Primary Health Care Nurses discussing sexual health
with older clients

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Abstract

Background: Primary health care (PHC) nurses are responsible for providing a comprehensive and accurate assessment of their clients’ health to ensure holistic care and improve health outcomes. Older adults (over 65 years) who are seen in PHC frequently have long term health conditions that impact on their sexual health, therefore sexual health assessment is essential in PHC settings.

Aim: The purpose of this study was to investigate what facilitates PHC nurses to engage older clients into a discussion about their sexual health issues.

Method: A qualitative exploratory, descriptive research method was used to explore the experiences and beliefs of PHC nurses working with older clients. In 2015 three focus groups were conducted with a total of 16 PHC nurse participants. Data were analysed thematically.

Results: PHC nurses are comfortable discussing sexual health with older adults when the discussion is part of an episode of care or when using a health assessment tool. Attitudes and beliefs of the PHC nurse affect the conversations, with some participants being uncomfortable if clients were of a different gender, ethnicity, or sexual identity. PHC nurses sometimes missed client cues and concerns in regard to sexual health.

Conclusion: Engaging older clients in discussion about their sexual health is problematic for PHC nurses. PHC nurses require a framework for sexual health assessment suitable for use with the older client. Undergraduate and postgraduate education needs revision, incorporating sexual health assessment into primary health care.
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*When life throws you curve balls realise this is an opportunity to strike a new path...*

Our family has had curve balls thrown at us during the process of this research which became opportunities resulting in time and space for completion of this study.

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Chapter One: Introduction

1.1 Introduction

This chapter presents a background to the topic, PHC nurses discussing sexual health with their older clients and introduces the research question, discusses some key concepts related to sexual health of the older adult in primary health and presents a glossary of terms and abbreviations used within the thesis. An overview of the study is presented explaining the purpose and aims of the research and the chapter concludes with an outline of the thesis.

1.2 Background

What facilitates primary health care nurses’ discussing health issues with older clients?
Sexual health is recognised as an integral part of an older person’s life and health (Lindau et al., 2007; World Health Organization, 2010). A study conducted in United States of America (USA) concluded that while there is a decline in active sexual activity among the ageing population (defined as older than 57 years of age in this study), a considerable number of older people continue to enjoy sexual intercourse (Lindau et al., 2007). Intimacy and touch is equally important to the ageing person as it is to others across the age spectrum; yet evidence reveals there is less opportunity for intimacy occurring in later life (Connolly et al., 2012; Gott & Hinchliff, 2003a; Mitty & Rheaume, 2008).

Stereotyping of the older adult exists in society (Abrams, 2015; Kirkman, Kenny, & Fox, 2013), together with inequality of sexual health services and an absence of sexual health research, policy and service planning for the older client (Kirkman et al., 2013). This is despite the high risk of sexually transmitted infections (STIs) amongst older adults (Minichiello, Rahman, Hawkes, & Pitts, 2012) and the effects of long term health conditions on the sexual health of the older adult (Lindau et al., 2007). Health care providers tend to be reluctant to talk about sexual health issues or undertake an adequate sexual health assessment on older clients (Gott, Galena, Hinchliff, & Elford, 2004b; Maes & Louis, 2011; Magnan, Reynolds, & Galvin, 2006). This is despite nursing scope of practice informing that holistic care is a nursing responsibility and comprehensive assessment should be part of this
care (Nursing Council of New Zealand, 2012). Comprehensive assessment should include sexual health assessment, especially for those clients with complex long term health needs (Saunamaki & Engstrom, 2014; Tsai, 2004). Opportunity for sexual health assessment of the older adult by primary health care (PHC) nurses occurs with presentation in general medical practice and in other PHC settings.

1.3 Positioning the researcher

My background is a registered nurse (RN) in primary health care (PHC), working predominantly with older clients presenting with long term health conditions. Anecdotal evidence reveal practices between both my colleagues and my own is limited or not undertaken with regards to our enquiry into the sexual health of older clients during consultations. Our practice invalidates the premise of comprehensive and multidimensional care of the older adult as endorsed in the New Zealand Primary Health Care Strategy (King, 2001), Primary Health Care Advisory Council (2009) and the National Guidelines for Health Assessment of the Older Adult outlined by New Zealand Guidelines Group (2006). As a PHC nurse, I wanted to know if PHC nurses and their older clients were having conversations about sexual health and what barriers or facilitators existed to these conversations occurring. These questions led to the current study.

1.4 Research question

This research arose from a concern by the researcher regarding the perceived reluctance of PHC nurses to discuss sexual health with their older clients. The following questions arose when deliberating on this topic:

- what facilitates PHC nurses’ discussion around aspects of sexual health with their older clients?
- do PHC nurses feel comfortable and prepared to ask clients about their sexual health or do they wait for the client to initiate the conversation?
- do PHC nurses want to include sexual health as part of their provision of holistic care to their clients?

The PHC strategy clearly identifies PHC nurses as crucial health professionals in the delivery of the PHC Strategy (King, 2001) and the provision of equitable health care, which includes equity in age (World Health Organization, 2010). Older adults should be afforded the same level of sexual health assessment as younger clients (World Health Organization, 2012). PHC
nurses have a responsibility to work to their scope of practice as RNs (Nursing Council of New Zealand, n.d) and within the capacity of the PHC roles to promote social justice which is outlined in the strategic goals of the PHC strategy (McMurray & Clendon, 2015). These considerations generated the research question: What facilitates primary health care nurses’ discussing sexual health issues with older clients?

The purpose of this research is to gain an understanding of the way PHC nurses engage older clients to discuss issues related to their sexual health. It was anticipated that investigation into the experiences and attitudes of PHC nurses would identify issues that either facilitate or inhibit nurses’ discussion of sexual health with their older clients. Knowledge gained from this research may have implications for development of nursing education programmes and nursing practice development and for further consideration into health planning and resources for sexual health assessment and sexual health services for the older client.

1.5 Discussion of key concepts, terms and abbreviations used in this thesis

Ageism
The World Health Organisation (2012) regards ageism as “the stereotyping of, and discrimination against, individuals or groups because of their age” (para. 3). A stereotypical societal perspective of ageism is that the older adult has no sexual feelings or desires and is not viewed as being sexually desirable by others (Fileborn et al., 2015).

Client
Client as used in this document refers to a person presenting for health care or management within a health care setting.

Cues
The term cue is used in this thesis to denote verbal or nonverbal prompt to initiate discussion. Zimmerman, del Piccolo and Finset (2007) discuss the use of the term ‘cue’ and consider its use in interactions between nurses and clients where non-verbal and verbal expression of emotion is used to recognise concerns and provide opportunity for discussion.

Heteronormative
Heteronormative is a term used to promote heterosexuality as a societal norm or the preferred sexual orientation within society (Oxford Dictionaries, 2016).
Holistic Care

Holistic nursing care is an approach encompassing the total care of the client that includes their physical, mental, social, emotional and spiritual needs (Ministry of Health, 2002). Te Whare Tapa Whā is a commonly used model in New Zealand that incorporates a holistic approach from a Māori perspective (Durie, 1999). The model depicts a whare\(^1\), the structure comprising whānau\(^2\), tinana\(^3\), wairua\(^4\) and hinengaro\(^5\). With all of these aspects working in harmony the whare stays strong and holistic health is achieved (King & Turia, 2002).

Lesbian, Gay, Bisexual, Transgender, Questioning or sometimes Queer LGBTQ

LGBTQ is an acronym of terms that include Lesbian, Gay, Bisexual, Transgender and Questioning or sometimes Queer (Spectrum Center, 2016). There are other acronyms to denote gender identity but LGBTQ have been selected for this study.

Lesbian: a woman who is sexually and emotionally attracted to other women (Spectrum Center, 2016).
Gay: a person who is attracted primarily to members of the same gender (Spectrum Center, 2016).
Bisexual: a person who is sexually and emotionally attracted to people of both genders (Spectrum Center, 2016).
Transgender: is understood as a person who does not self-identify to either male or female gender (Merryfeather & Bruce, 2014). Transgender may be interchangeably used with terms such as transsexual, drag queen, drag king and cross dresser (Spectrum Center, 2016).
Questioning: the process of exploring and disputing one's own sexual orientation and gender identity for various reasons, especially if there are doubts or uncertainty regarding their gender originality. (Spectrum Center, 2016).

Long term conditions (LTC)

Long term conditions which are also known as chronic health conditions, a common attribute to ageing, have a significant impact on people’s lives which may require long periods of health care interventions (World Health Organization, 2005) and can be largely attributed to the ageing New Zealand society. Two in every three adults in New Zealand have at least one long term condition (Ministry of Health, 2009) and long term conditions account for more than 80% of all deaths in New Zealand (Ministry of Health, 2009).

