produce and preserve social inequalities through the use and abuse of power relationships (Bryant, Dadzie et al. 1985; Ahmad and Atkin 1997; Carby 1997). The literature concerning sexual expression, ethnicity and gender in the last chapter indicated that there were powerful social inequalities associated with sex, men and ethnicity in British society. In this research where gender and ethnic identity play a central role in the lives of all those involved the methodological choices must encourage exploration and appreciation of the political and personal tensions arising in the lives of participants and the possible affects of this on all stages of the research process.

The theories underpinning this study acknowledge the importance of the individual and the social context to the ways in which power impacts on reality and the meanings derived from it (Miller and Dingwall 1997). As identified earlier the context in which power is exerted exists within the individual relationships that take place in society as well as in the structures that comprise it. The reflexive nature of the theories incorporated in these approaches encourages researchers to take account of variation in the range of truths existing within their own disciplines as well as wider society (Callaghan 1998). Theoretical debates in feminisms, ethnicities and criticalist standpoint research continue to emerge and develop from a range of perspectives within all three disciplines. Many of these 'voices within' have initiated change or challenge to the established truths within their disciplines and successfully encouraged critical thinkers to face the reality of unequal distribution of power therein. For example the challenges to feminism from black women and lesbian women

spearheaded the exploration of critical theories on marginal perspectives and continue to push the boundaries of knowledge and experience within women centred research (Lather 1991; James and Busia 1993). Similar examples are available in the wealth of contributions made in ethnicities based and criticalist perspectives.

The acceptance of an anti-essentialist and multidimensional nature to reality means that within these theoretical approaches there lies an embracing of different perspectives and alternative viewpoints. Researchers working from these theoretical standpoints accept that each viewpoint is valid in contributing to the development of knowledge (Letherby 2002). Alternative opinions or readings of a situation utilising different methods are therefore considered and critiqued by researchers from their own situated position rather than rejected because of their difference. In relation to researching sexual health and ethnicity this calls for a need to acknowledge the importance of the role played by epidemiological studies in bringing sexual health issues into public debate while continuously subjecting the data arising from these studies to critique and review by use alternative approaches.

Feminist and ethnicities based researchers in particular have emphasised a need to recognise the power dynamic that exists in the research process, particularly that between researcher and participants. Millen (1997) discusses the dilemmas associated with this in her research mapping the difficulties that can arise from conducting feminist based research on non-feminist women. Her experiences serve as a reminder that power is neither static nor uniformly applied and the differences resulting from this are reflected in the fact that not all women are uniformly downtrodden, some have relative social power and privilege through their ethnicity, socio-economic status or sexuality (paragraph 2.3). Thus research seeking to highlight the experiences of black women, lesbians or professional women will reflect very different experiences in relation to power and means of empowerment (Mirza 1995; Millen 1997; Johnson-Bailey 1999; Gill and Maclean 2002).

In research conducted from criticalist based perspectives, the researcher is primary instrument in the research process. All actions, experiences and information provided by the participants are explicitly interpreted through the researcher (Denzin 1998; Seibold 2000). The particular attributes or experiences of a researcher introduces biases into a research study, which must be acknowledged within these approaches and any possible impact on the study be explored at the outset (Sandelowski 2001; Morse 2002).

The importance placed on recognising the power inherent in particular social interactions including the research process and the different tensions set up as a result were important considerations in this study. This research has been expressly revealed as taking place form my own situated viewpoint as a black Caribbean female academic. From a theoretical perspective these aspects of my identity impact directly on the research through my position as researcher and my relationship to the participants in the research process.

Adopting a situated approach to this study highlights additional tensions brought about by the relationship between aspects of my own identity and experience, and that of the participants. This research fundamentally involves black Caribbean men as subjects of study in a project conducted by a black Caribbean woman. As such it incorporates sites of tension located across gender lines, socio-economic group and professional status. The theoretical perspectives underpinning this research require the tensions in this research to be acknowledged and exposed (Seibold 2000). This allows the relative power in my position as researcher and the resultant silences relating to my simultaneous closeness and distancing from participants on gender or socio-economic lines to be explored. The ethical issues associated with my position as researcher are explored in the final section of this chapter.

In research based on these feminist, ethnicities based and criticalist theories the way in which people make sense of their world and their experiences within it are an essential element in attempts to promoting understanding of the world (Sandelowski

2001). These experiences are in turn shaped by their past and individual experiences as well as the interaction with others and form part of the wider context in which perceptions of reality are formed (Olesen 1998). Applying these approaches to this study allows the full range of influences on experiences and their associated silences including historical, social, personal and political to be taken into account in contextualising experience. This would be important in order to expose the ways in which the inequities of society are reflected and preserved in and through the experiences of black Caribbean men and others associated with their sexual health decisions.

The importance of conducting studies which are openly located in the context within which the subjects exist is a central requirement of criticalist based theories (Seibold 2000). Accepting the multiple nature of realities in these perspectives places value on locating both research and participants within a particular time, place and social context in order to make sense of them. This is prerequisite in ensuring that the overall approach to the study is contextually informed and less likely to reinforce the existing silences in ethnicity and sexual health research where experiences are often still presented in unchallenged facts, which neglect the political and social world in which the experiences occurred and the research was conducted.

Researchers working from within criticalist, ethnicity based and feminist perspectives also identify the ways in which research needs to move towards working with the oppressed rather than for them (Banton 1977; Cotterill 1992; Johnson-Bailey 1999). In my research this was initiated through discussions with community group leaders and local black Caribbean people about the research study and the possibilities for sharing information about sexual health at community events. This provided opportunities within the process for establishing new relationships and developing existing partnerships with black Caribbean community groups seeking to address issues relating to sexual health in black Caribbean communities at a local level. Lather (1991) calls this reciprocity, the need for critical and feminist researchers to give something back and be concerned with more than getting 'more better data' (p 57).

This is related to the issue of research intent explored in these theories, whereby the research outcomes set out to have some 'usefulness' for the participants involved and their communities and in doing so seek to avoid the exploitative use of participants and communities (Bowes 1996; Harrison, MacGibbon et al. 2001).

I wanted to contribute to debates about ethnicity and sexual health and my professional experiences had convinced me of the need to add to the knowledge base in order to provide information on which sexual health services and care could be provided for black Caribbean men. After considering various theoretical approaches to this study in the light of these requirements and my conceptual notion of screaming silences, I found myself unable to adopt a single theoretical approach to this study. In order to determine the most appropriate course of action I decided to follow the example of other qualitative researchers who had reached similar conclusions. This was to consider which aspects of particular theoretical viewpoints were most applicable to the research project to be undertaken rather than attempting to adopt a single approach (Parahoo 1997; Pilcher 2001).

The aspects of feminisms, ethnicities based and criticalist theories as bodies of knowledge important to this study are that they emphasise:

- The situated and changeable nature of reality and what is perceived as truth.
- The relationship between the researcher and researched as a critical part of the research process.
- The importance of focussing on everyday experiences of both researcher and researched and how they may impact on the research.
- Research should strive to have some usefulness.
- Power and inequality as existing in many guises and impacting on all the issues above.

These shared aspects of the theories were incorporated into the decision to adopt a predominantly qualitative approach to the research study as the most appropriate.

In general qualitative approaches accept that all research participants, including the researcher, are not isolated from the world in which they inhabit thus the intention of studies conducted from these perspectives is produce and acknowledge the situated nature of the research (Pilcher 2001). Cotterill and Letherby (1993) go further in highlighting to qualitative researchers that adopting such an approach not only requires that they acknowledge the subjective nature of the experiences referred to in their work but also that they recognise the very experiences they recount are the result of further filtering and analysis through their own experiences as human beings. They write:

> 'We draw on our own experiences to help us understand those of our respondents. Thus their lives are filtered through us and the filtered stories of our lives are present (whether we admit it or not) in our written accounts' (p.74)

The association between the researcher and the participants is also of key concern in research studies conducted from these perspectives where attempts are made to reduce the distance between researcher and participant by accepting their roles as inextricably linked (Avis 1998; Hunter, Lusardi et al. 2002). Utilising a feminist, criticalist or ethnicity based approach to qualitative research requires that the possible tensions arising from the proximity in the identity of the researcher and participants must be explicitly explored as an influence on the study (Hammersley and Gomm 1997; Hasselkus 1997; Harrison, MacGibbon et al. 2001). In qualitative approaches, issues are therefore explicitly explored through the experiences and from the perspective of all those involved in the study, including the researcher (Silverman 2001). Attempts to understand events and experiences from these perspectives must take into account the social context in which they occur as well as the experiences themselves (Strauss and Corbin 1990; Williams and May 1996)

Utilising a qualitative approach in my research facilitated the inclusion of the personal experiences of the black Caribbean male participants and key players in the study. However the multiple nature of truth incorporated in the theories underpinning this approach necessitated that the epidemiological data which initiated my interest was acknowledged as part of the context in which these experiences took pace. At the same time the same theories enabled me to review this in the light of my own and the participants' social, historical and cultural positions in British society at the time.

Overall the decision to adopt a predominantly qualitative approach for this study was based on the wider theoretical contexts of research into sexual health and ethnicity together with the silences generated as a result of:

- The relatively 'immature' nature of the research subject
- The lack of any established theories on ethnicity, gender and sexual decision-making in black Caribbean men.

The importance placed on the role of the researcher as research instrument in qualitative studies and their relationship with the participants was a key consideration in determining the underlying theoretical approaches. Finally the need to include an exploration of the participants' experiences in context was of particular value in facilitating listening to the screaming silences in sexual health research.

3.1.2: Research participants

Participants in the study were black Caribbean men and other key players identified as playing a key role in their sexual health. Key players were black Caribbean women, sexual health professionals and partners of black Caribbean men. In order to limit the study it focussed on black Caribbean men who identified themselves as heterosexual. This limit was based on the outcomes of the exploratory study and the literature, which suggested that it was the sexual activities of heterosexual black Caribbean men that was most likely to be stigmatised as 'risky' (Sewell 1995; Ford and Norris 1996; Serrant-Green 2000).

To facilitate recruitment of participants from these specific groups a combination of purposive and snowball sampling was used to ensure all those included in the sample group fulfilled the selection criteria (Tarling and Crofts 1998). It was acknowledged that some participants could identify with more than one of the sample groups for example be a sexual health professional and partner of black Caribbean man. However, participants were recruited to the study on the basis of either belonging to a particular section of the community or playing a specific role in relation to black Caribbean men's sexual health and selected their own preferred sample group on this basis.

A total of 45 people took part in the study ranging in age from 16-45 years old. 30 were women and 15 were men. The women taking part comprised 11 sexual health professionals, 9 partners of black Caribbean men and 10 black Caribbean women. The male participants were all black Caribbean men. All but one of the sexual health professionals were white British. All participants took part in the focus groups. Biographical details of participants were collected prior to beginning the focus group using a self-completing questionnaire. The results profiling the research participants are shown in appendix 8. The information gathered allowed comparison of group composition to take place and assisted in the analysis of group responses (Bhatti 1995; Coyne 1997; Denzin and Lincoln 1998a). The questionnaire also asked participants to indicate their willingness to be contacted at a later date, to take part in the individual follow-up interviews if required.

Five focus groups were conducted, two comprising black Caribbean men, one of black Caribbean women, one of partners of black Caribbean, and one of sexual health professionals. 22 individual follow up interviews were conducted with participants from the focus groups, 4 with partners of black Caribbean men, 5 with sexual health professionals which included the one black Caribbean participant, 7 with black Caribbean men and 6 with black Caribbean women.

3.1.3: Recruitment procedures

Initial contact with participants was made either directly or indirectly through black and minority ethnic community groups or professional sexual health organisations. A named community group or professional organisation acted as the main recruitment point for each focus group. This was useful in helping to create some distancing of participants and researcher, which was particularly important due to the potential personal and professional conflicts that can arise when the researcher is a member of the community under study (Weis 1992; Stanfield and Dennis 1993).

Meetings were held at a variety of established community settings and sexual health organisations where potential volunteers were informed verbally and in writing of the details of the study. A named person in the organisation was identified as primary contact for the research through whom any organisational issues or concerns in relation to study could be channelled. My contact details as the researcher were provided to each person attending the meetings so that personal of private concerns could be made to me directly. Potential volunteers wishing to take part in the study were given the option of either notifying me directly of their decision or directing this information through the primary contact. Once verbal agreement to take part in the focus groups, in the first instance, was obtained all potential participants were given information concerning their rights as participants and the complaints procedures in the participant information sheet (Appendix 1) prior to securing written consent.

Interview participants were recruited via the focus groups from those indicating their willingness to be interviewed on the biographical data questionnaire. Participants taking part in the interviews were contacted within three weeks of the focus groups to arrange a convenient time to be interviewed.

3.1.4: 'Party mentality'

One of the issues that had to be considered in recruitment and selection of focus group participants is what I have termed 'party mentality'. Party mentality is both celebrated and despaired of within black Caribbean communities. It occurs at parties and other social gatherings whether these are formal affairs related to weddings and funerals or less formal private birthday or home-based functions. At its purest, party mentality is the unwritten assumption that if an invitation to an event is received by an individual they are free to bring one or more additional 'guests' who will be accommodated and made welcome by the host. A peculiarity of party mentality in black Caribbean communities is that it is usually only applied in cases where the host is of black Caribbean origin although anecdotal reports of similar customs have been noted in other ethnic groups (Mirza 1995).

Party mentality impacted on this research because of the black Caribbean identity of myself as researcher and the familiarity within the community of my work in sexual health. These factors could have been partly responsible for the positive responses to the focus group recruitment in that it may have minimised the risk of group sessions being abandoned due to low turnout. However, there was also the possibly a greater risk of excess turnout making the numbers unmanageable. In an attempt to manage the risk of 'party mentality' a maximum of 14 participants were set on each group. At the initial meeting with groups at the targeted recruitment point prospective participants were made aware of the restriction on numbers and informed that while they may 'bring a friend' if they wish, in the event of more than 14 participants reporting for a particular focus group then not all volunteers will be utilised in the group. This happened in one of the planned focus groups of black Caribbean men held at a local youth centre in Townsville.

In the event of over recruitment in this focus group priority was given to those known to be attending the group in advance. Negotiation with volunteers about participation occurred openly before the group started in order to obtain a mixed group in relation to age, employment and parental status. Other volunteers were

invited to either attend another group if appropriate or to indicate their willingness to be interviewed as individuals should the need arise.

A key feature of not causing offence in 'party mentality' is utilising negotiation skills, offering hospitality and assistance to the extra guest. Therefore those not taking part in the group were offered refreshments and travel assistance as required.

3. 2: Data collection methods and procedures

The theoretical approaches influencing this qualitative study included feminism, ethnicity based research and other approaches where the importance of marginalised discourses are central (Yarbro-Bejarano 1999). The need to explore a relatively under researched area and to be able to probe any issues raised in group discussions as they arise, led me to select an inductive approach to data collection (Denzin and Lincoln 1998a). Sexual decision making and individual attitudes to sexual expression have been said to be affected by the perceived reaction of peers and others involved in social interaction (Aggleton, O'Reilly et al. 1994; Beier, Rosenfeld et al. 2000; Adimora, Schenbach et al. 2001). I was therefore interested in exploring the possible impact of being in a social group on the nature of the discussion of a sensitive subject (Farberow 1963; Gibson 1996). In order to consider these points, it was appropriate to gather data from both individuals and a group setting.

Interviewing techniques were determined to be the most appropriate data collection methods for this purpose. They may be applied in a wide variety of forms and provided the scope required to fulfil the data collection requirements in this study. The range of possible approaches to interviews means that they may be used for both measurement and as an aid to understanding a particular aspect of society (Collins 1998). Individual face-to-face interviews are one of the most common type of interview but focus groups, mailed or self-administered questionnaires may also be considered to be types of interview (Marshall and Rossman 1995; Morgan 1997).

Focus groups and individual follow-up interviews were used as the main forms of data collection.

In this study the interviews were used to collect individual data and comprised one-to-one interactions between a single participant and myself. Focus groups involving myself, a co-worker and small groups of participants selected on the basis of the membership of specific the social groups identified earlier were used to collect group data. Issues relating to the decisions to use a co-worker in the research will be explored during the discussion of focus groups. The combination of methods used enabled consideration to be given to the impact of group dynamics and social interaction on the information obtained during discussion on such a sensitive issue such as sexual health (Lee 1993; Denzin and Lincoln 1998a).

3.2.1: The focus groups

Focus groups incorporate the systematic interviewing of several individuals on the same issues in informal or formal settings (Merton, Fiske et al. 1990). The interaction between participants and the researcher is used to generate a focussed discussion on the subject of the research. The purpose the discussion is to understand how people feel or think about an issue, service or experience by listening and gathering information. The aim is to obtain responses from the entire group in order to encourage the fullest possible coverage of the topic under discussion (Penman 1998; Seibold 2000). The nature of the discussions between participants and the management of that discussion by the researcher are important determining factors in the success or otherwise of a focus group as this affects the quality and usefulness of the data gathered to the study (Morgan 1998).

There are many types of focus groups and great debate over even whether they should be identified as focus groups or group interviews. However, the discussions generated in these situations are recognised as being special because the groups

involved are not naturally occurring but specific to a project in terms of purpose, size composition and procedures (Krueger and Casey 2000). The advantage gained in using this technique is that when successful, a focus group produces rich contextual data linked to the experiences of individuals, in a process that is stimulating to participants, aids recall is cumulative and elaborative (Morgan 1997). An added advantage in utilising this method in this study was that the group conversation mirrors more closely the interactive context in which discussions of sex and decisions take place, that is between people, rather than simply the question and answer of some one to one interviews (Green and Tones 2000; Wilson and McAndrews 2000). However, it must also be noted that because focus groups are formulated for the purposes of the research, they are not natural groups in a real sense and affects the nature of the discussions that take place. The usefulness of the method however in this study is supported by research suggesting that participants may find discussion of sensitive issues less threatening in a group setting where they may control the amount and timing of their contribution (Lee 1993; Johnson-Bailey 1999; Robinson 1999)

In a focus group the researcher determines how structured the discussion needs to be and directs the interaction according to the purpose of the interview(Robinson 1999). Skill in management and moderation of group discussions is required from the researcher to avoid these problems and what Morgan (1998) called 'group think'. This occurs when the group dynamics work to produce consensus on all issues and individual variations are sanctioned through the reactions of group members. The data produced appears as 'one voice' rather than the result of interaction of a group of individuals.

The skills required for group interviewing use those required when conducting individual qualitative interviews in that the researcher is still required to be flexible, empathetic and a good listener (Cotterill 1992; Harris and Inayat 1997). In addition the researcher acts as moderator in the focus group in managing the dynamics of the group discussion to stop one person dominating, encourage shy people to contribute. Without effective management, the emerging group culture based on the interactions

that take place during a focus group could interfere with individual expression. This may have the effect of silencing certain participants, despite the best efforts of the researcher. For some individuals the recall of events particularly in this study focussing on sexual expression, usually an advantage in a focus group, may highlight issues they do not wish to share in a communal environment (Kitzinger 1994).

As an experienced sexual health professional I had previously conducted many focus groups on sexual issues. This experience was invaluable in managing the focus groups and in particular counteracting some of the issues relating to group discussion of sensitive issues such as shyness, embarrassment and fear (Lee 1993). However, I was also aware of the marked differences in conducting such a group for a research study, rather than training and education purposes; For example the need to take a record of proceedings and the process of interaction to aid analysis. My impact on the focus group as researcher which is central to the theoretical approaches relating to the research was an additional aspect of the process that I am not usually required to consider in analytical detail in my role as sexual health professional. While my experiences of conducting group discussions of this sensitive nature proved useful it raises issues about the silences or omissions arising in the data due to the high level of familiarity with the subject (Krueger and Casey 2000). My familiarity with sexual health incorporated a degree of 'de-sensitisation' to some of the nuances of taking part in such a sensitive discussion. As such there was a risk that I may have underestimated the significance of particular issues or the reaction of others to a comment as 'usual' or expected in discussions of sexual matters.

The design of the focus groups in this study needed to account for these different aspects of the role as researcher rather than trainer. The focus groups were therefore conducted with the assistance of a co-worker. The use of a co-worker raised some considerations relating to their role in the data collection such as whether they werea research assistant for example or participant and how they would be introduced to

the participants. These issues were taken into account in advance of recruitment of the co-worker by determining the required characteristics of the co-worker for the study. Decisions relating to the gender, ethnicity and professional status of the co-worker were made in discussion with my supervisors and other sexual health professionals. It was decided that the co-worker needed to have some general medical knowledge and characteristics related to that of the participants but be ineligible as a participant in any of the focus groups. A black Caribbean female co-worker, born outside Britain who had some experience of running focus groups with nursing experience was recruited as most appropriate.

The role of the co-worker was primarily to assist in facilitation of focus group interviews and practical aspects of running focus groups prior, during and after completion of each focus group. She was introduced in the focus groups as an assistant to the researcher but clearly identified to participants as a general nurse and not a sexual health professional. On that basis they were informed she may herself ask questions to myself as researcher on issues which were unclear to her. A detailed breakdown of the role of the co-worker within the focus groups is shown in Appendix 2. Use of a co-worker in the focus groups has been recognised as being of great assistance in managing the practical aspects of data recording during the focus groups. For example, preparation of location, recording of interactions and assisting in the necessary de-briefing by the researcher following each focus group session (Morgan 1997).

It is important in focus groups to be able to record both the process and detail of data generation evolving from the discussion.

> *'The group interviewer must simultaneously worry about the script of the questions and be sensitive to the evolving patterns of group interaction'*
>
> (Frey and Fontana 1993)

The co-worker in this study was invaluable in ensuring the smooth running of focus group by assisting in recording of events occurring during focus group. She took secondary notes on events during focus group including, mapping position of participants, the order in which participants spoke, group dynamics (identifying main speakers or quiet participants), giving predetermined cues to researcher as necessary/agreed and secondary time-keeping.

In recording the process of data generation the co-worker and the researcher also recorded the reactions of participants to the issues raised in discussion. The majority of the notes were made by the co-worker to allow the researcher to concentrate on facilitation of the focus group discussions with minimal interruptions. However, on occasions when the co-worker was engaged in verbal exchanges during the focus groups, the researcher took over this role. Records noted for example whether participants in the focus groups expressed surprise, anger, shock, or appeared upset by the issues being discussed and the particular participants producing the reaction. Note of any such reactions were made by hand alongside the records of 'the order of speech'. A sample is shown in appendix 10.

The notes collated through these processes where then used during the analysis of the transcripts of focus group data to identify the issues that elicited an emotional response in participants as demonstrated by their non-verbal or verbal responses to the focus group discussions. The simultaneous recording of the nature of participants' reactions to the discussions and the persons involved also assisted in the selection of possible participants for the interview phase of data collection. Any participants reacting in an interesting or unanticipated way to the discussions could then be approached if necessary to take part in the individual interviews. The combination of these 'process' notes with the written transcripts assisted in the identification of what eventually evolved as 'screaming silences' in the study. Initially identified in the focus groups, these were further explored in the individual interviews. These 'silences' will be discussed in more detail in chapter six, 'Hearing the silences'.

The nurse training of the co-worker meant she was able to follow many of the medical general medical issues raised but as she was not a sexual health professional she highlighted issues and questions during the discussion and in the debriefing sessions after each group. This aspect of her role helped to counteract some of the desensitising effects of my status as 'expert' in sexual health.

Each focus group was planned to comprise between 8-10 participants. Thus 14 people were invited to join each focus group to allow for an attrition rate of approximately 25% and to retain a manageable group size should all those invited attend (Abrams and Scragg 1996; Morgan 1997; Denzin and Lincoln 1998a). Focus groups typically are composed of people who share particular characteristics that are important to the research. Traditionally focus groups are composed of people who are not known to each other, however the necessity and practicality of this in community based studies has been questioned by researchers (Krueger and Casey 2000). In this research taking place in a small section of a particular community in Townsville the chances of participants being known to each other was high. This raised ethical issues for the conduct of the research which are discussed in section three of this chapter. Practically specific inclusion and exclusion criteria relating to age, ethnicity and status as sexual health professional were applied for recruitment to each focus group in order to limit group size and assist in differentiation between group membership and minimise the impact of personal links on the study. Characteristics of membership to the particular groups included in this study are summarised below with further details shown in appendix 3.

Specific detail of criteria for black Caribbean men (BAC)

- black Caribbean men (at least one black Caribbean parent)
- 16 - 45 age group
- British by birth, naturalisation or citizenship
- Resident in UK

- Heterosexual (self declaration)
- Not primarily employed as sexual health professional

Inclusion in this focus group was restricted by age in order to mimic the criteria used in British based qualitative studies investigating STI infection rates by ethnic group (see Low et al 1997 and Lacey et al 1997). Ethnicity was determined by self- identity with the decision taken to include men who have at least one black Caribbean parent. This allowed for the inclusion of men of dual heritage who identify themselves as black. To maximise the emphasis on British experience, which is central to this study, participants had to be currently registered as British citizens and resident in Britain. The verification of British identity was also made according to self disclosure however, in general the parameters used within the British legal system relating to birth, naturalisation or citizenship at the time of the research study (Key statistics for local authorities 2003) were used as a general measure.

The issue of sexual expression and the perceived effects on sexual decisions are a complicating factor in this research. Discussions of black Caribbean men and their behaviour were identified in the literature as occurring mainly within the confines of heterosexual behaviour. Discussions of black Gay men are often presented in conflict or tension with black male identity (Hart and Boulton 1995). Inclusion of both openly gay and heterosexual issues within this research would have further complicated the issues and change the focus of the study such that different sets of participants would be required and alternative questions asked. The decision was made to therefore include only black Caribbean men who declared themselves to be heterosexual. As this focus group set out to explore the viewpoints and sexual health experiences of lay or non-expert black men, recruitment to this group was focussed on those who were not sexual health professionals by virtue of their main paid work. Self disclosure was the method used to verify expert status.

Two focus groups took place with black Caribbean men. One focus group comprised seven participants who were mainly employed or self-employed black Caribbean men aged between 23 and 42 years old. The marital status of these men varied, with one being single, two cohabiting and four married. The second focus group had a younger age profile by comparison with participants ranging from 16-27. This second focus group took place in a local youth centre and was initially over subscribed with 15 turning up for the session. However, after discussion and information about the time required for the group 5 were ineligible as they were below the age of 16 and three were unable to stay for the duration. Seven people therefore also took part in this focus group. Three of those taking part were students and four were unemployed.

Specific detail of criteria for black Caribbean women (BW)

- 16 – 45 age group
- black Caribbean women (at least one parent)
- British by birth, naturalisation or citizenship
- Resident in UK
- Not Sexual health professional
- Not known to be current partners of BAC taking part

Issues relating to age, expert status, ethnicity and citizenship for black Caribbean women attending this group mirrored those for black Caribbean men outlined above. In addition due to issues of confidentiality inclusion in this focus group was restricted to black Caribbean women not known to be current partners of the black Caribbean men taking part. The rationale in restricting the inclusion criteria in this way is to reduce the risk of other participants and the researcher becoming involved in the personal sexual relationships of the black Caribbean men and women involved.

Monitoring of these criteria was complicated by the fact that the black women may not know whether their partners would be taking part and the relationship between them may not be in the public domain. The methods used in an attempt to control

for this included self-disclosure and a decision not to actively recruit female participants on the basis of them being partners of the black Caribbean men involved. The black Caribbean women's focus group took place before the black Caribbean men's group and knowledge of partnerships was used to monitor the nature of the participants and subsequent selection of participants. Ultimately this approach does not guarantee that partners will not be unknowingly included in successive groups but every effort was made to avoid this complication.

One focus group comprising black Caribbean women took place. Ten black Caribbean women took part, ranging in age from 16 to 42 years old. Three of the women were unemployed, two were students and five were employed. Two of the women described their ethnic origin as dual heritage and the rest were black Caribbean. Four of the women were married, three cohabiting and three were single.

Specific detail of criteria for Partners of black Caribbean men (P)

- 16 – 45 age group
- Resident in UK
- Not Sexual health professional
- Living with or in long term relationship with black Caribbean male
- Not known to be current partners of BAC taking part

In this focus group the issues of expert status, age and residency were as for the previous two groups. For the reasons set out above, participants in this groups were not be recruited on the basis that they are known to be current partners of the black Caribbean men involved in the research. There were no restrictions on ethnicity placed on participants within this group in order to reflect the diversity of heterosexual partnerships with black Caribbean men. In order to maximise the differentiation of this focus group from that of black Caribbean women, recruitment actively included groups and centres which are not known to be specifically black

Caribbean organisations. The heterosexual focus of this study restricted partner identification to women only.

One focus group took place with partners of black Caribbean men. Nine women took part in this group. Their ages ranged from 16 to 42 years old. Two of the women were students, one was unemployed and the rest were in employment. Three of the partners described themselves as white British, two as dual heritage and four as black Caribbean. Two of the women were married to their black Caribbean male partners, three were cohabiting and four were not currently living with their partners.

Specific detail of criteria for Sexual health professionals (SHP)

- Currently working in sexual health within the UK
- Statutory, voluntary or community based
- Full or part-time workers

Sexual health workers were defined as those providing expert knowledge, advice, support or treatment for issues relating to sexual health. Where this includes

- The prevention, management or treatment for physical conditions resulting from sexual activity
- Provision of support for the management of the consequences of sexual activity. This may include psychological, social and practical assistance.

The definition of sexual health expert included those working in both statutory and voluntary capacity. This was necessary as many of the community based sexual health services, and some of the now well established 'mainstream' services began from voluntary or self-help initiatives. The emphasis here was to include a broad spectrum of approaches to sexual health and resist the tendency to concentrate on the negative or trouble shooting aspects of the service. For this reason, experts from community

support and preventative services as well as treatment and monitoring services were invited to attend the focus groups.

One focus group took place with sexual health professionals. Eleven participants took part in the focus group. All were white British and employed. The one community based black Caribbean sexual health professional was unable to make the time of the group but agreed to be interviewed at a later date. The sexual health professionals ranged in age from 23 to 45 years. Younger participants in this group would not be expected as the minimum age for qualified sexual health professionals would be expected to be 21 years. Among the participants in this group it emerged during discussion that one had a black Caribbean male partner.

The discussion generated during the focus groups were recorded on audiotape with the permission of the participants. In addition written notes were taken by both the researcher and the co-worker in order to record additional explanatory information including, group dynamics, seating plans and non-verbal responses to the issues raised. These additional notes were invaluable during the transcription of the audiotapes for recalling the context of points raised and assisted in decision making concerning which participants to follow up with individual interviews (Merton, Fiske et al. 1990).

The location for each of the focus group interviews was determined by what was most convenient to the majority of the participants. Access to a range of health, community and voluntary facilities, including those in other black and minority ethnic communities (apart from Caribbean communities) was negotiated in advance for this purpose. All centres were willing and able to provide rooms which can accommodate the need for easy access, technical back-up, privacy, safety and comfort which are recognised as essential requirements for conducting successful focus groups (Merton, Fiske et al. 1990; Morgan 1997; Denzin and Lincoln 1998a).

The questions in a focus group are predetermined to ensure that the discussion remains focussed on the purpose of the study. The nature, sequencing and range of questions used in the focus group are important in achieving this outcome. A semi-structured interview schedule was used to assist in directing the discussion in each focus group (see Appendix 4). The use of a semi-structured schedule allowed for easier management of the discussion to ensure that the main objectives of the study are adhered to but also for some exploration of pertinent points as and when they were raised in a particular group (Mason 2002). The schedule was piloted among individuals who were ineligible to take part in any of the focus groups to assess the clarity and ordering of the schedule prior to the commencement of data collection. As a result of the pilot some minor changes were made to the ordering of the questions. The same schedule was used in each group. The use of the same schedule across groups also facilitate comparison of data across groups (Morgan 1997).

The questions posed in the focus groups explored how heterosexual black Caribbean men are perceived in relation to their attitude to sexual health and the factors believed to influence their sexual decisions. Focus group participants were also asked to reflect on their own role in relation to black Caribbean men's sexual health. The initial questions posed to the focus groups were based around a series of prompts reflecting popular or stereotypical views of black men and sexual activity (see appendix 5). These were compiled from published data collected during the exploratory study which preceded the PhD and from literature available at the time of the data collection (Stoler 1997; Watson 2000; Serrant-Green 2001b)

3.2.2: Individual interviews

The aim of the individual interviews was to explore some of the issues arising out of the focus groups in more detail. The discussions were based around the emergent themes from the focus groups which allowed for further probing of issues raised by

the group and assisted in validating the initial analysis of the focus group discussions (Merton, Fiske et al. 1990; Morgan 1997).

A semi-structured interview schedule was also used to manage the individual interviews (Appendix 6). This acted primarily as a guide allowing for some ordering of the interview process while retaining the ability to vary the time, ordering or detail of particular questions if necessary (Harris and Inayat 1997). The use of a semi-structured schedule was consistent with the theories underpinning this research in that it fulfilled the need for flexibility in the research process and accepts that vocabulary and the understanding of it varies among people (Janesick 2001; Hunter, Lusardi et al. 2002). In using a semi-structured approach, the words used in the interview can be changed by the researcher, or qualifying examples given in order that the meaning may be conveyed as accurately as possible to the participants.

Individual interviews were primarily based around the focus group attended by the particular interviewee but as the research progressed included comments made by other focus group participants if pertinent. The prompts used in the focus groups were also used as an aide memoire in the interviews to assist in the recall of issues discussed in a particular group. Participants were shown the themes identified by the researcher from the focus groups and asked to validate whether they were an accurate reflection of the discussions that took place. This was important in providing validation of the themes identified and helped to facilitate the inclusion of participants at later stages of the research process beyond simply the generation of data (Kitzinger 1994) Participants were given the opportunity in the interviews to identify any other issues they felt were important that have not been identified so that any omissions or differences between the researcher perception of issues and that of the participant could be highlighted. The similarities and differences between the issues raised in the group setting and in individual interviews could then be compared and contrasted during the process of data analysis.

Participants in the interviews were also asked to reflect on any issues relating to the study that have been pertinent to them as individuals since the focus group. This gave participants and the researcher an opportunity to reflect on the impact of taking part in the focus group on the participant. It was during these discussions that many of the silences relating to sexual decisions, black Caribbean men and the wider community emerged. These are discussed in chapter 6 'hearing the silences'. In practical terms this presented an additional opportunity to address any issues of concern to participants arising out of the group, such as personal worries or the need for further information that they were unable to raise in the group setting.

The notes taken during the focus group relating to frequency of responses from participants assisted in determining which participants were approached for an individual interview. Interviews were conducted across a range of levels of contribution to the discussions. Approximately 4 people were interviewed from each focus group. These formed the sampling frame of the interviews. The location of the individual interviews was determined by what is most convenient to the participant. This raised a number of health and safety issues for the researcher, particularly if participants express a preference to be interviewed in their own homes (Lipson 1994; Denzin and Lincoln 1998a; Penman 1998). While efforts were made to avoid interviewing participants in their own homes strategies to manage these issues and ensure researcher safety were decided on prior to beginning data collection in the light of these concerns (Morgan 1997; Denzin and Lincoln 1998a). These strategies are shown in appendix 7 outlining the health and safety issues for the data collection phase. In the event no participants were interviewed in their own homes.

A breakdown of the profiles of those interviewed individually are shown in appendix 8.

3.2.3: Data analysis

A process of thematic analysis was used to analyse the data from the interviews, focus groups (Morgan 1997). In this approach tapes and transcripts recording data from the interviews and focus groups were transcribed verbatim. The records made by the co-worker of the order of speech within the focus groups was invaluable in assisting the transcription process in differentiating between speakers on the tape, particularly when exchanges took place in rapid succession or at very short intervals. The completed transcripts were then coded to protect the anonymity of the participants (Denzin and Lincoln 1998a). The coding structure consisted of letters denoting the focus group membership criteria used for recruitment of participants. In the coding structure the abbreviation BAC denoted black Caribbean men, P was used for partners, BW for black Caribbean women and SHP for sexual health professional. Each participant was then allocated a number for identification of individuals within a particular group for example, BW1, BAC7.

The transcripts from the focus groups were then examined to identify recurrent and important statements or phrases. Examination of the transcripts was conducted by asking continuous series of questions about the data initially based on the interview and focus group schedules with the associated prompts. These in turn generated other questions that are reflected in the section headings used in the chapters relating to the presentation of findings from this study (chapters 4-6). The subheadings associated with each of the questions identified in these chapters reflect the combination of themes arising out of the completed stages of data analysis. Details of the process of analysis through which the themes evolved are given later in this section.

The analysis of qualitative data involved the need to manage a large amount of raw data (Silverman 2000). In order to do this effectively a reliable method of coding and retrieving data needs to be employed (Miller and Dingwall 1997; Morgan 1997; Denzin and Lincoln 1998). Computer packages are becoming more acceptable in qualitative research as a tool for managing large amounts of data. This has been highlighted as having the advantage of assisting the researcher to move into the more

creative, analytical phase of data analysis rather than getting bogged down with the clerical tasks of cutting and sorting paper (Silverman 2000).

One of the main criticisms aimed at the use of computers in qualitative research is possibility of distancing researchers from their work and disembodying the participant from their comments (Seibold 2000; Sandelowski 2001). However, these criticisms often result from confusion between the ways computers are used in quantitative data analysis (to conduct the analytical calculations themselves) and their use in qualitative research as a data management tool (Pateman 1998).

In qualitative analysis, the key relationship in identification of themes is the researchers closeness and familiarity with the data (Kelle 1997). This involves constant examination, questioning and thinking about the data in order to identify the important issues. Often, the number of times an issue is mentioned is not automatically a reflection on its importance (Morgan 1997). A judgement on importance is made by the researcher through their familiarity with the context and processes affecting the data as well as the data itself, this can then be validated through discussion with participants or re-consideration of the transcripts (Gahan and Hannibal 1999; Richards 1999). A computer is unable to do this and cannot be used for this purpose.

The main benefits of using computers in qualitative research are in managing large amounts of data, often from different sources, speedily and accurately (Kelle 1997; Hunter, Lusardi et al. 2002). In addition because the coding process retains the data within its position in a transcript, as opposed to cutting and fragmenting transcripts, it is possible for the researcher to examine a code in its original position. This is useful in attempting to make sense of a code within the context in which the associated comments were made (Hunter, Lusardi et al. 2002).

The computer based tool for qualitative data analysis known as N*VIVO was used to assist in managing and sorting the data in order to facilitate coding of transcripts and

the identification of recurrent themes (Pateman 1998). While I was familiar with computer based analysis tools prior to this research, in order to improve the effective use of this tool in the study I attended a two day additional training course at the University of Surrey prior to commencing data collection. Data analysis initially took place in three phases. Phases one and two incorporated analysis of the written transcripts from the focus groups and interviews. In preparation for data analysis the transcripts from the interviews and focus groups were formatted as rich text documents, the format required in order to import them into the NVIVO programme (Richards 1999).

In phase one of the analysis the data from the focus groups was used to develop the initial categories in the coding frame. Review of the transcripts identified relevant categories or codes associated with a specific line, paragraph or section of text. This process was repeated with each transcript until no further new codes were revealed. The categories arising out of this coding process were then grouped under more abstract headings to identify broad themes. In phase two the same process was subsequently used in analysis of the interview data. The similarities and differences between the themes emerging from the focus groups and the individual interviews were then reviewed. This allowed the initial themes from the focus groups to be verified and modified or new themes added if necessary in the light of any additional information arising out of the interviews. As the themes developed, limits and characteristics of data included in each theme were recorded. This was particularly important as coding of the data utilising this method allowed more than one code to be attached to a particular section of text if the issues contained in it were relevant.

The analysis of the written data has been identified as occurring in two phases in order to identify the different processes involved. Phase one analysis needed to have been completed with each focus group prior to the corresponding interviews, in order that the initial themes could be included in the follow-up interviews. However, these two phases ran concurrently to some extent in that the timing of interviews and focus

groups meant that comparison across groups and reflection on the issues raised occurred concurrently as the research progressed.

In phase three the transcripts, the coded themes associated with them, together with the notes made by the co-worker and researcher of the process of interactions during the focus groups were analysed to determine the screaming silences in the study. The conceptual framework to this study places emphasis on the importance of the 'screaming silences' in any research. Analysis of the data collected during this study therefore had to include reflection on the non-verbalised and silent messages in generated in the discussions as well as the overt references made by participants.

During the focus groups, both the researcher and co-worker had also recorded information relating to the interactions of the group and participants' reactions to the subjects under discussion (see page 122). By combining the information recorded in the transcripts with the notes made of the non-verbal cues during the focus groups it was possible to review whether or how much group dynamics may have affected the data and highlight the issues which participants may have found difficult to discuss or disturbing. This helped to further confirm and identify the silences in the study. Many of these points had been taken into account in interviewing process from selection of possible interview participants to pursuing a particular line of questioning during the interviews.

This process of revisiting and cross referencing these different data sources from the focus groups together with the transcripts of the interviews through further questioning provided the vehicle to develop a picture of the screaming silences underpinning the issues in this study. For example, did any specific comments affect the flow of the group discussion, or did any individuals' reaction to a question trigger censorship by other members or demonstrations of embarrassment in others (such as blushing, aversion of the eyes from the speaker)?

Information relevant to investigation of the data collection process had been recorded alongside the order of speech, principally by the co-worker. This made it easier to examine whether the reactions were made by the same participant, occurred in response to the same issues in one particular group, or were shared across different focus groups. The time delay in between the interviews and focus groups also allowed the analysis to include a review the impact of these issues over time and in a different context, for example questions relating to the silences asked of the data during the analysis included; did the issues still cause embarrassment when re-visited at a later date? Were the participants' reactions to them or comments about them the same in a one-to-one interaction?

The impact of the identified silences on the data was an important consideration in the analysis. In relation to the themes emerging from the first two phases of the analysis, for example, could any explanation about the cause of the reaction or the importance of the issues raised in the themes be elicited through the identified silences?

Following completion of the third phase of data collection the coding frame, which had been developed after the first two phases, was reviewed. The existing codes were found to be adequate to incorporate some of the less tangible issues evolving as a result of considering the silences immersed in the data. Additional codes were therefore added which were more conceptual in nature to reflect the hopes, fears and aspirations of participants revealed through the screaming silences. The final coding frame containing fourteen heading codes and multiple sub-codes is illustrated in appendix ten. This was used as a basis to describe and formulate understanding of the data from the various sources.

It would have been ideal if the co-worker could have assisted in the development of the coding framework as the analysis progressed which would have helped to reduce the biases arising out of researcher personal interpretation. However, due to time constraints and work pressures this was not possible. However, the developing

coding frame was reviewed by the co-worker on at the end of each of the first two phases and discussed with the researcher on completion of the final phase of analysis.

It was noted earlier that data collection and analysis occurred simultaneously due to the variations in timings of particular focus groups and individual interviews. This allowed a process of constant comparison to take place between emergent and established themes with speculation on possible future findings. As the coding progressed and the framework was reviewed more consideration was therefore given to the emergent theories of influences on black Caribbean men's sexual health decisions than discussion of the particular details of an individual's experience. The coding frame therefore developed through this process of constant comparison from what has been described as a checklist to a more conceptual basis for encapsulating the experiences described by the participants (Denzin and Lincoln 1998a).

Review of the data using the coding frame was complete when no new codes emerged and all sub-codes were suitably allocated into an appropriate category. At this point attempts were made to conceptualise the main themes from the data. Within these themes the individual experiences, reflections and contexts, which influence the sexual decision making of the participants, varied. However unitying aspects of the experiences and issues needed to be developed such that they adequately reflect the issues impacting on the sexual health decisions of black Caribbean men as revealed through the experiences of the sample groups rather than any single individual. Three main themes finally emerged as a result of the analysis of the focus group and interview data: The negative stereotype of black Caribbean men's sexual behaviour as an influencing factor on sexual health experiences and decisions. The strategies used by participants to manage their sexual experiences in the light of the expectations associated with the stereotype and finally the nature and impact of the silences associated with black Caribbean men and sexual health behaviour.

In order to complete the analysis and present the findings from the data collection in a meaningful way which would preserve as much of the context and personal

experiences of the participants in their own words, these themes were named 'The nature of the stereotype', Living with the stereotype' and 'Hearing the silences'. These themes formed the final framework for analysing the data. A characteristic of this framework is that each theme is ever present within the experiences of participants influencing their sexual health decisions and experiences. However, they exist in a state of tension where one or more themes may dominate or recede dependent on the context in which the interaction occurs. The themes have been used to form the titles used in the data chapters to facilitate discussion of them. An introduction to the scope and nature of each theme is given at the beginning of the relevant chapter.

3.3: Ethical considerations

The decision to complete a qualitative study, influenced by aspects of feminism, criticalist and ethnicity based approaches raised a wide range of ethical issues for consideration in this study. Many of these issues arose from the political tensions inherent in this particular research setting where issues of identity, ethnicity and professional status converged with the study of a very sensitive subject. Punch (1986) referred to the politics of the research setting as being of great influence in research studies. His comment that 'politics' may be used to refer to the contexts and constraints of a study evolving from the micro-politics of personal relationships, through to the macro-politics of social power' (p7), is of particular relevance in this study where issues of social status, gender and ethnic identity had a strong impact on the research design, ethics and the process of data collection.

This section explores some of the ethical considerations related to the fluid and complex associations between myself as researcher, the participants, the sensitive nature of the research subject and the methods of investigation selected for the study. The ethical issues raised by this study were difficult to predict absolutely because they were bound up with my personal experiences as an established member of the black Caribbean community in Townsville and those of the participants combined with the

social, moral and political contexts of sexual health. As such the ethical issues themselves were potentially changeable and very context specific. This meant that they were interrelated and not easily separated, but artificial boundaries had to be set in presenting them, if only so that they could be addressed prior to data collection.

The decision to highlight the ethical considerations relating to this study at an early point in the study was intended to indicate that none of the situations highlighted were either fixed or constant. The discussion to follow occurs with the understanding that the situations presented and the issues impacting on them could change at any time during, after or even as a direct consequence of the study itself. Any such changes or unanticipated outcomes would be explored in the final discussion chapter.

The ethical issues impacting on this study fell into three main categories.

- Study specific issues related to the sensitive nature of the subject
- The insider role of the researcher e.g. knowledge of sexual health, the tensions relating to role of the researcher with regards to ethnicity and social class, issues of researcher safety and reciprocity.
- Issues related directly to the use of qualitative study designs and methods. For example the use of individual and group interviews, confidentiality and generalisability of findings

In order to reflect the complexity and close associations between the methodological and study specific issues, they are explored here under the following headings

- Moral and Social obligations
- Researcher identity
- The role of the researcher
- The research subject

3.3.1: Moral and social obligations

Many of the ethical considerations impinge on the moral and social obligations of the researcher in the research field. Good quality research which encourages research that strives to do no harm to participants as a result of their agreement to take part and is based on key ethical principles. The Royal College of Nursing (RCN) of which I am a member produces a statement of ethical practice which stresses the importance of informed consent, recognisable benefit of conducting the research alongside the requirement that participants are not harmed by the process and give consent for their participation (Royal College of Nursing 1998). Researchers are required to seek ethical approval for the planned research well in advance of data collection. Ethical approval for this study was gained from the Local Research Ethics Committee for the local trust in Townsville.

The issues of privacy and confidentiality emphasised in the RCN document are to some extent faced by all qualitative researchers and participants by virtue of the nature of the methodological approaches used (Harrison 2001). Some of these issues include maintaining participant anonymity and ensuring confidentiality of data (Denzin 1998a). The efforts taken by researchers to maintain confidentiality and reassure participants through decisions made concerning the study design are a reflection of the importance of this factor to the research process (Denzin 1998; Millen 1997; Mirza 1995). In research conducted under ethical guidelines, maintaining the privacy and protecting the identity of participants is key. In general the setting and participants should not be identified in print nor suffer harm or embarrassment by publication of the result (Punch 1986). Some of the issues raised relate to the necessary management of the process of entering and leaving of the field of research (Harrison 2001; Morse 2002).

It is recognised that in this research where purposive sampling was used in a relatively small population the feasibility of maintaining confidentiality presented a challenge.

The decision to use the pseudonym 'Townsville' for the location of the study and the changing of the names of well known agencies in the locality were part of the attempts made to protect the identity of individuals and groups. However, when the study is published and the name of the researcher known, this raises the question as to how difficult will it really be for 'Townsville insiders' to discover the identities that efforts were made to protect?

Ultimately in order to be of any true benefit and to potentially fulfil any of the 'usefulness' intent of the theoretical influences on it, this research study will have to enter the public domain and be published (Lipson 1994). This research combines in one study, issues of ethnicity and sexual activity which are still among two of the biggest subjects of discussion, debate and conflict in society (Stoler 1997; Penman 1998; Valkimaki, Suominen et al. 1998). I highlighted earlier in setting the context for this study the political tensions inherent in the association of ethnicity, gender and sexual decisions. These issues simultaneously impact on the moral and social obligations of the researcher to participants. Consideration also has to be given to the fact that qualitative research participants may not like the way they are portrayed in the finished research report (Robinson 1999). Thus while researchers cannot always either anticipate or be held responsible for all the outcomes or purposes to which their studies may be put (Letherby 2002; Morse 2002), I remain mindful of the risks and opportunities that the findings from this study may elicit.

It was difficult to separate the moral and social issues from each other in this study as they are highly interrelated and interdependent. For example, it is possible that my ability to conduct this study at all and whether this was sanctioned by the gatekeepers depended to some degree on my ethnic identity as much as the research design (Johnson-Bailey 1999). This will be explored further in the next section. It must be noted that in reality the true moral or social implications of the issues raised in this study for both myself and participants from Townsville, and the effectiveness of the

steps taken to account for them, may only become known once the study is in the public domain.

3.3.2: Researcher Identity

In qualitative approaches the researcher is the primary instrument of data collection though who all collected information is mediated (Hasselkus, 1997). The personality of the researcher is likely to influence the choice of the topic, the intellectual approach adopted and their ability in the field (Firby 1995). In addition other factors such as age, gender, class, social status, ethnicity and education may in turn open or close avenues to research inquiry (Johnson-Bailey 1999; Mason 2002). It is therefore important that the identity and past experiences of the researcher which provide familiarity with the topic, setting or participants, be made explicit from the outset and the possible impact on the research process explored.

The exploration of the ethical issues arising out of this study reflects on how I define myself, and the issues this raises for the study. As this is a personal exploration I will use the first person throughout.

In my personal and professional life, identity matters. In this study I identify myself as a black British female of Caribbean descent and active member of the black Caribbean community in Townsville. I am also a qualified and experienced sexual health worker and academic. All these aspects of my identity are seamlessly entwined as part of my personal experiences and as such individually and collectively had the potential to impact on the research study. What was evident from the outset were the tensions associated with researching across differences and through apparent similarities in gender, ethnicity and educational or social status. These were real issues to be managed in this study with the key ethical questions being concerned with questions such as

- How would my positioning as a black Caribbean female academic impact on the discussions arising out of the focus groups and interviews, on the ethics

committees decision to validate the study or on the participants' and the others' expectations of the study?

- What effects could this research have on my family and friends living in the black and minority ethnic communities in Townsville where this research takes place?

The tensions I had to contend with during this study were reflected in wider debates concerning the relationship between the researcher and the researched in situations where there are aspects of shared identities or experiences between them. Many of these issues have been explored by researchers from a range of traditions including feminism and ethnicity based research under the guise of insider/outsider perspective (see Kaufman 1994 , Johnson-Bailey 1999 , Rassool 1999).

In the context of this research study, some aspects of my identity appeared to locate me as either insider or outsider to the participants. As a black Caribbean born and raised in Townsville, I am an insider. I have personal knowledge and experience of what it is like to be simultaneously black, British and Caribbean in this city. As an insider I am aware of the social and moral expectations the black Caribbean community have of me as a black woman and as a black professional. However, simultaneously and almost in constant opposition to my insider status were the aspects of my identity that label me as a sexual health practice professional and university based academic. These aspects of my 'self' are neither common in themselves or in the experience of the majority of black Caribbean people in Townsville and epitomised my placing as outsider that persisted throughout the study. Conversely my positioning as a black academic meant I also found myself in a situation which was familiar to many black people in Townsville, the situation of being one of the relatively few black professionals fulfilling a particular role.

The issue of researcher identity was further complicated by the nature of the study to be undertaken; an exploration of the factors influencing the sexual health decision

making of black Caribbean men. Completing the data collection involved discussions with black Caribbean men, black Caribbean women, partners of black Caribbean men and Sexual health workers. Thus at all stages of the data collection I was required to interact with people who were likely to simultaneously relate to me as insider or outsider to themselves, the research subject or both.

The multifaceted nature of my identity impacted on whether I would be seen as an outsider or insider by the participants and gatekeepers of the research which could have had knock on effects for the study. It is pertinent at this point to point out that the gatekeepers in my research study included the formalised structures set up to assess the ethical nature of research conducted within the NHS Trust, as well as the less formalised (but no less stringent) appraisal of activities by community leaders and social gatekeepers in Townsville's black population. As a result I had to remain mindful of the way I presented myself in the research and in particular the implications of my interactions in both my private and professional life. For example my initial contacts with three of the black Caribbean organisations in order to recruit possible participants were preceded by detailed questioning about my family, heritage and attitude to Caribbean cuisine. Discussions with sexual health professionals in contrast began with informal chats about the exact nature and extent of my professional practice experience in sexual health compared to my experience as a university lecturer.

My positioning by participants also determined the nature of the information that participants chose to share in the focus groups (Miller and Dingwall 1997; Morgan 1997). For example, in if I was perceived as an insider black Caribbean participants occasionally expressed that they felt more at ease in discussing their views with someone they perceive to be 'one of them' or conversely felt more threatened by the fact that they would be discussing sensitive issues with someone they may meet in social settings. Sexual health professionals were also have been happy to discuss issues relating to sexual decisions and ethnicity with a fellow professional, but

alternatively some were concerned to present a 'politically correct' persona when this professional was a black Caribbean person.

My awareness of the effects of the apparent contradictions in my position on the research went beyond a perception of factors which may influence the ease with which access to the field is gained and the process of data collection is conducted. I remained acutely aware that completing this research study as a black Caribbean woman raised issues of risk and reciprocity for me as researcher. To some degree this was not unusual. Qualitative researchers often have to address possible expectations of the participants in relation to their studies in terms of the professional expectations that individuals and groups may have of them (Morse 1994; Maggs-Rapport 2001). On many occasions the issues are unlikely to require active management beyond the duration of the study, however, in my case the need to manage the impact of the study and its outcomes once it is completed may be inescapable.

There were possibly personal risks to me in that the subject of the study could result in participants offering information about their own sexual relationships. While this was not the purpose of the discussions *perse* and as a sexual health professional, was something I was experienced in dealing with, the difference in this study was that participants were not conversing with me as sexual health adviser and clients. There was a possibility that they may inform their friends and partners that they were taking part in the study. While I would adhere to issues of confidentiality all times as in a private consultation, I could therefore potentially have been approached by partners or friends of participants requesting information about their contribution to the study. The close social association between myself and some professional or lay participants meant that these approaches did not always occur within the traditional lines of academic communication through the university but could take place during my private time within the black Caribbean community.

The issue of community responsibility may impact on the expectations that the participants have of the outcomes of a research study and the researcher (Bowes

1996; Harrison, MacGibbon et al. 2001). In my study I remained vigilant that I did not make any promises or raise expectations that the conclusion of the research would directly result in any tangible change to the lives of individuals or services received by the black Caribbean community. I was aware of the possibility that expectations for change by the black Caribbean communities may have been higher because 'one of our own' conducted the research. This issue of what will change as a result of the research was voiced by one community group leader. My response was to talk about the wider implications to improving the sexual health of black Caribbean men as well as highlighting the planned collaborations with local community health groups to disseminate the findings and work through the implications once the research was complete.

In my general approach I took heed of the cautionary notes of Harrison, MacGibbon and Morton (2001) who warn against using the promise of reciprocity too lightly and ask researchers to think critically about what they mean by reciprocity and benefit, whose benefit and at what cost. They argue that as researchers, understanding of reciprocity itself shapes the experiences in the field and shape the research itself. This in turn helps qualitative researchers to adopt a more participative approach to their work. These comments were useful in helping me to identify the boundaries of my study prior to data collection. However, at the same time I personally struggled with the idea that as a member of the black community I did not wish to add my research study to the already large number of projects that black Communities have taken part in that 'do them no good' (Bhatti 1995; Mirza 1995; Bhopal 1997).

Due to word constraints I have been unable to discuss in detail all the aspects of my identity and the possible impact this could have had on the data collection. I have tried to highlight some of the major considerations I continued to think through in designing this study. The key point I wish to stress is that my identity as black Caribbean, female, sexual health professional and academic meant that I would at various times during the study be reacted to and interacted with on the basis that I was an insider, outsider and sometimes both. This had the potential to impact on the

study and sets the scene for my discussion of the other ethical considerations to follow.

3.3.3: Role of the researcher

In qualitative research the researcher is the main tool through which information is gathered in the data collection phase and processed in the data analysis phase (Crotty 1998; Denzin and Lincoln 1998; Hunter, Lusardi et al. 2002). While my researcher identity as outlined above and my relationship with the field of study seem to facilitate the role of the researcher, it also raised some particular ethical issues for consideration.

The theoretical approaches underpinning this research project suggest that ultimately research should encourage thinking and challenge beliefs about a subject (Lather 1991; Pilcher 2001; Morse 2002). In the context of research involving minority groups, the usefulness of the study could be perceived as a positive step towards counteracting the risk of the participants and their communities being further disempowered by the research study. Millen (1997) however warns researchers to be cautious about the true ability of their research to empower others, particularly where participants do not share the philosophical approach of the researcher or where they have more to lose from the experience. Where this possibility exists the question arises as to how empowering can the research be in real terms? Can researchers still claim to adhere to the promotion of empowerment and avoidance of exploitative research when the burden is to be born by the participants alone? These are difficult questions to answer but issues that must be faced in order to promote criticality in the approach to research.

It is important for researcher to be clear about the nature of empowerment or emancipation they aim to pursue in their studies (Bowes 1996). In this study the

findings will be used to consider the implications for sexual health professionals and service providers were identified earlier. Linking the findings from an academic piece of work to service provision or professional practice could be identified as promoting the usefulness of research within the boundaries of benefice to the participants. However, this again raises the question of whether the expectations of the black Caribbean community or sexual health services will be higher, the same or different because the study has been conducted by a black Caribbean researcher. What are the effects of non-delivery in this case? What would the potential impact be for other black researchers following on from this project? And how would any perceived 'non-delivery' following completion of the study impact on the lives of my family and friends living in Townsville?

These questions relate to issues of trust and betrayal in the research setting. Issues of trust and betrayal may become pertinent in qualitative research as the researcher enters the field and develops a relationship with the participants (Punch 1986). In this research study knowledge of or relationships with participants were occasionally already established through my personal or professional connections. However, as highlighted by Fine (1998) these relationships may change or result in different levels of identification with participants and the wider black Caribbean community as a result of being involved in the study.

The need to manage and remain aware of potential changes in my relationships or associations with the groups to which participants belong was made more acute in this study by the fact that my complete withdrawal from the field would not be possible. I would still live in Townsville once the study is completed and conduct my professional life in areas linked to sexual health. While this may have potentially reduced the impact of abandonment reported by participants in other studies (Harrison, MacGibbon et al. 2001) it may have also increased the impact of other issues related to the role of the researcher. These include those arising out of the researcher's inability to disassociate from the field (Johnson-Bailey 1999, Mirza 1995) and how to mange the consequences of publishing the outcomes of the research

(Millen 1997, Seibold 2000). For example, what are the possible consequences if my research appears to further stigmatise the sexual practices of black Caribbean men? I was unable to answer any of these questions at the preliminary stages of the research study, however they were considerations which remain in the silences which were still to be addressed after the time the study was completed yet affected the research making processes from an early stage.

3.3.4: Research Subject

As a black Caribbean female researcher and sexual health professional, I was aware that ethical issues were raised by the focus on sexual health decisions of black Caribbean. In conjunction with the challenge of focussing on black Caribbean men in my own city I was also prepared for the emergence of unanticipated consequences at any stage from data collection to completion of the study and publication of the findings (Sandelowski 2001, Morse 2002).

In itself the researching of sexual health decisions and risk taking, particularly when utilising a qualitative approach incorporates issues of sensitivity, questions of morality and exploration of experiences which are usually private (Gibson 1996; Hayter 1996). In the context of this study it was therefore important that the impact of taking part in the research on the participants was considered both in terms of methodological approaches used and personal consequences for individuals.

In relation to the methodological procedures used the design of the data collection tools and the organisation of the procedures were devised so as to focus on issues relating to sexual health decisions in general, rather than personal disclosure. However, it was recognised that in discussing sexual health issues, areas of personal concern to individual participants could be raised. As a sexual health professional I was aware that the nature of sexual health problems meant that often the realisation that a problem exists occurs at some time after the specific episode giving rise to it

and at times not anticipated by the individual (Conner and Norman 1998; Lupton 1999; Johnson, Mercer et al. 2001). I perceived that my experience in sexual health would be of benefit to manage questions or concerns of participants relating to sexual; health. In both focus groups and interviews I was required to address minor issues of concern and clarify questions of knowledge accuracy that occurred. However, consideration had to be given to the ethics of raising issues with participants which may potentially lead to anxiety that cannot be resolved during the focus group (Harrison 2001).

In order to minimise the chances of participants experiencing anxiety due to unresolved issues raised during data collection, a variety of sexual health services and support agencies in Townsville were made aware of the research taking place. The name and contact details of these agencies were provided to participants prior to data collection when participants' agreement to take part in the study was confirmed. These steps were designed to ensure that participants remained aware of the support available to them following their contribution to the study. This also ensured that the agencies involved were informed in advance in order that any anticipated referrals or requests for information and assistance by participants could be provided from a position of knowledge of the study. In addition in advance of data collection ethical approval for the study was secured from the local research ethics committee in the light of any potential harm to participants arising from discussion of personal, sensitive and potentially stressful issues (Lee 1993; Lipson 1994; Robinson 1999).

The ethical considerations arising out of the subject of the research also included the political tensions inherent in a study conducted by a black Caribbean woman investigating and discussing the sexual decision making of black Caribbean men. Issues of race, stereotyping and sexual expression as centralised in this study have been debated widely both in academic and non-academic settings (Ifekwunigwe 1997; Katz, Fortenberry et al. 2001; Kempadoo 2001). The problematic issues for this study were further complicated by the realisation that previous studies combining aspects of sexual practices and ethnicity have not always been well received by minority

communities. In fact on occasion they have been challenged as fuelling a push to label black people as 'risky' and 'unclean' in relation to sex (Estes 2000).

In conducting this study, it was also noted that research which combined ethnicity, gender and sexual risk taking, conducted from a black perspective could attract media interest, possibly resulting in a political and social backlash from minority ethnic groups (Dyer 1977; Punch 1986). This possibility was instrumental in my use of a co-worker to assist in the evaluation of the data collection process and also in the decision to provide contact details for the race equality support service in Townsville alongside the sexual health service information provided to participants.

Concluding comments

The methodological considerations in many studies may be closely associated with standard issues such as seeking informed consent, the appropriateness of research question and data collection procedures. In this study these issues are important but are at the same time confounded by the realities of managing the personal and political tensions associated with this research project. All researchers address the methodological and ethical issues brought about by the role of the researcher in a study at some stage in the decision making process (Denzin and Lincoln 1998). The issues presented here, particularly those discussed in the section on ethical consideration, are not claimed to be unique but it was important that the possible impact of this research on myself as researcher, the participants and black minority ethnic community of Townsville, be explored.

INTRODUCTION TO DATA CHAPTERS

This research study set out to identify the key factors influencing the sexual health decisions of black Caribbean men from the perspective of black Caribbean men and the key players in their sexual health. The findings resulting from the data collection and analysis are presented in the following three chapters. In each chapter a narrative style of presentation is used where the findings are combined with the analysis.

The continuous questioning of the data obtained from the transcripts employed during the analysis revealed three key themes which are denoted by the titles given to the three data chapters: 'The nature of the stereotype', 'Living with the stereotype' and 'Hearing the silences'. In each chapter direct quotes from the transcripts are used to illustrate the points. All participants' names have been changed to maintain confidentiality. Selection of the quotes was based on that which was the most appropriate resulting in some of the quotes being repeated in different sections of the chapters.

CHAPTER FOUR

THE NATURE OF THE STEREOTYPE

Introduction

In the literature chapter it was suggested that sexual health decisions are influenced by factors that impact on other types of health behaviour such as perception of self, expectations and the responses of other people (Conner and Norman 1998; Fonck, Mwai et al. 2002). During the focus groups, one of the most distinct and recurring themes arising out of the discussions was the sexual stereotype of black Caribbean men and impact of stereotyping on their sexual decisions. During the discussions many participants highlighted the ways in which their social interactions not concerned with sexual decisions were often influenced by the perceptions, beliefs and expectations associated with the this particular sexual stereotype.

This chapter addresses an issue raised by Pickering (2001) in his critical reflections on research and writings on stereotypes and stereotyping. He highlights a concern that much of the work presented in this area identifies the discriminatory and prejudicial effects of the stereotype on the victims with very little attention played to describing what the stereotype itself involves in the context in which it is used (p.xiv) Theneed to make clear the nature of the stereotype under discussion is important because stereotypes and how they are understood have been shown to vary over time, between and within social groups (Wyer 1998; Hinton 2000). Pickering (2001) claims that much of the work on stereotyping glosses over this issue and begins from a basis that the nature of the stereotype under discussion is generally clear, understood and unambiguous.

The title given to the theme detailed in this chapter is 'The nature of the stereotype'. It reflects the way the stereotype of black Caribbean men was described by participants in this study. In relation to sexual health and related nursing care however, the issue of stereotyping has not been subject to a long history of critique. The negative stereotyping of black Caribbean males has been regularly reproduced in the literature in relation to a number of general health subjects and the effects of its use discussed with few attempts to first establish the exact nature of the stereotype being discussed (Narayanasamy 1999b; Kempadoo 2001; Pilcher 2001). This chapter addresses that concern by identifying the nature of the stereotypes and stereotyping to be used in this study. This forms the basis of the discussion of the stereotype of black Caribbean men identified by participants in the study. It then goes on to explore the nuances arising out of the similarities and differences in the way the stereotype is made sense of by the participants in this study. These two issues form the basis for the presentation of this chapter and establish the platform for discussions in the two data chapters to follow and ultimately the study itself.

To some extent, participants felt that stereotypes were part of a natural ordering process in which people were categorised to provide a type of 'short hand' or reference point during an interaction. As a particular type of social interaction, sexual encounters were described by the participants as being no different from other interactions in that they were influenced by the assumptions of people on both sides. In the case of black Caribbean men, the sexual stereotype was seen as central to many of the assumptions affecting an encounter. This illustrates the ways in which reacting to others on the basis of the assumptions made about them was perceived by participants as something which occurred in all social interactions in varying degrees.

In relation to sexual health decisions, participants felt that black Caribbean men were the group most likely to be negatively perceived and stereotyped as a result of the beliefs and expectations held about them in society. This concurred with the findings of an earlier exploratory study conducted prior to this research project in which participants identified black Caribbean men as the greatest risk takers when compared

to women and men from other ethnic groups (Serrant-Green 2001b). The stereotype of the black Caribbean male referred to by the participants in the study was as a sexually irresponsible and often insatiable individual who had a high risk attitude to sexual activities:

The only view anyone has about black guys and sexual behaviour is that thing, you know you've got that thing of a player, and a true player, what's a true player?, a true player is a man that's got Mrs here, Mrs there, Mrs there but the thing about it is Mrs A knows about Mrs B and Mrs B knows about Mrs A.
(Remi, early 20s, black African Caribbean women)

My experience of black men is that they are there anyway but they are seen as bad news. They might think they are with their partners, but...I don't think they were ever there anyway.
(Louise, late 30s black Caribbean woman)

We do an exercise where they have to get out all the stereotypes, they may not necessarily think it (yeah) but the fact that people have heard all of that, and the ones for the black men are always, you know, about large penises, about irresponsibility, about having lots of children etc etc,
(Oscar, mid 30's, black Caribbean sexual health professional)

This particular way of viewing stereotypes as wholly negative is well researched as an important concept in disciplines such as anthropology, social psychology and movements such as feminism, anti-racism and Gay rights (Spears, Oakes et al. 1997; Stoler 1997; Ribbens and Edwards 1998). Much of this valuable work considers not only the nature of negative stereotypes but also the effects that the process of stereotyping has on the lives on the individuals involved.

In this study the approach taken is to distinguish between stereotypes as a particular frame of reference used with specific individuals or social groups and stereotyping as the process by which those frames of reference are actioned or experienced in society. Stereotypes and stereotyping are often discussed interchangeably in the literature

(Hinton 2000). However here a distinction is made between them in the initial phase of presenting the findings to facilitate identification of the nature of the stereotype of black Caribbean men pertinent to this research and the related discussion of the ways in which it impacted on their lives (chapter 5).

In presenting some of the ways in which the stereotype was evidenced in this study, this chapter also exposes some of the dilemmas and contradictions inherent in the stereotype itself by relating the issues raised by participants back to established literatures on stereotypes. Inherent contradiction has been highlighted as a core characteristic in stereotypes which much of the process of stereotyping seeks to mask, giving the illusion of order and certainty in the definition (Leyens, Yzerbyt et al. 1994). It is therefore important that in seeking to achieve a level of critical reflection on the sexual stereotypes of black Caribbean men and the impact of this stereotyping, that effort is made to expose the hidden dilemmas within it. This has been successfully achieved in a wide range of disciplines and subject areas but as yet remains relatively unexplored in the area of stereotyping in relation to ethnicity, sexual risk and health. Table 2 below identifies the sections associated with this first theme 'The nature of the stereotype'.

THEME: *THE NATURE OF THE STEREOTYPE*

4.1: How stereotypes are defined in this study

4.2: Participants' views of the stereotype of black Caribbean men

4.2.1: *Overview of the stereotype*

4.2.2: *Characteristics associated with the stereotype*

4.2.3: *Universality of the stereotype in black Caribbean men*

4.3: The stereotype as a black Caribbean male issue

4.3.1: *Sexual health professionals' views*

4.3.2: *Lay participants' views*

Table 2: Issues addressed in theme 1 'The nature of the stereotype'

4.1: How stereotypes are defined in this study

The term 'stereotype' is originally a printing term for the text casts used to ensure consistency and accuracy in articles which required the repeated use of information (Pickering 2001). However, the term has become increasingly associated with a range of disciplines such as cultural studies, social psychology and has been adopted in everyday use to reflect how certain groups and individuals are perceived in society (Brah, Hickman et al. 1999; Barker 2000). The term stereotype is often used interchangeably with categories or types in the literature despite the fact that these terms have different meanings. While all these terms are believed to refer to socially determined classifications, in general stereotypes are distinguished from categories or types in that they attempt to portray restricted representations of people which reduce them to a set of exaggerated and usually negative characteristics (Bhabha 1992; Collins 1998; Balsa and McGuire 2002).

The key attributes usually associated with stereotypes include an assumption that they are fixed in nature and related to people who are different to the majority or a socially accepted 'norm' (Donald and Rattansi 1992; Gill and Maclean 2002). The strength of the stereotype lies in its ability to present what appears to be a realistic and trustworthy 'blueprint' for identifying particular groups and a sound basis for appraising their actions (Leyens, Yzerbyt et al. 1994).

Viewed in this way, stereotypes can be seen as linking to issues of representation and how individuals or groups are identified in society. In its broadest sense, representations involve questions of inclusion or exclusion (Pickering 2001). Representations are actioned through the process of stereotyping which involves appraisal of information about an individual or group and the making of a judgement as to whether or not they belong to a particular category by establishing boundaries of 'them' and 'us'. The negative connotations which often accompany the everyday

association of a group or individual with a stereotype introduce the inference that 'difference' denotes inferiority (Schermerhorn 1978; Rassool 1999; Pratto and Espinoza 2001). The association of negativity with a stereotype is commonly reported in the literature despite the fact that the origins of the stereotype identify both negative and positive connotations as possible outcomes. In the stereotype of black Caribbean men feelings of desire, fantasy or longing are elicited alongside the negativity and inferiority it is set up to represent (Leyens, Yzerbyt et al. 1994; Hinton 2000).

Stereotypes are recognised as reflecting the social context in which stereotyping occurs. The nature and use of stereotypes often encompass the power relations and norms of behaviour in a particular society (Shohat and Stam 1994; Mac an Ghaill 1999; Pilcher 2001). Stereotypes may therefore denote the power relations between social categories, such as ethnicity, age and gender, and particular personality traits and types of behaviour (Carby 1997; Bhopal 1998; Brah, Hickman et al. 1999). The individuals who are stereotyped as a result are often therefore the less powerful in a particular society and the traits associated with them are often percieved as least desirable by particular societies.

The issue of representation, inclusion and exclusion in stereotyping have been explored by writers from feminist; ethnicities based research and criticalist perspectives. The issue of power in society as experienced through the use of stereotypes has been extensively explored through their writings from the position of 'other' (Bryant, Dadzie et al. 1985; Callaghan 1998; Estes 2000; Diekman, Eagly et al 2002). As 'other' to the white, male able-bodied norm, authors who are women, black people and people with disabilities write about the theory and realities of living with stereotypes from a position of relative social exclusion (hooks 1992; Ifekwunigwe 1997; Johnson-Bailey 1999). Many of these writers began their criticisms of stereotyping by highlighting how their experiences have been omitted from discussions into the impact of the stereotype. In addition they point out that where it has been included, the vast majority of the literature on stereotyping appears to reflect

third party observations of the impact of stereotyping by the powerful on the least powerful members of society and have been commented on in scientific terms without reference to their own perspectives (Lawson 1998; Olesen 1998; Pilcher 2001).

Through the writings of feminist and ethnicities based researchers what emerges is that when stereotypes are viewed critically as they are used in society, stereotypes appear to be more fluid, contradictory and changeable than suggested by the definitions. This is evidenced both in their nature and the way they are applied in society (Rassool 1999; Tusting, Crawshaw et al. 2002; Vonk 2002). Far from acting as a fixed, 'blueprint' they are context bound, being subject to change in use and interpretation over time and according to social situation. The contradictions inherent in stereotyping is clearly revealed through explorations of 'other' where the effect of highlighting the stereotype as forbidden, undesirable or negative appears to have the opposite affect of drawing attention to it, making it a curiosity, an example of that which cannot be admitted or accepted as a legitimate part of ordered society (Stoler 1997; Wyer 1998; Lupton 1999). The silences in the stereotype demonstrate the dilemmas within itself and how it is applied in the lives of those identified by it. This illustrates that far from the linear, rational use of stereotypes suggested by the definition, stereotypes are neither applied logically nor guaranteed to be interpreted in a uniform manner (Thompson, Judd et al. 1999).

Recent writings on stereotypes and their effects on society have suggested that their continued use damages both those who are the objects of stereotyping and those who use it as a basis for action (Thompson, Judd et al. 1999; Pickering 2001). The damage is said to arise from the fact that the myths and assumptions inherent in stereotypes create barriers in social interactions and relations between the individuals involved. This contrasts with the approach of presenting stereotypes as scientific observations of behaviour without adequate reference to the social context.

This literature above suggests that stereotyping works to present stereotypes as apolitical, absolute and invariable as the text casts from which the term is derived. In practical application however, it appears that it becomes increasingly difficult to sustain these aspects of the definition. However, rather than rejecting the stereotype as unsustainable in the face of such contradiction, the response is often to readjust the stereotype or the justification of it in order to account for the anomaly (Leyens, Yzerbyt et al. 1994). This raises the question of why stereotypes are not rejected when they do not fit and suggests that stereotypes are used because they are useful in some way.

Various suggestions have been made as to the 'usefulness' or role played by stereotyping in society, which will help to inform the exploration of the impact of the sexual stereotyping of Black Caribbean men on the experiences of participants in the study. These include the setting up of boundaries or indicators of belonging as mentioned above, as a basic social reference point for determining behaviour (Valentine 1998), or as a mechanism of social control which perpetuates inequality and justifies unjust treatment, social exclusion and bigotry towards particular social groups (Thompson, Judd et al. 1999; Woodward 1999; Pratto and Espinoza 2001; Vonk 2002).

As a result of the changeable and fluid way in which they are used and understood, a range of definitions of stereotypes exist. It is therefore important to clarify at the outset the definition of stereotypes used in a particular research study. Stereotypes in the initial stages of this study are identified with what has been called the traditional or 'common sense' view of stereotypes (Leyens, Yzerbyt et al. 1994). Stereotypes were therefore defined as:

> 'Shared beliefs about personal attributes, usually personality traits, but often also the behaviours of a group of people.'
> (Leyens, Yzerbyt et al 1994. p.18)

The definition of stereotypes was selected because it reflected the way in which participants spoke about the stereotype of Black Caribbean men in terms of beliefs about particular aspects of their attitudes to sexual activity or their character. In this chapter and throughout the study a distinction is made between stereotypes as defined above and stereotyping which is the process by which they are applied and actioned in society. Stereotyping, as referred to in this study is defined as:

> 'An exaggerated belief associated with a category. Its function is to justify (rationalise) our conduct in relation to that category' (Allport 1954 p.191)

This definition of stereotyping was selected because it reflects quite accurately the distinctions made by participants between the role and effects of the practice of using stereotypes to explain actions and judgements relating to sexual decisions in particular.

4.2: Participants' views of the stereotype of black Caribbean men

This next section in the theme 'nature of the stereotype' begins by presenting an overview of how the stereotype of black Caribbean men's sexual activity is perceived by participants. It then goes on to discuss participants' views on the specific characteristics they associate with the stereotype and their beliefs concerning the universality of the stereotype among black Caribbean men. This is achieved by addressing the following issues

4.2.1: Overview of the stereotype

4.2.2: Characteristics associated with the stereotype

4.2.3: Universality of the stereotype in black Caribbean men

4.2.1: Overview of the stereotype

Analysis of the responses from the focus groups, revealed a high degree of consensus between participants as to the links made between black Caribbean men and poor sexual decisions. Irrespective of the nature of the focus group or their relationship to black Caribbean men, there existed a general belief that the messages associated with stereotypes of black men and sexual attitudes were predominantly negative. The stereotype of black Caribbean men identified by participants was one in which the black Caribbean man was epitomised as sexually irresponsible with little regard for his own health and well being or that of his sexual partner:

'According to the stereotype all black men sleep around, make babies. Its all bad news. Black men are bad news. People say that cos that's all people know, that's what people know about history, that's what people know, they just act what they know.'
(Carl, mid 20's, employed black Caribbean male)

No well I believe the first one [reading] you know about black men, not using condoms and taking responsibility because it's a woman's job. I think that's true because I've knowmen say... I can't feel that kind of ting... no man... I can't use that, there can't be a barrier, you have to be with nature... but no man that can't work you have to think about AIDS and things like that. I haven't met a man who is faithful... I don't know if it's just me but I haven't met one who hasn't got a roving eye
(Monica, late 30's Black Caribbean woman)

These quotes illustrate very clearly an important issue in use of stereotypes. This is that despite the fact that the traditional definition of stereotypes given earlier does not refer to a negative judgement, stereotypes are generally used to categorise behaviours or personality traits which are perceived as bad in society (Hinton 2000). This was how the stereotype of black Caribbean men was referred to by participants, in predominantly negative terms. The tendency to associate stereotypes with negativity is well documented as not only epitomising the common sense understanding of

stereotypes in society but also as the approach taken in much of the published research about the subject (Pickering 2001).

While illustrating the links made between stereotypes and negativity, in general, the quotes also provide evidence of another important characteristic of stereotypes which was alluded to earlier. This is the important role played by 'judgements' in distinguishing stereotypes from categories. There is some suggestion in the literature that stereotypes are simply as a quick way of categorising people and making sense of the world so are fundamentally the same as other categorisations (Spears, Oakes et al 1997). What emerged from the analysis in this study however, was the degree to which participants did not discuss sexual stereotypes of black Caribbean men as a group of people simply to identify them as a distinct from other members of society, rather the stereotype was perceived as going beyond pure description to include an evaluative or judgemental component:

There's always a judgment isn't there? With a stereotype I mean. It's not just like saying he's big or something, it's like telling you what you think about that person or the way they act. Stereotypes are different.
(Ivan, late 30s, black African Caribbean male)

It could be argued that categories themselves are accompanied by a judgement in order to define them. For example in describing some one as young, old or blond haired requires that a decision be made about what constitutes that category and then a judgement made as to whether the individual or group fulfils the criteria for that category. However, the stereotypes of black Caribbean men, as discussed in this study were seen as more than a categorisation which denoted identification but included a judgement based on the beliefs that a person was 'good' or 'bad' which were difficult to overcome. Participants felt that once those judgements were made and the belief that it applied to all members of that group was continually reinforced, the stereotype developed.

In the case of the black Caribbean male and sexual decisions, what emerged in the data was that the participants believed that the sexual decisions of these men were perceived in society as being uniformly bad and this was an inherent part of what made it a stereotype in the minds of participants. The stereotype of black Caribbean men was therefore epitomised by participants as being predominantly negative and arising out of a general belief that black Caribbean men had an irresponsible attitude to sexual activity and sexual relationships:

I think people's attitudes to us is a key thing. Judging us before they know who we are. In terms of sexual behaviour it's got to be the stereotype cos that's what a lot of the judgements are based on.
(Lonnie, mid 20s, black Caribbean male)

However, in discussion the nature of the stereotype and why it was a black Caribbean male issue, the participants also raised an apparently contradictory point in relation to the stereotype. Some of the participants said they did not recognise it as wholly bad, despite the general consensus to see it as such and said that in some instances it actually had benefits and positive effects:

I think we got to admit it does give us a little edge with the ladies. I mean when we dress good we look sweet, some girls can't get enough. Makes you feel good. Don't it?
(Brett, late teens, black Caribbean male)

Yeh, I admit it. I've had girls come onto me cos I'm Black. Made the most of it too. I think we may as well take some smooth with the rough intit?
(Kris, mid 20s, black Caribbean male)

It appears therefore that despite the recognition of the negative connotations associated with it, the sexual stereotype of Black Caribbean men embodied some positive outcomes for those most affected by it. The existence of positive as well as negative experiences associated with a stereotype is a fundamental part of the traditional nature of stereotypes but is rarely acknowledged. This is an important

point discussed in some of the literature criticising the one-dimensional that is negative way in which stereotypes are often presented (Pickering, 2001).