\(^1\) House \\
\(^2\) Family \\
\(^3\) Physical aspects \\
\(^4\) Spiritual aspects \\
\(^5\) Mental and emotional aspects
Older adult
For the purposes of this study, the older adult refers to persons in the age range of 65 years and over. Sixty-five years is internationally recognised as the point from which people are known as the older adult (World Health Organization, 2016). New Zealand citizens are entitled to retirement income at this 65 years (Ministry of Health, 1997). In New Zealand persons over 65 years are projected to gradually increase in proportion to the population and by 2061 between 22 and 30 % of the overall population will be aged 65+ (Bascand, 2012).

Primary health care (PHC)
Primary health care (PHC) relates to care provided by health professionals to people who need health care provision outside of a hospital setting. Primary health care professionals could include practice nurses, Primary Health Organisation (PHO) nurses, nurse practitioners, occupational health nurses, nurses working in Māori or Pacific health services, pharmacists or general medical practitioners (GPs) (Ministry of Health, 2014). The New Zealand Ministry of Health launched the Primary Health Care Strategy in 2001 (King, 2001), which eventuated in the development of Primary Health Organisations (PHOs) which were established to provide vision and direction for primary health care services.

PHC Nurses
PHC nurses are registered nurses (RNs) who work across a variety of non-hospital based roles within the community. Practice nurses are employed by a general medical practice which provides primary health care to clients of all ages within that practice. PHO nurses are employed by a Primary Health Organisation to provide nursing care to clients within the geographical region of the PHO, supporting all general medical practices and clients within that region. Other PHC nurse roles include Occupational Health nurses and PHC nurses working for Māori and Pacific health providers.

Primary Health Organisations (PHOs)
Primary Health Organisations are funded by District Health Boards (DHBs) to work alongside general practices to support the primary health needs of an enrolled DHB population (Ministry of Health, 2014). The aim of PHOs is to promote an effective health care pathway for the clients within the community, through delivery of essential primary health care services and with an emphasis on equitable assistance to access for their health needs (Minister of Health, 2009).
Registered Nurse (RN)
A registered nurse in New Zealand has the qualifications and competence as prescribed in the Registered Nurse scope of practice, defined by Nursing Council of New Zealand (NCNZ) (n.d).

Sexual health
The term sexual health has been used throughout this study with the premise that the term also inherently includes sexuality when referring to the sexual health of the client. Sexuality is seen as a need of physical and emotional expression throughout the lifespan of a person and can be considered more than the act of sex (World Health Organization, (n.d.)). Including sexual health needs is a part of holistic nursing care and should not be excluded from the care of the older adult (Pangman & Seguire, 2000). Sexual health is defined by the World Health Organization (2010) as:

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled”.

Sexual health issues
In this document, sexual health issues refer to concerns or problems that an older adult has relating to all aspects of their sexual health. Sexual health issues can include a wide range of long term health conditions and/or prescribed medications which can impact on the older adults’ desire for and ability to maintain sexual health.

1.6 Chapter overview

1.6.1 Chapter One: Introduction
This chapter provides a background to this study, including the interest and background of the researcher. The research question “What facilitates primary health care nurses’ discussing health issues with older clients?” is presented with the purpose and aims of the study and discussion of the key concepts, terms and abbreviations related to the research question. The chapters of the study are introduced.
1.6.2 Chapter Two: Literature review

The literature review chapter critically examines both international literature and from within New Zealand which relate to PHC, nursing, sexual health and the older adult and identifies emerging themes. The themes identified from the literature are the need for intimacy and touch in the older adult; willingness of health professionals to ask clients about sexuality; willingness of older clients to ask health professionals about sexuality; attitudes and beliefs of nurses around sexuality; illness related to sexual health and the provision of sexual health services; and sexual health education for nurses. The literature review provides a rationale for undertaking the study.

1.6.3 Chapter Three: Method

The method chapter explores the descriptive exploratory approach used for this qualitative study to answer the research question. Methods and rationale used for gathering data using focus groups and the analysis of the data are discussed. The rigour of the study is reported.

1.6.4 Chapter Four: Results

The results identified key themes from the data analysis; factors enabling the primary health care (PHC) nurse or the client to initiate conversations about sexual health, willingness of PHC nurses to discuss sexuality with older clients, barriers to sexual health discussions occurring between the PHC nurse and their clients and the education and knowledge of sexual health for PHC nurses and their clients. The results and themes are presented in this chapter using verbatim quotations from participants to support and explain the themes.

1.6.5 Chapter Five: Discussion

The discussion chapter builds on the data and themes identified in the results and relate these to the extant literature. Key themes identified are enabling factors to conversations between primary health care (PHC) nurses and clients, barriers to conversations about sexual health between PHC nurses and clients and education and provision of services and resources.

1.6.6 Chapter Six: Conclusion

The thesis is concluded with a summary of the key findings with implications and recommendations presented for nursing practice, nursing education, nursing research and an overview of the limitations of the study is provided.
1.7 Chapter summary

In this chapter, it has been identified that sexual health is an integral part of the holistic care of the older adult but is not assessed effectively in primary health care (Gott et al., 2004b). As a PHC nurse, I wanted to know the experiences of other PHC nurses regarding what facilitates discussion of sexual health with their older clients. Findings from this study will add to knowledge about conversations between PHC nurses and their older clients and provide an evidence base for further research, development of appropriate education and nursing practice and resourcing of sexual health services. In the following chapter, the literature from both New Zealand and overseas will be examined and themes identified to support the research question.
Chapter Two: Literature Review

2.1 Introduction

In this chapter, literature is reviewed related to this study and emerging themes identified. A systematic review of current literature is an essential start to a research thesis, allowing the researcher to gain insight into the topic chosen (Whitehead, 2013). In this literature review, the gathering and analysis of national and international literature enabled refining of the research question and further establish research already undertaken in sexual health of older adults. A search for research concerning the discussion of sexual health with clients by primary health care (PHC) nurses was made and broadened to include other health professionals and a range of health care environments. The purpose of this literature review is to establish what is currently known about sexuality, sexual health and the older adult, particularly within New Zealand.

Literature for this review was sourced via Eastern Institute of Technology (EIT) and District Health Board (DHB) websites and published books from the researcher’s and colleague’s collections. Databases searched were: Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, Cochrane Library, ProQuest Central and Science Direct. The key words used in search terms were: sexuality, sex, intimacy, assessment, nursing, nurse, practice nurse, general practitioner (GP), general practice, primary health care, nursing care, age, ageing, aged care, adult, older adult, older person, later life, clients, patients, discussion, communication, barriers, facilitators, attitudes, beliefs, education and training. Cited in and reference lists of published articles have been used to search for similar literature.

Fifty-three articles were initially retrieved using the above search terms, of which 39 were relevant to the topic of sexuality and the sexual health of older adults. Two studies were conducted in New Zealand: (Gilmer, Meyer, Davidson, & Koziol-McLain, 2010), a quantitative survey undertaken in aged residential care; and Neville and Henrickson (2006) who investigated the perceptions of lesbian, gay and bisexual people of PHC services. Eight studies from Australia (Bauer, McAuliffe, & Nay, 2007; Fileborn et al., 2015; Kirkman et al.,
2013; Malta, 2013; Minichiello et al., 2012; Richters, de Visser, Rissel, & Grulich, 2014; Rowntree & Zufferey, 2015; Shuttleworth, Russell, Weerakoon, & Dune, 2010), one study from Portugal (Palha, Esteves, & Azevedo, 2009) and one study from the United States (US) (Snyder & Zweig, 2010) involved sexuality related to the older person but not particularly from a PHC perspective. The studies which focused on communication of sexuality in PHC were all based in the United Kingdom (UK) (Abrams, 2015; Bodley-Tickell et al., 2008; Bouman, Arcelus, & Benbow, 2006; Byrne, Doherty, McGee, & Murphy, 2010; Gott, Galena, Hinchliff & Elford, 2004a; Gott & Hinchliff, 2003a; Gott et al., 2004b; Heath & White, 2001; Lehmann, 2011), apart from two studies in the US (Maes & Louis, 2011; Magnan et al., 2006), which focus on sexual history taking practices of nurses in general practice. Studies by Saunamaki, Andersson, and Engstrom (2010) and Tsai (2004) both investigated communication of sexuality with older clients by nurses in hospital settings. Following a review of the abstract of each article, the article was then reviewed with more depth and catalogued into Endnote to define the key concepts and themes.