Recognising the positive aspects of stereotype linking black Caribbean men with sexual decisions is critical to this study as this was identified as one of the unique aspects that identified the sexual stereotype as a black Caribbean men's issue in the minds of some lay participants. The positive aspects of black Caribbean male sexual decisions linked to the stereotype were identified as relating to their sexual prowess and physical attributes:

There's no smoke without fire innit? When you think about it there's got to be some thing for people to say, oh well all black men have big lunch boxes, you know how they always say that they are well endowed, there has to be something for people to have that stereotype.
(Maria, late teens, black Caribbean woman)

Well at least they know what they're doing... not like some of the white guys I've dated.
(Nuala, mid 30s, white British partner of black Caribbean man)

The positive connotations of the sexual stereotype were very specifically discussed in relation to black Caribbean men. The acceptance of some positive aspect to the stereotype did significantly affect the participants views of the stereotype as mainly negative. However, it was seen by some participants as an influencing factor on their experiences of the way the stereotype impacted on the lives of black Caribbean men and their interactions with them. This will be discussed further in later chapters exploring the impact of stereotyping.

4.2.2: Characteristics associated with the stereotype

Having generally agreed that the sexual health decisions of black Caribbean men were predominantly perceived in relation to a negative stereotype, participants went on to discuss the specific characteristics they believed were associated with the negative

stereotype. There was a high degree of consensus in terms of the type of characteristics that participants felt were associated with the negative stereotype of Black Caribbean men and sexual decisions. In all focus groups participants differentiated between characteristics on the basis that some were innate, given and unchangeable while other characteristics were considered to be more social in nature and associated with learned aspects of behaviour.

Innate characteristics were defined by participants as being beyond the control of the individual. Of the innate characteristics identified by participants, the age and gender of the individual was most commonly referred to as a predetermining factor in poor sexual decisions amongst black Caribbean men. The following quotes illustrate the ways in which participants in all focus groups tended to associate youth and being male with poor sexual choices and irresponsibility for sexual health among black Caribbean men:

They're bound to be at highest risk...in some ways its probably not their fault... all those hormones, no real prospects, what else have they got to do?
(Erma, mid 20's, sexual health professional)

Our generation, we've seen certain things happen. The HIV thing, all the bad stuff that can happen, STI's, we've seen it all yeah, we know the effects. I don't think the younger people realise the effects until it comes closer to home to them.
(John, late 30s, black Caribbean male)

Participants did not only associate poor sexual decisions with physical aspects of an individual's identity. As for some other aspects of sexual activity, participants felt that sexual behaviour and attitudes were to a great extent learned through a process of socialisation. The key influences on these learned aspects of sexual activity were identified as being the example set by others, particularly parental influences and the personal experiences of the individual. This in turn was seen as being a reflection of the persons' socioeconomic status, culture and upbringing. Candice, a black

Caribbean teenager, sums up the way in which many participants visualised the links between socialisation and sexual decisions:

The experiences you have make a difference. It's not all decided at the beginning If you live in poorer areas, see your mum struggle as a single parent and never spend time with your dad... its all got to affect your view of life, sex and how things should be.
(Candice, late teens, black Caribbean woman)

In some ways the association made between youth, lower socioeconomic status, being male and poor sexual decisions was to be expected. There is much evidence to suggest that adolescence, a time of confusion, self discovery and physical change is associated with unpredictable behaviour and risk in general(Beier, Rosenfeld et al. 2000; Bennett and Bauman 2000). In addition there is also a wealth of literature documenting that men are less likely to take care of their health or engage in preventative health measures than women and that poverty significantly reduces health chances (Blum, Beuring et al. 2000; Fortenberry, Dennis et al. 2002). Thus the fact that participants were more likely to link adolescence as a stage of development or the male gender and lower socioeconomic status with irresponsible sexual decisions, poor sexual health and decision making is perhaps unsurprising. However, it does raise the question as to whether participants believed these issues only affect the sexual decisions of black Caribbean men or affects them all equally.

Evidence from the focus groups also exposed the way in which stereotypes are used to play down the differences within a group or streamline the range of people to whom it applies. This emerged in comments made by participants about other people to whom the stereotype may be applied. While the stereotype of negative sexual decisions was predominantly related to young, black Caribbean men from lower socioeconomic groups, some participants did identify some of its characteristics as applying to older black Caribbean men, men from different ethnic groups and women:

I think bad behaviour, you know sleeping around and that goes with being young. It's to do with the different expectations men have, with the generation gap weather they be black or white. It's that age thing.
(Frank, late 30s, black Caribbean male)

Bottom line is women do it for their self now, there's women that's controlling the sex thing regardless of what you might think, most menaren't really too bothered about it, young or old, right, it's the women who are into the sex market at the moment, it's women who want sex 24-7 and want it now!
(Nuala, mid 30s white British partner of black Caribbean man)

What was interesting about these examples however was that participants acknowledged that poor sexual decisions were not exclusively practiced by young black Caribbean men. However they still attempted to justify their belief about black Caribbean men's increased risk using stereotypical images and stopped short of exempting all black Caribbean men from an exclusive association with poor sexual decisions. In this quote, Sharlene responds to the earlier comments made by Nuala (see above) and attempts to explain why she thinks some women also seem to be acting less responsibly in relation to sexual encounters

But I also think, to counteract what Nuala was saying, is all the women behaving this way and reacting this way because they're finding themselves and they're empowering themselves or is it because of the way they've been treated socially?
(Sharlene, late 20s, white British partner of black Caribbean male)

The use of qualifying statements to explain in individual terms why person or group not associated with the stereotype exhibits characteristics associated with it, yet is not stereotyped is reported in the literature (Pickering 2001). The examples given also expose another way in which this particular stereotype is similar to others in that it embodies many contradictions one of which is the attempt to portray the individuals to whom it relates as a homogenous group even if this means continuously modifying the parameters for inclusion or exclusion as necessary.

Hinton (2000) discusses how the illusion of homogeneity associated with stereotypes is often preserved by highlighting idiosyncratic flaws in someone not belonging to the stereotyped group exhibiting those characteristics. In the same way examples of the same decisions in non-stereotyped groups are explained or excused on the basis of a contextual reaction or temporary occurrence. The issue of homogeneity of the stereotype of black Caribbean men will be explored further in the next two categories but is raised here as underpinning participants' strategies for maintaining a sense of the stereotype as they perceive it and managing the examples which do not equate with their definitions.

4.2.3: The universality of the stereotype in black Caribbean men

The persistent associations of the stereotype of poor sexual decisions with black Caribbean men raised the question of whether participants believed the stereotype applied equally to all black Caribbean men. The responses to this question revealed further contradictions in the way participants made sense of the stereotype and justified its association with black Caribbean men rather than other groups exhibiting the same behaviours. This was evidenced in the way participants discussed the 'truth' of the stereotype, how far did beliefs about it apply to all black Caribbean men? Participants were asked how universally they felt the stereotype reflected the way in which black Caribbean men were perceived in terms of their sexual activities. In response the vast majority of participants believed on the one hand that the stereotype was an accurate representation of the sexual health decisions of black Caribbean men, but on the other, did not believe it applied equally to all black Caribbean men.

These apparently contradictory statements were justified using the same parameters that had previously been cited by participants to explain the characteristics of the stereotype itself which associated black men with sexual behaviour. It has been previously outlined above that the characteristics associated with poor sexual

behaviour and the stereotype included age, socioeconomic group amongst others. Participants used these definitions as a basis to explain why the stereotype was not equally applicable to all black Caribbean men:

I think there is a class system going on, you hear black people talking about black people and niggers... a term used for certain types of black people... Chris Rock... this term is being banded about about ghetto people... It is interesting because people are jostling for position in the black community now in the way that if you read the history of Britain, it happened between the classes then...

(Nova, late 30s, black Caribbean woman, partner of Black Caribbean male)

I think nowadays a small handful are getting better and they are breaking the stereotypes and they are becoming more professional, they do want to stay within a family unit but I think the majority of them don't.

(Felicity, mid 20s, black Caribbean woman)

This differentiation raises two interesting points. The first concerns the nature of the stereotype itself and the almost contradictory use of heterogeneous general characteristics to specify the type of Black Caribbean male associated with a stereotype, which by its very nature requires that those who are stereotyped are presented as homogenous. It is interesting to note that despite accepting that not all black Caribbean men act irresponsibly in relation to sexual health, that none of the participants commented on this as sufficient evidence for them to discount the stereotype as inaccurate and reason to remove some black Caribbean completely from being included in it. They appeared happy to acknowledge the distancing of older, professional, married black Caribbean men from the worst aspects of stereotypical behaviour, but stopped short at excluding them from it all together.

The second point concerns the underlying message emerging from the data. In highlighting the differentiation between black Caribbean men and their proximity to the stereotype, what begins to emerge is the way in which the stereotype may possibly

be undergoing a process of change as a result of more open recognition of changes occurring within the black Caribbean community. In many of the focus groups involving black Caribbean participants, the emerging changes and differentiation amongst black Caribbean communities in relation to social stratification and economic differences was often commented on:

Things are more complicated now. We are not all suffering together. you can look in our community, you can look at people in the community and you can see that they're not all roughnecks, that they're different from each other, that they have their family, and they're educated... .its not the same for us all and all this has to be taken into account.
(Monica, late 30s, Black Caribbean woman)

This second point is an extremely interesting and to date has received little attention in the literature concerning sexual stereotyping or sexual health. It must be noted that these issues emerged almost as a bi-product of the discussion on Black Caribbean men and sexual decisions. They therefore were not explored fully however aspects of them will be included in later discussions in this study as they add some illumination to many of the comments made by participants about the impact of living and managing the stereotype. They also in themselves highlight an area for possible further investigation in future.

The regularity with which generalised characteristics such as youth, gender and lower socioeconomic group were specifically identified as epitomising the sexual stereotype of Black Caribbean men, combined with participants linking poor sexual decisions to other social groups, raises the question how accurate is the stereotype? Why and to what extent is the negative sexual stereotype still just a Black Caribbean male issue rather than just youth, male or poverty issue?

4.3: The negative sexual stereotype as a Black Caribbean male issue

In the focus groups participants, irrespective of their relationship with black Caribbean men felt that the negative sexual stereotype was an issue for black Caribbean men. However, as detailed in the discussion above, this did not stem from a belief that only black Caribbean men were irresponsible in their attitudes to sex, took risks with their sexual health or were unique in their approach to sexual activity. Rather what emerged from the discussions was the belief that participants felt that black Caribbean men were in their experience, more likely to exhibit the characteristics associated with poor sexual decisions or had experiences which participants identified as increasing the likelihood of sexual risk taking:

Sometimes it seems they are everywhere. Moving from one woman to the next, playing the field... no control.
(Louise, late 30s, black Caribbean woman)

Well I just think it's more likely to happen to us than other men... you know all the stuff that affects how you see sex and relationships. The bad stuff I suppose. We're more likely to have had experiences, having to struggle, the things that make you think its ok to act in a way that actually puts you at risk.
(Ivan, late thirties, black Caribbean male)

What was noted in the comments made by participants was that for them the association of black Caribbean men with the sexual stereotype was justified on the basis of evidence of degree and frequency, rather than exclusivity. This illustrates another interesting point about stereotypes in that they are often used as if they are applicable only to specific groups (Aral 2002). However, as suggested in this study, the stereotype may in reality be acknowledged to have general applicability, but be justified as relating to only one group on the basis of evidence other than having unique association or exclusive characteristics.

In response to the question 'what makes the stereotype particularly a black Caribbean man's issue?' participants offered a range of evidence to illustrate the 'truth' of the

stereotype and the strength of its association with black Caribbean men and sexual decisions. Both professional and lay participants felt able to justify through their own experiences their belief in the existence of both innate and learned characteristics which increased the risk of a black Caribbean man engaging in poor sexual decisions associated with the stereotype and so justifying their continued association with it.

There was some differentiation noted in the explanations given for the links between black Caribbean men and the stereotype by the different focus groups and their respective participants However, the basis of their beliefs, the explanations given and the evidence provided also revealed varying degrees of contradiction in the associations made and dilemmas for those participants making the judgements. For this reason the views of the sexual health professional and lay participants will be presented separately in the first instance so that the similarities and differences may be noted.

4.3.1 Sexual health professionals' views

Professionals working in sexual health commented on the disproportionately higher rates of sexually transmitted infection amongst black Caribbean men as justification for their beliefs. The information they referred to came from both the epidemiological data collated at their own place of work and from their knowledge of national statistics published in the professional and academic press. The sexual health professionals felt that the statistics were an accurate and true reflection of the level of sexual risk taking amongst black Caribbean men:

Well the stats don't lie do they... we know from the number who come here... and its not just a one off... most of the black Caribbeans are here repeatedly. They never seem to learn. (Ethel, late 30s, sexual health professional)

They come here after all. Although I do have to say that most of them don't come willingly, they are contact traced. But they still come and get treated and that's what counts. But you can tell from the

infection rates that they don't come early enough or don't really learn from the experience... otherwise there wouldn't be so much reinfection.
(Janet, late twenties, sexual health professional)

In addition, as illustrated by Ethel's quote, many of the sexual health professionals did not solely rely on the statistics, but further justified their belief in the reported statistics on the basis that their personal observations at work. These observations often referred to a wider range of issues related to sexual health decisions including condom use, attitude to sexual health in general and the decisions of black Caribbean men as service users:

And they would seek treatment more so than white boys I think, from seeing it, only seeing it what I see in clinics and it's not, it is a big clinic but...I do feel that the young black guys are not first of all afraid to come, seek help
(Erma, mid twenties, sexual health professional)

In discussing the behaviour of black Caribbean men when they used the sexual health services, professionals often referred to their personal feelings about black Caribbean men and how the men reacted to them as sexual health professionals. They described how they often judged the reactions and actions of black Caribbean men in relation to the stereotype and subsequently referred to this as expected or typical, providing further evidence of the veracity of the links they made between black Caribbean men and poor sexual choices:

I know I am more wary with black Caribbean men. I expect them to be less honest about their relationships. I try not to let it show, but sometimes it creeps up on you doesn't it, you can't help it?
(Cath, late 20s, sexual health professional)

Here, Trudy, a sexual health professional in her late twenties, talks about how she struggles with the attitude of black Caribbean male clients towards women.

I do find, and this again is generalisation because you'll always find the white equivalent, that they're quite disrespectful about women and I struggle with that. I mean obviously I've got to keep a neutral stance but it's the woman's fault that they've got this infection, it's nothing to do with them and what they do, they seem to struggle with taking responsibility for that.
(Trudy, late twenties, sexual health professional)

Trudy's comments are interesting because they also highlight the awareness expressed by some professional participants about needing to separate their personal beliefs from their approach to black Caribbean clients. This was often based on an acute awareness of the fact that the stereotype as they perceived it was not an adequate basis on which to base a professional judgement. Many of the sexual health professionals voiced their concerns about this but felt they had little else to rely on in trying to fulfil their professional role with this social group.

The problem is there's nothing to rely on. I'd like to see the facts but you're left trying to make sense of what other people say and what you hear... ..that's not very good, but you have to rely on something... there's nothing else.
(Trudy, late twenties, sexual health professional)

Sometimes it's difficult. I have a black partner and I have to go home after seeing other Black men who are behaving so badly... I know they are not all like that, but it'd hard not to get sucked into believing the hype when you deal with it every day.
(Ingrid, mid 30s sexual health professional)

In the quotes above, both Trudy and Ingrid revealed the personal dilemma many of the participants felt in using what they personally believed to be an inadequate or inappropriate frame of reference to inform their professional interactions with black Caribbean men. This feeling of unease with the use of the stereotype in professional circles was a recurring theme in the comments made by many of the professional participants and reflects the association of contradiction and tension with use of

stereotypes as well as definitions of them. This point will be returned to later sections in discussing the impact of living with the stereotype and managing its effects.

What all these examples have in common is the way in which participants justified their use of the 'evidence' that black Caribbean men were sexually irresponsible and rightly associated with the stereotype by referring to the number of men they believed acted in this way. For the professional participants, the number, or degree of poor sexual decisions amongst black Caribbean men was not just purely referred to in terms of use or attendance of sexual health clinics. They also referred to what they perceived as the abundance of examples of the consequences of sexual risk taking in the black Caribbean communities as justifiable evidence of the association of black Caribbean men with poor attitudes to sex and behaviour.

In referring to evidence of the links between the stereotype and the black Caribbean male, sexual health professionals spoke about the number of single mothers or the number of children born to black Caribbean men as an indicator of the negative attitude of black Caribbean men to relationships:

LSG : Where do you think that stereotype is sort of most you know, have you had, where have you sort of seen or heard that kind of reflected? Films did you say?

Harriet: No, I didn't say anything actually! (laughs) erm, possibly actually I would say by erm the girlfriends of black afro-Caribbean men and comments made by them. And the fact that you know erm, a lot of them do have a lot of children, a lot of black afro-Caribbean men have got a lot of children.
(Harriet, early 40s, sexual health professional)

What was interesting about the comments made by the sexual health professionals were the reasons they gave for the high numbers of single mothers and sexual partners of black Caribbean men. There was some suggestion from the focus group involving sexual health professionals that the expectations other people had of the

black Caribbean men, based on the stereotype played an important part in their sexual decision making. In some ways, sexual health professionals participants believed that because black Caribbean men were expected to act irresponsibly, not use contraception and have multiple partners, they were perhaps less likely to do so:

That's it. And how do the young afro Caribbean break away from that, erm, stigma that you know, (group talk together) yeah, you know, how they're seen as guys who date rather than high risk takers. Do they all you know, would it be seen as being uncool if they did take precaution.
(Fiona, mid 30s, sexual health professional)

I think it's the young guys, erm, it's like a machismo thing sometimes as well, you know, they're almost living up to that stereotype (group talks together) you're not a real man unless you've had this many partners so it's almost like you put it about to live up to that. And weather they do, maybe they don't even have that many partners but they're gonna tell you (laughs) I'm not saying it's true but if there is a stereotype and it is you know, men want to be seen as men and it can be quite macho.
(Trudy, late twenties, sexual health professional)

The impact of expectations on perceptions of a stereotype has been commented on in the literature, particularly in terms of the way stereotypes act as a self fulfilling prophecy (Abrams and Hogg 1999). As a self fulfilling prophecy, the stereotype simultaneously provides the yardstick against which decisions are judged and forms the basis for actions which encourage the stereotype (Hinton 2000). This is observed in this study in the way that the sexual health professionals questioned how easy it would be for black Caribbean men to act differently to the stereotype when there was a great deal of pressure to act in stereotypical ways.
It's hard isn't it? It's hard. The stigma to any colour or creed or sexuality. How are the young afro Caribbean's going to change this when they tend to be always perceived as this. Because they've got to go the same way, they can't break the pattern.
(Fiona, early thirties, sexual health professional)

You don't always realise that you've taken it in. I was with a black client when he said something and I remembered I'd seen that programme 'Babyfathers'[2] *and I thought you're just like that man on the telly, no respect for yourself.*
(Harriet, early 40s, sexual health professional)

The examples given above reflect the range of evidence provided by sexual health professionals participating in this study to justify their beliefs that poor sexual decisions remained associated with stereotypes of black Caribbean men rather than other ethnic groups. In general the issues raised as evidence of the why the sexual stereotype was an issue for black Caribbean men were not only expressed by sexual health professional. Many of the comments were also reiterated by the lay participants in the study. The lay participants comprised black Caribbean men, black Caribbean women and partners of black Caribbean men.

4.3.2 Lay participants' views

In common with the sexual health professionals, lay participants also justified their beliefs that black Caribbean men were less responsible sexually by giving examples of the numbers of black Caribbean men they knew who had multiple partners or children outside marriage:

Sometimes it seems they are everywhere...moving from one woman to the next, playing the field... no control.
(Louise, late 30s, black Caribbean woman)

Like someone said earlier, we all know men who live like that. If we didn't, there'd be no proof. We stand out, can't blend, well only in Inner Street... .so its obvious we're going to be noticed and if you look there what you see is lots of guys standing around. Lots of young girls pushing prams, and that's what they see. They put it together with the stuff they see like we said and bam... stereotype city.

[2] Six part national drama about black Caribbean men and their lives broadcast prior to study

(Dennis, late twenties, black Caribbean male)

One of the strongest messages emulating from the discussions with lay participants was the way in which some of the aspects of sexual decisions which bound black Caribbean men to negative sexual stereotypes were believed to be learned through social and personal experiences rather than pre-existing within a persons identity. Participants gave many examples to support these beliefs and identified the lack of positive male role models during the formative years as being of particular importance in determining attitude to sex and decisions. This comment by Adam, a young African Caribbean student, is typical of the experiences shared by other Black Caribbean men in the study :

Me and my mates... none of us saw our dads... well if we did our mums wee fighting with him...I know who he is but that's all. Learned about sex from my mum... bit embarrassing that... When you're Black and a boy you need someone to look up to, show you how to go on. Its more important to you I think than for the girls... all I learned from my dad was how to play around.
(Adam, late teens, black Caribbean male)

There have been some studies conducted outside Britain which have highlighted some association between role models and sexual risk taking (Beier, Rosenfeld et al. 2000; Blum, Beuring et al. 2000; DiClimente, Wingood et al. 2001). However, these studies do not really comment on whether the importance of role models to sexual decisions and attitudes was only related to the generation of study participants. In this study unlike the sexual health professionals who in general felt that the poor sexual decisions they witnessed was related to a lack of role models at the current time, lay participants expressed varying views about whether role models had been important in the past. Some believed what they witnessed was a lack of control or irresponsible attitude in the younger generation while others saw it as something longstanding within the black Caribbean community but had previously been little talked about outside the black community:

Well like the [reading] my dad certainly wasn't irresponsible he didn't abandon his children ..the parents seem to... like we were all brought up in a family unit with both parents but today you see a lot of single parent mothers, more than you did, well, twenty years ago.
(Chrystal, mid 30s, black Caribbean woman)

Well I can't remember everything people said but I do remember the guy talking about his dad running round town and what his mum said about him. To be honest I think the groupuere being quite open about it. My dad ran round here and there too. In a way it was part of life... I agree with most of the people in there, we saw it and just accepted it. Didn't really question it cos everyone we saw or knew was doing the same.
(John, early 40s, black Caribbean male)

The fact that the stereotype and sexual decisions of black Caribbean men inside the black Caribbean community had remained unspoken about to a great extent may account for the differences noted in the professional and lay participants views about the relative time over which stereotypical behaviour had occurred.

The literature on stereotypes has recently called for researchers to move away from investigating the nature and use of stereotypes using only present terms of reference (Pickering 2000). Some authors have suggested that in separating the past from the present use of stereotypes many opportunities to understand of how changes in stereotypes occur or how people make sense of them may be lost (Brah 1996; Hinton 2000; Kempadoo 2001). In this study some references were made by the lay participants to the historical links between black Caribbean men and poor sexual health decisions. Many of the lay participants who expressed that association with the stereotype was longstanding said it had changed over time but remained associated with colonial stereotypes of the black African male as sexually dangerous and uncontrollable. The black Caribbean participants in particular felt that the negative stereotyping of black Caribbean male observed today was closely related to the labelling of the African male during slavery:

It also relates to what they see us doing, surely, I mean if we weren't messing about then people wouldn't be able to say we were... I mean when I say we, I don't mean us here, just in general. But I think it is noticeable when you look around that some Black men are taking the piss.
(Carl, early 20s, black Caribbean male)

In choosing to act in the ways outlined above, the decisions of some black Caribbean men was perceived by lay participants as further stereotyping all black Caribbean men and those involved in the sexual encounter.

Concluding comment

Analysis of the data from the focus groups and interviews conducted during the data collection phase the stereotype of black Caribbean men as sexually irresponsible and risky emerged the most persistent feature influencing the sexual health encounters of black Caribbean men and their partners.

Stereotypes have long been established as an important tool in cultural analysis particularly in the investigation of labelling and discrimination in society. However, the literature about stereotypes has been criticised for the lack of attention given to clarifying the nature of the stereotypes under discussion. This is important as stereotypes are often ambiguous, containing contradictory elements and as such a shared understanding of what a particular stereotype entails cannot be assumed (Pickering 2001). In order to understand how a particular stereotype is made sense of in society and the impact they may have on the lives of individuals, it is necessary to identify and the basis from which investigations take place. This chapter has sought to present the participants' views concerning the sexual stereotype associated with black Caribbean men and their sexual decisions.

During discussions participants spoke about a range of characteristics they believed were associated with poor sexual decisions in general and black Caribbean men in particular. These characteristics included aspects of an individual which were innate,

such as gender, age and ethnicity, as well as socially determined influences such as socioeconomic group, culture and up-bringing..

In general participants believed that black Caribbean men were not uniquely associated with poor sexual decisions in so much as this could be witnessed in other ethnic group, in the decisions of women and people from more privileged backgrounds. Both lay and professional participants surmised that it was the fact that black Caribbean men were perceived as being more likely to demonstrate the characteristics associated with poor sexual decisions that reinforced their association with the negative stereotype. A key issue to evolve from this chapter was that it it was the frequency with which black Caribbean men were associated with irresponsible attitudes to sexual activities and participants' familiarity with the way Black Caribbean men were linked with the stereotype, rather then the exclusivity of the association which made it a black Caribbean male issue.

One of the important factors in the way lay participants recognised and made sense of the sexual stereotype of black Caribbean men were through links made between their experiences, the expectations of society placed on them and the colonial stereotypes of the black African male. It appears from the participants in this study that far from being a thing of the past, colonial stereotypes do matter and play a significant part in influencing sexual interaction and decision making.

Professional participants working in sexual health services mainly utilised their knowledge of statistical data as a starting point for justifying the, links made with black Caribbean men and poor sexual decisions. However, they too said these beliefs were reinforced through their own observations both within their professional roles and observations in the wider society.

Both lay and professional participants across all ethnic groups, agreed that the stereotype did not apply equally to all black Caribbean men. They referred back to the general characteristics they had identified as being associated with poor sexual

CHAPTER FIVE

LIVING WITH THE STEREOTYPE

Introduction

The stereotype of black Caribbean men that emerged from the focus group discussions and interviews was one in which black Caribbean men and their sexual decisions were almost inextricably associated with irresponsible attitudes and risky sexual activities. While providing some much needed information about the nature of the stereotype associated with black Caribbean men, this alone does little to illustrate what impact it has on their lives and sexual decisions. The identification of the stereotype related to black Caribbean men in the study leaves some questions unanswered. For example it gives no indication of how the stereotype affects the sexual decisions of black Caribbean men and whether any impact is restricted to sexual encounters. In essence it does not address the question of how black Caribbean men and other key players in their sexual health manage to live with the stereotype.

To address these questions, the discussion proceeded beyond description of the stereotype to consider the process by which they are applied in society. Stereotypes described out of context cannot give a full account of the role they play in relation to a particular issue. They need to be actioned or applied through social interactions, political decision making and other strategies in order to have some impact in society (Forgas and Williams 2001). In order to begin to understand the relevance to a particular group or specific subject there is a need to discuss stereotyping as an active social phenomenon and as such explore its impact within the social context in which it takes place. This chapter 'living with the stereotype' attempts to clarify some of these real concerns.

The social context in which many personal decisions often take place suggest that sexual health decisions may impact on the lives of others as well as the particular individual involved. This was evidenced in this study where key players discussed their own experiences of the impact of the stereotype and how their relationships with black Caribbean men were often affected by the assumptions made about black Caribbean men and their sexual activities.

The chapter therefore incorporates the experiences of black Caribbean men as central to the debates alongside those of black Caribbean women, sexual health professionals and the partners of black Caribbean men as key players in their personal and sexual relationships. The experiences of key players are included in recognition of the fact that sexual decision making does not take place in isolation but is affected by the actions and perceptions of others (Harding 1998; Fortenberry, Dennis et al. 2002).

Utilising the definition of stereotyping given in the last chapter as a starting point, this chapter explores how the beliefs associated with the sexual stereotype of black Caribbean men influenced and was used to justify the conduct of black Caribbean men and other key players in their sexual health. This is achieved by firstly illustrating how the sexual stereotypes of black Caribbean men are applied to and experienced in the lives of black Caribbean men. It will then go on to consider how the action of stereotyping black Caribbean men's sexual decisions affected the lives of participants beyond their sexual encounters. Finally the chapter will conclude with consideration of the strategies used by participants to manage the effects of the stereotype in their lives.

Table 3 identifies the issues associated with the theme 'Living with the stereotype'.

THEME: *LIVING WITH THE STEREOTYPE*
5.1: Participants' perceptions of the stereotyping of black Caribbean men
5.2: The impact of stereotyping on the sexual health of black Caribbean men
5.2.1: *Views of black Caribbean men*
5.2.2: *Views of key players*
5.3: Strategies for managing the effects of the stereotype
5.3.1: *Acceptance*
5.3.2: *Challenge*

Table 3: Issues addressed in theme 2 'Living with the stereotype'

5.1: Participants' perceptions of the stereotyping of black Caribbean men

During discussions with participants sexual stereotyping of black Caribbean men was epitomised as an inescapable fact of life. It was identified by all participant groups as influencing the perceptions, approaches and judgements of other people about black Caribbean men as well as their own interpretations of themselves:

As I said when you look at it black men are blamed for all sorts of things by all kinds of people both in the community and out. I'm sure if you looked at white communities there would be just as many examples there of people having affairs and men sleeping with other women, but the black guy stands out. Perhaps we're looking for it so we notice more, or perhaps we just grow up expecting it.
(Stella, mid 20's black Caribbean woman)

The black Caribbean men in the focus group described how it was difficult for them to avoid the way they were stereotyped on a daily basis. They provided examples of how the stereotype permeated their personal relationships and the assumptions others made about them and their sexual activities.

Well it's just that thing of not being able to escape. No matter what I suppose. Its something that you live with as a black man. Some are more aware than others but I think we all know it.
(Carl, mid 20's, employed black Caribbean male)

It's always there hanging over your head like a cloud when you meet someone new. I had it where I've been seeing a girl and when her friends meet me they're like, nudge, nudge, some of them don't even hide it, they just make comments to me or my girlfriend. He must be good at it, I just laugh most of the time. It's a pain, a. real pain
(Lonnie, mid 20s, black Caribbean male)

The above examples illustrate the ways in which stereotyping of black Caribbean men was experienced almost as a constant presence in the lives of participants. This is an important aspect of stereotyping and its impact on those who are stereotyped. The literature highlights persistence and constancy as inherent parts of the effectiveness and process of stereotyping (Robinson 1998; Mac an Ghaill 1999). In order to have an impact stereotyping must therefore be able to impart a sense of 'normality' about the stereotype with which it is linked. Stereotyping thus helps to reinforce acceptance of the truth of the stereotype and establish use of it as a basis for judgement as an 'understandable' or 'normal' process (Hinton 2000).

The success of the process of stereotyping in achieving this 'normality' in relation to black Caribbean men and sexual health is epitomised by the way in which it occurred almost undetected in participants' experiences. One of the issues that emerged out of the discussions about the inescapable aspects of stereotyping was the fact that participants did not always apply stereotyping consciously. There was evidence to suggest that the stereotyping of black Caribbean men occurred almost without any conscious thought or intent. On reflection of the way in which they had experienced situations where stereotyping had occurred participants described how they often stereotyped black Caribbean men unknowingly. For some of the key players it appeared that they only became aware of their tendency to stereotype black Caribbean men during the focus group discussions:

I think it makes you think, and I think as much as we all think that we are completely non-judgmental and you know I have been working here for a number of years and I certainly consider myself to be, but you cannot help stereotyping people. I think that's something as a result of that, that meeting made me think about when we get black afro Caribbean men in we automatically assume that they have more than one partner and I didn't think that's something that I did.
(Janet, late 20's, sexual health professional)

The comments made by participants regarding how unaware they were of their role in stereotyping gives some insight into how well the stereotyping of black Caribbean men has been incorporated into society. It also raises the issue that even when individuals are fully aware of a stereotype and accept that it is not an acceptable basis for judging others this does not always prevent the use of the stereotype. This point is commented on in the literature on both health behaviours and stereotyping. In both these areas some authors have criticised strategies which adhere to belief that knowledge and awareness alone are sufficient to bring about change and stop the use of the stereotype itself (Niven 2000; Pickering 2001). Thiswill be discussed further later when considering the consequences of the findings for sexual health professionals.

In the last chapter 'The nature of the stereotype' participants referred to their belief that the stereotype of black Caribbean men had existed for a long period of time. In some cases this was linked back to colonial images of slavery. The feeling that black Caribbean had been associated with poor sexual decisions for a substantial amount of time was carried forward in participants' perception of stereotyping as a process. As with the stereotype, they felt this arose from a combination of historical and present day influences and contributed to what they described as a feeling of permanency in the process of stereotyping as well as the stereotype itself:

People have made an issue of black men's sexual behaviour since slavery. Even today we see books, TV programmes and stuff about it. It's here to stay, always has and probably

always will be.
(Bobbie, late 30s black Caribbean partner of black Caribbean male)

This feeling that the stereotype is to a greater or lesser degree an established part of society and life in general is a key characteristic of the way in which stereotyping works to reinforce the idea that the stereotype is fixed and unchanging. This has been described as one of the central dilemmas in stereotyping (Pickering 2001). By working to present the stereotype as fixed stereotyping at first appears to work very much as categories do in trying to impose a sense of order. However, one fundamental difference is that stereotyping tries to do this without allowing any flexibility in thinking about that category (Leyens, Yzerbyt et al. 1994). However, it is often in trying to present that stereotype as inflexible that the problems of stereotyping and contradictions in the stereotype are most exposed (Costano, Paladino et al. 2002). In relation to this study participants progressively found it more difficult to justify the characteristics of the stereotype they had described and its association with all black Caribbean men when they tried to relate it to real life experiences:

I think in the men's clinic from working with the young lads anyway, I don't really see the young afro Caribbean's being any less responsible from the white ones, cos erm, when I was down there I did just like, it was just a head thing, and I counted how many white youths and how many black afro Caribbean's asked me for condoms in a week, and more afro Caribbean's asked me. so I'm not sure if that stereotype about condoms applies now.
(Lorraine, mid 30s, sexual health professional)

I remember thinking that was, you know, should we say that it's the younger ones, all young lads. Because I don't think it's, I didn't think it was just afro Caribbean clients who had, who act irresponsible, I found it all young lads.
(Trudy, late 20s, sexual health professional)

The quotes above suggest that participants were aware that contradictions to the sexual stereotype occurred all the time as witnessed through social events, personal

experiences and changes in society. This knowledge existed in direct contrast with the relatively inflexible way in which they had described the associations between black Caribbean men and the nature of stereotype in the previous chapter. Problems arose once participants tried to use a fixed notion of the stereotype to justify the stereotyping of black Caribbean men and their sexual decisions. The inflexibility imposed around the stereotype of black Caribbean men and sexual health decisions had the effect of exposing further the dilemmas and contradictions in the stereotype itself and its application in practice.

The dilemmas and contradictions exposed not only in the stereotype itself, but in the stereotyping process in which it is used, raised the question of what role participants felt stereotyping played in society. If the stereotype cannot be used without raising concerns as to its accuracy or applicability to black Caribbean men, of what use was it?

To some participants the stereotyping of black Caribbean men had a social role to play, providing society with someone to 'blame' for the problems associated with sexual health. Participants felt that this also provided some of the incentive for it to remain:

Yeh, suits them to make us look bad, means they don't have to deal with what's really happening. I mean it ain't just us that's doing them things. Having kids and playing around. But like my man says, they just want to point the finger at us, someone to blame. It's not like its nothing new, painting us bad. Not like this is the only time it happens.
(Brett, late teens, student, black Caribbean male)

The use of stereotyping as a labelling tool to attribute blame and identify others as risky or untrustworthy is well documented (Bhabha 1992; Estes 2000; Blair, Judd et al. 2002). The stereotyping of black Caribbean men however goes beyond descriptive categorisation and helps to establish and reinforce a particular view of society and the evaluation of black Caribbean men as a social groups within it (Kempadoo 2001). In

this case the view of black Caribbean men perpetuated is of an irresponsible and risk taking group of people.

Leyens *et al* (1994) said that stereotyping did not occur for its own sake but was practiced in society because it was useful. His comments have been supported by other authors who say that the judgements made as a result of stereotyping often reflected the norms and values of the society in which they were made (Mama 1995; McGrath 1998; Kemshall 2002). This was reflected in the comments made by participants who believed there was still an aversion to accepting sexual activity as normal and enjoyable. There needed to be a warning, a risk element to it and irresponsible black Caribbean men, fears about sexual infections and unwanted pregnancy fulfilled that role:

Like I said before we're bad news. Someone has to be the problem and I think we're it. Not that it's true but everyone acts like it is. Makes them feel good about themselves, there's always someone else to look down on. black men and sex, we're the scapegoats.
(Harry, teenager, unemployed black Caribbean male)

The social role played by the sexual stereotyping of black Caribbean men was seen by participants as linked to the stereotyping of black Caribbean men in general. A few of the participants felt that black Caribbean men were likely to be stereotyped as risky, dangerous and irresponsible by society in relation to a whole range of issues. Participants gave examples of the links made between black Caribbean men and violence, crime, and lack of educational achievement to illustrate their points:

It's there when you talk about schooling, violence, anything that goes wrong really. black youth is bad news... that's the deal. We all know the score. We grow up with it.
(Mostin, mid 20s, employed black Caribbean male)

The issues raised by participants concerning the fact that stereotyping in general worked to establish black Caribbean men as problems in society illustrate another

reported characteristic of stereotyping as a vehicle for reflecting power relations in society (Pickering 2001). In this way stereotyping results in the marginalisation or subordination of one group while simultaneously reinforcing measures of normality and dominance in relation to a particular issue (Pratto and Espinoza 2001). Some of the black Caribbean participants concurred with this view and pointed out that linking black Caribbean men with 'badness' was almost expected. They perceived stereotyping as a way of maintaining a negative view of black men as members of society in general and as sexual beings in particular:

No man too easy to put us down, get more publicity that way. Who's going to watch a programme or buy the paper if all is says is black men are doing great?
(Frank, late 30s, self-employed black Caribbean male)

Overall then the sexual stereotyping of black Caribbean men was perceived by participants as operating in much the same way as other stereotypes have been reported in the literature. It contained many dilemmas and contradictions of its own not least the fact that despite presenting it as based on a stereotype with discernable characteristics, participants were not always aware of their use of it and occasionally had difficulty in rationalising its use as a basis for their judgments. However, the key issue in the way stereotyping was described by participants was in the perception of it as 'inescapable, inevitable and permanent' by participants. This raises questions concerning how participants lived with the stereotype or effects of stereotyping on a daily basis and how it affected their sexual health.

5.2: The impact of stereotyping on the sexual health of black Caribbean men

In discussing the stereotyping of black Caribbean men it emerged that for participants in this study the inclusion of a judgement was a key factor in determining the potential impact of the stereotype on black Caribbean men. The judgement in this case was that the sexual health decisions of black Caribbean men were predominantly bad. This next section of the chapter explores participants' views as to the impact that

this predominantly negative judgement of black Caribbean men had on their sexual health and decisions.

The literature on both health behaviours and stereotyping includes articles discussing the impact of beliefs on health and decision-making (Niven 2000; Watson 2000). There is also a great deal of literature discussing the influence of beliefs about the risks associated with an activity on general health activities (Rosenthal and Moore 1994; Lupton 1999; Robin, Brener et al. 2002). However, there are few studies in the areas of sexual health which consider the impact of sexual stereotypes on health decisions from the perspective of the people and groups at the centre of the stereotype. Of notable exceptions are the works in the area of HIV/AIDS (Crepaz and Marks 2002; Valdiserri 2002). In seeking to explore the impact of sexual stereotyping on heterosexual male sexual decision making based on ethnicity however, it was not possible to find any similar inclusive studies where ethnicity was the primary focus and the study included the viewpoints of members of the specific ethnic group.

5.2.1 Views of black Caribbean men

Very early on in the focus group discussions with black Caribbean men about the way in which they were stereotyped and the impact this had on their life, participants discussed how they first became aware of the stereotype and the negative beliefs associated with it. The process of becoming aware of the stereotype was important as it had a great influence on the way many of the black Caribbean men approached their sexual decisions and their perception of how others perceived them.

Researchers in stereotyping highlight the importance of having some idea about how the concept of a stereotype was first formulated and then applied to a situation as this could assist in making sense of the contradictions and dilemmas which are part of the stereotype and the process of using it (Culley 1996; Culley 1997; Brah, Hickman et al. 1999). While many of these authors were referring to the development of the concept

of a stereotype on a societal or theoretical basis, this is equally applicable on a personal and individual basis in this study. The process by which participants became aware of the stereotype formed part of the context in which they formed an idea of what the stereotype entailed and subsequently the basis on which discussions about the impact on their sexual decisions developed.

Many of the black Caribbean male participants said they first became aware of the stereotype and its association with sexual activities in their early teens. For most of the black Caribbean men the process of becoming aware was signified by a particular event or experience. Many of them spoke about how during their teens they began to question sexually related events that had occurred in their families particularly related to their fathers:

I mean it wasn't just my dad, loads of people's dads did it. Some times you knew about it and sometimes you didn't. But as you get older, you make sense of a lot of things that didn't really click when you're a child.
(Ivan, late thirties, married, black Caribbean male)

The significant issue in the comments made by these participants was that generally the events they recalled were perceived as being normal and commonly occurring in their experiences and that of other black Caribbean men. As such the events identified as being of significance were described in terms relating them to an awakening or coming to a realisation about their world rather than a unique experience.

For some of the participants the experiences which triggered this awareness did not happen to them directly. On occasions the participants recalled the witnessing the experiences of others either in person or portrayed through the media and the impact this had on their own viewpoints.

Ernie, a Young black Caribbean male in his late teens described how he had watched a programme about absent fathers at the age of 13 and began to make comparisons between the characters on the screen and his own experience:

All the time they were talking about men walking out on their families, no cares, no responsibilities, and I began to wonder why they all seemed to be black men just like my dad and [name] *dad, in fact most of the kids I knew. Well black kids anyway.*
(Ernie, late teens, black Caribbean male)

In this comment, Kris talks about his experiences in the early eighties as a young boy and how his perception of comedy programmes involving black Caribbean men was affected by an off the cuff comment by a significant family member:

I used to laugh at them programmes showing black men, you know, players, running from one woman to the next, trying to keep from getting caught, then my granddad said, 'them just like you father'. Then it wasn't funny no more
(Kris, mid 20s, employed, black Caribbean male)

The common issue illustrated in the previous two comments is that for some of the black Caribbean men their awareness of the stereotype arose out of a realisation that this 'entertainment' was not fictional but a reflection of real life, their life. This issue has also been noted in research reporting the reaction of African American students to representations of black people in the media (Richeson and Pollydore 2002). Kris's comments evoked feelings of empathy from the other participants in the focus group who shook their heads in agreement at his comments and those of Ernie made earlier. Carl, who until then had contributed relatively little to the group said in response:

Yes that's deep man int it? When you realise them characters is you and yours... sort of gets to you. Can't get away from it, no matter what you do. I don't remember exactly, bit like my man there, but I knew by the time I was say 13 that people didn't rate us. Already put us in a group... a bad group

too. My mum used to tell me, and my dad about what would happen. Never really took much notice really, didn't understand. Well you don't when you're a kid do you?
(Carl, early 20s, cohabiting, employed)

This kind of personal awareness of the greater social significance of events which were initially perceived as individual experiences has not been previously been reported in literature about sexual health. However, it may be quite closely associated with discussions in feminist and criticalist literatures about the mechanism by which people become aware of their position in society and the effect of inequality on their lives (Cotterill 1992; Parker and Aggleton 1999; Pratto and Espinoza 2001). It is important to highlight that in discussing the role of the media in becoming aware of the sexual stereotype of black Caribbean men, the participants presented the media as a vehicle through which the message was transmitted rather than as a cause of the stereotype. This equates with participants' earlier comments in the previous chapter on the nature of the stereotype in which media influence was identified as reproducing and perpetuating images which existed in the real experiences of participants rather than creating them.

For other black Caribbean men the message about black Caribbean men being sexually irresponsible was openly discussed by their mothers, peers and others in their social networks:

She'd say black men are worthless, can't keep themselves quiet, no control, always looking for action outside the home. I didn't knowwhat she meant at first, but then when I heard her sister tell her dad got someone pregnant I knew what she meant
(Dennis, late 20s, employed, black Caribbean male)

Irrespective of the method by which black Caribbean men became aware of the stereotype the effect was ultimately the same. The impact of becoming aware of the stereotype made the individual more aware of the expectations that others had of

them as black Caribbean men. For the majority of the black Caribbean men in the study these first impressions established the basic belief that in relation to sexual decisions the expectations in society of them as black Caribbean men were mainly negative. This in turn was reported as having a great impact on the expectations others had of them as sexual partners or how reacted to them during sexual encounters:

My friends didn't think she'd go out with me, she was a good girl you see, good family and I was from off the corner. I could understand, her dad didn't want her wasting her time, getting pregnant with no ragamuffin bwoy. I know cos he told me
(Gordon, early 20s, unemployed, black Caribbean male)

Sometimes you get into a situation where you feel, yeh this is ok, I like this girl, we can talk, get to know each other a bit, then bam! She starts coming onto you like she thinks you will just have sex with her, no worries. So nowyou're thinking shit, what do I do?
(Kris, mid 20s, employed, divorced black Caribbean male)

The above quotes provide examples of the ways in which the negative aspects of sexual activity associated with the stereotyping of black Caribbean men impacted on their attempts to initiate sexual relationships. The discussions conducted during the focus groups and interviews revealed that the effects on expectations extended beyond new relationships or sexually inexperienced black Caribbean men. It appeared that as with the nature of the stereotype discussed previously, the negative connotations linking black Caribbean men with poor sexual decisions impacted on the sexual relationships of black Caribbean men from a wide range of backgrounds and at various stages from initial meeting to long term marriages:

I chose to have four children. I like children... my partner and I have been together for 12 years. But it doesn't stop people at school asking if all my kids have the same mother and whether that was the reason he [son] *was so disruptive. Would they ask that to a white man?*
(John, early 40s, married, self-employed, black Caribbean male)

It made me really mad that people thought I would leave her. I love her. It's my kid. Of course I want to see her, make sure they're ok.
(Gordon, early 20s, unemployed, black Caribbean male)

These experiences reinforced how the stereotyping of individual members of a social group occurs even in situation where the majority of the characteristics identifying the stereotype do not appear to exist (Wyer 1998). John for example above is in his early 40s, married with children, has his own business and lives in the suburbs rather than the inner city Townsville. However, despite the fact that the only factor linking him to the stereotype, his ethnicity is beyond his control, he too is subjected to the same negative expectations based on assumptions about his personal life as the caricature of the young, unemployed, single absentee fathers who epitomise the stereotype. The experience of John and others like him in the study adds possible further clarification as to why the stereotype was described by black Caribbean male participants as being inescapable.

In describing the nature of the stereotype participants referred to the stereotype as being predominantly negative but that the effects of it on their sexual experiences were not exclusively so. Some of the black Caribbean men expressed the view that in some instances the stereotype had inadvertent positive benefits for them as individuals. This was reinforced by the fact that they also described becoming aware of the impact of the association of the stereotype with sexual activity as incorporating more than experiences denoting black Caribbean men as irresponsible and untrustworthy. Participants reported that during this process of awareness they equally began to assimilate information to suggest that there may be potential benefits as well as costs associated with the stereotype.

In the examples used by participants to illustrate the positive aspects of the stereotype the over riding message was that black Caribbean men were sexually desirable and skilled as lovers:

When you see a woman with a black guy, you know she's satisfied, that's why they want us. Good loving. They know we can move. Keep them happy, that's why they stay
(Dennis, late 20s, single black Caribbean male)

I think we got to admit it does give us a little edge with the ladies. I mean when we dress good we look sweet, some girls can't get enough. Makes you feel good. Don't it?
(Brett, late teens, student, black Caribbean male)

The experiences reported by the participants in this study provide examples of how stereotyping which is based around a stereotype which is generally agreed to be negative can simultaneously contain perceived positive affects. The existence of both positive and negative characteristics as part of the fundamental nature of stereotypes and the reluctance to give equal recognition to the positive aspects of a stereotype in the literature has been discussed earlier. It is important here for two reasons. Firstly because it emerged as an influencing factor in the expectations that others had of black Caribbean men as sexual partners, which will be discussed later and secondly because it may provide some explanation for the feelings of ambivalence towards the stereotype reported by some of the black Caribbean men.

Ambivalence was one of the key factors underpinning the black Caribbean men's feelings about the experiences of living with the stereotype and its effects on their sexual encounters. As they became more aware of both the positive and negative effects of stereotyping they began to recognise not only the tensions and contradictions associated with the stereotype itself, but others' reactions to it. In the two quotes below, Carl and Nigel explain how the expectations of potential sexual partners often reflected conflicting beliefs about them as black Caribbean men and their attitude to sexual relationships:

On the one hand they like us to be romantic and caring, but then they also want a black man who is a bit dangerous. It's exciting isn't it? They want to tell their friends how bad we are.

(Nigel, teenager, unemployed, single, black Caribbean male)

They [girls] can't make up their minds, they avoid us cos they're broughtup to think we're trouble but they can't keep away. Always hanging around, trying to get our attention... It's like they want you to be super stud, Denzel Washington and a player all rolled into one. They don't know what they want. And half the time, neither do I, too much pressure man.

(Carl, early 20s, cohabiting, employed black Caribbean male)

In general the comments raised in the focus group revealed that for many of the black Caribbean men in the study the perception of them as good lovers was both a blessing and a burden. On the one hand it was celebrated by the young black Caribbean men in particular as one of the few situations in which they as members of society were recognised as being 'best' at something. The young black Caribbean men in the study felt that the portrayal of black Caribbean men in a positive light was such a rare occurrence that they had to embrace it and take advantage of any benefits it gave them:

Yeh, I admit it. I've had girls come onto me cos I'm black. Made the most of it too. I think we may as well take some smooth with the rough int it?

(Harry, teenager, unemployed black Caribbean male)

However these feelings were juxtaposed by feelings of confusion, anger and hurt expressed mainly by the older participants arising from the realisation that the negative association with poor sexual attitudes predominated in many people's assessment of them. There was a feeling that the positive view of them as sexually gifted or insatiable permeated aspects of their lives to such an extent that irrespective of their own personal conduct or evidence they did not conduct their lives according to the stereotype, this was the basis on which they continued to be judged:

There's no getting away from it. Don't matter what you do. I've been to college, I'm married, had my own business for years, they don't care. All they see is some black man from [inner city Townsville], *player they think, always making jokes about my girlfriends at work, what girlfriends?*
(Frank, late thirties, self-employed, married black Caribbean male)

As their awareness and experiences of dealing with the consequences of the contradictory expectations arising out of the stereotype grew participants felt that the only sure thing about the stereotype was the inescapable nature of its influences. This was reflected in how participants felt that assumptions about their sexual activities as black Caribbean men often spilled over into their social relationships and even their interactions with those working in sexual health:

They didn't know anything about me... and they didn't want to know... just gave me my treatment and get me out. They gave me that look that says 'you'll be back'... well I won't give them the satisfaction. If necessary I'll go elsewhere.
(Carl, mid 20s, cohabiting, black Caribbean male)

For the black Caribbean men their experiences in sexual health services led them to believe that many professionals that they came into contact with made negative assumptions about their sexual lifestyles. The exchanges made between Lonnie and Dennis below, in response to Carl's comment suggest that the black Caribbean men felt that the negative responses they experienced from sexual health professionals was because they had same low expectations of them as other members of the public:

Lonnie: *Yeh, and its not just with the normal people you know. When I go to the clinics and stuff, they can be like that.*

Dennis: *Yeh, and they should know better. They're s'pose to be glad you came there. S'pose to encourage you to deal with any little problems with shorty, knowwhat I mean?*

Research conducted into health care professionals' attitudes to sexual behaviour provides support for this view. Reports illustrate that many front-line health care professionals find it particularly difficult not to pre-judge the behaviour of what they perceive to be high risk clients and this often influences the quality of care clients receive (Lewis and Bor 1994; Valkimaki, Suominen et al. 1998; Lamp 2000).

This was evidenced in the practical experiences of the black Caribbean men in this study who utilised sexual health services. They identified that the factor that determined whether their experiences of the health services were positive or negative was the attitude of the nursing and front-line staff:

Some of the nurses are good, if you get a good one then everything's ok. You get a good vibe, they've got time to listen to you, they know where you're coming from. Others don't give a shit. They think they've got you sussed as soon as you walk in.
(Mostin mid 20s, married, employed black Caribbean male)

It depends who you see though. I don't really take much notice of the doctors, they're just there to take details and stuff. Don't really expect much from them. It's the nurses who you deal with most. They're the ones who make you feel good or not.
(Carl, early 20s, employed black Caribbean male)

The black Caribbean men's perception of the reaction of staff or the experiences of receiving a service by themselves or other members of their communities had a direct influence on their willingness to seek professional help for sexual health problems:

I go to the drop in centre in town. The staff there are great, always got time for you and the people on the door look you in the eye. That makes a big difference, you can relax.
(Ivan, late thirties, married, black Caribbean male)

The association between the attitude of staff, reported experiences of clients and health seeking decisions such as regular use and uptake of services has been the subject of health services research and widely reported in the literature for some time (Figlio 1989; Adler 1997; Luck, Bamford et al. 2000). However, in this study Carl, highlighted that in relation to sexual health and perceptions of black Caribbean men, the poor uptake of sexual health services arising out of the poor experiences black Caribbean men had of them, could itself be a contributing factor in reinforcing the idea that they did not care about their sexual health:

If people have a bad time let's say in a particular place, they won't go. Then where are they going? What help are they receiving? None that's what. Means infections and stuff keep going round, keep showing that black men don't care about themselves or anyone else, but it's never that simple, is it?. (Carl, early 20s, employed black Caribbean male)

This example again reiterates the extent to which the stereotype and its association with black Caribbean men acted as a self-fulfilling prophecy. As such, it remained very true to the fundamental nature of stereotypes and stereotyping in general in that it was used as an explanation for both the cause and effect of the activities to which it related (Pickering 2001). It also highlights the fact that far from being clear, linear and predictable the relationships between the stereotype, the effects of stereotyping and the experiences of black Caribbean men are often contradictory and confusing.

This raises questions as to how the black Caribbean men coped with the effects of the stereotype. What strategies did they use to try to make sense of the reaction of others to them or maintain some control over their sexual experiences? However, before these questions are explored it is important to remember that sexual health decisions are rarely reached in isolation. Accepting them as socially mediated to some degree as defined by the participants in this study, means that in order to get a full picture of the impact of living with the stereotype on the sexual decisions of black

Caribbean men the views and experiences of key players in their sexual health must be considered.

5.2.2 Views of key players

In many of the situations and experiences described by black Caribbean male participants, social and sexual networks were defined as playing an important role in the way the stereotype impacted on their lives. Research studies conducted outside Britain have highlighted the importance of social networks to sexual health decision making (Santelli, Lowry et al. 2000; Posner, Pulley et al. 2001; Rothenberg 2001). The social networks described by the researchers in these articles included people that were recognised by the subjects of the study as playing an important part in their personal lives and ongoing development. The term sexual social networks as used in this study refers to the key players who influenced the sexual attitudes and health decisions of the black Caribbean male participants on a professional and personal basis. These key players included family, peers, sexual partners and professionals working in sexual health services.

This section of the chapter explores another perspective on how the sexual stereotyping of black Caribbean men impacted on their sexual decisions. The views and experiences presented here are those of the key players who made up the sexual social networks of black Caribbean men. The importance of the part played by key players in sexual health decisions has not only been recognised in the literature but was identified as an important factor by the black Caribbean male participants themselves. The black Caribbean male participants perceived their sexual social networks as helping them to make sense of their own identity, manage the tensions associated with social or sexual interactions arising out of the assumptions associated with the stereotype and to rationalise the decisions of others which occurred as a result:

Without my partner and the rest of my friends I would find it hard to cope with the stigma and the pressures it bring. They help me to keep focussed on who I am and what I believe. So I remember that I'm not who they think I am.
(Gordon, early 20s, unemployed, black Caribbean male)

In the last section it was noted that having some notion of how people became aware of the stereotype associated with black Caribbean men and sexual health activity was useful in helping to establish the context in which many of the beliefs expressed by participants arose. This is equally of importance when considering the views and experiences of the key players who participated in this study. Becoming aware of the stereotype was commented on by many of the key players although in general few could recall a specific event or experience that initiated the process. Initial analysis of the transcripts from the focus groups and interviews revealed that for the majority of the participants the awareness was described as a gradual process or something that was always known:

Well I don't really know when I became aware of it, only that I did. It seemed that it just crept up on me. I know lots of black guys, always have, but I don't know how I knew that people thought they were bad news.
(Janet, late 20s, sexual health professional)

However, further analysis revealed that particularly for those partners of black Caribbean men who were not members of black Caribbean communities themselves, the reaction of their friends and family to their black Caribbean partner was recalled as being of particular significance as to how they became aware of the stereotype as an influencing factor in the lives of black Caribbean men:

I remember her face [mother] *when I brought xxx home. She wasn't pleased at all. I couldn't understand it as we had lots of black friends and visitors. She said she just didn't want me to get pregnant. He wouldn't stand by me, I'd be left alone with a baby.*
(Sharlene, late 20s, white British partner of black Caribbean male)

I couldn't believe it, one minute they're[friends] *telling me to avoid black men they're too much trouble, and the next they're asking about how good my boyfriend is in bed, making jokes and trying to get off with him.*
(Sonia, mid teens, white British/Arabic partner of black Caribbean male)

Only one of the sexual health professionals who took part in the study revealed she had a black Caribbean partner. Unfortunately this participant declined to be interviewed individually and so it was not possible to gain any insight into whether her experiences were different to those of the two non-professional partners mentioned above.

In the examples given by key players they repeatedly returned to the contradictory nature of the messages they received about black Caribbean men. On the one hand they recognised the predominant message portrayed about black Caribbean men and sexual health was that black Caribbean men were bad news, a sexual risk and should be avoided. However at the same time this view was constantly opposed by the less well defined and contradictory reactions to the stereotype which related to the promoting or celebration of black Caribbean men's prowess as lovers and the risk/thrill aspect this introduced into sexual encounters:

They like the fact that people think they are studs. They take chances, forget risk and have a good time. It gets the girls, they can't help themselves and for the first time West Indian men are on top.
(Debra, mid 20s, sexual health professional)

The comments of the key players about the contradictory and competing aspects of how black Caribbean men were perceived reiterated those of the black Caribbean men identified earlier. In conjunction with the black Caribbean men the key players also identified that the significance of these conflicting perceptions was that they influenced the expectations people had of black Caribbean men as sexual beings and influenced their relationships with them:

Sometimes it's difficult. I have a black partner and I have to go home after seeing other black men who are behaving so badly. I know they are not all like that, but it'd hard not to get sucked into believing the hype when you deal with it every day
(Ingrid, mid 30s, sexual health professional)

The key players themselves admitted that they reacted to black Caribbean men on the basis of the stereotype. It influenced many of their interactions with black Caribbean men including their decisions as to whether to begin a relationship with black Caribbean men, how to react to them as clients in sexual health clinics and even the advice they as parents gave to their children:

You don't always realise that you've taken it in. I was with a black client when he said something and I remembered I'd seen that programme 'babyfathers' and I thought you're just like that man on the telly, no respect for yourself.
(Harriet, early forties, sexual health professional)

If you didn't set limits there would be chaos. You have to feel in control. Sometimes there's a contradiction, I like black men but I am wary of their reputation.
(Connie, late teens, black Caribbean partner of black Caribbean male)

Overall there was agreement between the views of the key players and the black Caribbean men in that they said the stereotype was used as a yardstick against which the sexual decisions of black Caribbean men were measured. Many of their interactions and encounters were reported as beginning from a basic acceptance of the negative aspects of stereotype as a true reflection of how black Caribbean men were likely to behave and their reactions were based on that expectation. The onus was on the black Caribbean man involved to prove or disprove their initial assumptions, at which point they would modify their reactions accordingly:

I admit I am wary at first, you know what they're like. But if they seem ok then I soften up. You can't treat them all the same
(Lorraine, mid 30s, sexual health professional)

This use of the stereotype as a frame of reference was commented on earlier as being reported in the literature. In the absence of further evidence the key players often referred back to the evidence of their own eyes 'in the community' or the experiences of people known to them to support their belief that the stereotyping a useful way of making decisions about interactions with black Caribbean men and therefore use of the stereotype by themselves was justified:

Well I know it's a bit different but this sexual behaviour thing is like that, you know noticing what's around you, clues and that, than that tells you about black guys, about the stereotype, whether they are like that or not. I mean you look around you and see if they really do behave like that, that's how you make up your own mind from the stuff you've been told before.
(Nova, late 30s, black Caribbean partner of black Caribbean male)

The stereotype was therefore used as previously described by Carl (see page 183) as both the evidence for justifying its use and as an example of its effects. This epitomises the 'common sense' way in which people are said to justify or rationalise the continued use of stereotypes in relation to a particular group based on their own observations (Tusting, Crawshaw et al. 2002)

The inescapable nature of the stereotype and the impact it had on both the lives of black Caribbean men and their sexual social networks have been outlined. This begins to present a picture of the way in which the stereotype of black Caribbean men's sexual activities is actioned and experienced in the lives of the participants in this study. In the light of the information given by the participants the question of how black Caribbean men cope with the effects of the stereotype and the strategies they use to manage it remains to be answered. The last section of this chapter will address this question.

5.3: Strategies for managing the effects of the stereotype

The black Caribbean men said they were aware that the burden of stereotyping was borne by their partners and other close personal key players well as themselves. They described feelings of responsibility for those closest to them in their sexual social networks:

The problem is that it's not just you that suffers. Your friends, partner and family find themselves defending your relationships. Everyone gets involved, they're all affected (Dennis, late 20s, single black Caribbean male)

Recognising the effects of the stereotype on themselves and those closest to them was such an integral part of the experiences of the black Caribbean men in the study that they reported having to take a stance on relation to the stereotype. The stance taken was either to act in ways that reinforced and accorded with the stereotype or to make the alternative decision to act contrary to the stereotype and the expectations of others:

The sex thing is a major issue I think but it plays off all the other bad images. You just got to think about it whatever you do. Like we said in the group, can't get away from it, got to deal with it. Decide how you're life's going to be and act accordingly. Hopefully make the right choice.
(John, late 30s, employed black Caribbean male)

The black Caribbean men described how their approach to the stereotype provided a basis for approaching their daily activities and interactions with others. During the discussions a very strong message that emerged from participants was that holding a particular viewpoint and approach to the stereotype was about gaining control in order to face the inevitable impact of the stereotype. Taking a stance was the main starting point used to maintain a sense of control over the stereotype. For the black

Caribbean men in the study the clear message was that the need to take a stance was essential:

The thing is you can't ignore it. If you haven't thought about it then you're lost. Got to decide what you're doing and how to tackle it.

(Ivan, late thirties, married black Caribbean male)

This message did not just come from the black Caribbean men themselves but was also reinforced to younger men by their parents:

I tell my son, don't think they're not watching you. You gotta decide what you want, how you want to be. You've got no choice. Know your own mind, stick to what you know is right it's your only chance.

(Louise, early 40s, black Caribbean woman)

The black Caribbean men's reports on how they used the stance as a kind of blue print for action could be viewed as similar to the way they participants perceived the stereotype was used as a yardstick for their judgments. The stance taken by the black Caribbean men in relation to the stereotype enabled them to interpret the actions of others and determine their own reaction to a given situation. It played an important role in helping them to manage sexual encounters and other situations in which the stereotype influenced the interaction. Here Carl talks about the importance of taking a stance in order to avoid getting bogged down by the contradictory expectations people have about black Caribbean men in society:

I think [taking a stance] *that's the main thing and everything runs from that. its very complicated and difficult to deal with. Yes difficult to find where you are in all this. Make sense of it. But you've got to for your own peace of mind. Otherwise, confusion.*

(Carl, mid 20s, employed black Caribbean male)

The contradictory and often competing effects of the stereotype meant that having taken a stance in relation to the stereotype gave black Caribbean men some sense of control over managing situations, people and relationships. What appears intriguing is the way in which black Caribbean men use the same mechanisms for dealing with the stereotype and regaining a sense of control over it as were used by others to action the effects of the stereotype in the first place. Their beliefs that it was unjustly applied did not lead them to reject it, instead the stereotype was used as a reference point from which to determine actions. Once again the contradictions and dilemmas in stereotyping are revealed in the study as the strategies by which the process of stereotyping is applied also underpin the methods by which it is controlled (Wyer 1998; Rassool 1999; Hinton 2000).

Irrespective of the stance taken by black Caribbean men in relation to the stereotype, they felt that it was not possible to change either the use of the stereotype as a frame of reference in society or the negative connotations of black Caribbean men's sexual activities associated with it. However they also believed that the inescapable and persistent nature of its effects made it impossible to ignore:

It has survived this long that I can't see it going away... we just have to deal with it.
(Carl, early 20s, cohabiting, employed)

Whether the participants reported acting in accordance or contrary to the stereotype the key point was that the purpose of their decisions was to modify and control its impact on their lives. From this basic premise the discussions revealed how the black Caribbean in the study either strove to accept or challenge the impact of the stereotype in their lives as their main method of coping.

5.3.1 Acceptance

The majority of the black Caribbean men in the study reported employing strategies based on an acceptance of the stereotype and working 'with it' in order to manage its effects. Some participants tried to achieve this by acknowledging the possible impact it could have on their sexual and non-sexual encounters and modifying their own actions to allow for it. For example Ivan, a black Caribbean male in his thirties spoke of how he was always aware of the threat posed by the stereotype when walking home alone at night and acted in ways that anticipated the possible negative connotations that could follow:

I'm always conscious when I'm walking home of women's fears of black men. Particularly of being attacked by them. Its always the first thing they say, the attacker was or wasn't black. So if I am walking home and I see a woman on their own I cross the road or I
make a lot of noise so she knows I'm there, then I get past her as quickly as I can. I don't look at her, just stare straight ahead. I'm a big bloke. I don't want no-one getting the wrong idea.
(Ivan, late 30s, married, black Caribbean male)

Some participants gave examples in which they made a conscious effort to rise above the derogatory comments made to them and ignore people or situations where they felt the stereotype was unjustly being used to belittle or degrade them:

Sometimes I just ignore it when they [partner's friends] *make jibes about my sexual abilities or ask too many personal questions. It's my way of coping, make allowances for their ignorance. Don't give them the satisfaction of knowing they're getting to you... that's what they want. Once you get mad they've won.*
(Lonnie, mid 20s, cohabiting black Caribbean male)

In making changes to the way they approached social and sexual encounters with others, participants felt they could avoid or minimise the negative effects of the stereotype and reduce its power over them. They rationalised their actions as giving

them the control over the stereotype that they wanted in that they were not allowing it to lead them into situations where they would be vulnerable.

Not all the participants advocating acceptance of the stereotype acted to accommodate its negative effects. Some participants chose instead to use the stereotype to their own advantage in sexually related encounters. This alternative choice was selected by some of the younger black Caribbean men in particular. As with the previous participants mentioned above they remained aware of the assumptions associated with the stereotype and the ways in which their actions may be interpreted in the light of those assumptions. However, rather than making allowances for the interpretations of others they used the positive and negative expectations of the stereotype to their own advantage, often acting in ways which accorded with the assumptions made about them:

Because they think we're irresponsible means they don't expect too much of us... I can come and go as I please. It's great, if a girl gets too bossy I just move on. You'd be surprised, some of them just love a bad man, the badder the better.
(Adam, teenager, student black Caribbean male)

Through their efforts the black Caribbean men saw themselves as taking an active role in determining any effect that the stereotype would have on them, the interaction or the other people involved. The use of the stereotype by black Caribbean men as a vehicle for managing situations was predominantly, but not exclusively practiced by the younger participants or in situations involving their sexual partners. In the quote below Ivan describes how he used the negative expectations about black Caribbean men to avoid receiving poor service or being seen by inexperienced staff who he describes as 'amateurs':

Sometimes I just pretend to be mad, impatient. Walking about, not sitting down, it means they [SHP] *don't try and mess with me. Don't want to upset me see? They*

don't palm me off with no amateur either. I hate that when they try to waste your time. That's what happens if you don't play them first.
(Ivan, late 30s, married, black Caribbean male)

While the actions of Ivan may appear shocking, when viewed in the context of the literature about the way in which black and minority ethnic people's experiences of service provision are often marred by poor staff attitudes and inequitable treatment, it is perhaps understandable (Khan 1987; Leininger 1997; Karlsen and Nazroo 2002). Fiona, one of the sexual health professionals suggested that if staff were more aware of the experiences of black Caribbean clients they may find it easier to make sense of their reactions:

I think it may change some peoples attitudes, they might understand why black guys get so up tight or why they are aggressive if you seem to be ignoring them. You're just having a bad day but they have this all the time, they don't know.
(Fiona, mid 30s, sexual health professional)

This issue along with the implications of the stereotype and its effects on black Caribbean men for sexual health professionals will be discussed further in the final discussion chapter. Fiona's comments here just serve as a reminder of the importance of the wider context in which stereotyping takes place to any critical understanding of its effects in society (Leyens, Yzerbyt et al. 1994).

For many of the black Caribbean men the belief that the stereotype was inescapable meant that they had accept it as part of their lives and find ways to live with and minimise its effects as far as possible. In order to do this the men reported using the expectations associated with the stereotype as a basis for action. Their decision to either act in ways that were contrary to or in accordance with the stereotype was determined by the particular context in which hey found themselves and their past experiences. Accepting the stereotype was not perceived as giving into the stereotype

or other people's expectations of them but gave them a feeling that they were living with the stereotype rather than fighting against it.

5.3.2 Challenge

The majority of the black Caribbean men in the study however, expressed a different view of the way in which the stereotype should be reacted to. They rejected the suggestion that because the stereotype was ever present and inescapable, that fighting it was futile:

We have to fight people's perception of us. We can't just accept it. That's been the problem so far, black man's lot, to accept things. If we do how will things ever change? We will continue to live under the same cloud as our parents. I don't want my kids and their children to put up with the same old thing.
(Kris, mid 20s, employed, black Caribbean male)

Instead these participants not only advocated that change was required but that there was a degree of responsibility brought to bear on black Caribbean men to challenge the stereotype. There was a sense in which the bulk of the responsibility for seeking to bring about a change was accepted as resting with the black Caribbean participants, their partners and the black Caribbean community as those most directly affected by the stereotype:

I just think that when people outside look at the community and how we as the adults behave. They judge us on that basis. If a black guy acts badly towards his family, or is violent or whatever, than it seems like it's not just him that the finger is pointed at, but all the rest of us too. I think there is a responsibility to the community, to your selves and your family, not to put yourself in that kind of situation. Not to waste your opportunities to improve yourself.
(John, late 30s, employed black Caribbean male)

Challenging the stereotype and society's perception of black Caribbean men's in general and their sexual decisions in particular was believed to be the only effective mechanism by which the impact of the stereotype could be controlled now and reduced in the future.

The strategies employed by the black Caribbean male participants were underpinned by a decision to work against the stereotype and people's negative assumptions about black Caribbean men. They attempted to achieve this in a range of ways including how they presented themselves in social situations, the manner in which they approached individuals and the life choices they made:

I always make sure I'm well presented. Doesn't matter if no one else there is. I want them to notice me, notice I'm neither unnecessarily loud, irresponsible or trouble, but I'm still black
(Dennis, late 20s, employed, Single)

I chose not to get married, to have my son and to live with my partner. I'm happy with that. When other people ask me how many kids I have I can say one and I'm proud of that, not because I need their approval, but because that's the choice I made.
(Carl, mid 20's employed, cohabiting)

Many of the black Caribbean men felt that as a result of their actions there were alternative examples available in the community of black Caribbean men's decisions which did not conform to the expected stereotype. Participants believed that this fulfilled two requirements for securing change and counteracting the stereotypical image of black Caribbean men. Firstly it provided role models for other black Caribbean men particular the next generation and secondly, it was a visible presence of responsible, respectable black Caribbean men for the rest of society:

If you don't' control yourself and think about the attitude you Breeding in the youths, all they got is them programmes telling them black men is bad and we just there breeding babies. You got to get your tings but there's a time and a place [pause] people got to think about that.
(Mostin, mid 20s married black Caribbean male)

I think in general it just reflects how black men are seen, stereotyped if you like in the community. I mean we're bad news. That's the starting point and to some extent, unless we as individuals do anything to change people's minds or challenge what they think, that's the view that remains.
(Carl, mid 20s, employed black Caribbean male)

The importance of having positive role models to positively influence decisions has been identified in the literature on health behaviours (Beier, Rosenfeld et al. 2000; Blum, Beuring et al. 2000; DiClimente, Wingood et al. 2001). It was also identified by other key players as well as black Caribbean men as an influencing factor in developing a person ethic about sexual health and sexual relationships. Participants referred to role models in the context of managing the effects of the stereotype as one of the key strategies by which young black Caribbean men would be less likely to perceive living up to the stereotype as their only (or best) option:

They've got to see black men succeeding, having good relationships, how else are they going to change? Going to believe there's an alternative? It doesn't matter if that person isn't their dad. As long as they know some good black men
(Margaret, early 40s, employed black Caribbean woman)

The importance of role models formed part of a more general group of strategies suggested as ways of ensuring that the stereotype did not have the same impact on individuals or the black Caribbean community in the longer term. Participants involved with the upbringing of the next generation of black Caribbean men were particularly keen to actively change the opinions and approaches of future generations. Thus great efforts were made to stress the importance of childrearing,

setting a good example and encouraging higher aspirations in black Caribbean children:

It's like that singer says, it's our future, we gt to nurture them and don't let bad things happen. Make them aspire to be better than we are and more than others expect them to be. That's what's important, that's what will lift us out of this mess.
(John, early 40s, married, self-employed, black Caribbean male)

There was a common belief underpinning the suggestions made by those participants advocating the need to challenge the stereotype that even if the stereotype was inescapable for them, this was not unchangeable over time. This contrasted with the approach taken by others who felt acceptance and adjustment was the way forward. The most important issue for all the black Caribbean men however was that the impact of the stereotype was a real and occasionally dominant factor in their experiences. The stereotype was believed to be changeable through the concerted efforts of black Caribbean men and all those involved in their social or sexual networks. Their purpose in challenging the stereotype through the decisions they had made not to live up to the negative expectations associated with it was based on a belief that it was a way of achieving the changes they wanted.

Concluding comments

The stereotype of black Caribbean men as sexually irresponsible and risky emerged from the focus group discussions as the most persistent feature influencing the sexual health encounters and social interactions of black Caribbean men. During exploration of the impact of the stereotyping of black Caribbean men and their sexual decisions many challenging and difficult issues were raised for participants. What became acutely apparent through these discussions was the way in which the stereotype and its effects permeated far beyond the sexual health experiences of black Caribbean men and their sexual partners.

The stereotype was perceived as underpinning the reactions, actions and expectations of black Caribbean men and others in their sexual social networks. The term sexual social networks as used in this study referred to the key players who influenced the sexual attitudes and health behaviour of the black Caribbean male participants on a professional and personal basis. These key players included family, peers, sexual partners and professionals working in sexual health services.

The assumptions made by others about black Caribbean men on the basis of the stereotype often impeded communication and interaction with black Caribbean men. As a result of this the black Caribbean male participants believed that they had to make a decision about how to control and manage the impact of the stereotype in their lives. They felt compelled to take a stance in relation to the stereotype, either to act in ways which concurred with the stereotype but use the expectations associated with it to their advantage, or to take the opposing view and conduct themselves in ways that refuted the negative beliefs that linked them as black Caribbean men with the stereotype. This was described by the black Caribbean men as a necessity; the stereotype could not be ignored.

One of the interesting factors about the way black Caribbean men actioned their need to take a stance against the stereotype was that they used the same mechanisms and approaches that were used in the process of stereotyping them as a social group. They used the stereotype itself and their interpretation of it as a starting point, determined their own approach to it and used this as a blueprint for action.

However the stereotype itself was a site of tension and this impacted on the actions and decision making of the black Caribbean men. They often reported receiving conflicting messages about the stereotype. This was reflected in some 'positive' responses to the stereotype, particularly in relation to beliefs about their sexual prowess and abilities. However for the majority of the participants this was both a blessing and a burden.

The reality of living with the stereotype was much less clearly defined than their idea of the nature of the stereotype suggested. Changing expectations of them on a contextual basis, unsubstantiated assumptions made about their personal life and indecision about the amount of knowledge individuals had about their own use of the stereotype introduced a degree of uncertainty into the equation. The only sure thing about the stereotype in the minds of the black Caribbean men was the tenacious hold it appeared continue to have in their lives and the fact they had to take a stance towards it in an attempt to manage it. Dependant on the stance taken by the black Caribbean men strategies were put in place to either accept and accommodate the stereotype, or to challenge it.

As mentioned at the outset, the discussion concerning the stereotype was at times challenging and emotionally upsetting for participants. In the individual interviews some of the participants also reflected on the nature of the discussions that occurred in the focus groups about the stereotype and highlighted how the experience of taking part in the discussion had affected them outside the study.

During these discussions what became apparent were the many things which participants found difficult to say, unable to address or hard to come to terms with during the study. In the analysis of the transcripts a series of common themes emerged identifying these difficulties as the things which still cannot be said about black Caribbean men, sexual health decisions and risk taking. These issues will be presented and explored in the next chapter.

CHAPTER SIX

HEARING THE SILENCES

Introduction

Early on in the data collection phase the stereotype of black Caribbean men as sexually irresponsible in their attitudes and approaches to sexual relationships emerged as a dominant theme in the research. The first two data chapters have outlined participants' views about the nature of the stereotype, its role in society and their experiences of living with its effects on a daily basis.

The comments expressed by participants presented the stereotype as a key factor in the sexual health experiences of black Caribbean men and of great influence in their sexual and social interactions. However, the conceptual framework underpinning this research study is based on a belief that what is unsaid or silent in the public sphere is as important as what is known, spoken and understood (Carby 1997; Brah, Hickman et al. 1999). The issues raised in this third data chapter are overtly linked to the conceptual notion of screaming silences identified in the introduction to this study. The need for the researcher to be aware of the screaming silences in any research and the effects this may have on the study underpinned the methodological approaches used in this research. The development of a theme associated with this concept supports the approach taken to the study from the outset.

The title 'Hearing the silences' is used in recognition of the persistent screaming silences remaining in this study or 'things that still can't be said' in relation to black Caribbean men and sexual decisions. The Screaming silences noted in this chapter are epitomised by the issues that participants either verbalised or demonstrated through

their reactions as being inappropriate for discussion, difficult to express or unwilling to divulge. The nature of the screaming silences emerging from the data collection and the range of factors influencing them will be presented in this third data chapter.

'Hearing the silences' in any research study helps in forming a view of the research as a whole by adding the missing detail from the context in which social issues are actioned in society and managed in individuals' lives (Catterall and Maclaren 1997). During the interviews many of the participants reflected on their experiences of taking part in the study and the consequences that the research outcomes may have for black Caribbean men, the Caribbean community and other key players in their sexual health. This chapter fulfils the conceptual requirements of this qualitative study in highlighting the conflicts, contradictions and dilemmas within the data and is included to ensure that the silences and the reasons for them are exposed.

Research conducted or influenced by feminist and criticalist traditions accepts that silences, like biases in research are to some extent unavoidable (Mirza 1995; Millen 1997; Johnson-Bailey 1999). Some silences remain hidden because they relate to fundamental issues concerning the nature of humanity and may never fully be answered as both the questions and response to them change over time (Crotty 1998; Denzin and Lincoln 1998). Other silences are context bound within a study and arise directly from the process of conducting the research study itself or may develop as a consequence of the findings (Hunter, Lusardi et al. 2002).

This third data chapter begins by introducing the silences arising out of the recurring theme of the stereotyping of black Caribbean men explored in the last two data chapters. In doing this the chapter considers how the silences themselves impact on the life experiences and attitudes of black Caribbean men and key players in their sexual health.

Table 4 illustrates the issues associated with this theme.

THEME: *HEARING THE SILENCES*

6.1: Silences associated with this study

6.1.1: Proving the stereotype right

6.1.2: Proving the stereotype wrong

Q2: Silences, black Caribbean men and sexual health decisions

Table 4: Issues addressed in theme 3 'Hearing the silences'

6.1: Silences associated with this study

In describing the factors influencing sexual health decisions and risk taking of black Caribbean men participants consistently referred to the ways in which the life chances and daily experiences of black Caribbean men impacted on their sexual health. From the outset participants comments expressed a view that factors such as the social and personal experiences of an individual either facilitated their sexual health choices or made them more difficult (Karlsen and Nazroo 2002; Kemshall 2002). It has already been noted that from very early on in the initial discussions about factors affecting the sexual experiences of black Caribbean men the stereotype emerged as a dominant theme.

However, while this initially appeared to be the dominant message expressed by participants as the data collection and analysis phase progressed, what began to emerge through participants' discussions of their experiences of taking part in the research, were the tensions, conflicts and inconsistencies in their view of the stereotype. The contradictions that emerged in their understanding of the role of the stereotype and its usefulness as the basis for judgement of black Caribbean men and their sexual decisions underpinned the issues which emerged as the silences in this study.

During both the focus group discussions and individuals interviews it became apparent that for some participants, taking part in the research and openly discussing issues relating to black Caribbean men and sexual activity was difficult. There is evidence in the literature to suggest that participants may find it hard to discuss issues relating to sensitive or private subjects such as sexual decisions (Frey and Fontana 1993; Lee 1993; Pilcher 2001). The sensitive nature of sexual health as a research subject had therefore been anticipated as a potentially restrictive issue in this study and allowances were made for this occurrence in determining the study design.

Analysis of the data and reflection on the research process however, revealed that the difficulties this study presented for participants were not just related to fact that it was concerned sexual decisions per se. For many of the participants the challenges posed by this research related directly to the sexual stereotyping of black Caribbean men. Participants expressed concern as to the perceived impact and consequences if the outcomes of the study helped to either reinforce or disprove the veracity of the stereotype of black Caribbean men as sexually insatiable, irresponsible and risky. This first section of this data chapter will present the silences which emerged directly in response to these concerns.

6.1.1: Proving the stereotype right

The majority of the participants in the study felt it was important to address the underlying issues of high rates of sexually transmitted infections among black Caribbean men and what they perceived as the large number of unplanned pregnancies in the black Caribbean community. For the key players with personal links to the black Caribbean community, these were seen as real issues which impacted on their lives and that of those closest to them:

Despite all the problems you know, I won't give up. I can't, what will happen to me and my family then? What chance have my boys got if I don't fight for them?
(Kris, mid 20s, employed black Caribbean male)

Professionals working in sexual health felt there was a need to understand more about why the infection rates for STIs were disproportionately high in black Caribbean men. This was percieved to be an essential requirement if any change in health chances was to be achieved. This excerpt from my interview with Fiona a sexual health professional is a good illustration of the thoughts of some sexual health professionals:

LSG: what do you think stops things changing?