Six themes emerged from the literature review: the need for intimacy and touch in the older adult; willingness of health professionals to ask clients about sexuality; willingness of older clients to ask health professionals about sexuality; attitudes and beliefs of nurses around sexuality; illness related to sexual health and the provision of sexual health services; and sexual health education for nurses.

2.2 Need for intimacy and touch in the older adult

The importance of intimacy and touch is acknowledged in the literature (Garrett, 2014; Malta, 2013; Mitty & Rheaume, 2008) and accepted as a vital need of all people but of greater significance to the older adult who may be socially isolated, experiencing sexual dysfunction due to chronic disease, or who may be single (Gott & Hinchliff, 2003b). There is less opportunity for sexual intimacy and touch to occur in later life (Connolly et al., 2012; Mitty & Rheaume, 2008). However, Bauer et al. (2007) argue that sexuality could be a key component of the older persons’ life, vital to their maintenance of healthy interpersonal relationships, self-concept and sense of integrity. Sexual desire and need remain, despite the potential for increased health problems or sexual dysfunction due to long term health conditions in the older person (Moreira et al., 2005).
Gott and Hinchliff (2003b) refute the belief that if the older person is not sexually active, sex is no longer important to them. According to Bouman et al. (2006) in the Nottingham study of sexuality and ageing, the older adult may have similar ageist views of sexuality as the general population but the need for love and sexual intimacy is still vital. Freedom of sexual expression and intimacy is acknowledged by Bentrott and Margrett (2011) as being essential to the wellness of a person, contributing to the quality of life of the older adult; including their life satisfaction, as well as physical and psychological wellbeing. Freedom of sexual expression occurred in the 1960’s and 1970’s, with the so-called “baby boomers” (the generation born between 1946 and 1965) (Kirkman et al., 2013). People who experienced increased sexual liberalism, are now coming into their older years and bringing with them freer sexual expression than previous generations (Rowntree & Zufferey, 2015). Older adults who are in intimate relationships are reported to have improved cognitive functioning, greater independence, increased life expectancy and decreased risk of cancer and cardiovascular disease (Bentrott & Margrett, 2011).

The literature reviewed underscores the need for intimacy and touch in the older adult in order to maintain a healthy life. Sexual health therefore is an important aspect of nursing assessment of the older adult. In the next section of the review, the willingness of health professionals to discuss sexual health with older adults is investigated.

2.3 Willingness of health professionals to engage older clients about sexual health

The importance of discussing sexuality and providing holistic care to clients is explained by Magnan et al. (2006). Clients in this study preferred nurses to initiate sexual health discussions, however nurses waited for the client to initiate the conversation (Magnan et al., 2006). Nurses hesitated initiating conversation regarding sexual health as they considered this too private an issue to discuss with clients (Magnan et al., 2006; Saunamaki & Engstrom, 2014). Nurses perceive conversations about sexual health are too confrontational for clients and an invasion of the client’s privacy (Saunamaki et al., 2010). Heath and White (2001) suggest that nurses may find asking clients about sexual health issues so difficult that they avoid the subject totally.

Gott et al. (2004a) and Gott and Hinchliff (2003b) found that although PHC nurses were usually the first health professional the client visits for sexual health concerns, the role of the PHC nurse was more aligned to prevention and treatment of sexually transmitted
diseases, providing contraceptive advice and performing smear tests. Nurses were more comfortable initiating conversations with clients about sexual health when it was related to consultations involving long term health conditions known to affect sexual function (Zeiss & Kasl-Godley, 2001). Nurses claimed that no routine discussions or questioning occurred around sexual health issues or sexual dysfunction during nursing consultations (Gott et al., 2004a). Maes and Louis (2011) from the US found that only 2% of nurse practitioners include a sexual health history when assessing the older adult. The main barriers to effective inclusion of sexual history taking were lack of time, interruptions and a lack of communication skills (Maes & Louis, 2011). Saunamaki and Engstrom (2014) identified barriers to addressing sexual health including lack of time, lack of support from the employer, heavy workload and lack of places to talk with patients in private. Bentrott and Margrett (2011) also note lack of privacy as one of the reasons health professionals avoid discussing sexual health with older clients.

Gott et al. (2004b) conducted a study to identify barriers to discussion of sexual health in PHC using semi-structured interviews with GPs and practice nurses within practice settings in the UK. Differences between health professionals and clients such as gender and ethnic dissimilarities, older clients and those who were non-heterosexual reduced the likelihood of discussion about sexual health issues. Strategies identified to encourage communication included sexual health awareness education for nurses and sexual health information made available to clients (Gott et al., 2004a). Health professionals’ unwillingness to ask clients about sexual health may be related to the belief that older clients do not wish to discuss these concerns during consultations (Moreira et al., 2005).

2.4 Willingness of older clients to ask health professionals about sexual health

Older clients may be reluctant to ask a health professional about a sexual health problem (Gott & Hinchliff, 2003a). Moreira et al. (2005) found that although half of all participants in the Global Study on Sexual Attitudes and Behaviours (GSSAB) had experienced at least one sexual problem; less than 19% had attempted to seek professional help. However, there is an expectation by the older client that their GP will enquire about their sexual health (Moreira et al., 2005). In the GSSAB study, only 9% of participants had been asked during a routine visit to their GP about their sexual health but 48% of men and 41% of women participants thought they should be asked about sexual health in the course of a routine consultation (Moreira et al., 2005). Gott, Hinchliff, et al. (2004b) found that many
participants in their study focused on the barriers to older adults seeking treatment for sexual problems and appreciated the opportunity to discuss sex and sexual health when this was offered by the GP. Bentrott and Margrett (2011) concur that older adults welcome the opportunity to discuss sexual health issues with their health providers.

Providing an opportunity to discuss sexual health with older clients and having an open-minded willingness to do so may improve the communication of sexual health by primary health care nurses. The success of older adults’ sexual health consultations with health providers may be partially attributed to the attitudes and beliefs of nurses around sexual health (Bouman et al., 2006).

2.5 Attitudes and beliefs of nurses around sexual health

According to Maes and Louis (2011), attitudes of nurses towards the older adult may be influenced by societal beliefs and attitudes, including misconceptions and stereotypical views society has towards sexuality of the older adult. In the UK, Abrams (2015) conducted a comprehensive study of the British population which revealed widespread prejudice-based ageism associated with the older adult. From age 55 years and upwards discrimination against the older adult was nearly twice as likely as any other form of discrimination and with almost a third of respondents viewing the over 70 age group as being more incompetent and incapable than younger people (Abrams, 2015). Likewise, in Nottingham, UK, Bouman et al. (2006) examined literature investigating attitudes of health professionals and staff from nursing and residential homes towards later life sexuality and concluded largely negative attitudes, such as discreet silence, distaste and tunnel vision displayed towards the sexuality of the older adult. In contrast, Shuttleworth et al. (2010) found that most of their respondents who were nursing managers from aged residential care, expressed positive attitudes towards the normality of sexuality in the older adult and acknowledged the rights of residents for sexual expression. Everett (2008) discussed the effect of nurses’ beliefs and attitudes on their care of residents in long-term residential care and encouraged the use of a framework for managing ethical issues that nurses in aged care facilities may face when addressing sexual health with residents.

White (1982) developed a scale for the assessment of attitudes and knowledge towards sexuality in the older adult (ASKAS) to improve the sexuality assessment and care of older clients and recommends health professionals use the ASKAS model for client assessment.
Palha, Esteves and Azevedo (2009) used the ASKAS scale in Portugal in 2009 with medical and nursing students and found undergraduate medical students and psychiatry resident doctors were more inclined to have positive attitudes towards sexual health with their older clients, however nursing students had largely negative attitudes towards older adults and their sexual health. The researchers recommended increased opportunity for education of all medical and nursing students in sexual health (Palha et al., 2009). In a similar study Snyder and Zweig (2010), using participant surveys found that psychology students in the US had greater knowledge on factors related to ageing processes than medical students. However, both psychology and medical students had gaps in their knowledge around sexuality (Snyder & Zweig, 2010). Snyder and Zweig (2010) found attitudes of the psychology and medical students towards sexuality and ageing were related to demographic variables of the students such as their gender, ethnicity, educational level and socioeconomic background.

Negative attitudes among health professionals toward sexual health in the older adult is not uncommon (Bouman et al., 2006). Bouman et al. (2006) describe three types of attitudes that a health professional may have towards initiating discussion on sexual health with the older adult: firstly the attitude of discrete silence rather than discussing sexuality; secondly, distaste towards sex involving older people; and third is a narrow-mindedness towards sexuality as an act using genital organs and including only heterosexual relationships.

Heteronormative beliefs occur within society (World Health Organization, 2012) and older adults are often by default, regarded by nurses as heterosexual (Gilmer et al., 2010). Nurses may experience difficulty discussing issues related to sexual health with clients with alternative sexual behaviours and those with sexual orientation and cultural ethnicities different to their own (Gott et al., 2004a; Pangman & Seguire, 2000). Gott et al. (2004a) found there was a general belief among nurses that discussing sexuality with these groups could cause offence.

Using questionnaires to collect data from older women in Australia, (Fileborn et al., 2015) identified women’s need to have of practitioners to recognise diversity when discussing sexual health concerns with them, rather than imposing normative views during their consultations. Neville and Henrickson (2006) reported the importance of disclosure of sexual identity to healthcare professions for appropriate attention to health needs. Neville
and Henrickson (2006) suggested that sexual identity should be integrated into health interviews and that nurses be inclusive in their delivery of care and education when interviewing lesbian, gay, bisexual, transgender and questioning (LGBTQ) clients. According to Gott et al. (2004b) the importance of using appropriate terminology and language by providers when discussing sexuality is critical to health outcomes.

Saunamaki et al. (2010) questioned 88 nurses using a sexual attitudes and beliefs survey in a Swedish hospital. The researchers concluded that Swedish nurses experienced higher levels of barriers to discussing sexuality with older clients, than those found by Magnan et al. (2006) in the US. Over 40% of nurses in the study by Saunamaki et al. (2010) believed that sexuality should be discussed only if the client initiated the topic. Magnan et al. (2006) gathered information from nurses in a large metropolitan medical centre in the US working in inpatient and outpatient areas (oncology, medical and surgical). Client care was influenced by nurses’ attitudes and beliefs to sexuality and nurses’ experience, education; and the area they worked affected these attitudes and beliefs (Magnan et al., 2006). Experienced nurses were more comfortable addressing sexual concerns (Magnan et al., 2006).

According to Saunamaki et al. (2010), there should be increased opportunity for further education in sexuality for nurses and more research into understanding why barriers in communication of sexuality with older adults still exist. Additionally, Saunamaki and Engstrom (2014), urge further education and support from the workplace for nurses to have access to assessment tools which enable discussion of sexuality with the patient.

If nurses have negative attitudes regarding their own sexuality, it may be difficult for them to assist others to maintain a positive attitude toward sexuality (Glass & Dalton, 1988). Nurses who have negative attitudes and beliefs about sexuality in the older adult are less likely to discuss sexual health with their clients (Magnan et al., 2006). This reluctance to address sexual health issues could result in fewer opportunities for older adults to receive treatment for sexual health problems and sexually transmitted infections (STIs) and with little probability for referrals to sexual health services.
2.6 Illness related to sexual health and provision of sexual health services

Sexual health is a lifelong issue and any change to the sexual health of the older adult due to illness can have a major impact on clients' personal lives and their relationships with partners (Heath & White, 2001). With the increasing population of older adults, the rates of STI and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are also increasing in this age group (Minichiello et al., 2012; World Health Organization, 2010). Due to chronic disease and the altered presentation of STIs in the older adult, symptoms may go unrecognised (Maes & Louis, 2011). A lack of early diagnosis can prevent recognition of disease-related complication and lead to poorer prognosis (Bodley-Tickell et al., 2008). Maes and Louis (2011) also address the lack of discussion around prevention of STIs with the older adult in primary health, which may only be initiated by a nurse when the nurse identifies a problem. Maes and Louis (2011) recognise the increase in STIs in the older adult and the influence that nurse practitioners can have in the primary and secondary prevention of STIs among older clients. Minichiello et al. (2012) notes the increased rate of STIs among older aged women globally and the need for resources to be developed to encourage safer sexual practices. Minichiello et al. (2012) confirms the increased vulnerability of older people to STIs is due to less safe sexual practice, limited sexual health services for older people, the introduction and use of pharmacological interventions, high divorce rates, healthier lives, increased longevity, being widowed, internet dating and increased sex tourism.

Long term conditions can have a profound impact on the sexual health of the older adult, not only by the decline of sexual dysfunction but also, for example, the effects of pain, breathlessness, incontinence and reduced mobility (Heath & White, 2001). People who present to PHC with long term conditions may become predisposed to secondary sexual health dysfunction as a consequence of their condition and/or prescribed medications, especially in cases of diabetes and heart disease (Loeb, Penrod, Falkenstern, Gueldner, & Poon, 2003). Identification and addressing of sexual dysfunction by health professionals can prevent subsequent social withdrawal, relationship difficulties or depression (Zeiss & Kasl-Godley, 2001). Although older adults with long term conditions may experience sexual dysfunction, they should also expect to maintain satisfying sexual relationships (Pangman & Seguire, 2000). Discussion with clients on the side effects of medication and how medication and surgical treatment may affect their sex lives will inform choices and promote appropriate use of medication (Zeiss & Kasl-Godley, 2001). Client awareness of sexual health
problems may signify warning signs of more serious underlying illness which emphasises the need for improved communication of sexual health with clients (Magnan et al., 2006).

According to Gott et al. (2004b), sexual health services are geared towards younger clientele, which can exclude older clients. Minichiello et al. (2012) argues that ageism may be the reason that older people are left out of STI prevention campaigns. Kirkman et al. (2013) and Shuttleworth et al. (2010) also observe that sexual health campaigns in Australia have been initiated by research, not driven by national policy. If health professionals identify sexual health problems, there are a lack of providers in Australia who are funded to deliver services to the older client (Kirkman et al., 2013). According to Tsai (2004), one of the perceived barriers to nurses undertaking a sexual health history was the lack of professionals and sexual health services to which clients could be referred. Tsai’s (2004) study called for professionals with expertise in sexual health management to be used by nurses as mentors and educators in sexual health. There is a link in the literature between the level of sexual health education of nurses and the attitudes and beliefs of nurses to sexuality in the older adult (Magnan et al., 2006; Saunamaki & Engstrom, 2014).

2.7 Sexual health education for nurses

Current undergraduate, postgraduate and professional development sexual health education focuses mainly on reproductive health, relating primarily to clients 30 years and younger and with little correlation to the World Health Organisation (WHO) definition of sexuality being a central aspect to human life (Kirkman et al., 2013). Research by Snyder and Zweig (2010) using the ASKAS assessment tool, found that psychology and medical students have relatively little exposure to education and clinical experiences related to sexuality and ageing. The lack of education and experience influenced their ability to engage older clients in open dialogue regarding sexual health (Snyder & Zweig, 2010). Including sexual health of the older adult into healthcare gerontology curriculum will enhance confidence of students working with the older adult (Snyder & Zweig, 2010). Maes and Louis (2011) also found that for nurse practitioners to improve sexual health care provision for their older clients, it would be beneficial to have continuing education on sexuality and sexual health and additionally be provided with tools to improve assessment of the older adult. Saunamaki et al. (2010) suggests using the Permission, Limited Information, Specific Suggestions and Intensive Therapy (PLISSIT) model as a guideline for sexuality education of undergraduate nursing students. The PLISSIT model can be used to assess and manage the sexuality of
adults and has suggested questions to guide the discussion of sexuality (Wallace, 2004). In a study by Rowntree and Zufferey (2015) using focus groups to collect data, aged care nurses identified the need for improved sexuality education as well as introducing guidelines and policy around documentation of clients sexual needs. By defining sexual expression as need, Rowntree and Zufferey (2015) suggest staff are reminded that clients are sexual beings and are empowered to add sexual needs to their care planning.

The importance of including education on sexual health issues into undergraduate and postgraduate nurse education was addressed by both Gott et al. (2004a) and Magnan et al. (2006). Both authors note there is a lack of education about sexual health needs of clients and any advancement in this education will improve the confidence of nurses to address sexual health with clients while enhancing the nurse’s counseling ability (Gott et al., 2004a; Magnan et al., 2006). Much earlier, in 1988, Glass and Dalton (1988) also discussed the need for improved education for nurses on sexual health among older adults, to begin to change nurses’ negative attitudes of sexual health, increase comfort, confidence and gain correct information on sexual health.

Kirkman et al. (2013) also found a need for ongoing professional development of the health workforce in sexual health across the lifespan and recommends sexual health education be included in Australian healthcare policy to ensure quality and consistency of standards and guidelines. Sexual health education was also noted by Shuttleworth et al. (2010) in their discussion on the lack of national policy to provide education in sexual health for staff in aged residential care. Earlier Tsai (2004) described the need for sexual health education among Taiwanese nurses, either during undergraduate nursing education or within professional development. Tsai (2004) recommends using clinical specialists or nurse practitioners to provide mentoring and role modeling in addressing sexual health issues in practice.