SHP5: I think that in terms of black men which is what you're interested in the lack of information about them stops us. I mean everyone who tries to prove that there are issues to be faced hits a problem because the evidence isn't there. I mean the only information we have nowis that they have high infection rates... that just makes any explanation you try to give sound like an excuse.
(Fiona, mid 30s, sexual health professional)

However, despite expressing valid justifications for their willingness to take part in the study and the importance of the subject some participants expressed a sense of guilt and experienced conflicting emotions about taking part. These participants felt that in discussing the negative aspects of black Caribbean men's sexual decisions their comments may themselves reinforce the negative stereotype of black Caribbean men as sexually risky and irresponsible:

Since we met I've thought about the whole thing. I'm not even sure if I should have said those things, am I colluding to make things worse, just by taking part in the discussion?
(Margaret, early 40s, black Caribbean woman)

The concerns of these participants were based on a belief that if the negative stereotype of black Caribbean men was seen to be 'proven' or reinforced by the outcomes of the study, they as participants would have contributed to the further stigmatising of black Caribbean men. For participants, the study outcomes would

help to prove the stereotype if they appeared to provide evidence to demonstrate that black Caribbean men were in fact sexually irresponsible in their attitudes and approaches to sexual decision making.

Feelings of guilt associated with use of a stereotype have been reported in the literature Pickering (2001) said that the social stigma attached to stereotypes often impacts on those using the stereotype as a point of reference as well as those to whom it is applied. This was reflected in the explanations given by candidates for their feelings. The participants believed that this outcome could have far reaching consequences on their work and relationships with black Caribbean men:

I don't know it's important to do something, but at what cost? The problem is we won't know what will come out till it's finished... that's the scary bit, thinking am I helping or making things worse?
(Cath, late 20s, sexual health professional)

Many of participants who were interviewed commented that in the period since the focus group they had pondered on the discussions that had taken place. They were acutely aware of the frequency with which black Caribbean men were associated with being sexually irresponsible and risky in their approach to sexual health. Participants were therefore concerned as to whether any further damage to the perception of black Caribbean men and their sexual decisions had been caused as a result of their contribution:

You have to be careful. It's not something that you talk about with just anyone. There are enough people hating us already. You don't want to make things worse.
(Kris, mid 20s, employed black Caribbean male)

There is little evidence in the literature to suggest whether the impact of stereotypes may be directly related to how familiar it is or the frequency with which it is referred to. Much of the literature on stereotyping focuses on the stereotyping that occurs

between individuals and groups who are seen to hold different positions of power in society. It discusses the impact of stereotyping on inter-group relations from perspectives centred on exploring the influence that relative power or powerlessness has on the social identity of the groups and the individuals involved (Leyens, Yzerbyt et al. 1994). It could be argued from the comments made by participants that their angst related to a different question. This is may be more concerned with the nature of the person making the comment and the inferences that may be drawn from the source of the information, rather than simply the information itself.

For many of the participants in the study their concerns about their contribution to proving the stereotype related to a feeling that condemnation of black Caribbean men by them as members of the black Caribbean communities, sexual health professionals or partners of black Caribbean men was in some way worse than if the comments had come from people who were not key players in their sexual health. They reported feeling that their contributions left them with a sense of betrayal:

I never felt I could say these things before, it's not really the done thing, is it?, saying black men can be bad when you're black yourself you're always wary of giving people the wrong impression or twisting your words, being careful to mind what you say
(Maria, early 20s, black Caribbean woman)

As members of social groups forming part of the sexual social networks of black Caribbean men participants were aware that they were party to information that was not widely available to others. They felt that this brought with it responsibility to protect the groups by maintaining control of the information they had. In revealing their insights into black Caribbean men they felt they had failed in their perceived personal, professional and social responsibility for black Caribbean men, the black Caribbean community and themselves.

Sometimes I feel I have to agree with other people like me, not because I want to say everything is great but because I'm wary of what happens to us as a group if we start to paint black men as bad to the outside world, like everyone else does, what happens to us then?
(Chrystal, mid 30s, black Caribbean woman)

The feelings expressed by participants about their possible role in reinforcing the stereotype revealed how this study occasionally breached the boundaries of the group identity and responsibility and challenged the participants' understanding of their responsibilities for the group. For many participants feelings of guilt and betrayal accompanied personal reflection on whether they were being responsible members of their social groups. The key issue in this dilemma for participants was whether they were colluding against black Caribbean men.

If the study proved the stereotype right how far would they by being involved, be perceived by their social networks and other key players as damaging the reputation of black Caribbean men. The possible impact this could have on their group's relationship with them was of real concern. In particular, whether their contributions to the study were likely to be accepted as genuinely assisting in the advancement of sexual health research or just another excuse to degrade the image of black Caribbean men as sexual beings:

I think this is important but I have worried abut it you know, talking about black men in this way. Is it ok to do this? To talk about the problems?
(Monica, late 30s, black Caribbean woman)

The black Caribbean men and other key players who were members of the black Caribbean community highlighted a very specific concern in relation to their contribution. This related to the fact that they had not only provided evidence which possibly corroborated negative beliefs about black Caribbean men and sexual activity but had done this from a black perspective.

In the individual interviews the black Caribbean participants, more than any other reflected on the impact that providing what could be perceived to be negative viewpoints about black Caribbean men, as black Caribbean people, could have on themselves and the wider community. There was a sense in which their concerns were about more than the further stigmatising of black Caribbean men as a marginalised group, but also about the morality in 'Damning your own':

If they find out we have the same opinions then we might be seen as no different to anyone else, dissing black men. It's worse in a way, we know them and we're still doing it. That's what will get out, they won't bother to try and understand why. They'll just hear that bit of the argument and ignore the rest.
(Bobbie, late 30s, black Caribbean partner of black Caribbean male)

If the above quotes are considered alongside the earlier point about feelings of responsibility and group identity, an important issue in the social role of stereotypes as a component of group membership is introduced. It illustrates the ways in which stereotypes as well as excluding and marginalising groups of people may conversely also be useful in providing an accepted indicator of belonging (Richeson and Pollydore 2002). This issue will be explored further as this chapter progresses.

The contribution of the black Caribbean participants was essential to this study which sought to include a black Caribbean perspective into this research. Without the input from black Caribbean men and women, this study would not have provided much of the evidence about the sexual decisions of black Caribbean men and the black Caribbean communities' attitudes towards them. Evidence for many of the issues raised here concerning black Caribbean men as a marginalised group is not easily accessed in the public domain and would have remained difficult to obtain otherwise. Taking part in this research required the black Caribbean participants and their partners to take on issues which potentially had private and personal consequences in their lives. These participants were acutely aware of the responsibilities associated

with this and the possible impact the study could have on the lives and sexual health of black Caribbean men.

It is important that the costs involved in research for the participants is recognised by researchers, not only because there is a need to recognise that the research study cannot be completed without their contribution but because of the individuals costs to individuals which often remain hidden in the final report (Ribbens and Edwards 1998; Pilcher 2001).

Overall the participants expressed a great sense of responsibility for black Caribbean men and the sexual social networks to which they belonged. They wished to contribute to the study but did not wish to provide evidence which could be used as more ammunition to belittle black Caribbean men. There was therefore a degree of unease about expressing some of their views during the study. One participant, Carol illustrates the feelings of many of the black Caribbean participants in describing her fears that she had 'provided another stick to beat black men with':

I don't know if I could cope with that, finding out that what I said gave the haters more ammunition, more evidence that their prejudices were right. Black men are bad news.
(Carol, late 30s, black Caribbean woman)

Earlier discussions revealed that participants in the study were fully aware of the stereotyping of black Caribbean men as having both positive and negative consequences in the lives of black Caribbean men. However, their expression of concern about the consequences of proving the stereotype made no reference to this. Concerns expressed about the effects of proving the stereotype related only to the negative connotations associated with it. The positive 'benefits' of proving the stereotype for black Caribbean men or their sexual relationships were not alluded to by any of the participants. As a result, it is not possible to provide any direct evidence as to why the issues identified as positive beliefs about the stereotype were not identified as a significant aspect of proving the stereotype.

During the interviews participants expressed concern that if the study proved the stereotype the knock on effects would be to provide evidence which could further undermine the efforts being made to change the negative perception of black Caribbean men in general and their sexual activities in particular. This included both the individual efforts of black Caribbean men such as the decision to present themselves in non-stereotypical ways and the efforts of sexual health professionals and other key players to influence the attitudes or approaches to black Caribbean men in society.

Participants wishing to bring about a change in the perception of black Caribbean men or the services provided for them felt their efforts were already often under threat from both inside and outside their social networks. In the previous chapter 'Living with the stereotype' the black Caribbean men said that indirect challenges to their efforts could be evidenced through the actions of black men who continued to act in accordance with the stereotype. While key players felt their efforts were often undermined by the attitude of colleagues when interacting with black Caribbean men, the way in which black Caribbean men's needs were actioned through sexual health policies or practices and the attitude of black Caribbean communities to them.

The important issue for participants' who were trying to bring about a change in the impact of the stereotype in the lives of black Caribbean men, was the fact that there was little evidence available to support the continued reliance on the stereotype as truth in today's society. While this was in itself a source of frustration for the participants who felt that it often resulted in unsubstantiated assumptions being made about the negative sexual activities of black Caribbean men, the lack of evidence simultaneously provided the justification for their objections. Ultimately those making the claims about black Caribbean men and their sexual activities could be challenged to 'prove it'.

There was some concern therefore that this study, if it suggested that the negative aspects of sexual decisions linked to the stereotype was relevant to black Caribbean men in today's society, this could in fact provide evidence that deprived them of a defensive argument and simultaneously provided their opponents with the proof they needed:

I mean the problem is we don't know what the outcome will be. I mean what if we give them the evidence? The proof that black men really are like that, you know, trouble, irresponsible, wasters, whatever. What then, what chance have we got to change anything?
(Monica, late 30s, black Caribbean woman)

What is revealed once again by this issue is the contradiction of the stereotype and stereotyping process. To some extent, this reflects the literature which points out that the damage caused by a stereotype is not always overtly apparent or directly related to the purpose for which it is used (Bhabha 1992; Forgas and Williams 2001). Thus it could be anticipated that irrespective of the intent of the participants, the stereotype if proven could continue to have a negative impact on the lives of black Caribbean men. This may occur either by directly demonstrating the negative views of black Caribbean men are justified, or indirectly by weakening the argument of those who are attempting to change the perception of black Caribbean men as sexually irresponsible and risky.

This attitude to the perceived threat posed by the study to efforts to manage or bring about change in the impact of the stereotype in the lives of black Caribbean men was an important aspect of the research process which was not obvious at the time of the focus groups. It only began to emerge during the individual interviews and in the period following completion of the data collection. It identified an issue which could not be fully explored in the confines of this study but is introduced here as an influencing but hidden factor in the research and as a possible area for future investigation.

The issues raised in this first section of the chapter related to participants wish not to collude with attempts to further marginalise and denigrate black Caribbean men through their comments about their sexual decisions. Participants found many of the issues difficult to talk about and questioned the usefulness of their contribution to proving the stereotype in any long term strategies to bring about change. This has exposed some of the silences in the study as reflected in the difficulties participants faced in taking part in this research. The silences identified so far begin to illustrate some of the tensions and conflicts faced by black Caribbean men and other key players when trying to make decisions that affect sexual health and in their encounters with black Caribbean men.

6.1.2 Proving the stereotype wrong

As the impact of the stereotype emerged as a central theme in participants' perceptions about the sexual health decisions of black Caribbean men, it seemed reasonable to assume that proving the stereotype wrong would be of primary importance. However, despite a great degree of consensus that this would be desirable, some participants also voiced concern as to the wider consequences of this as an outcome to the study.

The aspects of the stereotype that made it appear truthful to the participants has previously been described as its permanency and applicability to black Caribbean men rather than another ethnic group. Proving the stereotype wrong for participants therefore involved providing evidence in the outcomes of the study that black Caribbean men were no more risky in their attitudes to sexual activities than the rest of society. It could also involve undermining the universality of the stereotype by demonstrating that not all black Caribbean men were irresponsible or lived up to the expectations associated with the stereotype.

During discussions with participants about the reality of living with the stereotype (see data chapter 2) they expressed a view that the stereotyping of black Caribbean

men had a social role to play in society. The previous chapter also highlighted how the black Caribbean men in particular felt that the stereotyping they experienced worked to identify and 'place' them (albeit, negatively) as a group in society:

In a way it's kind of always been like that. like that guy said in the group. black menmen trouble. That's the role they like us to play. Can't fight it really it's like it's our job. Makes them fel better about themselves 'cos we're the bad guys.
(Lonnie, mid 20s, unemployed black Caribbean male)

This would seem to suggest that proving the stereotype wrong would be welcomed by the black Caribbean men in the study and those seeking to bring about a change in the negative perception of them as sexual beings. However, some of the participants said that they did not feel that proving the stereotype wrong was necessarily a good thing.

Some of the black Caribbean men felt that despite the negativity associated with it, the sexual stereotype was part of their identification in society. To some extent, the stereotype was part of who they were, it identified their place in society and acted as a marker from which they had made many of their lifestyle decisions and plans. Ernie, a young black Caribbean man sums up the feelings of some of the black Caribbean men that the stereotype was a known quantity, and while its effects were not always welcomed, at least they were familiar and therefore the black Caribbean men knew how to deal with them:

At least you know where you are with them kind of views and you can act accordingly. When you don't know what they want you are always on edge, trying to work out what they mean. What they want and what's your next move.
(Ernie, early 20s, unemployed black Caribbean male)

The importance of socially recognised roles to formation of a sense of self has been well documented in the literature (Gibbs 1988; Bhabha 1992; Hinton 2000; Forgas

and Williams 2001). Stereotypes are illustrated as useful as relatively quick and short hand points of reference to help others to locate individuals as members of a group or to affirm perceptions about group characteristics (Leyens, Yzerbyt et al. 1994; Kempadoo 2001). The comments made above by Ernie and other black Caribbean men suggested that the sexual stereotyping of black Caribbean men was used in much the same way by the black Caribbean men themselves. This is interesting because it could at first seem reasonable to assume that a negative stereotype would not be accepted or used to develop a sense of self-identity by the stigmatised group.

Much of the literature exploring the role of stereotypes as an identification tool in society presents the use of stereotypes as a frame of reference discusses this largely as a one way process. The picture presented is most likely to be from the perspective of the most powerful in society as those who apply the stereotype (Mac an Ghaill 1999; Parker and Aggleton 1999). The perspective of the stigmatised group or individuals when included, tends to be presented as a reaction against the unwanted stereotyping by others who themselves are not members of the marginalised group (Sewell 1995; Narayanasamy 2000; Richeson and Pollydore 2002). However this was not only perspective that emerged in this study with some black Caribbean men articulating different concerns.

In the individual interviews three of the six black Caribbean men interviewed felt that the stereotype was an important part of their history which made them who they were today. Its loss could render them invisible in relation to sexual health as they were in many other aspects of social life. In this way they felt they would have contributed to the further eroding of black Caribbean men's identity. They went on to express concern as to how if it is disproved by the research outcomes, the loss of the stereotype would to some extent lead to a loss of part of themselves and a degree of uncertainty as to how to react in certain situations:

I mean it's a pain but it's part of what we know. We've dealt with it all our lives. If it's not there maybe they'll come up with something worse to put on us. At least we know this label, know what it means and how to control it, deal with it.
(Mostin, mid 20s, employed black Caribbean male)

Articles discussing the way in which stereotyped individuals valued the sexual stereotype as an important part of their own identity were difficult to find in the literature. A few articles discussing the impact of HIV/AIDS diagnosis on stereotyping of identity were discovered but these concentrated on the negative impact of disease on social identity and made no reference to the positive adoption of any aspect of the stereotype by the subjects of the study (Valkimaki, Suominen et al. 1998; Valdiserri 2002). No published articles or reports relating to this issue as a phenomenon of sexual health decisions were identified. This may account for one of the reasons why the use of the stereotype by black Caribbean men to affirm their own identity was not anticipated at the outset.

The importance of the role played by the stereotype in a shared social understanding of self for the black Caribbean men was also reflected in their responses to each other during the focus groups. During the focus group the common experiences of the black Caribbean men in relation to the effects of stereotyping in their lives often led to very private and emotional issues being raised. The interactions and responses of the black Caribbean men to these discussions illustrated strong feelings of support based on shared identity and experiences between the group members which was not dependent on a prior relationship or knowledge of each other.

To some extent the experiences of living with the stereotype recounted by the black Caribbean men to each other acted as a kind of social indicator. This reflected the process by which group membership and belonging is based on the recognition of clues and comments which indicate to an individual that another person was 'one of us' (Mac an Ghaill 1994; Richeson and Pollydore 2002). These clues facilitated the discussions by providing a sense of belonging or community between participants.

At different points in the discussion there appeared to be a recognition amongst participants that as members of the same social group they shared a degree of insider knowledge which did not need explanation. Much of the insider knowledge concerned the lives and experiences of black Caribbean men as members of a particular social group. The black Caribbean participants in particular felt their insider knowledge was important not only because it contributed to the groups' identity but also because it contained aspects which separated them from the general population and other similar ethnic groups:

Knowing what really goes on makes us who we are. Even when you go to a different place, you can look at another black person and know. There's a connection..
(Candice, late teens, black Caribbean woman)

Belonging to a recognised social group is reported as bringing with it a sense of responsibility for the group (Pratto and Espinoza 2001). This was reflected in the comments of both the black Caribbean men and other key players in their sexual health:

We know how tings go with us, know who, what and where we've got to protect that for all our sakes. It's not just about me and my crew it's about us all.
(Harry, late teens, unemployed black Caribbean male)

Arising out of the acceptance of the responsibility that came with belonging was a belief that information released by them could potentially weaken the boundaries signifying the unique characteristics of black Caribbean men as a group. It has already been revealed that some of the black Caribbean men and participants in their sexual social networks felt that many of the characteristics which associated black Caribbean men with the stereotype were not exclusive to them and often displayed by others in society. In fact the only characteristic discussed in 'The nature of the stereotype' which was exclusively black, male and Caribbean was the stereotype itself. Without

this particular aspect of the stereotype, poor attitudes to sexual health and irresponsible sexual decisionss would be attributed to age, gender and socioeconomic status as it is for the members of other social groups (Santelli, Lowry et al. 2000; Wilson, Uuskula et al. 2001).

If the possibility of discrediting the stereotype through the outcomes of this study is considered in the light of this perceived responsibility for group identity, then it could be seen as a possible threat to black Caribbean male sexual identity. Without the stereotype black Caribbean men would be exposed as 'no different to anyone else' and sexual health would no longer be an issue which separates or identifies black Caribbean men from the rest of society. While this could have a positive impact on their sexual health in that they would be less likely to be stigmatised as risky based on their ethnicity, their reticence about dismissing it altogether suggests there is a fear that the cohesiveness of their identity as a group which came across quite strongly in the research was seen as being potentially under threat from this outcome.

The above discussion exposed a silence around the black Caribbean men's concerns about the negative consequences of dispelling the stereotype on their shared sense of identity, community and their ability to protect their own. When viewed in this way, it is reasonable to see why removing the stereotype despite it being predominantly negative may be viewed by some of the black Caribbean men as also embodying a degree of loss. This invites investigation into what is lost in relation to black Caribbean men's sexual health as a result of proving the stereotype wrong.

The black Caribbean men were not the only participants to discuss the unwelcome aspects of proving the stereotype wrong and revealing the associations between sex, decisions and risk to be more universal. Some of the sexual health professionals interviewed commented that the stereotype provided a basis for many professional justifications for identifying black Caribbean men as an area of unmet need. This was backed up by evidence from both policy literature and qualitative research articles available at the time of the data collection concerning sexual health and risk reduction

where funding, highlighting and reasoning of the need to target black Caribbean men in relation to sexual health referred directly or indirectly to the negative stereotype (Department of Health 1993; Department of Health 2001; DiClemente, Wingwood et al. 2002).

These professional key players had earlier expressed in the focus groups a degree of frustration as to the restrictive impact that lack of information concerning influences on the sexual health of black Caribbean men had on their attempts to plan services and deliver care effectively to this client group. However, in the individual interviews they voiced concerns that if the without the stereotype and society's acceptance of it as true, they would be left with nothing to support their requests for the provision of funding and resources to assist in their work with black Caribbean communities:

It's a terrible thing to say but it does help sometimes playing on peoples prejudices helps when you are competing with other requests for help
(Lorraine, mid 30s, sexual health professional)

The basis for their concerns were revealed by a review of the literature and supporting information provided for various research funding opportunities relating to sexual health and risk. In many of these documents black and minority ethnic groups, particularly black Caribbean men are highlighted as an area of critical concern because of the quantitative links between race, ethnicity and sexual health (De Cock and Low 1997; Fenton, Korovessis et al. 2001; Fonck, Mwai etal. 2002). The professional participants said that opportunities for funding of service were to a degree dependant on the belief that irresponsible and risky sexual attitudes were linked to ethnicity. They would therefore feel that in contributing to disproving the stereotype, they had damaged the possibility of future change in the way sexual health services and support for black Caribbean men was provided.

In these examples and others participants' body language and decision to only make these comments in the interview suggested that these views were difficult to admit

openly. All the participants volunteering these views about the stereotype preceded their comments by reaffirming that if used, their contributions would not traceable back to them. The fear of association with the outcomes of the project itself therefore was revealed as incorporating points of tension for some of the participants. A further issue of concern to some participants related to the potential impact of refuting the universality of the stereotype among black Caribbean men on relationships between the black Caribbean participants and their communities.

In earlier discussions concerning the veracity of the stereotype participants highlighted that they believed the negative stereotype was more likely to be related to black Caribbean men from lower social classes, with poor education backgrounds, living in the inner city areas of Townsville. In these discussions many of the black Caribbean participants made efforts to distance themselves from the risks associated with poor sexual choices by making clear the differences between themselves and those they perceived to be at risk:

I'm talking about some people near where my mum lives. It's not like that where I live, people have different lives. We've made different choices, but you still have an idea what goes on.
(Chrystal, mid 30s, black Caribbean woman)

In the discussions that followed and in the individual interviews some black Caribbean participants openly expressed their fear that if they did not make the differences between themselves and 'these kind of people' explicit, they would be associated with them. This was in sharp contrast to the earlier concerns raised in relation to the consequences of negating the stereotype on the shared sense of identity in black Caribbean men:

I feel bad but I have to make sure people know I'm different that I live a different way, not that I'm ashamed of my roots but I don't want people getting confused, thinking we're all the same.
(John, late 30s employed black Caribbean male)

The efforts taken by some participants to create a distance between themselves and the characteristics of those they associated with the stereotype reflected an underlying change that participants said was currently taking place within the black Caribbean community. In the interviews participants qualified their statements by saying that the black Caribbean community was becoming less homogenous. There was a growing awareness within the black Caribbean community that for the first time in Britain 'we are no longer all struggling together' and 'some are more equal than others'. This was something which was perceived to result from the availability of better opportunities and rewards for hard work, in this generation in ways that were impossible in the past:

It's not like it was for our parents. We have much more going for us. They had to stick together against all the pressures. We don't have to do we? We can manage most of the time by ourselves
(Kris, mid 20s, employed black Caribbean male)

As a result participants felt they needed to distance themselves from the negative connotations placed on black Caribbean men's sexual activity and celebrate their own personal achievements. Researchers, authors and activists in race and ethnicity have been highlighting the need to recognise and account for the vast amount of differentiation that exists within black and minority ethnic communities for a long time (Ahmad and Atkin 1997; Bhopal 1997; Brah, Hickman et al. 1999). However what was interesting about the comments made by participants in this study was that on the whole they spoke about the differences within the black Caribbean community as if they were emerging for the first time. This raises the question as to why, and also why now, perhaps the answer lies in the comments of Dennis, a black Caribbean male participant who highlighted that professional black Caribbean people are now greater in number, and achievement is less likely to be seen as an exception within the black Caribbean families:

Well there's more black professionals about now aren't there? It's not such a shock to see a brother or sister doing well. I mean there could be more but at least we're there. So now we notice more, notice that some of us are doing ok.
(Dennis, late 20s, employed black Caribbean male)

On further examination the majority of the black Caribbean participants expressing this particular concern were young professionals or self-employed individuals. The only non-professional participants who expressed this view were students who aspired to go to university themselves and mothers who wanted their children to attain high academic achievements. Differences in socioeconomic situation and social class brought about by this situation may account for why the distancing that these black Caribbean participants engaged in was not always an easy or unproblematic thing to do. The term 'the enemy within' describes the feeling expressed by some of the black Caribbean participants that in seeking to differentiate between themselves and risk takers, they were left with a feeling that in some way they were colluding with those pointing the finger at the lack of achievement or morality in others:

You do feel that you're no better than anyone else, saying look at me, I'm ok why don't the rest of you sort yourselves out? It's not like that, but you can't help having a bad feeling about it.
(John, late 30s, employed black Caribbean male)

In the focus group discussions participants stated that they believed that there were aspects of society that worked to undermine the achievements and advancement of black communities and black Caribbean men in particular. They highlighted the fact that in the past the cohesiveness of black Caribbean communities was the factor that gave many of their parents' strength to cope with the lack of opportunities available to them and oppression they faced. There was a feeling that in some ways, while they had been rightly given more opportunities and greater access to services than their parents that this in itself could be viewed as undermining or fragmenting the identity of black Caribbean people as a group.

The conflicting situation of distancing self and simultaneously acting to demonstrate closeness to the black Caribbean community exposed another contradiction in the use of the stereotype by black Caribbean participants. It created personal dilemmas for individuals and was considered as both a celebration of personal achievements and a threat to group identity.

The changes in the black Caribbean community as described by participants epitomised to some degree the class system of Britain as it is generally understood (Fiske and Taylor 1991; Barker 2000). Black Caribbean participants in the research used different terms of reference to describe and compare their own experiences from other black people of a particular socioeconomic status, area of residence and occupational background.

I would think that is a stereotype of a certain type of black man. Many of the black men that I know would not allude to that sort of statement, that they are black men and so they make babies. A lot of men that I would know would not make that statement. It is a stereotype of a certain type of black man. Those that are wortless.
(Nova, early 40s, partner of black Caribbean male)

I don't really mix a lot in the areas where trouble goes on. I mean I'm very busy, got my own business and that. It might seem like I'm not working directly with the community but I think it's important, yes I do.
(John, late 30s, employed black Caribbean male)

The current recognition of an evolving black Caribbean 'class identity' is an interesting issue arising out of this study. Surprisingly little attention has been given to this social phenomenon so far in the health literature, particularly when consideration is given to the fact that social positioning and access to services has been linked to health chances for a very long time. It will be interesting to monitor the possible future impact that the stratification within black Caribbean communities could have on the health chances of this section of society.

Throughout the focus group discussions participants talked about the importance of improving the sexual health of black Caribbean men by challenging the negative perceptions of them as sexual beings by others and encouraging a sense of responsibility in the men themselves. Further probing of these issues during the interviews and focus groups revealed however, that simply providing evidence to disprove the stereotype or people's assumptions about black Caribbean men would not resolve all the issues.

This first section of the chapter has revealed many previously little discussed areas of concern raised by participants about the role played by the stereotype in the lives of black Caribbean men and the wider implications of proving or disproving it as a basis for judgement. Overall participants demonstrated that they experienced competing anxieties associated with reinforcing or disproving the stereotype as a result of the outcomes of this study. In exploring these concerns, participants reflected on the possible effects these two outcomes could have on the identity of black Caribbean men as a social group, the cohesiveness of black Caribbean community identity and efforts to improve the sexual health chances of men from black Caribbean communities.

So the question remains as to how this adds to the understanding of this research study. What do the silences and concerns of participants as revealed in this study say about black Caribbean men and their sexual health decisions?

6.2: Silences, black Caribbean men and sexual health decisions

The preceding data chapters identified a wide range of factors relating to the dilemmas and conflicts inherent in the sexual stereotype of black Caribbean men and the affects this had on their lives. Black Caribbean men in the study gave many examples of the ways in which their decision making in general life as well as their sexual experiences were adversely affected by the stereotype and the associated

negative portrayal of them in society. This was presented and openly discussed by all participants as impacting on the perception that black Caribbean men had of themselves and on the expectations of others. Some of the participants expressed concern that the stereotype of black Caribbean men had persisted for such a great length of time and despite changes in the acceptability of the stereotyping as a process today, it was still central to many sexual encounters involving black Caribbean men:

Well I was thinking how long its gone on and what are the chances its going to ever change, that we can ever change it. I mean I agree that it's a bad thing but, well I was thinking, people have made an issue of black men's sexual behaviour since slavery. Even today we see books, TV programmes and stuff about it. It's here to stay, always has and probably always will be. In some ways it's all that people really think about in terms of black men and relationships.
(Bobbie, late 30s, partner of black Caribbean male)

The silences that emerged during the analysis of data in this study revealed that the stereotype and the sexual decision making of black Caribbean men existed in a much more complex relationship that initially revealed by the focus group discussions. Far from simply being identified as a frame of reference for sexual decisions or social interaction as previously discussed, black Caribbean male participants began to reveal the role played by the stereotype as part of their understanding of their own individual and group identity as black Caribbean men. This was further complicated by the admission made by key players working in sexual health that the stereotype was useful in locating black Caribbean men's sexual health as an area of need and an essential aspect of strategies to improve their health chances.
Both these perspectives exposed a dilemma for participants in that the stereotype could neither be dismissed completely of accepted unconditionally. Either outcome was perceived as having a detrimental impact on black Caribbean men, the black Caribbean community or key players in their sexual health.

The issue which emerged from these discussions as uniting what was said, known and openly acknowledged by participants with the silences that emerged from the

highlighted issues were the inherent tensions underlying sexual decision making. Participants regularly referred to and gave examples of issues which created a tension for them either in their understanding of the nature of the stereotype, the process of stereotyping or even the management of sexual encounters involving black Caribbean men:

It's difficult to know sometimes what to do for the best. To take on board the things people say about black men or just to ignore it. Sometimes you can't help yourself, you dong it withothinking. There's so many things that feel wrong, but when you see people doing it, acting like that, you don't know what to think. Sometimes it makes sense.
(Gerrie, mid 20s, partner of black Caribbean male)

The silences revealed in the study were an important factor in recognising the existence of tensions in the experiences of participants in terms of their attempts to make sense of the contradictions in the stereotype as they experienced it and the impact this had on their sexual decision making. Without reference to the silences in the study, the tensions and dilemmas in the experience of black Caribbean men could have appeared to be solely related to the sexual stereotype and its impact on their lives. However, once the silences were included in consideration of the context in which sexual decision making takes place, the tensions and contradictions underpinning many of the dilemmas appeared to be part of a wider picture. Acknowledging the silences in the study allowed a clearer view of the social issues associated with the stereotype and the implications they could have for social or sexual interactions involving black Caribbean men.

The wider importance of the stereotype was revealed by the degree to which the stereotype permeated other aspects of the lives of black Caribbean men and the key players in this research beyond the direct reference to sexual decisions. The stereotype which was predominantly linked by participants as being associated with sexual decisions could not be confined within this subject area. Once discussions developed the stereotype acted as a vehicle for discussion of wider issues such as

identity, group belonging and the 'usefulness' of particular ways of viewing individuals or social groups.

Once these other avenues of reference were opened up in relation to the stereotype through the silences, what emerged was that to some extent participants accepted dealing with tensions and negotiating their reactions to them as an inherent part of all decision making to varying degrees. They described how they believed that the process of reaching sexual decisions took place in much the same way as other decision making in their lives. Thus for many of the black Caribbean men in particular, sexual health was just another example of the daily decision making which occurred against a backdrop of indecision, contradiction and uncertainty.

You approach sex like everything else. It depends on what else is going on, what else is expected of you and what responsibilities you have.
(Gerrie, mid 20s, partner of black Caribbean male)

The close association between tensions associated with the stereotype, sexual decision making and their general life experiences, may account for why the black Caribbean male participants found it difficult to isolate their management of the impact of the stereotype from other issue sin the discussion. In some sense this should not have been surprising as the study asked questions about a specific aspects of their experience which was difficult to separate out from other aspects of their lives. This is a common issue in qualitative research where participants are asked to isolate and reflect on one aspect of their experience as opposed to another which they may perceive to be inextricably entwined (Collins 1998). In this particular study this experience was reflected in the black Caribbean participants' responses to questions about managing the stereotype and the effects on their sexual health decisions. The comments of Gerrie quoted above demonstrate well the way participants gauged their responses and appraisal of sexual health encounters according to other social roles, expectations and responsibilities as well as their future aspirations for themselves and their families.

The silences in this study allow the issue of sexual health decision making and the black Caribbean male to be appraised within a wider context which acknowledges the emergence of the stereotype as a central issue identified by participants but not exclusively the only issue. To a degree, the tensions in the study highlight that while the stereotype appears to be solely associated by participants with black Caribbean men, the silences would suggest that far from being a unique process, sexual stereotyping if viewed as a social decision making tool, is neither unusual or unique to black Caribbean men.

The tensions in sexual health decision making could therefore be acknowledged as not just a black Caribbean male issue. The emerging picture from the inclusion of the silences is that sexual stereotyping of black Caribbean men, utilising the stereotype as a basis for judgements serves as a specific example of how beliefs, expectations and even social identity are actioned in society through the experiences of an identifiable social group.

If this is indeed the case then it could be speculated that all sexual decisions take place amidst feelings of tension arising out of conflicting social beliefs and expectations about the sexual nature of individuals or groups and of even sexual decisions themselves.

Concluding comment

Taking part in any research project has both costs and benefits for individual participants and the wider community. Through the application of an appropriate approach to the research project participants help the researcher to fulfil the requirements of the study by answering the research questions as accurately and fully as possible.

This research set out to explore the factors influencing the sexual health decisions of black Caribbean men from the perspective of themselves and those closely associated with their sexual health decision making. The methodology underpinning the research design used is derived from awareness that both life experiences and research are influenced by factors which may not always be immediately apparent or known to everyone. This aspect of life has been called screaming silences.

Accepting that silences are inherent in research required that attempts were made to make them explicit throughout the study. This included the need to remain vigilant to the silences generated within and by the study as well as those existing prior to beginning the investigation. Silences need to be made explicit in order that the conclusions and discussion arising out of the findings can be assessed in the light of the silences rather than despite them.

This chapter presents some of the silences noted during the data collection phase of this research project. The silences generated during the focus groups and interviews reflect the issues that participants found to be inappropriate for discussion, difficult to express or unwilling to divulge. As such they epitomised the things that 'still can't be said' about black Caribbean men and sexual health.

The range of issues highlighted by participants included the tensions, personal conflicts and professional dilemmas they faced in taking part in the study. Some of these issues were apparent to them prior to agreeing to take part in the study but some of the effects were only acknowledged once their contribution was over.

Some of the participants felt that the problems associated with black Caribbean men and sexual decisions were part of a greater struggle to manage the day to day conflicts in their lives, sexual relationships and the negative assumptions made about them in society. Others felt that the issues were firmly linked to the stereotypical perception of black Caribbean men as sexually irresponsible, untrustworthy and risk takers.

The silences generated from these opinions about the situation of black Caribbean men revolved around participants' reflection on the possibility of the study outcomes eliciting evidence which either reinforced the stereotype or appeared to undermine it as a legitimate frame of reference for the sexual decisions of black Caribbean men. Discussion of the issue uncovered tensions and dilemmas for participants as to the impact of the outcomes on themselves, other black Caribbean men and the wider black Caribbean community.

Many of the participants said that taking part in the study was the first time they had shared or voiced their doubts and concerns about the possibility of improving the sexual health of black Caribbean men or the consequences of denouncing the stereotype. These issues elicited feelings of betrayal, hope for future change, responsibility for others and collusion in participants at different points.

Overall this theme has demonstrated that the arena in which sexual decision making takes place is a complex one. It is affected by many unspoken but significant influences, presented here as silences. The silences impacting on the participants in this research were to some extent as unavoidable as methodological biases linked to the process of data collection and researching such a sensitive issue amongst a relatively small population. Other silences discussed were perceived to be a fundamental part of life and experience of the black Caribbean men and the key players in their sexual health that they would never be resolved without social change. Yet other silences were created by this research study itself and participants experience of taking part.

This chapter 'Hearing the silences' has contributed to revealing the context in which the research was conducted but more importantly has added further insight into the tensions and personal conflicts which influence the sexual health decision making of black Caribbean men. The silences suggest that to some degree tensions are inherent in all social interactions between different groups to differing degrees and sexual

interactions involving black Caribbean men may be considered to be another specific example.

CHAPTER SEVEN: CONCLUDING DISCUSSION

WORKING WITH SILENCES

Introduction

This study set out to identify the factors influencing the sexual health decisions of black Caribbean men and to explore how these factors impact on their sexual health seeking or risk taking activities. The initial picture emerging from the data is the significant role played by the stereotype of black Caribbean men as sexually risky and irresponsible in their sexual health experiences. The three major themes discussed in the data chapters 'The nature of the stereotype', 'Living with the stereotype' and 'Hearing the silences' begin to explore the ways in which the sexual interactions of British black Caribbean men are affected by real and imagined references to this stereotype. Derived from the data, the themes provide an insight into the social and sexual scripts associated with black Caribbean men and sexual health behaviour. These themes present a situated view of the ways in which the stereotype directly affects the sexual health decisions and social practices of black Caribbean men in specific sexual contexts. The themes also illustrate the indirect influences of the stereotype on black Caribbean men's sexual health decisions. This is evidenced by exploring the impact of the stereotype on social interactions between British black Caribbean men and other key players in their sexual health.

This concluding discussion is entitled 'Working with silences'. The title reflects the importance of remaining aware and taking account of both the known and unknown contexts in which sexual health decisions occur. The chapter sets out to do two things. Firstly to locate the stereotype of black Caribbean men within the study by exploring the importance placed on it by participants as an influencing factor in sexual decision making of black Caribbean men. In doing so, the chapter reflects on

the broader theoretical themes underpinning this study and the significance of the screaming silences in comes of this study. The integration of the theories and silences associated with the study will help in considering whether the stereotype can be viewed as the main influencing factor on the sexual decisions of black Caribbean men.

Secondly, the chapter discusses the policy and practice implications of the study findings for sexual health professionals seeking to provide for the needs of black Caribbean men. It will then go on to identify potential areas for further research in sexual health and ethnicity.

Prior to fulfilling the two objectives outlined above, the chapter begins with an overview of some of the methodological challenges faced in completing the study. By presenting the limitations of the study factors that need to be taken into account in study are exposed at the outset. This sets the context for the discussion that follows.

7.1: Limitations of the methodology

The methodological approach to this study was selected because it appeared to offer the best opportunity for collecting the required information for addressing the research questions. However on completion of the study there were a number of points which limited the data collected and incorporated a degree of bias in the findings. Acceptance of some limitations and bias was expressed in the methodology chapter as an inevitable aspect of this and every research study. However, the theoretical approaches underpinning this study include an expectation that the relevant biases and limitations be made explicit. (Appleton 1995; Crotty 1998). Therefore, prior to discussing the findings of the study some of the limitations and possible biases arising from the methodology will be explored. The specific issues discussed here relate to: the use of a directive framework (prompts) in data collection; the relative benefits of adopting alternative approaches to data collection; issues arising from the nature of the sample and gaps in study design.

a) The use of a directive framework (prompts) in data collection

A directive framework in the form of 'prompts' was used in the focus groups as a starting point for initiating discussions about perceptions of black Caribbean men and their sexual health behaviour. This method was used in recognition that a key requirement of data collection was to initiate some discussion about these notions and use them as a springboard for exploring the factors believed to influence black Caribbean men's sexual health decisions. The use of prompts or vignettes are a useful tool for initiating conversations in focus groups or ensuring the discussion remains 'focussed' around the desired subject (Krueger and Casey 2000).

The prompts arose from analysis of literature and media sources available prior to data collection. They were informed by the comments of participants during the exploratory study, which preceded this main research project. The information gathered from the various literature and media sources was analysed to identify areas of convergence in relation to black Caribbean men, sexual behaviour and risk taking. The main areas of agreement were then compared with the transcripts from the interviews in the exploratory study to derive the main themes. Direct quotes from, the literature, media or interview transcripts were selected to form the prompts used in the focus groups. The selected prompts were deemed the most appropriate because they reflected the general 'common sense' notions about black Caribbean men and sexual behaviour from a variety of perspectives.

The main reason for using a directive framework was in recognition of the sensitive nature of the subject of black Caribbean men and sexual activity. It was felt that by directing the discussion at the outset participants may have clearer understanding of the focus to be taken in the discussion in relation to sexual health and ethnicity. The use of prompts introduced some distancing of participants from the more personal or intrusive aspects of the study (Lee 1993). Participants would then be able to manage from themselves the pace and degree to which they involved their own experiences

into the developing discussion. This could also help to reinforce the reassurances given by the researcher that the research was concerned with the issues rather than their own personal sexual experiences. In gaining ethical approval for the study the use of prompts as initiators of discussion was welcomed by the ethics committee as a useful tool in helping them to understand the scope of the prospective study and the focus of the discussions. The extent to which this in turn reflected the ethics committee's own uneasiness about qualitative research into sexual health and ethnicity remains unknown. However, their positive response to the use of prompts suggests that the prompts were instrumental in gaining approval for the study to take place.

Reflection on the use of prompts on completion of the study offers an alternative perspective to their value as a guide or tool for initiating discussion. It must be considered whether the use of a directive approach to the focus groups may have limited the scope of the issues discussed by participants. The effect of using the prompts may have gone further than simply acting as a guide for maintaining focus by inadvertently directing the discussions in a more restrictive plane than planned. The emergence of the stereotype for example as a consistent frame of reference used by participants in each of the focus groups could to some degree have occurred as a result of the prompts selected. It is important to note that while the prompts themselves did not name the stereotype *per se*, they indirectly highlighted predominantly negative aspects of sexual behaviour in black Caribbean men. This could have played a part in linking the stereotype and black Caribbean men's sexual activity in the minds of participants as a way of articulating these particular behavioural and sexual choices.