2.8 Chapter summary

The review of the literature in this topic has identified six themes relating to PHC nurses discussing sexual health with older clients. They are: the need for intimacy and touch in the older adult; the willingness of health professionals to ask clients about sexual health; the willingness of older clients to ask health professionals about sexual health; attitudes and
beliefs of nurses around sexual health; illness related to sexual health and provision of
sexual health services and sexual health education for nurses.

This literature review has established the need for intimacy and touch in the older adult,
despite barriers and societal norms that hinder the older adult to discuss sexual health with
health providers. Nurses bring into client consultations their own beliefs and attitudes
towards sexual health in the older adult which may affect their ability to conduct purposeful
and effective consultations with their older clients. The literature supports the importance
of sexual health assessment and support for the older adult. The increasing rates of STIs and
sexual health problems in the older adult may be accentuated by the lack of sexual health
communications within primary health care and the lack of education for providers on how to
communicate effectively with clients around sexual health. National policy and funding
targeted mainly towards younger age groups has led to sexual health services not being
accessible to the older client population nor onward referrals being made.

It has been established that there has been no research undertaken in New Zealand relating
to PHC nurses assessment and communication with the older adult. There is a scarcity of
international research focusing on the attitudes and beliefs of nurses towards sexual health
in the older adult. Research has been conducted within residential care and with health
professionals other than PHC nurses. There has been no research conducted which use focus
groups to obtain data. The findings of this study will provide current and local evidence of
communication about sexual health with older adults by PHC nurses. This research will build
on current knowledge providing further evidence and support for undergraduate,
postgraduate education and professional development in sexual health in the older adult for
nurses and appropriate national policy development and health service provision for sexual
health services for the older adult.
Chapter Three: Method

3.1 Introduction

The method chapter extends the information gathered in the literature review to explore methodological frameworks and research methods which best utilise the investigation and collection of data for this study. The rationale for the use of a qualitative design and focus groups for this study will be evidenced. Research planning including ethical considerations is discussed and the subsequent gathering and analysis of the data presented. The rigour of the study is reported, discussing the trustworthiness in the data gathered through examination of the credibility, dependability and transferability of the research.

3.2 The use of qualitative research

The purpose of this study is to increase understanding of the way primary health care (PHC) nurses engage older clients to discuss issues related to the client’s sexual health. The choice of an appropriate research design was essential to the research process. Consideration of the research question and the aims of the study allowed for a choice of design which gave the ability to answer the research question effectively. Qualitative research allows the gathering of data of participants’ experiences, attitudes and beliefs thus increasing insight into human behaviour and experience (Harding & Whitehead, 2013; Ritchie & Lewis, 2003; Whitehead, 2013).

Creswell (2003) describes qualitative research as exploratory and used where the research variables are not known, as the topic may be new or has never been studied with a particular group. As the research question in this study aims to elicit opinion and knowledge from PHC nurses, a qualitative exploratory descriptive approach was considered to be the preferred approach (Ritchie & Lewis, 2003). Exploratory research enables the initial gathering of data to establish new ideas and learning, in order to understand the meaning of experiences (Robinson, 1999). Focus groups were chosen as the data collection method, using an interpretive approach that allows initial understanding of the research question and the gathering of social data using a flexible and sensitive approach (Robinson, 1999). Focus groups fit well with the potentially sensitive topic of sexual health.
3.2.1 Focus groups

Focus groups are a qualitative research method involving group interviewing using a facilitator to guide the group’s discussion around a set of topics (Morgan, 1998). Focus groups are used on their own or as part of other data collection methods to understand the experience of individuals (Redmond & Curtis, 2009). The interaction of participants within a group allows the understanding of experience to emerge, which would not happen with other methods (Webb & Kevern, 2001). Focus groups enable the researcher to generate information and understand and interpret the experiences and meanings of participants through open discussion (Doody, Slevin, & Taggart, 2013b; Ritchie & Lewis, 2003).

Acknowledged advantages and disadvantages using focus groups as a research method are summarised in the following table:

<table>
<thead>
<tr>
<th>Advantages of the focus group method</th>
<th>Disadvantages of the focus group method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economical with time, cost and resources</td>
<td>Number of questions may be limited by time</td>
</tr>
<tr>
<td>Flexibility</td>
<td>May not be representative of larger population</td>
</tr>
<tr>
<td>Gain multiple perspectives</td>
<td>Sensitive topics hard to maintain anonymity</td>
</tr>
<tr>
<td>Allows open discussion</td>
<td>Difficulty maintaining objectiveness</td>
</tr>
<tr>
<td>Homogenous group encourages participation</td>
<td>Dominance of individuals within the group</td>
</tr>
<tr>
<td>Helps to identify further areas of research</td>
<td>Facilitation requires expertise</td>
</tr>
<tr>
<td>Natural weeding out of ‘extreme’ views</td>
<td>Conflicts may arise with differing personalities</td>
</tr>
<tr>
<td>Consistent and shared views identified</td>
<td>Risk of breaches of confidentiality</td>
</tr>
<tr>
<td>People with literacy issues can be involved</td>
<td></td>
</tr>
<tr>
<td>Discussion of ‘taboo’ topics helped by group support</td>
<td></td>
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</tbody>
</table>

(Doody, Slevin, & Taggart, 2013a; Robinson, 1999; Shaha, Wenzel, & Hill, 2011)

There is an opportunity for participants in focus groups to reflect on their thoughts and feelings while interacting and considering how their opinions sit with the rest of the participants in the group (Kitzinger, 1995). Robinson (1999) describes the conversation and interaction that occurs during focus groups as generating more dialogue and discourse than available in an individual interview. This is supported by Shaha et al. (2011) who describe focus group conversation as generating rich data that is economical with time and resourcing. However Doody et al. (2013a) cautioned against focus groups being used as an
inexpensive alternative to individual interviews. Tausch and Menold (2016) also observe that the focus group results may not generalise to a larger population and should be used to identify but not explain variables.

There is a risk of participants being less likely to participate fully in a focus group when discussing topics considered as sensitive with the result of less meaningful data being gathered (Shaha et al., 2011; Tausch & Menold, 2016). Nevertheless, focus groups can provide collegial support for topics considered sensitive, as less inhibited participants can comfort and support those who are more vulnerable (Robinson, 1999; Whitehead, 2013). Focus groups are described as less intimidating than individual interviews by Whitehead (2013).

Debate exists on the optimum numbers of participants for focus groups. Curtis and Redmond (2009) discuss factors to consider when deciding on group numbers. Focus group size is dependent on the topic, how much is known about the topic and how well the facilitator can manage the discussion (Curtis & Redmond, 2007; Doody et al., 2013a). Numbers of participants will depend on the information that each participant is able to contribute and the ability to maintain stimulating group discussion (McLafferty, 2004). If the group is too large, it may be difficult to control the conversation but if there are too few participants, there may be domination by one or two participants or an individual may feel obliged to speak. The common number of focus group participants is eight to 15 according to Whitehead (2013). Morgan (1998) suggests optimal focus group numbers as being 10 to 12, Robinson (1999), five to eight and Tausch and Menold (2016) consider four to six participants as the preferred number for health research, especially when the topic concerns sensitive issues. Whitehead (2013) notes however that the richness of the data obtained is more important than the number of participants when planning the size of focus groups.

The duration of focus groups should not exceed two hours (Curtis & Redmond, 2007; Doody et al., 2013b). The two-hour maximum recommendation is based on an individual’s ability to concentrate physically and mentally (Doody et al., 2013a). Further Ritchie and Lewis (2003) state the time taken to conduct a focus group is dependent on the time required to answer topic questions and whether the participants are known to each other.
The role of the focus group facilitator is to introduce the topic, explain the ground rules and encourage the group to feel comfortable and at ease (Curtis & Redmond, 2007). The facilitator being of the same homogenous group as the participants, dressing in a similar way and being accepted by the group, adds to the promotion of the group’s comfort (Curtis & Redmond, 2007; Freeman, 2006).

As suggested by Curtis and Redmond (2007) and Vogt, King and King (2004), the facilitator does not participate in the discussions, nor interrupt the discussions and is not a passive observer. The facilitator does however need to encourage quieter participants to talk when required and to express their thoughts and feelings on the topic (Whitehead, 2013), yet remain objective, empathetic and not contribute as a participant (Redmond & Curtis, 2009; Vogt et al., 2004). Doody et al. (2013b) emphasize that the most important role of the facilitator is to ensure that the main topic has been addressed and all participants have had an opportunity to discuss the topic.

### 3.2.2 The use of focus groups in nursing research

Focus groups are an appropriate and popular method for nursing research, allowing understanding of relationships between nursing participants and their shared experiences (Curtis & Redmond, 2007; Webb & Kevern, 2001). Focus groups are frequently used in nursing research as nurses are often comfortable discussing nursing practice with colleagues in a team environment (Estabrooks et al., 2005). Exploratory descriptive approaches using focus groups are acknowledged as an appropriate tool to use when there is a scarcity of research on a topic, as this approach helps to identify, understand and explain variables for investigation and could encourage further research to be conducted in this area of nursing (Curtis & Redmond, 2007).

### 3.3 Ethical considerations

This study is informed by: the Treaty of Waitangi (King & Turia, 2002); Health and Disability Commissioner Code of Rights (Ministry of Health, 2010); Health Information Privacy Code (Office of the Privacy Commissioner, 1994); and the Code of Ethics (New Zealand Nurses Organisation, 2010).

The research was guided by the principles of nonmaleficence (prevention, avoidance or minimisation of harm to participants) and beneficence (that this study has a basic tenet of a worthwhile outcome) as outlined in New Zealand Nurses Organisation (NZNO) Code of Ethics.
These principles informed the following sections in this chapter: informed and voluntary consent, respect for privacy rights of participants, acknowledgement of the Treaty of Waitangi, and minimisation of harm and storage of data.

Approval for this study was granted from the Eastern Institute of Technology for research proposal progression (Appendix 1) with Eastern Institute of Technology Research Ethics & Approval Committee approval granted on 3\textsuperscript{rd} August 2015, reference number 13/15, (Appendix 2). Locality approval for the study was granted from the region’s DHB in August 2015 (Appendix 3).

3.4 Method

In this study, focus groups were considered an appropriate method to use as the sample group of PHC nurses were working in similar PHC nursing environments and were likely to be engaging in similar sexual health discussions with their older clients. The use of focus groups for this study allows the identification of common views of the PHC participants while allowing disclosure of differing views (Robinson, 1999). The homogeneity of this group of nurses would encourage their participation and aid in the generation of comprehensive data in a study which can be considered ‘sensitive’ (Doody et al., 2013a; Robinson, 1999). Homogeneity of focus groups and interaction between the participants in focus groups allow for greater depth in the discussion than is possible with individual interviews (Tausch & Menold, 2016).

3.4.1 Recruitment

Inclusion criteria were registered nurses with a current annual practicing certificate who were employed in a PHC setting. Participants were required to have regular contact with clients over the age of 65 years. Purposive sampling as described by Barbour (2005) guided the composition of the focus groups. Purposeful sampling enables the recruitment of participants for a qualitative study who are believed to be the most appropriate for the investigation of the research topic (Castellan, 2010). Apart from the inclusion criteria and the homogenous nature of the Primary Health Organisation (PHO) and practice nurses approached, there were no other criteria placed on participants as to their status or cultural group.

Prospective participants were PHC nurses recruited from two PHOs and general practices in a region in New Zealand. To recruit participants, the researcher addressed two practice
nurse forums and one PHO community clinical nurses (CCNs) weekly meeting in two regions in New Zealand, close to the researcher’s locale. The practice nurse forums meet monthly and provide opportunity for professional development and collegial support. The forums had attendances of approximately 35 and 12 respectively. The CCNs meeting was a weekly meeting attended by 10 PHC nurses employed by the PHO. At the practice nurse forums and the CCNs meeting, the researcher requested a 10 minute time slot to present an overview of the proposed research. Information for Research Participants sheets (Appendix 4) were handed out to inform prospective participants about the study. Prospective participants were assured during the presentations that the focus groups would adhere to stated start and finish times to promote recruitment as participants were being asked to participate in focus groups out of normal work hours. Some prospective participants had personal conversations with the researcher at the meetings, for more in-depth information about the study. Four participants requested the hard copies of the Consent Form (Appendix 5) at the meetings which they completed and handed to the researcher directly.

Prospective participants were asked to contact the researcher via mobile phone or email within one week of each meeting. When the prospective participants contacted the researcher, the prospective participant was sent via email the Consent Form (Appendix 5) and invited to return the completed Consent Form to the researcher via email. Twelve Consent Forms were returned via email. All those who returned their Consent Forms to the researcher and who wished to participate were recruited into the study.

Table 2 (over) shows the numbers of participants in the study and composition of the focus groups. Target numbers of focus group participants were four to six per focus group over two to three geographical locations. The resulting numbers were 16 participants, in three focus groups over two geographical locations. The group size was chosen to allow for sufficient numbers for diversity of opinion and information but still allow for participants to feel sufficiently comfortable in each focus group to each share their thoughts and experiences about this potentially sensitive subject (Freeman, 2006). There was a near even match of PHO nurses to practice nurses between the groups which gave the focus groups balance to both PHC work environments. All participants were female. The final numbers of participants (16) and the variation of status and cultural groups of the participants allowed for diversity but also homogeneity as described by Barbour (2005).
Table 2: Focus group participants

<table>
<thead>
<tr>
<th></th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
<th>Focus Group 3</th>
<th>Total Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO Nurses</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>in General Practice</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Both PHO and Practice</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>

3.4.2 Planning of focus groups

Planning of the focus groups was critical to success of the study and required consideration of the focus group environment, the structure of the focus groups, the topic guide (Appendix 6), additional information and forms required to gather data.

Permission for the use of seminar rooms for the focus groups to be held was requested from locality managers at two regional PHO sites and these were provided without charge. The seminar rooms had whiteboards, were large enough for ease of conversation between participants and to accommodate the number of participants. The rooms were easily accessible and quiet, allowing for confidential information sharing. Bookings for these rooms were made from five to seven pm to ensure sufficient time for set up and clearing of the rooms.

Focus group planning included setting topic guide questions to be used as prompts for guided discussion (McLafferty, 2004; Ritchie & Lewis, 2003). The Topic Guide (Appendix 4) questions were centred on issues that had arisen from the literature review and were kept as broad as possible to encourage open dialogue. Ritchie and Lewis (2003) describe the purpose of the topic guide as a method of initiating discussion and assisting participants to understand the style of data collection.

A Supplementary Participant Information sheet (Appendix 7) was designed to gain demographic information from the participants and give depth to the understanding of the data. This included information on the age, gender and ethnicity of the participants as well as their current area of nursing service, the length of time working in PHC and how long they...
have worked in their present area of work. Participants were also asked to note their first nursing qualification and if they had any post graduate nursing qualifications.

### 3.4.3 Piloting the focus group

A pilot focus group was facilitated prior to the study, with six PHC participants who were not involved in the research study. The pilot focus group allowed for a testing of the environment, the equipment and the facilitation of a group using the Topic Guide (Appendix 4). As the researcher had no previous experience of data collection, the pilot focus group was an opportunity for learning and practice. Directly following the pilot focus group, participants were asked for a verbal evaluation of the focus group and the focus group process was discussed.

The pilot group provided valuable opportunity to observe how PHC nurses discussed the topic in a group setting and aided the facilitator in how to redirect conversation when necessary. The participants in the pilot focus group spoke eagerly across each other which made review of the digital recording difficult. Instruction in allowing each participant to speak without interruption was included into the focus group introductions. Participants noted that there was a lack of focus on the research question and the topic guide with discussion frequently heading off track.

The pilot group was not held in the same environment as the study focus groups and this was an oversight which would have improved the time taken for the initial set up of the first focus group. There was no whiteboard available at the pilot focus group venue and with the research questions only available on paper, the topic questions were not readily available for all participants to refer to and see easily. Following the pilot focus group, a Focus Group Check List (Appendix 8) was written to enhance the set up of the focus groups and ensure that no items were forgotten.

A digital recording device was used in the pilot focus group together with the researcher’s mobile phone which captured improved sound quality and was easier to use. Both the mobile phone and digital recorder were used for the focus groups to ensure the backup of data. The selection of snacks at the pilot focus group was found to create background noise on recording so were changed to quieter options of cut up fruit and sandwiches for the subsequent focus groups.
3.5 Conducting the focus groups

Encouraging conversation and promoting comfort with a potentially sensitive subject for participants was an important consideration when conducting the focus groups. The researcher acted as facilitator for the focus groups and was there to set up the room 30 minutes prior to the focus groups. Participants were encouraged to arrive slightly earlier if possible to allow for snacks and drinks to be served prior to discussion. Chairs were positioned around a large square table that enabled positioning of drinks, snacks and recording equipment.

The research question and topic guide questions (Appendix 6) were written onto a whiteboard in the room, read out at the beginning of each focus group, and referred to during the focus groups. The topic guide questions were verbally followed with more specific questions when required to elicit more detail or to redirect the conversation back to the topic. These questions were posed in an open-ended way to encourage discussion (Harding & Whitehead, 2013).