The extent to which the association between black Caribbean men and the stereotype emerged as a consequence of the prompts cannot be measured in retrospect. The use of prompts generated through evidence from a variety of sources would seem to suggest that the 'negative' association between sexual behaviour and black Caribbean men's sexual activity is fairly well established within social scripts. The question then

seems to be whether the negativity can confidently predicted to be the stereotype or whether the familiarity of the term simply provides a convenient label by which the association may be named. This will be discussed further later in the chapter.

b) Adopting alternative approaches to data collection

In the methodology chapter, the methods and process of data collection utilised in this study were identified as being the most appropriate. However they were by no means the only possible options available for addressing the research question and other data collection methods or processes could have been used. This section of the chapter considers some of the alternative approaches that could have been adopted in the study and the possible consequences for data generation.

One way in which the limitations brought about by adopting a directive framework may have been avoided would be to use fewer prompts and employ a more 'open' forum for the focus group discussions. This approach however would have to take into account the dilemmas in making methodological choices, particularly in relation to sensitive subjects such as sexual health and ethnicity. As previously discussed in the literature chapters, sexual activity and black Caribbean men is a difficult issue to talk about and research. This was further evidenced in the 'silences' embedded in the experiences of participants and exposed during discussions. The reactions of participants and information from the literature reveals that there is a tension between conducting research which allows participants freedom of speech and facilitating exploration of difficult subjects. In this study, the fact that ethnicity and sexual health and the experiences of black Caribbean men are silenced, means that permission to speak about them for the benefits of research needs to be acquired, given and legitimised.

The tensions inherent in researching such sensitive issues were apparent at different stages during the data collection. On occasion in the individual interviews, participants articulated their discomfort in speaking openly about these subjects and

sought reassurances from myself as researcher that it was ok to do so. Other interview participants openly voiced how they were happy to have had the opportunity to discuss such issues in a forum that was judged by them to be 'safe'. These comments add weight to the suggestion that perhaps the use of a directive framework had the unexpected effect of giving participants permission to not only speak about the silences or 'unknown' aspects of their experiences but the subject itself.

Using a more open forum however, could have been easily incorporated into the process of data collection using focus groups and interviews while still facilitating discussion of sensitive issues. This would have been achieved by use of personal narratives and vignettes or asking open ended questions such as ' what does black Caribbean men's sexual behaviour mean to you?' or 'how do you feel black Caribbean men are viewed in terms of their sexual behaviour?' Such approaches would have had the benefit of encouraging participants to use their own words to describe their perceptions of black Caribbean men and sexual activity (Robinson 1999). This more open approach may have resulted in the highlighting and development of discussions around a different strand of issues relating to black Caribbean men's sexual health distinct from the stereotype and its impact. The decision to adhere to the directive framework however meant that this option was not made available to participants. It is therefore not possible to predict the degree to which development of alternatives to the stereotype may have been restricted by use of the prompts.

The use of a less directive approach in itself cannot be guaranteed to produce different results in relation to the subject under study from that emerging through use of a structured approach(Silverman 2000). A whole range of factors impact on the issues discussed in the focus groups including familiarity with the topic, researcher aptitude, the nature of the participants and the social scripts associated with the subject matter. The stereotype may still have emerged as a theme using a more open ended approach to the initial questioning. Conducting additional research into the same subject utilising a less formalised approach is the only way to test the tenacity of

the stereotype as a frame of reference. This could also have given some indication as to the appropriateness of using a more open line of questioning for the study at the outset out. A method that could possibly have tested out these issues would be to increase the number of focus groups and utilise a directive approach with some of the focus groups but not with others. If the selection criteria remained the same for all groups it would have been possible to analyse whether the stereotype emerged as readily in group discussions independent of the use of prompts. If so, it would have been interesting to note whether the nature of the ensuing issues discussed or the way in which they were articulated would be the same as exposed through use of the singular directive approach taken in this study.

c) Issues arising from the nature of the sample

The decisions made prior to recruitment concerning the inclusion and exclusion criteria for participants and the procedures for recruitment were designed to ensure that a range of participants took part in the study. A range of local community groups and professionals were approached and informed about the study for recruitment purposes. Contacts with lay participants were made in areas of Townsville with varying concentrations of black Caribbean communities as recorded in the census data from the local race equality unit. Listings of statutory, voluntary and self help sexual health services were used to locate sexual health professionals for the study. These strategies were used to ensure that a variety of black Caribbean men and people making up their sexual social networks were included.

Overall a reasonable spread of participants were recruited covering all proposed sample groups. These were black Caribbean men, black Caribbean women, partners of black Caribbean men and sexual health professionals. Within the sample there were great variations in terms of socioeconomic group, educational level and employment status. These can be seen in the participant profiles in appendix 8. On closer inspection of the sample profiles there are some particular nuances in the sample group, that may have placed some limitations on the data generated. For

example the parameters set on age meant that all the participants fell into the 16-45 age group. This limitation was placed on the sample in order to mimic as far as possible the age range used in the published quantitative studies into sexual risk and ethnicity. While this could be justified on the grounds of comparability, the focus on black Caribbean men may have warranted a wider brief in relation to age.

The patterns of migration from the Caribbean from the 1950's in Britain meant that men older than the upper age limit of 45 might have had some useful insights to add to the discussion, particularly in relation to the context in which decisions occur. Many of these participants would have lived through a critical time in the defining and shaping of the political and social contexts which underpinned the sexual experiences and expectations of the generations that followed. Participants in the study regularly referred to older family members and the impact of previous generations on their sexual health behaviour. Inclusion of the views of participants from this era would have therefore enhanced the discussion of the findings.

The lower age limit was also employed to facilitate gaining ethical and local community approval to conduct the study. Interviewing those under the age of 16 about sexually related subjects is very problematic and rightfully subject to public scrutiny and often more stringent ethical controls. However, the number of young people (below the age of 20) taking part in the study was limited. Of the participants 3 out of 30 women and 4 out of 15 men taking part were teenagers. The teenagers raised some fascinating insights into the way in which they perceived and made sense of black Caribbean men and sexual behaviour. This was particularly apparent with respect to the 'positive' aspects of stereotyping and the usefulness of the stereotype. This small section of the sample group provided a good contrast to the older age groups taking part but due to their restricted numbers could not be analysed as a distinct category. If more teenagers had been recruited and definitive focus group for teenagers conducted, some of the issues particularly relating to the 'scripting' of sexual behaviour within black Caribbean communities could have been probed to greater depth.

In relation to gender, the bias in the study related to the inherent gender profile of particular focus groups. The delimitation on the ' self declared' heterosexual identity of the black Caribbean men, coupled with the proportionally high levels of female nurses compared to men meant that the overwhelming majority of participants were female. In fact the only focus group in which men predominated was that comprising black Caribbean men. To a great extent this reflects the realities in the experience of all heterosexual men. Heterosexual partnerships coupled with managing sexual health through the support of a historically female profession mean that this outcome is likely in studies focussing on any ethnic group. However richer data may have been gained by perhaps targeting more male workers in sexual health for interview. This could have been achieved by widening the scope from a health focus to include perhaps a social care perspective such as those working in probation, social services or youth and community services.

The partners of the black Caribbean men taking part in the study were predominantly black Caribbean women. Again a different emphasis and more explorations could perhaps have been gained into aspects of living with the stereotype by actively recruiting women who did not belong to black Caribbean communities. Such targeted recruitment may have helped to ascertain the degrees of similarity and difference in experiences within this particular section of black Caribbean men's social sexual networks. This could be further advanced in another study if groups containing only black Caribbean partners, only non-black Caribbean partners and mixed groups were used.

d) Gaps in study design

Some of the decisions made with regard to study design resulted in some gaps in the study design that limited the depth or breadth of analysis of the data possible. Of particular importance were the limitations placed on age of participants, the failure to actively recruit from a wider range of sexual health professions and use of a female

co-worker. The very specific age range utilised in the selection criteria coupled with a broader acceptance of British nationality either by birth, naturalisation or citizenship meant that there was no reliable information collated to delineate between recent and migrants to Britain and earlier generations. Arbitrary guesses could have been attributed on the basis of age, however, in studying a community where migration has continued to varying degrees over the last 55 years, this would be an inadequate strategy on which to base research findings. The vast potential variations in social, ethnic and culturally specific experience during the formative years of migrant populations is well documented (Mama 1995; Mac an Ghaill 1999; Whitehead 2000). This highlights a key issue in relation to personal experience, socialisation and community identity raised in the literature chapter. Issues of racism and political discussion of the impact of the stereotype, surprisingly failed to materialise to any great degree within the focus groups. The question arises as to whether the fact that the researcher was also a member of the black Caribbean community instilled in the black Caribbean participants a sense of 'no need' to mention these issues explicitly as they were 'known'. Similarly for non-black participants or sexual health professionals, the effect may have been to curtail such discussions in the face of a black professional. Both potential outcomes have been highlighted in literatures on race, stereotyping and ethnicity (Sewell 1995; Price and Cortis 2000; Richeson and Pollydore 2002)Perhaps overall the lack of any real delineation with regards to migration and citizen status in the study worked to silence this issue. The implications of this issue will be discussed further in the next section, 'Locating the stereotype'.

Information relating to the migrancy of participants could have been collected relatively easily in the questionnaire of biographical details of participants. Such information could then have been included in the discussion and subsequent analysis of issues raised during the focus groups and interviews. This would have allowed comparison of perceptions, experiences and reactions to sexual decisions of black Caribbean men across or within generations to be made. The ability to carry out such analysis would have been useful in complimenting findings from lay and professional groups or different members of the sexual networks. For example, participants'

comments relating to generational differences in attitudes to risk could have been contextualised much more effectively with reference to their personal experiences of political and social change.

The strategies employed for recruiting sexual health professionals to the study aimed to include a wide breadth of sexual health services. However, this was not achieved. As discussed in the methodology chapter despite efforts to include a range of health care professionals this section of the sample were predominantly workers in statutory health services. Voluntary providers of sexual health services were approached to take part and appeared interested in the study. Constraints of time, last minute problems and difficulties in arranging times when workers could attend focus groups were the main reasons for failure to recruit. These issues are commonly faced in recruiting for focus groups in general but compounded by the situation of voluntary, lay or self-help participants (Krueger and Casey 2000).

The nature of voluntary sexual health services is such that workers often work in evenings and weekends, at times when the focus groups were conducted. Focus groups conducted during the day were equally difficult to access as prospective participants also had daytime paid employment, not associated with sexual health. The literature suggests various mechanism that could be used to overcome this including liaison with voluntary group organisers or accessing group workers individually may be a way forward (Merton, Fiske et al. 1990; Morgan 1998).

In this study however, individual discussion of the sexual health of black Caribbean men would fail to fulfil the requirements of the study to gather data pertaining to group understanding of the issues. As such the thoughts of voluntary service providers could only be reflected in relation to the group discussions of statutory sexual health worker. This would mean that the information gathered from voluntary groups would be marginalised with respect to the main methodological processes. A situation, which would be contrary to theoretical, approaches underpinning the study.

The lack of diversity in sexual health workers taking part is a regrettable omission in the study. Voluntary services were at the forefront of much of the early support work in relation to sexual health (Shilts 1988; Screen 1992). The failure to recruit from this section of service provision remains a key limitation in the study. More direct liaison with group organisers would be required in order to conduct a subsequent study formulated around voluntary services. This may be a way of addressing the gaps left by their absence here. Further information could also have been gained by widening the scope of the study to include health and social care as previously mentioned. Many of the voluntary services in sexual health such as work with women, drug users, homeless families or black Caribbean communities affiliate themselves with social care and welfare. As such they may not have seen their work as directly pertaining to sexual health and this may have added to the problem of recruitment.

A broader scope on sexual 'health' may have provided a larger pool of potential recruits. Perhaps sufficient contacts could then have been made to run a health and social care focus group, which was much, more representative of the voluntary sexual health services. In recognising this limitation however it must be kept in mind that the majority of sexual health care takes place via statutory provision (De Cock and Low 1997; Department of Health 2002). Therefore the study data gathered from sexual health workers is useful in providing an insight into the views of the majority service providers.

The use of a female co-worker is the final limitation related to study design to be cited here. The decisions to use a co-worker in the focus group were outlines in the methodology chapter. Great thought went into determining the characteristics of the co-worker, particularly in relation to gender, ethnicity and professional (nursing) status. The section of a female, black Caribbean co-worker introduced a gender limitation in that no males were involved in the data collection or analysis. There is much discussion in the literature relating to gender identity of researchers and the impact on the research process (Cotterill 1992; Andersen 1993; Bhopal 1998). Many of these issues were highlighted in the methodological chapter. The possible biases

arising from a lack of a male perspective on the data collection or analysis were deemed to be less important than the need for the co-worker to have some experience of running focus groups and black Caribbean communities. These factors were the primary concern in the recruitment of a co-worker. In the end a female researcher with the required experiences was recruited.

This study is based on theories in which reality is accepted as being multiply constructed within a particular social context (May and Williams 1998). The study therefore set out to investigate views of back Caribbean men's sexual health from a particular perspective. This has been achieved with a dominant female researcher perspective. During conduction of the focus groups the gender identity of the researchers did not appear to have any overt impact on the data collection process. In all focus groups participants did not question the lack of a male researcher and did not raise this as a point of concern in the individual interviews. In fact the ethnicity of the researcher and the expertise in sexual health were the only issues raised by participants which directly related to the researchers. This may have been assisted a range of factors. The researcher and co-worker's experience in conducting focus groups may have helped to put participants at there ease. In addition the fact that most sexual health workers are female may have attributed to the lack of a male researcher being accepted by participants. However in the light of the need to expand the pool of sexual health studies in this area, further research is welcomed. Studies reproducing the methods used conducted with either a wholly male research bias, or both genders are needed. This could provide valuable insight into the effects of researcher gender identity on the discussion of sexual health.

This first section of the chapter has outlined some of the limitations arising out of the methodological decisions taken in the study. The issues raised here are by no means an exhaustive account of all the possible constraints and concerns affecting the data. Rather they have been set out to highlight the main considerations forming the context in which the study findings were derived. These limitations need to be kept in mind as they contextualise the discussion that follows.

7.2: Locating the stereotype

There is a wealth of quantitative data indicating the higher incidence rates of sexually transmitted diseases amongst black Caribbean men (Fenton and Wellings 2001; Hughes, Brady et al. 2001). This data provided the impetus for this research project and the exploratory study discussed in chapter 1, 'Setting the context'. It was anticipated that utilising qualitative approaches to researching sexual health would facilitate exploration of why black Caribbean men appeared to be at disproportionately high risk of sexual ill health. One of the main issues arising out of the high incidence rates for STIs was the suggestion that black Caribbean men took greater risks with their sexual health than men from other ethnic groups.

The findings from this study however, do not suggest that black Caribbean men are engaging in activities involving greater risks to their sexual health than men in other ethnic groups. Analysis of the data from the focus groups and individual interviews suggest that the sexual experiences of black Caribbean men are mainly influenced by the same socially determined factors impacting on the rest of society. Responses by participants indicated that in common with other ethnic groups risk taking amongst black Caribbean men was associated with youth (Fortenberry, Dennis et al. 2002), socioeconomic group (Blum, Beuring et al. 2000) and a lack of positive role models (Beier, Rosenfeld et al. 2000).

However, at the same time participants in the study did perceive black Caribbean men as having a more risky and irresponsible attitude to sexual relationships than other men. This suggests that while the wider social contexts in which sexual decisions are made appear to be the same, a different script is at play in judgements of black Caribbean men and their sexual conduct. The findings from the study reveal that scripting of black Caribbean men's sexual behaviour contains significant additional elements based on a predominantly negative sexual stereotype of black Caribbean

men. This stereotype is overtly linked to historical, racist references about the sexual expression of men of African Caribbean origin rooted in the colonial past of Britain and America (Screen 1992; Sollars 1996). In response to questions about what they believed to be the main influences on the sexual practices of black Caribbean men, this negative stereotype emerged as the dominant frame of reference used by participants as a basis for discussing the sexual decisions of black Caribbean men.

In itself, the reported use of a stereotype as a basis for making decisions or forming judgements about individuals is nothing new. The use of stereotyping and stereotypes as a frame of reference in society is well established in the literature and often reported as a common method of categorisation in society (Balsa and McGuire 2002; Blair, Judd et al. 2002). The data chapter 'The nature of the stereotype' reveals that the stereotype of black Caribbean men identified by participants mirrors other social stereotypes acting as a legitimised frame of reference. The sexual stereotype of black Caribbean men as described and experienced by participants embodies the essential characteristics of stereotypes in general as discussed in the earlier chapters.

Discussion of stereotypes earlier in the literature chapter identified how stereotypes are often exclusively applied in society in relation to a particular social group despite comprising 'general' characteristics (Oakes, Haslam et al. 1994). The sexual stereotype described by participants was also applied in this way, being perceived as exclusively relating to black Caribbean men as an identifiable group in society. This link to black Caribbean men in particular rather than men in general retained a degree of persistence over time with participants making overt links with slavery and black men's experiences of migration. This persistence of association with the identified group is recorded in the literature as a key characteristic of stereotypes and the process of stereotyping (Tusting, Crawshaw et al. 2002).

The sexual stereotype of black Caribbean men and the stereotyping of their sexual decisions can therefore to some extent be perceived as part of a normal phenomenon in British society due to its lack of uniqueness when judged alongside other

stereotypes. It exists within a recognisable socially constructed framework that mirrors the commonly recognised methods for identifying and applying stereotypes in society. A frequently used method for proving the veracity of the negative stereotype in relation to the sexual decisions of black Caribbean men, were the examples viewed by participants within Townsville. Experiences of witnessing lone mothers, multiple partnerships and absenteeism as fathers amongst black Caribbean men were cited as 'proof' that the stereotype was true.

The sexual stereotype of black Caribbean men described by participants itself, adds very little to vast amount of articles discussing the components of stereotypes. Through Participants' experiences of the stereotype it is revealed as contradictory and changeable in both application and relative importance. This means it is simultaneously acted on as a fixed entity yet adjusted to fit the particular context in which it is applied. The stereotype therefore both exists and elicits socially determined contradictions and tensions in order to function. This is in concordance with fluid notions of how reality is socially constructed and the associated acceptance of multiple concurrent scripting of behaviours and events (Gagnon and Simon 1973; Vance 1991).

The state of tension under which black Caribbean men live with the stereotype as a constant frame of reference in their lives provides examples of how this contradictory phenomenon is experienced as a social reality. They also provide additional examples to support recent criticisms in the literature objecting to the way the term stereotypes is used to refer to fixed 'categories' of people and behaviour with little regard given to the essentially contradictory and judgmental nature of stereotypes (Pickering 2001).

The issues discussed in the first two data chapters provide valuable practical examples of the contradictions inherent in social scripts in general. They further expose the contradictions and tensions governing stereotypes, the process of stereotyping in social interactions and the judgements made as a result. Many of the contradictions are highlighted in participants' comments about the anomalous and antagonistic ways

in which black Caribbean men and the stereotype are associated. For example as with other stereotypes, that relating to black Caribbean men is described by participants as being predominantly negative (Leyens, Yzerbyt et al. 1994). However, the 'negative' sexual stereotype is simultaneously associated with positive sexual attributes such as sexual prowess. This in turn is perceived by participants as having a beneficial impact on the ability of black Caribbean men to attract a sexual partner.

The tensions arising from these 'cost-benefits' of the way the stereotype was experienced was further complicated by participants' reluctance to dismiss either association. Rather both the negative expectations that black Caribbean men were irresponsible as sexual partners and the advantage this gave them co-existed. Participants openly acknowledged their perception that the fact that black Caribbean men had many sexual partners was due to irresponsible attitudes to sexual health and illustrative of their heightened risk taking. The black Caribbean men spoke of the stresses of managing these contradictory aspects of the stereotype. They recognised both the positive advantages for themselves when seeking new sexual partners alongside the burden of 'living in its shadow' in established relationships. It is interesting to note the role played by the stereotype in identifying them as good lovers also labelled them as undesirable partners in long term personal relationships.

The judgement of others based on contradictory aspects of a stereotype and the impact on those labelled by a stereotype provide another dimension to the social scripting of behaviour. The practical tensions experienced by black Caribbean men in trying to mange the stereotype and its effects in their social encounters emerged as an important aspect of this study. The personal experiences of dealing with contradiction are often forgotten or little referred to in the literature on stereotyping or common sense understandings of stereotypes (Shohat and Stam 1994; Wyer 1998; Siegrist, Cvetkovich et al. 2002). Instead stereotypes are more likely to be presented as fixed, clear and oversimplified (Bhabha 1992; Balsa and McGuire 2002; Blair, Judd et al. 2002). This presented view of stereotyping is then more likely to be described and analysed from a third party perspective.

Viewing sexual stereotypes as components of flexible, scripted and socially constructed realities is a useful tool in attempting to broaden the way in which stereotypes are presented. A more flexible approach makes it possible to look beyond the nature of the sexual stereotypes as simply contradictory and begin to question the role or purpose of the association with black Caribbean men and their sexual behaviour.

The message that emerges quite strongly from the data is that for British black Caribbean men, sexual interactions are affected by the view of them as sexually irresponsible and insatiable. The view of black Caribbean men as sexually irresponsible and insatiable has direct and specific affects on their sexual experiences and relationships. The sexual stereotype embodied both the positive and negative consequences of this viewpoint. The social pressures brought about by living with the stereotype reflected in the experiences shared by participants. For example they described increased pressure for their relationships to succeed and the ways in which it influenced the expectations placed on black Caribbean men in non-sexual interactions. The sexual stereotype can therefore be seen as playing a key role in not only scripting the sexual behaviour and experiences of black Caribbean men but also their individual and collective identities as members of society.

Research into the social construction of masculinity explores the various ways in which masculinity is defined and experienced in society. Rather than a fixed commodity or finite collection of attributes masculinity exists in different guises within and between societies and varies over time (Connell 1996). As with other socially determined aspects of humanity masculinity is also scripted through social conventions and relationships as much as genetically coded physical traits. Social construction as applied to masculinity, recognises the way differences are constructed in the social relationships between different types of masculinity. Differentiation in society is applied and understood through socio-political dominance, subordination and alliance as well as the existence of physical difference itself (Hall 1991; Abrams

and Hogg 1999; Adams 2000). Relationships in society between masculinities and social structures are thus constantly formed, changed and reaffirmed in everyday practical settings. The social mechanisms through which this constant change occurs are individual and shared experiences of social exclusion, inclusion, intimidation and exploitation (Connell 1996). Masculinities are therefore closely aligned to other determinants of position and power in society such as ethnicity, social class and gender. Understanding masculinities and how they impact on sexual health for example means appraising them within a wider context. Sexual ill health or healthy choices for black Caribbean men does not occur in isolation from other aspects of their life. There is a need to focus on the conditions under which masculinities arise both historically and politically as well as examining the personal and cultural effects on sexual activity produced as a result.

The experiences of black Caribbean men in relation to sexual stereotyping arise from the interplay between ethnicity, class and masculinity. This provides a framework for assessing and exploring the practice of masculinity in particular situations within a changing structure of social relationships (Hall 1991; Parker and Aggleton 1999). The experiences recounted by participants in this study provide very good examples of the practical effects of social expectations on sexual behaviour. The experiences of black Caribbean men in the study reflect the social relationship between masculinity and dominant cultures from the perspective of marginalised positions in society.

In this guise the stereotype was described as indirectly impacting on the sexual health decisions of black Caribbean men. This occurred through its affect on their social interactions with other key player such as peers, family members and sexual health professionals. The indirect effects of the stereotype are experienced through the negative attitudes of others in dealing with black Caribbean men and the appraisals made about their black male identity as perpetrators of sin, violence and carriers of disease.

The wide range of sexual situations in which the stereotype was perceived as playing a part raises the question of whether the stereotype can be viewed as the key influencing factor on the sexual health decisions made by black Caribbean men. If so, the stereotype is the answer to the research question cited in the introduction, which was

- To identify the key factors influencing the sexual health decisions of black Caribbean men and explore how these factors may impact on their health seeking and risk taking behaviours.

At first glance it could be surmised that the stereotype is the main factor influencing the sexual health decision making of black Caribbean men. The range of both sexual and non-sexual situations in which participants alluded to it adds weight to this assumption. However, as the study progressed and the analysis of the data proceeded what became apparent was that the focus of the study had undergone a degree of change.

The methodology chapter identified that those involved in the research process including the researcher and the study itself formed part of the contextual script of the study. Completing the study may therefore change the script in ways that could not have been fully anticipated in advance. This fits closely with Gagnon's observations about the use of scripting perspectives in sex research (Gagnon 1990). He advises that the process of applying such a perspective has the potential effect of altering the social contexts in which sexual scripts themselves are maintained. To a degree the issues raised in the limitations section concerning the decision to use a prescriptive framework in data collection reflects this process. The dilemma between using prescriptive methods for initiating discussion (such as the prompts) and a need to give permission to speak of hidden or silenced subjects also embodies a changing of the established arena for sexual health discussions. The prompts successfully allowed silenced issues to be discussed but in voicing these issues it potentially

changed them, bringing into the open factors that were previously unknown and unproven.. The impact this may have on future research into sexual health and ethnicity is at present unknown.

The initial aim of the study was concerned with identifying the factors influencing the sexual risk taking or health seeking decisions of black Caribbean men. The initial objectives of the study were

- To identify the key factors influencing the sexual health decisions of black Caribbean men.
- To explore how the identified factors are believed to impact on the sexual health decisions of black Caribbean men in terms of their sexual health seeking and risk taking behaviours.
- To consider the possible consequences and challenges of the factors identified for sexual health professionals seeking to provide sexual health care for black Caribbean men.

Analysis of the data revealed that the first of the three objectives stated at outset had altered in the process of investigation. This had a knock on effect on the second and third objectives which were dependant on it and resulted in a slightly different emphasis evolving in the study.

The differential rates of STI infection reported in the quantitative studies and the lack of qualitative information concerning black Caribbean men and sexual decisions mentioned earlier had led me to question why these disparities existed and acted as an impetus for conducting this research (Serrant-Green 2000). The first objective was devised on the basis of the existing research and my experiences of working in sexual health in the early eighties. However at the outset, the possible explanations for the differences in STI incidence among black Caribbean men was anticipated to result from specific identifiable factors underpinning the sexual decisions of black

Caribbean men. I anticipated that in discussion the participants would reveal a selection of discreet factors they felt were the main influences on black Caribbean men's sexual decision making. However, in practice participants described events, feelings and experiences which were much more complex. Rather than discernible sexual encounters these covered self identity, personal management strategies, assumptions and expectations as well as cultural or community responsibilities all of which reflected a series of relationships which included either sexual and non-sexual constraints or opportunities. The discreet, specific factors I had anticipated out the outcome failed to emerge.

Further exploration of these much more complex issues using a social constructionist approach revealed possible explanations for this failure. The 'factors' I sought were could not be identified or appraised as separate entities from the socially constructed scripts in which they resided. They could not be named in isolation because they did not exist in that way. The social scripts gave rise to them, sustained and changed them through a complex process involving individual and group understandings of black Caribbean men, sexual health and risk. The issues addressed during the discussions and arising out of the analysis were derived within these complex formations. The sexual decisions of black Caribbean men were closely related to the social, political and personal context in which sexual health decisions are made. The first objective therefore was therefore incorrectly focussed on the discovery of discreet factors. It was not that the factors did not exist, rather that they were to a greater or lesser extent hidden within the little exposed social scripts governing the spaces where black Caribbean ethnicity, male gender and sexuality intersect. Pursuing achievement of the first objective revealed the existence of a specific sexual script concerning black Caribbean men which was still to be revealed. The focus of the study therefore altered during the process of analysis to learn more about the social context in which the scripting occurred.

The shift in focus highlights a gap in research on sexual health, which was not apparent at the beginning of this study. This gap is situated in the need to move from

attempting to identify the influencing factors on sexual decisions to exploring the socially constructed contexts in which the sexual decisions are made by black Caribbean men. The analysis of the data it revealed it was not possible to locate absolute factors because the scripts governing the landscapes in which factors emerge, are identified and exist remain hidden. They are silenced as a result of a range of influences discussed in the setting the context chapter including the sensitive nature of the subject, the dominance of quantitative approaches and racism. The question 'in what context do black Caribbean men make sexual decisions?' formed no part of my thinking at the outset to some degree because I was unaware that such a landscape was still awaiting discovery. On reflection perhaps the research question should have been changed as the study progressed. However, on discussion with my supervisors I decided to pursue the original set objectives utilising a broader frame of reference as a different way of seeing the influencing factors. The aim became to expose the socially derived relationships between factors revealed by participants as pertaining to black Caribbean men's sexual health and pre-existing social scripts through the collated data.

Components of the socially constructed scripting of black Caribbean men's sexual decisions were progressively revealed through the process of data collection and analysis. It helped to re-centre my thinking about the sexual decisions of black Caribbean men to include wider socially determined issues such as identity, difference and the impact of inequality. These issues precede the original research question in that they are located in existing power relations in Britain, which underpin the concerns that gave rise to this study.

The broader social and cultural focus needed for fulfilling objective explicitly refines my initial recognition for the need for more qualitative sexual health data to compliment and support the quantitative information available. It specifically exposes a lack of information about the psychosocial arena in which black Caribbean men make sexual decisions and the range of scripts associated with it. Of particular interest are the points of apparent convergence and harmony between the black Caribbean

participants' perceptions of sexual situations and that of their sexual social networks. The data reveals a high degree of agreement between black Caribbean men and the significant others involved in their sexual health. Issues such as the overtly negative characteristics of the stereotype, the use of this as a frame of reference and the inescapable impact it has on sexual interactions are of particular importance. Open recognition and assimilation of these aspects of social and personal experience are currently absent in discussions of sexuality, ethnicity and risk taking in health behaviours. Insight into how sexual decisions are made sense of and managed in the lives of black Caribbean men in British society form a key part in the scripting of sexual health behaviour in Britain. In the absence of any evidence pertaining to this aspect of black Caribbean men's experiences it is difficult to determine the exact nature or source of the influences on their sexual decisions.

Recognition of the need to understand the wider context in which decisions about health behaviour take place is well established in health and social care provision in general (Conner and Norman 1998; McGrath 1998; O'Dowd and Jewell 1998). It has also been well researched in relation to ethnicity, gender and heath care provision (Culley 1996; Ahmad and Atkin 1997; Narayanasamy 1999; Nazroo 2001). However, as discussed in the methodology and literature chapters explorations of the impact of ethnicity, gender and social status on sexual health decisions and studies utilising qualitative methods of enquiry are relatively rare in sexual health research.

Reflecting on the sexual health decisions of black Caribbean men using a social constructionist perspective allowed the search for factors influencing behaviour to take on a wider perspective. Attention could now be given to the importance of negative expectations and differential experiences on sexual decision making. Through a social constructionist approach aspects of participants' experiences expose how sexuality, ethnicity and judgements of behaviour intersect in British society at this particular point in time. This had knock on effects for addressing the second objective, which was

- To explore how the identified factors are believed to impact on the sexual health decisions of black Caribbean men in terms of their sexual health seeking and risk taking behaviours.

Once the 'factors' influencing sexual behaviour had been revealed to be more complex, contextually bound and socially constructed than anticipated objective two also had to be addressed within a similarly broad focus. The impact on sexual risk taking and health seeking behaviours of black Caribbean men in this study could not be confined to explaining individual choices in isolation from the marginalised positioning of the participants.

The methodological approaches taken in the study and the theories underpinning them were instrumental in facilitating adoption of a more open approach to analysing data to fulfil objective two. The fundamental benefit of the qualitative approaches used in this study compared to the established quantitative approaches to sexual health research was that both sexual and non-sexual influences on scripting of sexuality could be exposed. In addition equal emphasis could be placed on what is said and that which is not usually said in the context of sexual health. The use of criticalist, feminist and ethnicity based perspectives applied within a social constructionist framework proved to be of great benefit in exploring the gaps left by the traditional over reliance on quantitative methods in sexual health. As theoretical approaches underpinning this study they allowed the data to reflect much more closely the inferred, unspoken and unquantifiable aspects of a socially taboo and sensitive subject such as sexual health and black Caribbean male experience (Gamson 1992; Hendriks 1992; Gibson 1996).

The experiences of the participants illustrated the ways in which the racism and inequality embedded in society are conveyed through the stereotyping of black Caribbean men's sexual identity and behaviour. Black Caribbean men demonstrated through the recounting of past incidents, thoughts and feelings how their sexual

decisions and choices were affected directly or indirectly by subtle forms of racism. These were identified by the men as existing in the selective portrayal of them as 'bad news', sexually insatiable or irresponsible. Conversely the black Caribbean men also revealed the tensions inherent in their positioning as sexually sinful with confessions that notoriety also gave them relative status and sexual appeal.

The same contradictions were also apparent in the examples given by black Caribbean women, partners of black Caribbean men and sexual health professionals. Utilising different examples, each focus group shared experiences of managing and determining their response to black Caribbean men within this contradictory frame of reference. In the chapters 'Living with the stereotype' and 'Hearing the silences' they described the stereotype as an inescapable aspect of their dealings with black Caribbean men. It affected their private, social and professional interactions with black Caribbean men. These participants showed great awareness of the unsatisfactory, unstable and racist nature of the stereotype that typified these beliefs. However, they still felt compelled to use it in the face of no other alternative. Objective two therefore revealed the complexities of the effects of scripting of sexuality when related to ethnicity and gender on the sexual contexts and as a consequence on the decision making process for black Caribbean men.

The need to learn more about the socially constructed context in which sexual decisions are made by black Caribbean men emerged most strongly as a consequence of considering the screaming silences in the study. The screaming silences identified by participants served to reinforce the importance of the wider psychosocial context to the sexual decisions of black Caribbean men rather than simply relate the issues voiced by participants solely to the stereotype.

Screaming silences is the term used in this study to epitomise areas of research and experience which are at best under-researched and require more development, or are at worst historically and/or politically undervalued, absent or invisible. Screaming silences locate the subordinate position of particular scripting perspectives as an

aspect of social construction. It mirrors similar concepts used by criticalist, feminist and ethnicities based researchers to allow them to describe and locate the experiences of marginalised peoples or hidden viewpoints in society (Christian 1989; Collins 1991; Olesen 1998; Letherby 2002). The emphasis placed on the hidden or unexplored minority perspectives in these research approaches and my own study is based on a belief that the information arising from these sources have something to add to the understanding of a subject (May and Williams 1998; Pilcher 2001). So what do the screaming silences revealed in this research tell us about sexual health decisions of black Caribbean men?

Through the issues raised in the focus groups and interviews a whole range of factors are identified by participants as sources of dilemma and conflict in their lives. The examples given by participants are associated directly or indirectly with the stereotype. Many of the factors cited by participants are deemed to be inherent characteristics of the nature of the stereotype of black Caribbean men. Others result from the effects of its application in the lives of participants. The Chapter 'Hearing the silences' explores the conflicts arising directly or indirectly from the stereotype. Through discussion of the screaming silences embedded in the data, the underlying tensions inherent in the scripts associated with sexual decision making are exposed.

Taking note of the screaming silences allows the importance of scripts contained in the context in which sexual decisions are made to emerge. These silences are associated with making sense of and negotiating a way through the tensions associated with sexual decisions. For example in the focus group involving black Caribbean men, participants spoke of the importance of their experiences as a child growing up without the presence of a father figure on their sexual and social decisions. The absence or presence of significant black male mentors in their early lives shaped their reactions to the stereotype, views of responsibility in relationships and how they chose to present themselves as adults. The links made by participants between male role models, community expectations and their own decision making

raises questions of how scripting imparts or affects a developing sense of self, locating an individual in time and space within a cultural community.

The sense of self and its relationship to a socially constructed identity was particularly poignant in the comments of some black Caribbean men when they recalled becoming aware of the stereotype through television programmes caricaturing 'players'. This was juxtaposed by the pragmatic approach of some of the younger participants who openly acknowledged their intent to use the negative expectations to their advantage. Both sets of reactions acknowledge the existence of the stereotype but adopted radically different reposes to dealing with it. Gagnon (1973) discusses the active role of humans in scripting their own identity, which contradicts the suggestion that as a socially constructed phenomenon, scripts incorporate a 'given' sense of self. The necessity of processing social scripts in order to give them meaning sheds light on what the participants described as 'becoming aware' of the stereotype at specific points in their lives.

The social constructionist approach underpinning this study acknowledges the existence of both individuals and shared influences on sexual behaviour. The existence and acknowledgement of the stereotype occurred at both levels in the examples cited by participants. The scripting of black Caribbean men within negative stereotypes preceded the birth of all participants so in a sense evidence of it in society was always there. There was a communal understanding of the nature of the stereotype among black Caribbean men both theoretically and in the examples from black Caribbean communities to which the men belonged. However, any communal interpretation of black Caribbean male sexuality and the effects of it remained unacknowledged by the participants on a personal level until processed by them as part of their individual development. Hence in many of the examples they gave 'becoming aware' was a realisation or re-evaluation of existing information for each participant rather than discovery of previously unknown facts.

Considering the scripted aspects of individual and communal social decisions was a key element in reassessing the impact of the stereotype on sexual health decisions of black Caribbean men. Without this approach, the active role played by the individual, communal, historical and experiential components of their decisions would be lost. In this thesis, the sexual decision making of individual black Caribbean men could therefore be taken to be simply a matter of immediate response or the isolated appraisal of a situation.

Through the application of scripting perspectives in this study, the evidence given by participants is seen to involve more than a response or reaction to the stereotype. It also encompasses complex socially derived processes involving both individual and shared appraisal of the stereotype, personal experiences and social expectations. It is only when the responses of participants are viewed in the light of the social scripts and the screaming silences enveloped within them, that the true significance of the stereotype in the sexual decisions of black Caribbean men emerges. The literature identifies that the true meaning of events in the social sphere can only be understood when viewed within the framework of the scripts that contain them (Gagnon 1973). As a result rather than identifying sexual decisions as an isolated caricature associated with black men of African or Caribbean origin, the stereotype appears to be part of wider social issues affecting this group of men such as inequality, social status and sexual identity.

The screaming silences therefore reveal the process of living with and managing the effects of the stereotype as described by participants as one of many social scripts governing aspects of their daily decisions. The stereotype is not a unique aspect of black Caribbean men's lives but one of a range of issues that must be managed alongside non-sexual responsibilities. In many of the examples given by the participants, the tensions associated with managing the stereotype and the contradictions within it were closely aligned with other aspects of their experiences not associated with sexual encounters. This seems to have resulted from not only the 'normality' conveyed by the stereotype itself but also the interplay between non-

sexual and sexual behaviours in sexual decision making in general. As a result members of the society may find it difficult to differentiate between stereotypes as they apply to a particular social group or context and their 'normal' reactions to social encounters (Blair, Judd et al. 2002; Diekman, Eagly et al. 2002). This phenomenon reflects the ways in which stereotypes like other scripted reference points often become so closely incorporated into a society over time that associated behaviours and reactions to them are assimilated into other aspects of life (Abrams and Hogg 1999).

Assimilation of the stereotype as part of the scripting of black Caribbean men into British society helps to explain why black Caribbean men in the study found it difficult to differentiate between dilemmas faced in their sexual decisions and those that were part of their everyday lives. They used similar strategies to manage both. For example, the way in which some participants reported the dilemmas involved in 'taking a stance' in relation to the stereotype by choosing to accept or challenge its impact on them, mirrors their concerns about choosing to establish an identity/lifestyle outside the existing black Caribbean communities' expectations of them. The silences surrounding participants concerns about the emerging stratification within black Caribbean communities as a result of changes in socioeconomic status further illustrate the links with social construction. Through the silences scripting behaviour is demonstrated to be changeable and malleable. Relating sexual health behaviour to obligation, risk and responsibility through social scripts as discussed in the literature chapter, helps to illustrate why participants do not appraise and react to the stereotype in isolation from past or future experiences. Instead participants claim to modify their responses to the stereotype according to their appraisal of their current roles and responsibilities as well as their future aspirations.

Much of the literature about stereotyping has explored the role stereotypes play in society in terms of assisting in identification and categorisation of individuals and social groups (Fiske and Taylor 1991; Leyens, Yzerbyt et al. 1994; Hinton 2000). In general the discussions in these articles explore the role of the stereotype from a third

person perspective. Identifying through observations of society the ways in which stereotypes of others are used and made sense of in society. The screaming silences in this study revealed the importance of the role of the sexual stereotype from the perspective of those most affected by it, black Caribbean men and other key players in their sexual health. While this perspective emerged late on in the analysis of the outcomes and so was not fully explored in the study, it raised some interesting points for further exploration of the scripting of black Caribbean male sexual experiences.

For black Caribbean men the stereotype was revealed as an important component in their own sense of identity. It was part of their history, outlining and to some extent illuminating their difference from other minority ethnic groups as well as the majority population. Writers on ethnicity, identity and community have discussed the importance of shared history in giving a sense of self and a sense of belonging to displaced peoples and their descendants (Bhabha 1997; Brah, Hickman et al. 1999; Estes 2000; Blair, Judd et al. 2002). In general these authors discuss issues of identity and belonging in relation to the positive or life enhancing aspects of community, relationships with the country of origin and the of cultural identity.