The preparation time encouraged initial scene setting, completion of a Supplementary Participant Information sheet (Appendix 7) and introductions. Participants were welcomed both individually and collectively with a short mihi6 (Appendix 9) and each participant was introduced to the group.

Data were collected by digital audio recording using both a digital recorder and a mobile phone during the focus groups and written notes were taken. Individual voices in Focus Group One were difficult to identify for data analysis, as there were participants in this group who were unknown to the researcher. This highlighted the need to identify the voices of each participant by number with their first dialogue to assist with data analysis and this was introduced with subsequent groups. Questions and discussion continued until all questions had been addressed and participants had answered the research question. The topic questions (Appendix 6) were repeated at the end of each focus group discussion to allow any further comments to be made from participants before recording was stopped.

The recording time for Focus Group One was 39 minutes 23 seconds, Focus Group Two was one hour six seconds and Focus Group Three was 33 minutes 42 seconds. The researcher took notes and observed verbal and nonverbal interaction amongst participants during the

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6 Welcome or personal introduction
focus groups and these notes were collated and used as data. Nonverbal observation allowed the researcher to note impressions and observations of the participants and the group dynamics (Shaha et al., 2011).

3.6 Data analysis

Digital recordings were transcribed by the researcher. The researcher chose to undertake the transcriptions to allow for immersion in and reflection of the data while completing the process of transcription. Immersion in the data by transcription increases the understanding of the data and the validity of the research findings (Polit & Beck, 2010). To add to validity and reliability of the data, two research supervisors reviewed all transcripts.

Following initial reading of the transcripts, each focus group was given a number (one to three), participants were numbered in each focus group and every line of transcript numbered to allow identification and gathering of data. Thematic content analysis was used to order the data into themes and sub themes (Harding & Whitehead, 2013). Thematic content analysis is described by Whitehead (2013) and Braun and Clarke (2006) as a tool for analysing themes and patterns within data.

Themes generated from the transcripts were pasted into a new document which formed a document of results. Inductive analysis, described by Braun and Clarke (2006) as data driven analysis, was used. Analysis of the identified themes with reading and rereading, allowed deeper immersion in the data as did checking the transcripts back to the original digital recordings (Braun & Clarke, 2006). Coding into categories of conversation clusters manually with mind mapping allowed more clarity and a honing of the emerging themes (Burgess-Allen & Owen-Smith, 2010). The categories formed from these clusters of similar ideas and themes identified from the participants stories allowed the researcher to gain understanding of the data (Braun & Clarke, 2006). Data were gathered and themes identified within the data. Transcripts were emailed to both supervisors who independently read the transcripts and reviewed and discussed emerging themes with the researcher. Immersion in the data continued until the results were written.

3.7 Informed and voluntary consent

Informed consent was obtained from every participant prior to data collection. Informed consent in research is described by Lobiondo-Wood and Haber (2013) as providing
information to participants that is understandable with sufficient time to consider participation, free from coercion and treating people with respect. All potential participants were provided with the Information for Participants sheet (Appendix 4) during the forums and the meeting. The Information for Participants sheet (Appendix 4) provided detail regarding the topic of sexual health of the older adult, what participating in the research would involve, the benefits and possible risks of participating, the rights of the participants, the opportunity to withdraw at any stage from the study and maintenance of confidentiality. The Consent Form (Appendix 5) explained the process for maintaining confidentiality and anonymity. The Information for Participants sheet (Appendix 4), the Consent Form (Appendix 5) and the opportunities to ask further questions ensured that consent was informed and participation was voluntary. Providing a week for the return of the consent form allowed participants time for consideration whether to take part in the study.

3.8 Respect for privacy rights of participants

Respect for participants includes protection of privacy and confidentiality (Office of the Privacy Commissioner, 1994). The venues for the focus groups were within quiet PHO meeting rooms. At the beginning of each focus group the researcher advised that confidentiality is assured and asked participants to also maintain confidentiality of others in the group and not to discuss who was present in the focus group, nor any discussions from the focus group, outside the group. All data was made non-identifiable with use of pseudonyms and data, either recorded or written, were stored securely at the researcher’s home. Digital files, consent forms, transcriptions and field notes are stored in a secure manner in a password protected computer and will be held for five years, for audit purposes and then destroyed. The only people who have access to the audio recordings and transcriptions are the researcher and the research supervisors.

3.9 Acknowledgement of the Treaty of Waitangi

The focus groups were conducted to ensure that Māori participants were as comfortable as possible to discuss a potentially sensitive subject. Hence this study was underpinned by the Treaty of Waitangi as outlined by King and Turia (2002). Māori nurses were involved as participants in this research and their voices were invaluable to gathering a greater understanding of their experiences. Adherence to tikanga7 as outlined by Hudson, Milne,
Reynolds, Russell, and Smith (2010), is designed to enhance mana\textsuperscript{8} and contribute to constructive relationships. This is achieved by ensuring the principles of the Treaty of Waitangi including: partnership, participation and protection of Māori (King & Turia, 2002) were applied to this study.

Consultation about the study was undertaken with the Māori Health Care team at the region’s PHO for any cultural concerns that needed to be addressed. A letter of support and verbal feedback from the Kaitiaki\textsuperscript{9} of the Māori Health Care team was received which acknowledged the contribution that this research could have for Māori PHC nurses and clients (Appendix 10). Hudson et al. (2010) emphasise the importance of kawa\textsuperscript{10} and tikanga to inform ethics within research and stresses all research which includes Māori is important to Māori.

The participant-researcher relationship is based on partnership where contributions of both parties are valued equally. Protection of the participants’ privacy, rights and their beliefs was ensured throughout the study. A short mihi\textsuperscript{11} (Appendix 9) by the researcher welcomed participants into the meeting space which acknowledged the topic and the contributions of the participants. The researcher lives within an extended Māori whānau\textsuperscript{12} and is aware of aspects of tikanga pertaining to sexuality. The reproductive and sexual areas of the body are regarded as tapu\textsuperscript{13} and there was the potential of Māori participants feeling whakamā\textsuperscript{14} when discussing sexuality related topics. Māori participants were offered the opportunity to debrief with the Māori health team as required throughout the research.

3.10 Minimisation of harm

Supervisors, Māori health team, mentors and literature provided guidance through processes to promote wellbeing of participants and minimisation of harm. Harm was avoided by ensuring participants’ confidentiality and gaining their informed consent.

The potential for discomfort due to the sensitive nature of the conversation within the focus groups was acknowledged at the planning stage of the study. To minimise the potential of

\textsuperscript{8} Māori honour, authority or respect  
\textsuperscript{9} Māori guardian or trustee  
\textsuperscript{10} Māori protocol  
\textsuperscript{11} A Māori welcome or personal introduction  
\textsuperscript{12} Family  
\textsuperscript{13} Sacred  
\textsuperscript{14} Shy
harm to participants, detail regarding the research topic was provided in the Information for Research Participants sheet (Appendix 4), by the process of thesis supervision and the sensitive facilitation of the group.

Questions in the Topic Guide (Appendix 6) were generic in nature, designed to not cause offence nor elicit personal information from participants. Topic Guide (Appendix 6) questions were used in the pilot focus group and no distress was observed or concern voiced by participants. Counseling support was made available to the participants through the region’s Employee Assistance Programme (EAP). No participants withdrew from the study.

An offer was made to send a summary of results of the study to participants, if requested and report back to the individuals involved in the focus groups. Fourteen participants responded that they would like a Summary of Results for Participants (Appendix 11) and this was provided, by sending the Email to Participants (Appendix 12) following the analysis of results. Feedback was received via email from six participants (Appendix 13). All six participants concurred that the results summary was a true reflection of the focus groups. One participant would have liked more discussion on intimacy and believed that a male participant in the focus groups would have improved the gender balance.

There was no identified power inequity between the prospective participants and the researcher. The researcher was working in a similar clinical area as the participants at the time of the data collection and knew most of the participants professionally. Due to working in this area of PHC the researcher also has an understanding of issues that may arise when discussing sexual health with older clients, however it is acknowledged that this understanding may also constitute a bias. During the introduction in each focus group the researcher declared the role of facilitator and that this role did not allow for inclusion of the facilitator into discussion. The facilitator was able to maintain this role throughout all three focus groups.