The dilemmas recounted by some participants during the discussions in this study however are interesting because they relate specifically to the stereotyping of black Caribbean men. This provides a slightly different insight into the aspects discussed by the authors above in that unlike many of the issues raised in their work these concepts of self relate to images and historical connections which are popularly seen as wholly negative. While issues of identity and belonging linked to negative stereotypes do not form the main focus of this study and cannot be fully explored here, the study highlights a possible area for future research. The role played by the stereotype in securing a sense of self in black Caribbean men, and the potential for 'loss' if it is refuted, adds to the influencing sexual scripts associated with black Caribbean men and the overall context in which sexual decisions are made. The usefulness of the stereotype to black Caribbean men challenges the commonly accepted notions of the stereotype as a negative concept in society and broadens the

'positive' aspects of it beyond the supposed physical attributes or sexual status and prowess of black Caribbean men.

Issues raised by key players in the research concerning the role of the stereotype suggest that the usefulness of the stereotype and feeling of ambivalence associated with its use are not only an issue for British black Caribbean men. The professional context in which sexual health information, treatment and support is given has been affected by the lack of qualitative research into sexual health (Bolton 1992; Adler 1997; Duncan and Hart 1999). This is borne out by the screaming silences revealed in the experiences of sexual health professionals in this study. As a consequence the need for more research based information about the relevant aspects of the social experiences of clients and how this may impact on sexual decisions is highlighted by both qualitative and quantitative researchers (Lacey, Merrick et al. 1997; Lamp 2000; Katz, Fortenberry et al. 2001).

As a result of the broadened scope for exploring the factors influencing the sexual health decisions of participants which formed the focus of the first two objectives the third objective also underwent a shift in focus. Assessing the implications of the findings for sexual health professionals working with black Caribbean men also required review and appraisal of the impact of social scripting of sexual health, ethnicity and risk within health care service provision. For many of the professional participants in this study, the stereotype was identified as the only sure thing they felt able to refer to in determining their actions or reactions to black Caribbean male clients. It also formed a basis for justifying their applications for additional resources to provide for the needs of this client group.

As with participants' awareness of the racist undertones in use of the stereotype in the social encounters, in the professional sphere the adoption of the stereotype also gave rise to feelings of ambivalence. Sexual health professionals describe how the sexual health care they provide based on references to the stereotype and the statistical data on risk available to them is often given amidst feelings of tension and personal

conflict. These feeling are discussed by participants as a consequence of the over reliance on medical models of treatment in statutory sexual health services. Feelings of inadequacy result from the social construction of sexual health as an area of care need in Britain. At the present time it is not unusual to find a lack of wider sexual health knowledge in many of the nursing staff working in sexual health clinics. The feelings of dissatisfaction and frustration expressed by the sexual health workers participating in the study appears to arise from this as much as from the continuously rising demands of an over pressured service. These aspects of the knock on effects of social construction of sexual health within society and how this interacts with the scripts governing the position of black Caribbean men within it had to be taken account in determining the boundaries and constraints on any recommendations.

Increasing demands for services and staff concerns about their inability to provide holistic patient care to minority ethnic clients are not unique to sexual health services (Mulholland 1995; Gerrish, Husband et al. 1996; Leininger 1997). However in many other areas of health care statutory services provide a range of 'complimentary' services such as patient liaison groups, support networks and home care services to support staff and patients. Services such as these often lie outside the statutory remit and are community based. However, they work closely with statutory services and their clients to manage and understand the implications for health and lifestyle of a wide range of conditions including diabetes, cancer and other chronic or life threatening conditions (Adler 1997; Department of Health 1997; Department of Health 1999). Some notable pilot centres for integrated sexual health services have begun to be established in recent years (Royal College of Nursing 2000; Department of Health 2001). Data from this study suggests however that this has yet to be fully recognised and integrated into the general sexual health services outside the voluntary sector in Britain.

The screaming silences in this study complete the picture of the context in which black Caribbean men make their sexual decisions. The context in which sexual decisions take place is revealed to be associated with far more than the negative

scripting of stereotypes of black Caribbean men or the process of stereotyping. It involves society's shared beliefs, attitudes and expectations about a particular group in relation to sexual health. These beliefs, attitudes and expectations are flexibly constructed through sexual and non-sexual scripts. These scripts may become increasingly assimilated into the norms of a society such that they impact the activities that take place in that society and on the daily experiences of individuals. In terms of sexual health, they have been found in this study to affect professional service delivery and the health care experiences of specific client groups.

Anomalies and contradictions in the sexual experiences of black Caribbean men are revealed through recognition of the modifying effects of wider socially constructed issues. In this study of black Caribbean men's sexual decisions they emerged during exploration of the silences residing at the intersection of ethnicity, sexuality and behaviour. The sexual stereotype of black Caribbean men therefore cannot be accepted as the sole influencing factor on their sexual decisions. Instead the stereotype is identified as part of a complex range of influences which make up the social context in which sexual decisions are reached by black Caribbean men. The impact of the stereotype and process of stereotyping on black Caribbean men are specific components of sexual scripts involving black Caribbean men. As such the experiences shared by participants provide examples of the way beliefs and expectations, whether real or imagined, associated with the sexual health of a particular social group are lived out in society.

If social construction and scripting are taken to be central to sexual decisions making as revealed in this study, then it suggests that the beliefs and expectations involved in making sexual decisions are not the same for everyone. From analysis of the data it appears that participants believe that in sexual interactions, making decisions about sexual issues and any associated interactions, are affected by the specific individuals involved. Sexual interactions involving people differ depending on the expectations and beliefs of the individuals involved and the groups to which they belong. This is borne out in the literature on scripting perspectives and the social construction of

behaviour which identifies the existence of many scripts with areas of overlap and divergence at the level of the individual, group or wider culture (Gagnon 1999; Douglas 1992).

Taking this broader focus into account it is pertinent at this point to return to the question which was posed earlier in the context setting chapter: Why is it that black Caribbean men in Britain are identified as more risky and irresponsible in their approaches to sexual health? This is where the stereotype re-enters the discussion. For British black Caribbean men at this particular point in time, the stereotype holds a key position in the process of making decisions about their sexual encounters and relationships. It influences the appraisal of black Caribbean men and their sexual decisions by key players, black Caribbean communities and members of society as a whole.

At the beginning of this chapter it was recognised that this research takes place at a particular point in time and is conducted amongst a relatively under researched group utilising a small sample size. As with any research study, limitations are introduced as a result of the methodological and practical constraints of conducting research. The emergence of the stereotype as a key frame of reference in the sexual decisions of black Caribbean men and the scripts underpinning judgements of them or their behaviours must be appraised in the light of these limitations. As a socially determined and derived aspect of black Caribbean men's experiences in Britain the impact the stereotype has is liable and susceptible to change over time and within the interactions of particular individuals (Hinton 2000; Pickering 2001; Vonk 2002). This means that accepting the significance of the stereotype in this study, does not infer that either the nature of the stereotype as described here or its association with black Caribbean men's sexual decisions are inevitable or permanent.

The range of considerations and concerns presented by participants highlights the fact that stereotyping cannot be claimed to be an inherently dominant frame of reference for sexual health decisions in general. The stereotype is of central concern

to this study because the subjects of the research are black Caribbean men. The stereotype emerged as an important factor in the context of this study. It maintains a historical, social and political link to the social scripts denoting the sexual decisions of black Caribbean men and their positions in society (Bhabha 1992; Goldberg 1993; Blair, Judd et al. 2002). This suggests that other subject groups may elicit different contextual references not relevant to this particular study. Therefore substituting black Caribbean men as the subjects of research into sexual health decisions with another social group would not necessarily mean investigating the effects of another stereotype.

Together with the limitations noted earlier and the atypical use of qualitative approaches in this study into sexual health, the recognition that the context of sexual decisions are relative to the subject group limits the number of direct generalisations that can be made from the outcomes. The findings of this research do offer a new contribution to knowledge related to sexual health research in general and particularly to efforts to clarify the reasons for the disparities in STI rates in black Caribbean men. The contribution of this study lies in the suggestion that sexual health decisions and choices black Caribbean men make takes place in the broader context of the social scripting of sexual behaviour by black Caribbean men, their sexual social networks and wider society. These scripts incorporate the real or imagined beliefs and expectations that society has of black Caribbean men within socially constructed relations between sexuality, ethnicity and behaviour. The social construction approach applied in this study reveals that this situation is not unique to British black Caribbean men, to some degree the sexual decisions of all individuals in general are made in the context of their social and personal appraisal of important issues. It is the nature of the important issues associated with the scripting of the sexual behaviours and identities of a particular social group which informs the types of appraisal that occur and to some extent the judgements reached as a consequence.

The important aspects of any script to members of a particular social group in reaching sexual decisions are determined by a range of factors which contribute to the

social context in which decisions occur.. These include group and individual concepts of self, views of key players and the perceived expectations of society. Together with some of the aspects of sexual health identified in the literature such as perception of risk and consequences of risk taking (Macgill 1989; Lupton 1999; Luck, Bamford et al. 2000). The social context in turn denotes how scripts are identified, sustained or changed at a particular point in time.

What has also emerged in this study is the importance of what is not said, difficult to say or rarely acknowledged in relation to sexual health. These are the screaming silences exposed in this study that help to determine the context in which black Caribbean make sexual decisions. Silences are and inherent part of the social construction of reality at a particular point in time and are present in all social scripts. Taking note of the screaming silences associated with sexual health in general and a specific social group in particular leads to greater understanding of the context in which sexual decisions take place. Without an awareness of the silences there is a danger of focussing too narrowly on the obvious influences and the risk of findings being restricted to the description of specific aspects of a sexual encounter with little real understanding of the wider psychosocial or experiential issues at play.

The findings of this research add to the efforts to increase the qualitative information base on the relationship between sexual health and ethnicity. In doing so the study supports and compliments the considerable amount of quantitative data available, thus opening up additional avenues for research and enquiry into associations between ethnicity and sexual health. The study is particularly important in the drive to develop strategies to reduce the comparatively higher rates of sexually transmitted infections amongst black Caribbean populations in Britain by identifying potential avenues for exploring the 'how' and 'why' questions that remain unanswered by the statistical data on sexual risk taking. In focussing on the experiences of black Caribbean men in Britain the study contrasts with much of the currently available qualitative data which centres on the USA or Africa (Blum, Beuring et al. 2000; DiClemente, Wingwood et al. 2002; Fonck, Mwai et al. 2002). Thus opening up a

different (marginalised) view and generating further evidence for the mapping of the British sexual arena and the scripting of sexuality perspectives in black and minority ethnic communities.

In order to make sense of the sexual health decisions of a particular social group this research suggests that attention needs to be placed on identifying the nature of the sexual scripts and the screaming silences pertinent to that particular group. Consideration can then be given to how both aspects may influence individual and group understanding of sexual interactions and the possible impact this has on sexual decisions.

7.3: Implications for sexual health policy, practice and education

This research study initially arose out of my concerns about the disproportionately high rates of sexually transmitted infections amongst black Caribbean men and the lack of adequate explanations for the disparity. The study is rooted in my professional experiences as an outreach worker and nurse attempting to provide for the needs of black Caribbean men in Townsville. From its conception therefore this research study retained deeply practical roots. The methodological approaches underpinning this study reflected the importance of retaining links to practice and 'real life' applications in research. Research conducted from ethnicities, criticalist and feminist perspectives attempts to be of 'some practical use' to the groups and individuals involved. (Mirza 1995; Bowes 1996; Pilcher 2001). To this end the third objective of the study was set. This was:

- To consider the possible consequences and challenges for sexual health professionals seeking to provide for the health care needs of black Caribbean men in the light of the key factors identified in the study.

This next section of the discussion identifies some of the ways in which the issues raised in this study may be of practical use in a nursing and sexual health care context. This is achieved by focussing on how the outcomes from this study can be used to inform approaches to address the sexual health needs of British black Caribbean men. In doing so it takes on board the impact of the broader focus in terms of the socially constructed nature of sexuality, ethnicity and health behaviour revealed in the preceding section. The third objective of this study will therefore be explored using current sexual health policy as a framework to discuss the implications of the study for sexual health practice and education.

The context setting chapter at the beginning of this thesis identified how the overall approach to sexual health policy, service provision and practice in Britain has come under increasing scrutiny in the last few years (Harding 1998; Johnson, Mercer et al. 2001; Kinghorn 2001). A paucity of qualitative evidence and theoretical frameworks to support the quantitative exploration of sexual health within a health care context is still evident in Britain. However, there have been moves to challenge and broaden the scope of current sexual health practice at the levels of health care policy and professional practice (Royal College of Nursing 2000; Department of Health 2001; Department of Health 2003).

In the period during which this study was completed the British government launched a major strategy in an attempt to reduce the high rates of sexually transmitted diseases and unplanned pregnancies across the country. This is the national strategy for sexual health and HIV for England generally referred to as 'the sexual health strategy' (Department of Health 2001). This strategy has sparked production of various consultation documents and guidelines on sexual health from professional bodies (Royal College of Nursing 2001) and commissioned agencies (Department of Health 2003). As mentioned in the literature review the sexual health strategy recognises the unequal burden of sexual ill health borne by socially excluded groups in society including black and minority communities. The sexual health

strategy and associated reports outline various recommendations for change in sexual health service provision and preparation of professionals which may be associated with the outcomes of this study.

7.3.1: Sexual health policy and practice

One of the main recommendations from the sexual health strategy is that sexual health services should focus on local needs, setting targets in line with national priorities and monitoring their progress amongst local populations. These requirements are part of the drive to ensure sexual health services are responsive to both national requirements for raising the standards of sexual health provision and to the different needs of the local populations in line with the NHS plan (Department of Health 2000). These recommendations are reinforced in the Royal College of Nursing's own sexual health strategy which was produced in response to the national sexual health strategy. It sets out a way forward for nursing professionals to fulfil the requirements of the national sexual health strategy (Royal College of Nursing 2001).

Both the national sexual health strategy and that of the RCN identify the need to develop sexual health services to challenge and address the disparity of sexual ill health amongst marginalised groups. They highlight the fact that provision of a national (sexual) health service for all, needs practitioners who are aware of the factors which predispose or increase the risk of sexual ill health and act as barriers to effective service provision. The RCN strategy calls for attention to be paid to the wider issues of sexual health such as the role of stigma and discrimination or the relevance of psychosocial, cultural and ethical issues for individual clients or groups (p.12). This reflects the issues and concerns raised by participants in this study.

In discussing their experiences of sexual health services what became apparent was the tensions that often arose in sexual interactions involving participants due to professionals' lack of real insight into the broader psychosocial factors impacting on the sexual health decisions of black Caribbean men. Participants' experiences as

professionals and clients exposed how the vast amount of knowledge that existed about aetiology and treatment of sexually transmitted infections for example was insufficient in itself to feelings of satisfaction with sexual health services. Parameters such as job satisfaction, appropriate service delivery and receipt of good equality sexual health care were evident in the examples discussed by participants. In general participants did not feel that good service was always forthcoming in the case of black Caribbean men. Discussions in the focus groups revealed that good service was more likely to be associated with a sense of empathy and reduced distance between sexual health professionals and the client than with the efficiency of diagnosis and treatment (Abdullah 1995; Baker 1997; Balsa and McGuire 2002). For example, none of the black Caribbean men participating in the study felt that their physical treatment by sexual health professionals was inaccurate but they often reported feeling that staff had little insight into their life experiences and pre-judged them in a negative light.

Professional participants were aware of their lack of insight into the factors influencing the sexual decisions of black Caribbean men and described their reluctant reliance on the stereotype as the only option. The fact that nurses felt that the quality of service provided for clients from black and minority ethnic groups was inadequate was not a new revelation in itself. It exposed another example of nurses' generally poor level of knowledge and lack of confidence in addressing clinical issues relating to ethnicity and health reported elsewhere (Gerrish, Husband et al. 1996; Culley 1997; Duldt 1999).

The importance of revealing a lack of ethnically relevant knowledge in this study is that it highlights that there is a clinical need to focus on sexual health beyond the development of further medical treatments and procedures for detection of sexual disease. Previous quantitative research studies focussing on sexual health and ethnicity suggested the need for further research based information to broaden general understandings of sexual ill health. However, they have not linked calls for broadening the evidence base to the development of clinical skills for working with black and minority ethnic clients (Adler 1997; Fenton and Wellings 2001; Crepaz and

Marks 2002). For example it may be useful in staff development training to allocate some of the continuous professional development sessions to educating staff about the ethnic, ecomomic and social identities of the minority ethnic communities accessing their services. This knowledge can then be applied to consider the clinical implications for providing sexual health services from a specific ethnic viewpoint. This would help to foster a greater awareness of the contexts in which sexual decisions are made and diversity within clients accessing the service. It would also work to increase sexual health professionals' basic knowledge and reference points of the lifestyles and choices of minority ethnic people in the locality as it relates to sexual health.

In response to the problems highlighted by participants when accessing sexual health services, the study therefore suggests there is a need to focus on what appears to be general issues of life and lifestyles of black and minority ethnic people. Black Caribbean participants' did not call for development of specific sexual health services for black Caribbean men. Instead they suggested a need for services which were conversant with the situations faced by black Caribbean men and able to provide for their needs appropriately.

The findings of this study suggest that in order to achieve improvements in sexual health services for black and minority ethnic communities sexual health services need to become much more aware of 'who' the local community are and reduce the distance between themselves and their clients. Action to fulfil these requirements support the local and national priorities requested in the RCN and national sexual health strategies.

The national sexual health strategy goes some way towards this in suggesting that professionals become more aware of the local situation as it relates to sexual health. The strategy encourages sexual health providers to conduct a local needs assessment to identify where people a high risk of sexually transmitted infection are located and what their concerns are. However, the issues raised in this study suggest that

conducting such an assessment may be enhanced by placing greater emphasis on the context in which the decisions preceding sexual risk taking or sexual health seeking activities take place.

The context in which black Caribbean men make and manage their sexual decisions plays a significant role in determining sexual behaviour. This suggests that sexual health professionals need to be more aware of the political, historical and social aspects of sexual health as well as the management of specific medical conditions. This means that increasing professionals' knowledge of the minority ethnic community cannot take place in a historical or political vacuum. To do so would only serve to repeat the 'menus' approach to race and ethnicity discussed in the literature chapter. In turn this would hamper attempts to make sense of the context of decision making as many of the 'how' and 'why' questions concerning behaviour would be unanswerable. For example, without an appreciation of the historical linkage to slavery and promiscuity, and the cultural norms of marriage and parenting, the burden of the stereotype and its association with questions about black Caribbean men's marital status or number of children would be missed. Thus if a professional who posed this line of questioning was met with hostility, it may be difficult for them to formulate any possible explanation for such a response and instead result in labelling of the client as another 'angry black man' with little control of his sexual behaviour.

Concentrating on the context of sexual decisions would enable the broader view of sexual health called for in the strategy to take account of the wider underlying determinants of health which are often unaccounted for in traditional health needs or performance reviews. This information will help to increase the knowledge base to support sexual health professionals in identifying how their efforts to interact with British black Caribbean men in relation to their sexual health may be helped or hindered by the arena in which these interactions take place.

The lack of importance placed on sociological and political considerations by nursing practice in the past may account for the lack of awareness of ethnicity related issues reported in this study (Culley 1996; Ahmad and Atkin 1997; Narayanasamy 2000). The distancing reported between professionals working in sexual health services and their black Caribbean male clients has already been highlighted as mirroring the heath context in general. The comments of the professional participants in this study seemed to support this approach in that they repeatedly spoke of how they felt the sexual service was isolated from the black Caribbean communities and other non-health related services and the problems that they faced as a result.

In order to reduce the distance between professionals and client groups one suggestion arising from the data is that providers of sexual health services should develop services in discussion with local service users and organisations. This supports the idea of developing an inclusive approach to health practice with local communities rather than for them. Inclusive practices are a central component of the theories underpinning the methodology in this research and are in harmony with the need to promote research which is 'of use' to the participants and their communities (Millen 1997; Ribbens and Edwards 1998; Pilcher 2001).

The sexual health strategy supports this approach to service development, encouraging the development of working partnerships between sexual health service providers and the local community. Such partnerships are recognised as requiring the input of additional organisations, groups and individuals that are not usually identified as key consultants in practice development. The rationale behind this approach is based on the recognition that many local communities have established links with community based services which could be of benefit to both clients and professionals in sexual health (Department of Health 2003).

While the sexual health strategy and RCN documents repeatedly mention a need to widen the consultancy basis of sexual health provision beyond the services of GUM clinics and increase the links between sexual health services and local communities,

much of the detailed discussion still revolves around formalised health services. The targets set for improving the public's sexual health and for measuring service efficiency remain generally exclusive of non-statutory provision, with 'complimentary' sexual services discussed in secondary terms.

The findings of this study expose the impact of the wide range of social contexts on sexual decisions of black Caribbean men. Of particular importance is black Caribbean mens' reliance on non-health based services, social sexual networks and support agencies to help them manage or address their sexual health related problems. This suggests that the call for professionals to build professional networks with others outside the NHS mentioned in the strategy needs to be more forcefully applied. Voluntary and self-help groups have been the mainstay of holistic sexual health services and services to black and minority ethnic communities for some time (Hendriks 1992; Pitts 1996; Penman 1998; Balsa and McGuire 2002). In fact much of the statutory approaches to sexual health being introduced have their roots in the practices of HIV/AIDS agencies such as The Terrence Higgins Trust, London Lighthouse and black HIV and AIDS Network (Green and Tones 2000; Watson 2000; Wilson and McAndrews 2000; Valdiserri 2002).

The need for a wider consultancy base in sexual health service development and care delivery is reinforced by the fact that many of the issues as impacting on sexual decisions of black Caribbean men are not directly related to a health care context. As such the support systems and sources of help utilised by black Caribbean men are not confined to health care providers. The important role played by the voluntary sector in sexual health and ethnicity based services calls for a more central role to be given to non-statutory or health based provisions in sexual health professionals' efforts to learn about the local black and minority populations. Black communities in Britain have from the time of mass migration developed community organisations and associations. These associations support individuals and minority communities while also providing centres of learning about their particular cultures. These groups often visit or are visited by educational institutions, individuals and other services wishing

to learn more about the lives and values of a specific ethnic group. Health care services in general and sexual health services seldom take up opportunities for such visits and should be encouraged to do so in order to advance their own professional development.

Developing an awareness of the political, social and historical contexts underpinning the sexual health experiences of local black Caribbean men and can only be achieved by stepping out of the confines of 'statutory only or statutory first' modes of consultation. Only then can links be forged and networks developed in partnership with whole range of organisations and individuals working with black Caribbean communities on a daily basis. Taking advantage of the educational opportunities already available to them through the communities within the local area would be a good first step to reducing the distance between sexual health services and their minority ethnic clients.

In order to widen the scope of the parameters considered to be important in needs assessment of sexual health, professionals will need to overcome the distancing of one sexual health services from another, as well as their client groups. The study revealed that as reported in sexual health strategies, sexual health professionals were often unaware of the role and scope of other sexual health service providers. In addition, few professionals had experience of working in other areas of sexual health (Royal College of Nursing 2000; Department of Health 2001; Royal College of Nursing 2001). These divisions in service provision formed part of the context in which black Caribbean men and other key players experienced sexual health services in Townsville.

The sexual health strategy reiterates how the ability of sexual health professionals to provide for the needs of their clients may be severely hampered by their lack of awareness of the range of services and support available to clients. The restricted view of sexual health services was reflected in the ways participants' often referred to the role of sexual health professionals. Their role was mainly discussed in relation to

prevention of infection or pregnancy rather than the life enhancing, holistic view of the World Health Organisation or professional health care bodies (World Health Organisation 1986; Wilson and McAndrews 2000; Royal College of Nursing 2001). For the black Caribbean men in this study the poor responses they received from professionals in relation to their sexual practices worked to further reduce their level of service satisfaction. The result was that they were reluctant to seek out assistance from sexual health clinics unless in dire straits.

Some key areas of integrated sexual health service provision are being piloted in different areas of the country where the established medical model for addressing sexual health problems are integrated with other non-health based services, complimentary therapies as well as family planning and social care services. While these services are relatively new and have yet to be fully evaluated, early indications are positive. The integration of health and social care services focussed on improving sexual health are reaching traditionally hard to reach populations such as young men and people from lower socioeconomic groups (Purves 1997; Green and Tones 2000; Spencer 2001). Assuming the early positive indications are sustained, expansion of the availability of these services would be recommended by the outcomes from this study. These innovative sexual health services would serve as an excellent blueprint for developing sexual health services which take into consideration the socio-cultural and political context in which sexual health decisions occur thus beginning to address some of the concerns raised by black Caribbean men in this study.

7.3.2: Implications for education and training

The above discussion highlights the need to increase sexual health professionals' awareness of the context in which sexual decisions occur. However, raising awareness alone, has been shown to be unlikely to result in any improvements in health or levels of services. Without any accompanying improvements in the skills levels of staff or changes in organisational structures, it is difficult to put knowledge into practice

(Lewis and Bor 1994; Leininger 1997). This was evidenced in this study by sexual health participants' awareness that the service they provided was not meeting the needs of this client group and expressed concern about this. Despite this sexual health professionals in the study were not able to effect any real change in the workplace as they were unsure of what or how to achieve this.

Dilemmas faced by health care staff concerning how to overcome gaps in service provision are reported in the literature. In particular criticisms are made of some health promotion approaches where giving information to raise awareness is equated with the ability to bring about improvements in health with little real indication of how this should be actioned (Ewes and Simnett 1993; Adler 1997; Balsa and McGuire 2002). The points raised by the sexual health professionals support these concerns and suggest that education and training of all staff into how to apply service requirements at a local level is required. This training should be made available to those providing sexual health advice and care alongside awareness about the needs of specific client groups. As suggested by this study, clear links between awareness raising, social contexts and personal experiences are key aspects of any attempt to improve, manage and maintain the sexual health of black Caribbean men.

Though discussions with sexual health professionals and other participants in the study it emerged that their experiences have implications for the type of sexual health training and education made available to nursing staff. The education and training about sexual health received by the professional participants working in sexual health services was very restricted. Sexual health professionals reported that much of specialist training they received was focussed on disease recognition. Little or no reference made during their training to the impact of variations in social experience, ethnicity or gender on sexual health. As a result, while they as professionals, felt able to competently manage the technical aspects of identifying and treating sexual illness, they generally did not feel competent to deal with the broader sexual health needs of black Caribbean men. This meant that the sexual health professionals often relied on either the stereotype as a basis for determining their actions or ignored the wider

social issues raised by clients and simply treated their medical conditions which often gave rise to negative appraisal of the sexual health service by clients. This emerged in the data as a source of disparity between the expectations clients had of the service and in the desire that the professionals had to provide good quality care to the black Caribbean men.

Poor or inadequate training has long been identified as a barrier to provision of appropriate health care for people from black and minority ethnic groups. There have been calls for changes in the approaches to transcultural and multiethnic training of nurses as a result (McGee 1992; Abdullah 1995; Culley 1997). However, as discussed in the setting the context chapter, currently there is a dearth of underlying knowledge about the ways in which ethnicity and sexual health interact. It follows that without this, any changes to the present teaching and training of nurses to work in sexual health will be compromised. The literature also discusses the ways in which negative attitudes and expectations of health care staff in other disciplines has been shown to impede access to services and dissuade clients from seeking help (Macbeth and Shetty 2001; Karlsen and Nazroo 2002). The findings of this study suggest that issues of negativity impacting on quality of service also exist in relation to sexual health care.

In line with the sexual health strategy, the concerns raised by participants in this study demonstrate that sexual health professionals require specialist training to enhance their ability to deliver sexual health services from a broader knowledge base. Training programmes need to be developed to include aspects of the social, political and cultural context of sexual decision making as much as clinical skills and drug therapies. The wide range of issues discussed by black Caribbean men in 'Living with the stereotype' also highlight the effect that prejudice, unsubstantiated beliefs, stereotyping and poor attitudes can have on sexual health decisions and experiences. This means that if education and training for sexual health is to have an impact on service delivery in general, staff training and personal development must also focus on addressing the attitudes and beliefs of staff about sexual health and practices as well as the general public. For example, sexual health training and continuous

professional development could include many of the practical workshops found in good quality race awareness or equality training. Of particular use would be introduction to the politics of race and ethnicity, use of case studies for reflective work on appraising the impact of interactions with those of a different ethnic group to oneself and general communication skills.

The data chapters 'Living with the stereotype' and 'Hearing the silences' also illustrate how sexual health issues impact on the life experiences of black Caribbean men beyond the boundaries of their sexual encounters. The embarrassment, lack of skill in dealing with issues and inadequacy of training to deal with sexual health issues identified in this study mirrors the findings of researchers into issues of ethnicity and health care discussed in the literature review. In this study focussing on the sexual health of black Caribbean men problems separately associated with issues of sexual health care and ethnicity in these other studies combine. They are evidenced in the experiences and comments made participants. The combination of ethnicity and sexual health as a focus of this study, reveals how some of the problems faced by staff working in sexual health services result from personal appraisal of deficiencies in professional competence. In providing from the needs of black Caribbean men, sexual health professionals highlighted difficulties in dealing with generic issues of ethnicity and health as much as from issues directly related to sexual health.

The introduction of generic training in communicating around ethnicity and health as suggested above, if provided alongside specialist sexual health training will help to equip staff with the tools for establishing a sound base for quality service delivery and client care. Staff in sexual health services need to be given information about the social and cultural experiences of minority ethnic groups to which their clients belong. This needs to be made available together within structured clinical training in sexual health. This will provide opportunities to explore the clinical implications for sexual health within a structured training programme. Sexual health professionals can then begin to develop for themselves a clearer idea of the range of skills they need to address the needs of black Caribbean men. Strategies for appropriate training and

professional development may then be devised which would enhance the service provision and levels of professional competence for working with this and other groups relevant to the particular locality.

The wider context of sexual health findings of this study also means that sexual health issues are important influences in the health of individuals outside the confines of sexual health services. The inescapable aspects of the stereotyping and strategies to manage it were evidenced in participants' private lives and interactions with others in different health related situations. There has been a great deal of research conducted in general health arena investigating the attitude of nurses in mainstream services to the sexual health care needs of their clients (Lewis and Bor 1994; Koshiti-Richmond 1996; Irwin 1997). Much of this data outlines the problems faced by nursing staff and clients when sexual health issues appear to impact on care or need raised with clients in general settings. The importance of the context to sexual decisions and sexual health emerging in this study therefore provide further evidence of the difficulties introduced by restricting sexual health training to GUM staff. This suggests that while sexual health work remains a 'specialist' post registration practice area, good quality sexual health advice requires a more holistic approach required to be achieved. This could be better served by incorporating teaching basic skills of communication around sexual health for health care staff in general as well as specialist practitioners. Introduction of the holistic approach outlined above into general continuing professional development and pre-registration training would be the simplest way of achieving this. Such a programme would ensure that newly qualified and already registered staff would be adequately prepared to address the needs of minority ethnic clients.

7.4: Opportunities for future research

There are a number of opportunities for further research arising from the completion of this thesis. These have come about as a result of considering some of the

limitations of the study and from issues raised during the process of conducting the study itself.

One limitation of this study was that it was conducted in one city in Britain amongst a relatively small section of the minority ethnic community. It could be argued that the importance of the context in sexual health and the issues faced by black Caribbean men in this study are more generalised to sexual health itself or the nuances of Townsville life, rather than to any interaction with ethnicity and gender in British society. The lack of British based qualitative data in this area makes it difficult to prove or contest these claims beyond the boundaries of this research. This will only come about through repeated additional qualitative research in sexual health and ethnicity utilising larger samples and different locations.

At the beginning of this chapter the fact that the majority of sexual health professionals taking part in the study worked in statutory services and GUM clinics in particular was cited as a limitation. The dominance of GUM professionals in sexual health service provision is a common situation in many cities in Britain but is by no means universal. It would have been be useful to gain information from sexual health service providers from voluntary and self-help agencies as well as the vast number of sexual health charities. The difficulties in achieving significant number of voluntary agency participants due to the small pool of voluntary services in Townsville, was discussed earlier. However, an alternative if this study was repeated would be to recruit from voluntary sexual health service providers from neighbouring cities. While these would not be able to be incorporated directly into the study as another focus group due to the differences in social, economic and cultural context compared to Townsville they could act as a source of comparison for the broad issues raised by sexual health professionals.

An important aspect of this study was the relationship between the researcher and participants. The ethical and methodological concerns arising out of this study being conducted by a black Caribbean woman who is a sexual health professional were

discussed in detail in the methodology chapter. This very specific perspective is recognised as giving a relatively atypical viewpoint in sexual health research. However, this has been invaluable in initiating qualitative research that combines the very sensitive issues of sexual health and ethnicity. Further research from other perspectives is now warranted to compliment, contrast and challenge the findings here in order that a broader dialogue on sexual health decisions and ethnicity may develop.

The small sample size used in this study combined with the lack of an established pool of qualitative research in the area restricted the number of generalisations that could be made. This process of conducting this study utilising qualitative approaches raised a number of issues that could not be fully explored in the study but provide a basis for future research and development in sexual health. The key issue arising out of this study is the importance of the context in which sexual decisions are made to the sexual risk taking of black Caribbean men. However the emergence of this at a late stage of the thesis and the constraints of time and focus in the original research question meant that the nature of the components of the contexts for black Caribbean men could not be fully explored. The initial overview of the context revealed in this study indicated it to incorporate a wide range of influences including personal family history, professional beliefs, socioeconomic group and community expectations.

The focus on black Caribbean men in this study was justified based on the quantitative data indicating their higher rates of STI compared to men from other minority ethnic groups. However, focussing on the screaming silences in the same data sources highlights questions concerning the sexual health decisions of other minority ethnic groups. One possible area of further research would be to utilise the same methods applied in this study to investigate the extremely low reported rates of GUM attendance and STI infection in South Asian men (Lacey, Merrick et al. 1997; Low, Daker-White et al. 1997). Such a study would not only provide a basis for

comparing the contexts of sexual decisions in two minority ethnic groups, but open up discussions into another under researched group in relation to sexual health.

The key players in the study were invaluable in providing some insight into the sexual social networks involved in the sexual decisions of black Caribbean men.
While much of the information reported in the data chapters reflected on the comments of black Caribbean participants and sexual health professionals the partners of black Caribbean men provided some very interesting comments which warrant further study. Many of the issues raised by partners of black Caribbean man gave some insight into the process of becoming aware of the stereotype and the wider context of reaching sexual decisions from a perspective that was simultaneously integrated with and distanced from that of their partners. It was interesting to note that partners often appeared to be caught up in their own 'rationalisation' of this dual positioning in sexual decisions. The feelings of a need to protect the black Caribbean men in the lives and yet make sense of their own experiences are an intriguing aspect of the thesis that invites further investigation.

The focus group discussions revealed other aspect of the experiences of participants, which while not solely related to the sexual decisions were of potential areas of research interest. One of the main issues revealed in the data chapter 'hearing the silences' was the recognition by black Caribbean participants of increasing stratification based on socioeconomic development and increased educational opportunities occurring in black Caribbean communities. In relation to this study this impacted on the viewpoints of black Caribbean participants and other key players about sexual decisions. It also went beyond discussions of sexual behaviour and illustrated changes in social scripting of identity, belonging and community being increasingly recognised within the black Caribbean communities as a whole.

The process of social change in the black community as an aspect of changing British society is nothing new. It has been discussed in sociology, anthropology and education theories for a long time through literatures mapping black and minority

group experiences in Britain (Bryant, Dadzie et al. 1985; Bhopal 1998; Brah, Hickman et al. 1999). The impact of socio-economic changes within the black communities on sexual decisions and other aspects of black Caribbean experience cannot be anticipated at present. However, mapping and monitoring the process of recognising change from within the community and its effects on sexual health would be of benefit to range of health and social care disciplines. This in itself raises ethical issues in relation to researching emerging silences within a particular ethnic group. The concerns of the participants about the consequences of their contribution for themselves, their families and the community as a whole suggests that in pursuing new avenues of research strategies must be developed which make it safe for the diverse members of black and minority ethnic communities to speak out.

Concluding points

This study takes place at a time when sexual health is coming under increasing scrutiny from researchers, the government and professional bodies in Britain. It arose out of concerns about the lack of qualitative data investigating the links between sexual health, gender and ethnicity despite large amounts of quantitative data indicating the disproportionate rates of sexual ill health amongst black Caribbean men.

The study exposes the key roles played by socially scripted contexts in the sexual decisions of black Caribbean men in Britain. In doing so, the study neither denies nor negates the value of quantitative research approaches or the experiences of black Caribbean men in other countries to the debates on sexual health. Sexual health itself is a relatively under researched area of health outside the specific investigation of HIV and AIDS (Green and Tones 2000; Department of Health 2001). The comparative lack of a range of research in the sexual health in general calls for sustained efforts to utilise different approaches to build the evidence base in this area of health. This qualitative research study is therefore produced to compliment the established

quantitative research studies rather than oppose them and provide an additional view of sexual health and ethnicity.

The study originally set out to identify the 'factors' influencing the sexual health decisions of black Caribbean men. However, as discussed in section 7.2 analysis of the data revealed that the issues raised reflected more about the socially scripted sexual experiences of black Caribbean men as an essential precursor to the original research aims. As a consequence in completing the first two objectives the study underwent a subtle need to refocus the investigation on a much broader base. This involved documenting the little explored socially scripted arena in which black Caribbean men engage in sexual or social interactions. These social scripts emerged as the central influencing 'factors' in the study impacting on their sexual health decisions.

The inclusive nature of the methods and theoretical approaches underpinning this study requires that the research have some usefulness beyond the production of a PhD thesis. Objective three is fulfilled by outlining some of the implications of the outcomes for sexual health education, policy and practice in this final discussion chapter. In Britain there are currently various strategies being launched and implemented by the government and professional health care bodies in an attempt to reduce the pool of sexual ill health and reduce the relatively high rates of unplanned pregnancy amongst the population. In these strategies, the need to find ways of improving the sexual health of members of marginalised groups such as black and minority ethnic communities is of utmost importance.

This thesis concludes that sexual health decisions continuously occur in light of social and personal appraisal of issues important to an individual. This forms the socially constructed context and social scripts within which sexual decisions take place. It is the ways in which sexual and non-sexual scripts are identified, sustained and experienced that determine the key influences on sexual decision making in black Caribbean men. Isolated 'key factors' are impossible to understand or identify without reference to these pre-existing socially constructed frames of reference.

The scripted context is part of normal social interactions and experiences in society and as such is to some extent time and place specific, based on group and individual concepts of self, the experiences of others and the perceived expectations of social groups or society as a whole. In order to make sense of the sexual health decisions of a particular social group, more efforts need to be placed on identifying the nature of the scripts at play in their particular sexual context and how it may influence their own and key players' understanding of sexual interactions. Any possible impact this may have on sexual decisions may then be identified and appraised in context of individual and shared understandings of sexual health behaviour.

The findings from this study suggest that for British black Caribbean men their sexual interactions are affected by real/imagined references to a socially constructed and scripted stereotype of them as sexually irresponsible and insatiable. The context in which their sexual decisions take place is to a great extent affected by the political, historical and social aspects associated with black Caribbean men, stereotyping and sexual expression. The significant role played by the stereotype of black Caribbean men in sexual interactions involving them and other key players suggests that sexual health professionals need to be more aware of these aspects of black Caribbean male experience in dealing with this client group.

It is suggested that sexual health professionals seeking to provide for the needs of black Caribbean men should take time to focus on the local and national contexts in which black Caribbean men make sexual decisions. Efforts to do this would begin to identify and address the specific sexual health needs of British black Caribbean men. Alongside changes in staff training and service provision proposed in the recent sexual health strategies and directives, a context based approach to sexual health care would be invaluable in improving the sexual health of black Caribbean men. It would be much more ethnically and culturally appropriate enhancing the effectiveness the recommendations suggested in the sexual health strategy for improving the sexual health black and minority ethnic communities in general.

Despite the small scale of the study and the problems inherent in researching such sensitive issues in health care this research study has used qualitative methods to explore the sexual health decisions of black Caribbean men. This has explicitly been conducted from the perspective of black Caribbean men and other key players in their sexual health. In doing so the study has opened up new avenues for dialogue about the socially constructed context in which adult sexual decisions take place in Britain and the impact ethnicity has on this. New avenues include recognition that the theoretical approaches used in this study, the methods employed and the means by which the study arose were situated from my own black, British, Caribbean, female viewpoint. As such they too are scripted in particular ways which have impacted on the study. This view however contrasts with the non-British or quantitative focus of much of the current research incorporating issues of sexual health and ethnicity.

This situated research study acknowledges and accepts that it has in no way exhausted the silences associated with sexual health, black Caribbean men and ethnicity. Further silences remain, have been and will be produced directly as a result of its completion and subsequent publication of the findings. Recognition of the impact the study may have on the silences and associated social scripts means that other perspectives and methods must be employed in future to move this area research and practice forward.

APPENDICES

STUDY INFORMATION SHEET

Black Caribbean Men, Sexual Decisions and Silences
A Qualitative Study

'You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and partners if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this'

What is the purpose of the research study?

Sexual health behaviour and the choices people make are influenced by whole range of factors including, social grouping, education, peer pressure and access to services/information. The effects of the choices are reflected in the rates of unwanted pregnancy, increasing rates of sexually transmitted diseases and continued rise in HIV infection. On a personal level they may seriously affect the life chances of the individual. The social burden of providing support for individuals is borne by families and communities as well as the health and social services. At present there is very little information on the factors affecting sexual health choices, particularly in relation to minority ethnic communities. This research study is particularly concerned with Black Caribbean men who are often mentioned in discussions of sexual health behaviours but about whom little is actually known. The research study aims to identify and explore the key factors influencing the health seeking and risk taking behaviours of Black Caribbean men in relation to sexual health. The information will be used to consider how sexual health services and professionals can best provide for the sexual health care needs of Black Caribbean men.

Why have I been chosen?

The research study will consist of 5 group discussions and approximately 25 individual interviews. You have been invited to take part as either a Black Caribbean man or a member of a group that impacts directly or indirectly on their sexual health experiences. I would particularly like to talk to people working in sexual health, partners of Black Caribbean men and Black Caribbean women.

Do I have to take part?

Participation is completely voluntary. It is up to you whether you decide to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at anytime and without giving a reason.

What will happen to me if I take part?
The group interviews will be co-ordinated by myself take approximately ninety minutes to complete. Each group discussion will be based on the same questions. With the permission of the group the discussion will tape recorded. All participants will be invited to indicate their willingness to take part in the individual interviews if required. Those who volunteer will be contacted within 3 weeks of the group discussions to arrange a convenient date and time for the interview. Participation in the focus groups is completely voluntary and is not dependent on your willingness to volunteer for a follow-up interview. The interviews will take approximately 45 minutes to complete. The interviews will also be tape recorded with your permission.

What other information will be collected in the research study?
As part of the preparation for the group discussions I will collect details relating to your age, sex, ethnic group and occupation in order to ensure that a mixture of people from different backgrounds are included in the research study.

Will the information obtained in the research study be confidential?
All the information collected about you during the course of this research study will be kept strictly confidential. Anything you say will be treated in confidence, your name will not mentioned in any reports of the study and care will be taken so that individuals cannot be identified from details in reports of the results of the research study. All tapes of the interviews will be destroyed once the research is complete. Your participation in the research study will not be reported to anyone.

What are the benefits of taking part?
There will be no personal benefit to yourself in taking part in the research study but your co-operation is highly appreciated. It is hoped that the results of the research will help those working and providing services in sexual health service to provide for the needs of Black Caribbean men.

What are the possible risks and disadvantages of taking part?
There are no physical or medical risks in taking part in the research study. However some of the issues discussed in the interviews could include some sensitive topics or raise questions relating to sexual health or ethnicity. If you have any questions about the study itself or the interviews and focus groups please contact me at the address shown below. If you wish to discuss any concerns arising from issues discussed in the study, please contact any of the following organisations who are aware that the research study will be taking place and are able to provide any information you may require.

1. **The Health Shop, Nottingham** **Tel. 0115 9475414**
2. **Department of Genito-urinary Medicine, Nottingham** **Tel. 0115 9627744**

3. Nottingham and District Racial Equality Council Tel. 0115 9586515
4. The Centre for HIV and Sexual Health, Sheffield Tel. 0114 2261900

What will happen to the results of the research study?
The research study is part of my PhD at Nottingham University. On completion of the research study a full copy of the report will be available from the library at the university. Extracts from the research may appear in nursing, medical and social science books and journals. In all cases no individual will be mentioned or identified by name and coding will be used to maintain confidentiality

What if I wish to complain about the way in which this research study has been conducted?
If you have *any* cause to complain about *any* aspect of the way in which you have been approached or treated during the course of this research study, please contact the Principal investigator: Laura Serrant-Green by telephone on (0115) 9709265 or email laura.serrant-green@nottingham.ac.uk Otherwise you can use the University of Nottingham complaints procedure and contact the following person: **Douglas Robertson, Research Business Unit, University of Nottingham, University Park, Nottingham NG7 2RD**

Information sheet version2. Mar 2002

APPENDIX 2

Role of Co-worker and characteristics of co-worker

Primary use of co-worker is to assist in facilitation of focus group interviews and practical aspects of running focus groups. The co-worker does not ed to be a sexual health professional but should have some insight into health care in general. The co-worker should also be ineligible as a participant in the study although they may share some of the characteristics of those taking part in the study. The role of the co-worker during this aspect of the data collection phase will be as follows

Planning phase

To meet with researcher to

- Familiarise self with requirements of focus group in relation to study aims.
- Agree roles and responsibilities of co-worker and ground rules for focus groups
- Discuss and agree strategies for health and safety during data collection.
- Agree personal arrival and departure time/arrangements for each focus group
- Agree situations and process for giving 'cues' to researcher during focus groups
- Once time of each focus group confirmed, arrange time/location for debriefing with researcher following focus group

Before start of focus group

- Welcome focus group participants and help to settle in (take coats etc..,)
- Offer refreshments
- Distribute Biographical details forms and name badges
- Ensure a consent form has been completed for each participant attending focus group.
- Make researcher aware of any participant who does not have a consent form

- Check tape recording equipment (primary recorder and back-up) and that sufficient audiotapes, spare batteries are available.
- Put up 'do not disturb signs' on interview room doors if necessary
- Collect completed biographical details forms and check contact details are included for all participants agreeing to take part in interviews

During focus group

Emphasis is on supportive role to researcher to ensure smooth running of focus group and to assist in recording of events occurring during focus group.
Co worker will be required to

- Monitor equipment during focus group
- Take secondary notes on events during focus group including, mapping position of participants, group dynamics (speakers, who is quiet)
- Cues to researcher as necessary/agreed
- Secondary time-keeping

On completion of focus group

- Collect badges
- Offer refreshments to participants, check travel arrangements, expense claims for participants
- File biographical details questionnaires
- Label audio tapes
- Give out contact cards
- Confirm time/location for debriefing with researcher

APPENDIX 3

Focus group inclusion criteria

Black Caribbean men (BAC)

- Black Caribbean men (at least one parent)
- 16 – 45 age group
- British by birth, naturalisation or citizenship
- Resident in UK
- Heterosexual
- Not Sexual health professional

Target recruitment per group – 14 volunteers

Key access point (timing of group)

Group1: Bredren (eve)
Group 2: City colleges(afternoon)
Group 3: Hylife community centre (afternoon/eve)

Specific detail of criteria for Black Caribbean men

Inclusion in this focus group will be restricted by age in order to mimic the criteria used in British based qualitative studies investigating STI infection rates by ethnic group (see Low et al 1997 and Lacey et al 1997). Ethnicity will be determined by self- identity with the decision taken to include men who have at least one Black Caribbean parent. This will allow for the inclusion of men of dual heritage who identify themselves as Black. To maximise the emphasis on British experience, which is central to this study, participants will be restricted to those currently registered as British citizens and resident in Britain. The verification of British identity will also be made according to self disclosure however, in general the parameters used within the British legal system at the time of the research study will be used as an general measure.

The issue of sexuality and the perceived effect on sexual decision making is a complicating factor in this research. Stereotyping of Black Caribbean men and their behaviour appears to reoccur within the confines of heterosexual behaviour. Discussions of Black Gay men are often presented in conflict or tension with Black male identity. Inclusion of both gay and heterosexual issues within this research would further complicate the issues and change the focus of the study such that different sets of participants would be required and alternative questions asked.

As this focus group sets out to explore the viewpoints of lay or non-expert Black men in the area of sexual health behaviour, involvement in this group is restricted to those who are not sexual health experts by virtue of their paid or voluntary work. Self disclosure will be the method used to verify expert status.

Black Caribbean women

- 16 - 45 age group
- Black Caribbean women (at least one parent)
- British by birth, naturalisation or citizenship
- Resident in UK
- Not Sexual health professional
- Not known to be current partners of BAC taking part

Target recruitment per group - 14 volunteers

Key access point (timing of group)

SiS (eve)
Diverse community project (afternoon)

Specific detail of criteria for Black Caribbean women

Issues relating to age, expert status, ethnicity and citizenship for Black Caribbean women mirror those for Black Caribbean men outlined above. In addition due to issues of confidentiality and the fact that the participants may be known to the researcher, inclusion in this focus group is restricted to Black Caribbean women not known to be current partners of the Black Caribbean men taking part. The rationale in restricting the inclusion criteria in this way is to reduce the risk of other participants and the researcher becoming involved in the personal sexual relationships of the Black Caribbean men and women involved.

Monitoring of these criteria may be complicated by the fact that the women may not know whether their partners will be taking part and the relationship between them may not be in the public domain. The methods used in an attempt to control for this include self-disclosure and a decision not to actively recruit Black female participants on the basis of them being partners of the Black men involved. If the Black women's focus group takes place before the Black Caribbean men's group, then knowledge of partnerships will be used to monitor the nature of the participants and further recruitment may be necessary to gain a wider pool of participants. Ultimately this approaches do not guarantee that partners will not be unknowingly included in successive groups but every effort will be made to avid this complication.

Partners

- 16 – 45 age group
- British by birth, naturalisation or citizenship
- Resident in UK
- Not Sexual health professional
- Living with or in long term relationship with Black Caribbean male
- Not known to be current partners of BAC taking part

Target recruitment per group – 14 volunteers

Key access point (timing of group)

Hope community centre (afternoon or eve)
Agartha (eve)
City Colleges (afternoon)
Diffuse (afternoon)

Specific detail of criteria for Partners of Black Caribbean men

In this focus group the issues of expert status, age and residency are as for the previous two groups. For the reasons set out above, participants in this groups will not be recruited on the basis that they are known to be current partners of the Black Caribbean men involved in the research.

There are no restrictions on ethnicity within this group in order to reflect the diversity of heterosexual partnerships with Black Caribbean men. In order to further differentiate this focus group from that of Black women, recruitment will actively include groups and centres which are not known to be purposefully Black Caribbean organisations. However, as previously discussed, the heterosexual focus of this study restricts partner identification to women only.

Sexual Health Workers

- Currently working in sexual health within the UK
- Statutory, voluntary or community based
- Full or part-time workers

Target recruitment per group – 14 volunteers

Key access point (timing of group)

Self-help directory and GUM clinic (afternoon or evening)

Open help (afternoon or evening)

Specific detail of criteria for Sexual health workers

In this group sexual health workers will be defined as those providing expert knowledge, advice, support or treatment for issues relating to sexual health. Where sexual health includes

- The prevention, management or treatment for physical conditions resulting from sexual activity
- Provision of support for the management of the consequences of sexual activity. This may include psychological, social and practical assistance.

The definition of sexual health expert includes those working in both statutory and voluntary capacity. This is necessary as many of the community based sexual health services, and some of the now well established 'mainstream' services began from voluntary or self-help initiatives.

The emphasis here is to include a broad spectrum of approaches to sexual health and resist the tendency to concentrate on the negative or trouble shooting aspects of the service. For this reason, experts from community support and preventative services as well as treatment and monitoring services will be invited to attend the focus groups.

APPENDIX 4

Focus group interview schedule

Introduction

- My name is Laura. I am a PhD student at the University of Nottingham and I also work there as a lecturer in adult health.
- The purpose of this focus group is to discuss some of the factors influencing the sexual health behaviour of black Caribbean men.
- Thank you for agreeing to take part in this study
- You have been asked because your point of view is important
- There are no right or wrong answers
- There is no obligation to talk about or comment on anything that you find uncomfortable

Anonymity

- The answers you give during the focus group will be anonymous. You will be assigned a false name in the final report so that anyone reading it will not be able to find out what you said
- This form which I have signed is your assurance of anonymity

[give participants the anonymity form]

- With your permission I would like to record the discussion that takes place.
- If anyone has anything confidential to say, or feels they would like the tape switching off at any point, just let me know.
- After the focus group, the audiotape will be transcribed from tape to paper. The tapes will be kept in a locked cupboard to which only I have access and will be destroyed once the PhD is completed.
- I would be grateful if you would all sign the consent form for me to record the focus group discussion

[give participants the consent forms to sign]

- Does anyone have any questions about what I have said so far?
- If anyone would like me to stop for any reason during the discussion please let me know.
- Right if there are no further questions, I will begin

Clarification question

- Before we begin the discussion I think it would be helpful to clarify what is meant by sexual health behaviour
- Firstly what does the term sexual health include?

Prompt: Prevention of STIs, prevention of unplanned pregnancy
Being able to express your sexuality freely
Being seen by others as a sexual being
Being seen as an individual
Ability to be part of a loving relationship of your choice.

- So now we have some idea of the scope of sexual health, how do you think the issues we have mentioned relate to sexual health behaviour

Prompt: knowing where to go for help and advice about sexual problems
Being able to access information/help for prevention of unplanned pregnancy, getting help or treatment for STIs.

Prompt: knowledge and attitude to sex – both self and others
Knowledge and attitude to risk taking

Prompt: What about the attitude of other people, how could this affect sexual behaviour?

<u>Key questions</u>

Here are list of comments I have collected relating to Black Caribbean men. (distribute comments).

1. do you think any of these comments are an accurate reflection of how the sexual behaviour of Black Caribbean men is viewed?

1a) if so, what kind of message do they give?
Prompt: lack of responsibility
Attitude to relationships
Stereotyping
Physical attributes
Lack of commitment
Sexual prowess
Lack of gay identity

1b) if not, why not?

Prompt: popular viewpoints
Media impact
Where ideas come from
Experience
stereotyping

[if specific comments have been singled out by more than one person]

1b) Some people have mentioned (state specific comment) why did you pick that one?

Prompt: popular viewpoints
Media impact
Impact on individual experience
Stereotyping of black men

2) Do you think these comments affect the way people react to black Caribbean men?

Prompt: impact on personal relationships
Attitudes to black men from peers, partners and social contacts
Attitude of sexual health workers
Meeting strangers
Acquaintances and friendships
Reaction of people when you meet them socially, professionally
Work life
Interaction with black men

3) how do you feel the points we've discussed would affect black men

Prompt: Impact on self identity, who you are
Deciding to seek help
Impact on personal relationships
Attitude to sexual health services
Where to seek help, who to ask
Approach to new relationships
Approach to risk taking

4) do you think anything we have talked about could affect Black men's attitude to sexual risk taking?

Prompt: laissez-faire attitude
Attitude to risk, cautiousness
Strategies for assessing risk

Strategies for reducing risk
Hierarchy of risk, pregnancy/STIs
Situations in which risks may be taken
Assessing sexual partners for 'risk'
Risk to self
Risk to others

5) we've talked about risks. If someone had taken a risk and they may need advice, treatment or help, what do you think would influence whether a black Caribbean man would seek help?

Prompt: attitude of others, peers, partners, sexual health workers
'Judgment' according to stereotype
assessment of severity of risk
familiarity with situation
possible impact of consequences on lifestyle
pressure to seek help
fear
knowledge of sexual problem
sense of control
relationship with other persons involved
disclosure (how much of behaviour/situation was known)

6) what do you think would affect where he chose to go for help?

Prompt: familiarity with services
information from peers/social networks
pressure from significant others
links with community
past experience
experiences of others
perceived seriousness of problem
sense of control of situation

7) Many of the things we've mentioned could relate to all men, in what ways do they particularly relate to black men?

Promptstereotyping of black men
Attitude of community/social networks
Sexual health services
STI risk
Attitude to sex outside marriage
Attitude to single parenthood
Provision of services to minority ethnic groups

Concluding questions

8) Now we've talked generally about how a wide range of things, including how other people may affect the sexual behaviour of BAC. One thing we haven't discussed in detail is how you as a group of (Focus group name) fit into the discussion.

What effects or influences do you as a group of (Focus group name) have on the sexual behaviour of BAC?

Prompt
- stereotyping of black men
- Attitude to black men
- Mentorship/education role
- STI risk
- Attitude to sex outside marriage
- Attitude to single parenthood
- Provision of services to minority ethnic groups
- Men and sexual health
- Relationships, professional or personal
- Providing support

9) What do you think are the most important issues influencing the sexual behaviour of black men?
10) would anyone like to make any further comments?

Conclusion

- Thank you for participating
- This has been a very successful focus group
- I hope you have found it useful
- Your opinions and comments will be very valuable to the study
- If you are unhappy about anything please let me know, you can write to me or telephone if you prefer. My contact details are on the information sheet
- Once the data has been transcribed and analysed i will write a report and send you a copy through the post.
- This will probably be in winter this year
- I will be contacting some of you to invite you to take part in individual interviews to discuss some of the outcomes from today's discussion
- Before you leave i would like to ask you to complete this brief questionnaire.

[give everyone the demographic questionnaire}

APPENDIX 5

Prompts used in focus groups and interviews

' I think I mentioned before concerning Black men in particular... .and the stereotypes that they are less likely to use condoms or take responsibility for protection... .because they see it as a woman's job'

Professionals working in GUM clinics felt that the Caribbean men they saw as clients were mainly cases of re-infection rather than new cases, resulting from poor levels of responsibility for self.

'We are Black men. That means we make babies'

Black men have great bodies, like D'angelo,... ... theyare so beautiful. I like a cool tough guy, you know.

My dad certainly wasn't irresponsible, he didn't abandon his children. But with my generation expectations can be low on both sides.

For black men I think the issue is a complex one tied up with racism and peoples prejudices concerning black men's sexual behaviour and responsibility

APPENDIX 6

Individual interview schedule

Thank you for agreeing to take part in these interviews. With your permission I would like to tape record interview. I would like to use these interviews to discuss some of the things that were talked about in your group. **(Switch on tape)**

Here is the list of comments that I used to start the discussion in your group. From the topics we discussed in your group I have identified the following issues **(Show themes)**

- Do you feel these sum up the main points that were raised in your group?

Prompt - Why? Are there any particular issues that you felt were important?

- Is there anything that you remember discussing in the group that I have not listed?

- Do the points I have listed raise any other issues for you?

Prompt - What makes you say that? Can you tell me a bit more about it?

- Now that some time has passed, is there anything else that has occurred to you relating to BAC and sexual health behaviour?

Prompt - What makes you say that? Can you give any examples? How do these things affect the sexual behaviour of BAC?

- What issues do you think the things discussed in your group raise for sexual health professionals working with BAC?

Prompt - What makes you say that? Can you give any examples?

- Do you think sexual health services are equipped to work with BAC?

Prompt - Why? What makes you say that? Can you give any examples?

Well that's the end of my questions, before we finish is there anything else you would like to add? **(Give time)**

Thank you again. (Offer refreshments and make sure can get home)

APPENDIX 7

Health and Safety strategy

In conducting the data collection phase of this study there are a number of potential issues relating to health and safety of the researcher that could arise. The main concerns relate particularly (but not exclusively) to the interview phase of the data collection where participants may request individual interviews in their own homes.

In order to minimise the risks to the safety of the researcher the following precautions will be taken during data collection.

Organisation

- Written confirmation of all agreed focus group and interviews will be sent to appropriate individual/group once date and times are agreed.
- Hard copies of all correspondence relating to data collection to kept in research filing system.
- A research diary will be kept for researcher and co-worker to timetable appointments and meetings during data collection.
- Timing and general location of focus group or interview will be logged in research diary
- For focus groups, contact telephone number for venue and contact name of group leader/coordinator will be logged in diary
- For interviews, agreed 'name' of participant to be interviewed will also be logged in diary
- Travel to and from data collection sites will be by private transport or pre-booked taxicab
- On departure to, arrival at and departure from interview site, researcher will telephone co-worker or relative to ensure someone is aware of whereabouts at all times.

During data collection

- Researcher and co-worker to meet by prior arrangement for travel together to and from focus group venues whenever possible
- Researcher and co-worker to arrive at focus group venue at least an hour before scheduled start time.
- During focus groups, researcher and co-worker to position selves so that entry and exit points to room are clearly visible and easily accessible by one or both of them.
- For individual interviews researcher should ideally try to avoid conducting these in private home of participant.

- On entry to interview venue, researcher to position self close to, or within easy access of entry/exit door and so as to minimise obstacles between sitting position and exit.
- Ensure audio-taping of interview discussion begins prior to introduction to interview and continues until researcher has left interview venue.
- Researcher to carry personal alarm at all times during interviews.

Following data collection

- If travel from focus group together is not possible, researcher and co-worker to leave venue together and make contact within 2 hours of departure.
- Following interviews taking place away from participant's home, researcher to ensure that participant has transport away from interview venue
- If transport for participants is required, this should be prearranged by pre-booked taxicab.
- Researcher and co-worker should never offer lifts home, or share transport with participants

APPENDIX 8

Profiles of interview participants

Black Caribbean men

KRIS

Aged mid twenties, employed. Divorced. Father of three children from previous marriage.

LONNIE

Aged mid twenties, unemployed. Cohabiting with current partner. Has no children.

ERNIE

Early twenties, unemployed. Has regular partner but not cohabiting. Has no children.

MOSTIN

Mid twenties, employed. Married with two children. Also has one child from previous relationship.

HARRY

Late teens, unemployed. Single. Has no children.

JOHN

Late thirties, employed. Married with children.

DENNIS

Late twenties, employed. Single. No children.

Black Caribbean women

CANDICE

Late teens, black Caribbean ethnic origin. Student, no children.

CAROL

Late thirties, black Caribbean ethnic origin. Employed. Married with children.

MONICA

Late thirties, black Caribbean ethnic origin. Employed. Cohabiting with partner. Has children.

CHRYSTAL

Mid thirties, black Caribbean ethnic origin. Employed. Married, no children.

MARIA

Early twenties, black Caribbean origin. Unemployed. Single, no children.

MARGARET

Early forties, black Caribbean ethnic origin. Employed. Single with two children.

Partners of black Caribbean men

BOBBIE

Late thirties, student. Black Caribbean ethnic origin. Not living with partner. No children.

NOVA

Early forties, employed. Black Caribbean ethnic origin. Married with children.

GERRIE

Mid twenties, employed. Black Caribbean ethnic origin. Cohabiting with partner, no children.

NUALA

Mid thirties, employed. White British ethnic origin. Married with children.

Sexual health professionals

LORRAINE

Mid thirties, female. White British ethnic origin. Married with children.

FIONA

Mid thirties, female. White British ethnic origin. Single with children.

CATH

Late twenties, female. White British ethnic origin. Single, no children.

JANET

Late twenties, female. White British ethnic origin. Cohabiting, with children.

OSCAR

Mid thirties, male. Black Caribbean ethnic origin. Married with children. Oscar did not take part in the focus group due to work commitments on the day but agreed to be interviewed after reviewing the transcript of the focus group. This occurred with the full consent of the SHP attending the focus group.

APPENDIX 9

Participant profiles

profile areas for participants	participant name	participant code	gender	age group	employment status	ethnicity	parent?	other info	interview?
4	Maria	BW1	F	18-22	unemployed	AC	no		
5	Candice	BW2	F	16-22	student	AC	no		
6	Margaret	BW3	F	43-45	employed	AC	yes		
7	Louise	BW4	F	38-42	employed	DH	yes		
8	Stella	BW5	F	23-27	unemployed	AC	yes		
9	Carol	BW6	F	38-42	employed	AC	yes		
10	Monica	BW7	F	38-42	employed	AC	yes		
11	Chrystal	BW8	F	33-37	employed	AC	no		
12	Felicity	BW9	F	23-27	student	DH	yes		
13	Remi	BW10	F	16-22	unemployed	AC	yes		
14	Sharlene	P2	F	28-32	employed	WB	yes		
15	Marla	P3	F	33-37	employed	AC	no		
16	Jessie	P4	F	33-37	employed	WB	no		*
17	Bobbie	P5	F	38-42	student	AC	no		*
18	Nuala	P6	F	33-37	employed	WB	yes		*
19	Nova	P7	F	38-42	employed	AC	yes		*
20	Sonia	P8	F	16-22	unemployed	DH	yes		
21	Connie	P12	F	16-22	student	DH	no		
22	Gerrie	P14	F	23-27	employed	AC	no		

Participant profiles

profile areas for participants	participant name	participant code	gender	age group	employment status	ethnicity	parent?	other info	interview?
23	Bernice	SHP1	F	23-27	employed	WB	no		
24	Erma	SHP2	F	23-27	employed	WB	yes		
25	Janet	SHP3	F	28-32	employed	WB	yes		*
26	Cath	SHP4	F	28-32	employed	WB	no		*
27	Fiona	SHP5	F	33-37	employed	WB	yes		*
28	Lorrraine	SHP6	F	33-37	employed	WB	yes		
29	Trudy	SHP8	F	28-32	employed	WB	no		
30	Debra	SHP9	F	23-27	employed	WB	no		
31	Ethel	SHP10	F	38-42	employed	WB	yes		*
32	Harriet	SHP11	F	43-45	employed	WB	yes		
33	Ingrid	SHP19	F	33-37	employed	WB	yes	Black partner	
34	Adam	BAC1	M	16-22	student	AC	no	teenager	*
35	Brett	BAC2	M	16-22	student	AC	no		
36	Carl	BAC3	M	23-27	employed	AC	yes	cohabiting	*
37	Dennis	BAC4	M	28-32	employed	AC	no	single	*
38	Ernie	BAC5	M	16-22	unemployed	AC	no		*
39	Frank	BAC6	M	38-42	self-employed	AC	yes	married	
40	Gordon	BAC7	M	16-22	unemployed	AC	yes		
41	Harry	BAC8	M	16-22	unemployed	AC	no	single	
42	Ivan	BAC9	M	38-42	employed	AC	yes	married	
43	John	BAC10	M	38-42	employedl	AC	yes	married	*
44	Kris	BAC11	M	23-27	employed	AC	yes	divorced	*

Participant profiles

profile areas for participants	participant name	participant code	gender	age group	employment status	ethnicity	parent?	other info	interview?
45	Lonnie	BAC12	M	23-28	unemployed	AC	no	cohabiting	
46	Mostin	BAC13	M	23-27	employed	AC	yes	married	
47	Nigel	BAC14	M	16-22	unemployed	AC	no	teenager	
48	Oscar	SHP0	M	33-37	employed	AC	yes		*

APPENDIX 10

The Coding Frame

Details of primary and secondary codes

(1) /tensions
- (1 1) /tensions/managing tensions
  - (1 1 1) /tensions/managing tensions/personal life
  - (1 1 2) /tensions/managing tensions/work life
  - (1 1 3) /tensions/managing tensions/family life
- (1 2) /tensions/expectation ~reality
- (1 3) /tensions/nature of tensions
  - (1 3 1) /tensions/nature of tensions/personal
  - (1 3 2) /tensions/nature of tensions/professional
- (1 4) /tensions/living with tensions
  - (1 4 1) /tensions/living with tensions/making sense of self
  - (1 4 2) /tensions/living with tensions/making sense others

(2) /living with stereotype
- (2 1) /living with stereotype/home life
- (2 2) /living with stereotype/work
- (2 3) /living with stereotype/personal relationships

(3) /definitions
- (3 1) /definitions/sexual activity
- (3 2) /definitions/sexual health
- (3 3) /definitions/risk
- (3 4) /definitions/stereotype

(4) /Stereotype
- (4 1) /stereotype/impact
  - (4 1 1) /stereotype/impact/relationships
  - (4 1 2) /stereotype/impact/community
  - (4 1 3) /stereotype/impact/family
  - (4 1 4) /stereotype/impact/others
  - (4 1 5) /stereotype/impact/self
- (4 2) /stereotype/nature
  - (4 2 1) /stereotype/nature/negative
  - (4 2 2) /stereotype/nature/positive
- (4 3) /stereotype/source
  - (4 3 1) /stereotype/source/family
  - (4 3 2) /stereotype/source/community
  - (4 3 3) /stereotype/source/media
  - (4 3 4) /stereotype/source/other

(6) /attitudes
- (6 1) /attitudes/sex
- (6 2) /attitudes/risk

(6 3) /attitudes/relationships
(6 4) /attitudes/BAC
(6 5) /attitudes/others

(7) /reactions
(7 1) /reactions/peers~community
(7 2) /reactions/partners
(7 3) /reactions/media
(7 4) /reactions/professionals

(9) /expectations
(9 1) /expectations/professionals
(9 2) /expectations/family
(9 3) /expectations/community

(10) /experiences
(10 1) /experiences/professionals
(10 2) /experiences/relationships
(10 3) /experiences/community
(10 4) /experiences/early

(11) /knowledge
(11 1) /knowledge/risk
(11 2) /knowledge/BME communities
(11 3) /knowledge/services
(11 4) /knowledge/BAC

(12) /risk
(12 1) /risk/perception
(12 2) /risk/indicators
(12 2 1) /risk/indicators/physical~practical
(12 2 2) /risk/indicators/social
(12 2 3) /risk/indicators/historical
(12 3) /risk/blame
(12 4) /risk/thrill

(13) /influences~sources
(13 1) /influences~sources/family
(13 2) /influences~sources/media
(13 3) /influences~sources/peers
(13 4) /influences~sources/others

(14) /support sources
(14 1) /support sources/family
(14 2) /support sources/community
(14 3) /support sources/services
(14 4) /support sources/partner
(14 5) /support sources/self reliance

(16) /BAC sexual health

82 (16 1) /BAC sexual health/attitudes
83 (16 1 1) /BAC sexual health/attitudes/BAC
84 (16 1 2) /BAC sexual health/attitudes/professionals
85 (16 1 3) /BAC sexual health/attitudes/family & friends
86 (16 1 4) /BAC sexual health/attitudes/community
87 (16 2) /BAC sexual health/expectations
88 (16 2 1) /BAC sexual health/expectations/personal relationships
89 (16 2 2) /BAC sexual health/expectations/professionals
90 (16 3) /BAC sexual health/experiences
91 (16 3 1) /BAC sexual health/experiences/positive
92 (16 3 2) /BAC sexual health/experiences/negative
93 (16 4) /BAC sexual health/responsibility
94 (16 4 1) /BAC sexual health/responsibility/self
95 (16 4 2) /BAC sexual health/responsibility/community

96 **(17) /speaking out**
97 (17 1) /speaking out/positive consequences
98 (17 2) /speaking out/need
99 (17 3) /speaking out/feelings about
100 (17 4) /speaking out/negative consequences
101 (17 5) /speaking out/duty and responsibility

102 **(18) /role models**
103 (18 1) /role models/need for
104 (18 2) /role models/types
105 (18 2 1) /role models/types/community
106 (18 2 2) /role models/types/family
107 (18 2 3) /role models/types/media
108 (18 2 4) /role models/types/none
109 (18 3) /role models/importance
110 (18 4) /role models/acting as
111 (18 5) /role models/future role

Monitoring notes of FG

27/03/02
Focus Group: Afro Caribbean Women

Number of participants 4 (5 including co-worker)

Participants	Talk Identifier
Maria	1
Margaret	2
Candice	3
Louise	4
Stella	5
Carol	6
Monica	7
Chrystal	8
Felicity	9
Remi	10
Co-worker	CW
Researcher	R

Order of Talk

R	R	R	3	4	3	CW	4
2	2	1	4	CW	CW	3	R
3	5	4	R	R	3	2	4
6	3	6	7	6	8	6	8
4	1	5	4	5	7	3	9
1	CW	CW	9	4	R	R	R
CWRR	4	4	CW	R	4	2	4
MT	R	R	2	3	R	R	6
CW+R	4	4	R	R	2	4	3
R	R	R	M	4	R	3	5
4	1	4	R	R	2	CW	6
10	8	9	8	10	4	3	8
2	3	7	5	8	3	2	1
CW	4	R	1	4	R	3	5
4	4 ***(RRR)***	4	R	CW	1	CW	9
6	8	8	3	4	5	6	10
4	3	R	4	3	R	3	8
4	4	3	R	R	3	R	8
10	4	6	5	6	7	6	3
3	R	R	4	3	R	4	1
4	4	4	CW	R	4	R	R

surprise (raised eyebrow - comment)

(10) giggling at intervals.

discomfort by (4) in response

annoyed by inference. (comment) by (10)

laughing

CWLR: co-worker leaves room
CW+R: CW and Remi enter room
MT : turns not recorded.
RLR/RR: Researcher leaves/returns to room

(9) uncomfortable at various points. distracted/averting gaze.

(10) giggling/laughing at 'inappropriate' times.

Participant Turn Frequencies

Participant	Frequency of Turns
1	8
2	9
3	23
4	34
5	8
6	11
7	4
8	10
9	4
10	4
CW	11
L	37

...ays of sussing people out, checking them. Most of the time we don't do it openly. But we all have expectations.

LSG: so do you think the expectations of Black men can influence how people react to them?

P7: yes I do. I don't think its always obvious though, I don't think you always know what people think at the time. I mean thinking about what happened to me when me and my last partner split up, well it wasn't until after that that I realised what people thought about him. As soon as we split up, people were saying, yeh we knew it wouldn't last. He'd run off, they all do...and these are the people who were my friends and all the time they thought that. I know that kind of thing happens all the time, you know people telling you what they thought of you man or girl or whatever after they've gone but I think it's the fact that they were saying he did that because he was Black, you know...like that was it. Nothing more to discuss, he was Black and he left...just as expected. I mean if people are thinking like that, they must be acting like that too. I mean I knew before that they weren't dead keen on him I suppose but never thought about the stereotype thing, just thought they weren't impressed with him going out without me all the time.

LSG: Could that not have been just a clash of personalities? How does that make it an issue about stereotyping?

P7: well I suppose it could be, that's how I took it at first, but then as time passes and people say other things, I mean all these girls are Black too, they got Black men, well most of them have anyway. And it was a bit like us really in the group, they've had experiences, things that have happened to them and on a few occasions they've said, [ex-partner's name] was like that wasn't he? A waster, running round town...so I know that's what they were getting at. My brothers have talked about it too, how people have treated them, girls and their families, like they're going to get their daughters pregnant and do a runner, or like they have women here and there... so I do think its more than just a clash. I think its about the stereotype and how strong it is. Even now, even to day, like we said in the group, can't remember who said it, we still talking about it, still trying to get away from the Black buck image.

LSG: what do you mean?

P7: Well all this times gone past. Black people are doing lots of things we didn't do before but it's still there. In a way no matter what you do there's that expectation, that thought that if you're a Black men you're going to stray...going to have women all over the place. we're still living with that, well Black men I should say.

LSG: does it affect all Black men do you think?

P7: mostly I think although as I said some of them seem to be able to act like it doesn't but yes, I think all Black men are affected. But it's not just them. Their families are too. I mean me and my bloke split up cos we just didn't click anymore, but as I said, people just assumed he was running like some other Black guys had done. They saw him going and put that spin on it see? But it wasn't just him they put that on, it's on me and my kids, I'm the one who got left by a Black man, another single parent. Single Black woman with kids. Well it ain't like that, he still sees the kids, still takes them out. We probably argue less now we're not in the same house. But people don't see that. He left me full stop. Nothing else to know...[pause] he's a good dad, he's a good bloke but we just got together too young, didn't really know what we wanted. But all that gets lost, because we lived up to people's expectation you see, he left, I've got the kids end of story.

LSG: how do you think that relates to some of the other things we talked about?

P7: well I was thinking afterwards about the discussion about how we as partners play our part and that. I remember someone said about making an effort to change things in the future, you know for the kids and that. Well I agree, course I do, it would be nice to think that my kids didn't have to deal with the same kind of stuff. Not just about their sexual behaviour, but generally too. Especially the boys, trying to guess what people think of them ...because their Black I mean, not just because of how they act. I mean it would be great but I don't know if we can ever get to that point really....I don't know. Sometimes I think, are we kidding ourselves...what makes us think its gong to work?...that Black Caribbean men are ever going to be rid of the stigma, rid of the negative way people view their behaviour? But I suppose we've got to keep trying otherwise what'll happen? We can't just give up, let things go on as they are, can we?

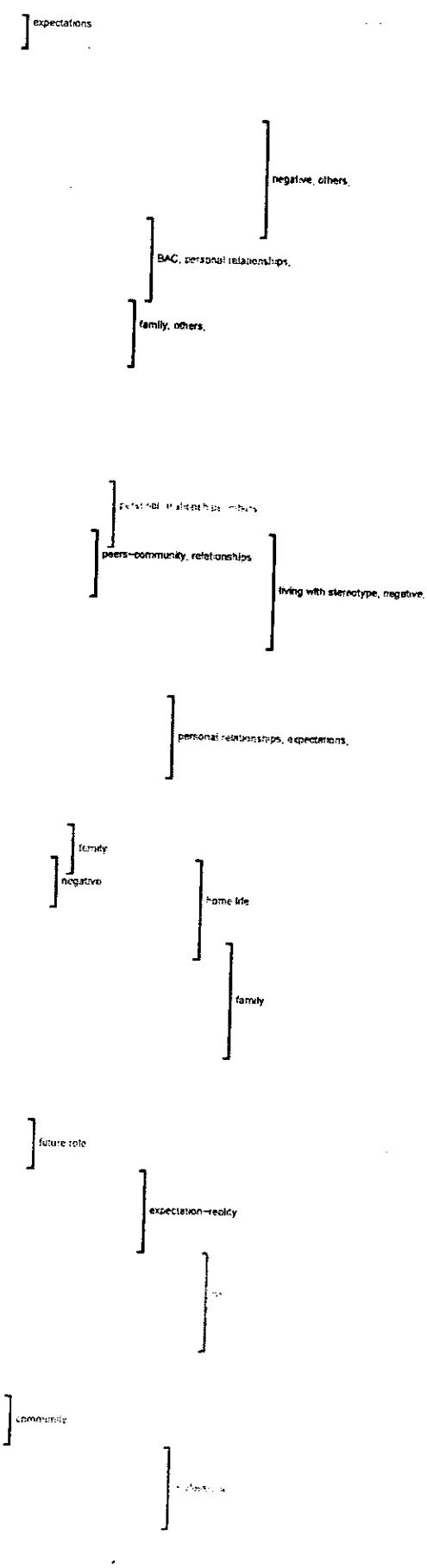
LSG: Do you think it's mainly about change in the Black community?

P7: I'm not sure. I think its part of it. I mean if we think those things and act towards each other in that way, what chance is there that anyone else outside got of changing their expectations? But I think we've also got to put some pressure on other people. I mean if we're talking about sexual behaviour, then there's things that people dealing with that kind of advice or stuff need to do. Things like looking to see if they are helping black people, men and women, to behave more responsibly rather than just blaming them. I think that goes for everyone, in and outside the community. what are we doing to help and what are we doing that's not helping or making things worse? I can't really give you an answer, you know what to do exactly, I don't work in them places, doing that job. I just know we all need to think about it.[silence]

LSG: is there anything else you want to say?

P7: no that's it I think. I don't know if I've helped, not really ...scored many questions have I? anyway I hope it's ok.

LSG: no thanks you've been a great help.



G: Firstly, do you think the key points listed here sum up the main ings we talked about in your group?

: errm…yes I think so. Everything seems to be mentioned that I can member, Yes.

G: Are there any particular issues that you felt were important?

: well the issue about stereotyping I remember in particular. We talked lot about what it was, what it meant and that. I remember it seemed to e quite important. One of the things I think though was not so much bout what we said but about actually taking part in the group, you know alking about Black men, our men and their sexual behaviour. That really t home with me.

SG: what was it about that that struck you?

: well I think it was just doing it really. Just being in a situation here you didn't have to worry about what people thought or whether they ere getting the wrong end of the stick…… It could have been quite dodgy alking about having partners who were Black men and that…but I enjoyed t because I knew the others would know what I meant…didn't have to xplain every little thing… they just knew….

LSG: what do you mean?

P7: I mean talking about Black men and sexual behaviour, its difficult isn't it when you're a Black person, or when your partner is Black. I mean you know how things are, you know that Black men are made to look like they're wasters and that. We know that, but like being in a group where they're all with Black guys its different some how, I mean we talked about all kinds of things…and I didn't feel awkward. Even though there were some white girls there you know? they're with Black guys too so they sort of was like us, knew what we was on about. So there was no like feeling that you were with people who didn't understand. There was a connection that's what I mean.

LSG: do you think it affected the answers people gave?

P7: I don't know, couldn't say but for me it was just better I think. Don't think I would have been the same in another group, you know if there were people who didn't know where I was coming from. I think I'd have been a bit more wary.

LSG: Ok. Now as you said, the discussion covered lots of things about Black men and sexual behaviour. Now some time has passed is there anything else that has occurred to you about that?

P7: hmmm…I think that a lot of the things we talked about had to do with expectations, you know what we expect from Black men, how they are expected to behave. That's how the stereotype comes into it. Its like an expectation about Black men and the kinds of things they get up to. Yes I think expectations is a big thing in all this

LSG: how do you think it affects sexual behaviour?

P7: There are different levels of expectations. We put up with different things and want people to behave differently, especially if we feel responsible for their behaviour or if it will affect our families. So maybe we act differently, to what people do. Like if a stranger, some one we don't know is treating his woman bad we turn a blind eye, we don't say anything, its nothing to do with us. Bt if its our daughter, or someone we know then we get all up tight, mad you know, want to sort him out. I think that's life really, its no different with sexual behaviour to anything else. Its about how we expect people to behave and whether they do what we think they will, or they should.

LSG: so are you saying that our expectations make a difference as to how we judge sexual behaviour?

P7: yes I am. I think thought what we expect is based on loads of things, like the stereotype, in Black men I mean. Its based on how we expect certain people to be because that's our experience and what we've been brought up to believe. I mean that's why the stereotype is important or not important, I mean keeps coming up when you talk about Black men, because its what we know, what we've been told. We're only told about the stereotype and Black men, doesn't apply to anyone else, so we only link it with them. So in a way it sort of gets to be part of what we think about when we talk about Black men. Part of our expectation of them.

LSG: Does that mean we don't make up our own minds? We just act on what people tell us?

P7: no I'm not saying that. But we sort of get to know, from the things we see as we grow up, whether things are true or not. Sort of see if those things really do happen. I mean we 're told as kids about Santa Claus and we believe presents come down the chimney and that but as we get older we notice things, like your mum hiding stuff or buying what other people ask for, then w click, can't be true. Well I know it's a bit different but this sexual behaviour thing is like that, you know noticing what's around you, clues and that, than that tells you about Black gys, about the stereotype, whether they are like that or not. I mean you look around you and see if they really do behave like that.that's how you make up your own mind from the stuff you've been told before.

LSG: do you think that's how it happens all the time?

P7: not all the time but it sort of how we build up a list of things to help us next time. I mean each relationship is different but certain things do seem to follow. In the grup for instance, when we talked about [illegible] shark him out, everyone nodded or said yes,

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