3.11 Rigour

In this study using an exploratory descriptive approach, there is an emphasis on exploring meaning rather than measurement (Doody et al., 2013a; Harding & Whitehead, 2013). However, ensuring validity and reliability of the study is necessary to establish rigour (Freeman, 2006; Liamputtong, 2008; Thomas & Magilvy, 2011). Graneheim (2004) and
Thomas and Magilvy (2011) describe ensuring trustworthiness in qualitative research through credibility, dependability and transferability with all three also being regarded as interrelated. Credibility attends to the fit that exists between the dialogue of the participants and the representation of this by the researcher (Liamputtong, 2008). Dependability describes the reliability of the research which is shown if an audit trail can be reliably followed by another researcher (Thomas & Magilvy, 2011). Transferability assesses if findings can be transferred to another setting or group (Graneheim & Lundman, 2004; Liamputtong, 2008). Transferability can also be described as generalizability (Polit & Beck, 2010; Ritchie & Lewis, 2003), when the analysis explores the truth of the findings to the parent population, true to other settings or contexts or applicable to a more general application (Ritchie & Lewis, 2003).

To ensure credibility of this study the research was conducted following a review of relevant and current literature. The design of the study was an appropriate choice to answer the research question. Participants were selected to cross the range of PHC working environments. Diversity of participants adds richness to the study and enhances credibility (Graneheim & Lundman, 2004). Data were analysed transparently using thematic data analysis. All meaningful data were included within themes and results reported openly with similarities and differences within the data described. Intense inquiry and discussion with supervisors of the study also enhanced the credibility of this research.

Dependability is shown in this study by the research audit trail described within this chapter, as outlined by Thomas and Magilvy (2011). This chapter explains in detail the purpose of the study, participant selection, data collection, and data analysis and how rigour is demonstrated. Dependability was also established by sending a summary of results to participants (Appendix 11) via email (Appendix 12) ensuring accuracy of the data by participant feedback. Feedback was received from six participants following a request for feedback on the Summary of Results for Participants (Appendix 11). This feedback confirmed the dependability of the data and contributed clarity and depth to the results, adding to the rigour of the study. Critique of the study at regular intervals by two supervisors also ensured dependability of the research.

The ability to ensure transferability from this study to other areas (for example, PHC participants in other regions of New Zealand; nurses working with older clients in other work
settings) is demonstrated in the findings. Demographic data and details of the research participants have been explained. Understanding of participant demographics gives meaning to the applicability of the research and its ability to be transferred to other groups (Thomas & Magilvy, 2011).

Limitations and strengths of the research are recognised and declared. Piloting of the focus groups was an important step in establishing trustworthiness of the study (van Teijlingen & Hundley, 2002). Amendments were made to the focus group environment and facilitation of discussion following the pilot focus group to improve subsequent focus groups. Using digital audio also acted to ensure dependability and credibility of the study (Curtis & Redmond, 2007; McLafferty, 2004). The full transcription of the focus groups and the use of two supervisors to independently review and encourage self-reflection of the researcher have helped to minimise bias.

The researcher’s prior experience as a PHC nurse afforded ‘entry’ to this group of PHC nurses which may have resulted in participants feeling more able to disclosure experiences that might not have been offered without the researcher having this background. As a PHC nurse there is potential for the researcher to be regarded as part of the group of participants and for participants to provide responses they think the researcher may be seeking. Asking questions in a leading manner can bias results (Vogt et al., 2004). The researcher may also accept comments as being true without consideration to alternative views. However, the researcher made a concerted effort to remain as distanced and neutral as possible from the research process to increase dependability of the research. Researcher bias is identified in the background of the researcher who was a PHC nurse, NZ European, female, heterosexual and of middle class socioeconomic status.

The focus groups were conducted in one region in New Zealand and can be seen as a snapshot of the broad PHC nursing service in New Zealand. It is acknowledged that this is an exploratory study in a relatively unexplored area of research. There was an effect of hierarchy evident in one focus group which had a PHC nurse who was working with older adults in a nursing role but also as a manager and the other participants may have felt hesitant to be open and honest with their responses. The facilitator managed this by encouraging discussion from the more hesitant participants in the group.
3.12 Chapter summary

This chapter describes the detail in development and planning of the research undertaken, participant recruitment, how the focus groups were conducted, data analysis and adherence to ethical considerations providing auditability of the research process. The literature review identified a need for research to be conducted and justifies the research method used.

The method, process and analysis of this focus group study has been discussed and validated within this chapter. Thorough planning and design of this research has allowed for the collection of valuable data. Participants were treated with respect and ethical considerations adhered to as required by the Treaty of Waitangi (King & Turia, 2002); Health and Disability Commissioner Code of Rights (Ministry of Health, 2010); Health Information Privacy Code (Office of the Privacy Commissioner, 1994); and the Code of Ethics New Zealand Nurses Organisation (NZNO) (2010). The analysis of the data and review has confirmed rigour of the study within the capabilities of focus group research. The following chapter presents the results of this study.
Chapter Four: Results

4.1 Introduction

In this chapter the results of the study will be described. Demographic data collected describe the participants, their practice environment and experience. Themes and subthemes, which emerged from participant’s experiences, form the headings in this chapter. The main themes are factors enabling the primary health care (PHC) nurse or the client to initiate conversations about sexual health, barriers to sexual health discussions occurring between the PHC nurse and their clients and the education and knowledge of sexual health for PHC nurses and their clients. Participant’s verbatim reports have been used to report the themes and are evidenced in italics.

4.2 Demographics

Demographic data were collected from participants at the beginning of each of the three focus groups in order to establish the workforce represented by this group of 16 participants.

Demographics

<table>
<thead>
<tr>
<th>Total Participants</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>26-35 Yrs</td>
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</tr>
<tr>
<td>35-45 Yrs</td>
<td>1</td>
</tr>
<tr>
<td>45-55 Yrs</td>
<td>7</td>
</tr>
<tr>
<td>55 Yrs+</td>
<td>5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
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<td>Maori</td>
<td>2</td>
</tr>
<tr>
<td>Pacific</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
<tr>
<td>Years in Health Care</td>
<td></td>
</tr>
<tr>
<td>&lt;10Yrs</td>
<td>6</td>
</tr>
<tr>
<td>10-20Yrs</td>
<td>6</td>
</tr>
<tr>
<td>&gt;20Yrs</td>
<td>4</td>
</tr>
<tr>
<td>Years in Current Role</td>
<td></td>
</tr>
<tr>
<td>&lt;10Yrs</td>
<td>13</td>
</tr>
<tr>
<td>&gt;10Yrs</td>
<td>3</td>
</tr>
<tr>
<td>Qualifications</td>
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<td>6</td>
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<tr>
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<tr>
<td>Bachelor of Nursing</td>
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<tr>
<td>Postgraduate</td>
<td>5</td>
</tr>
<tr>
<td>Master or Higher</td>
<td>5</td>
</tr>
</tbody>
</table>

Figure 1: Demographics of focus group participants
All participants were female. The majority were aged over 45 years (75%), with seven aged between 45 and 55 years and five over the age of 55 years. One participant was aged between 36 and 45 years and three were aged between 26 and 35 years. This compares with the 2014 to 2015 nursing workforce statistics where 63% of PHC nurses were over the age of 45 years (Nursing Council of New Zealand, 2015).

Most participants identified as being ‘other ethnicity’ with two participants identifying as Māori and two participants as Pacific. Over 60% of the participants have worked in PHC for 10 years or more with four participants having worked in PHC for 20 or more years. Eighty percent of participants have worked in their current role for less than 10 years.

The nursing qualifications held by the participants were distributed between Hospital Certificate (6 participants), Diploma of Nursing (5 participants) and Bachelor of Nursing (5 participants). Of the 16 participants, six had no post graduate qualifications. Of the remaining 10 participants, five had postgraduate qualifications of Masters or higher.

4.3 Enablers to conversations about sexual health between PHC nurses and clients

Participants described the ability to connect and communicate effectively with their clients as an important step in relationship building and increasing the feeling of comfort between the client and the nurse when discussing sexual health issues. According to the participants, successful conversations about sexual health with the older client are dependent on having a trusting relationship, privacy and a relaxed environment, having time to engage and allowing clients to initiate the conversation, nurses picking up cues/concerns about sexual health, using appropriate language and discussing sexual health during context of care. Using an assessment tool to facilitate discussion, nurses’ willingness to discuss sexual health, experience, age and gender of nurse and cultural similarities and differences as identified by participants were also enabling factors.

4.3.1 Trusting relationships

Knowing the client and having a professional relationship with the client was perceived as very important for the majority of participants who felt a professional nurse-client relationship should be established before initiating conversation about sexual health,
There is an element of trust that needs to be established too.... When you have that trust relationship people feel they can ask you about intimate personal things (FG1, P4, line 40)

I guess having a good relationship makes a difference and asking that sort of thing (FG2, P5, line 469)

I think familiarity and relationship enables anyone to talk to their health professional ... and being approachable... (FG3, P1, line 159)

Most people I see I have a relationship with, I’ve known from before ... sometimes it needs to come in the second or third consultation with people because it’s not, they don’t find it easy to talk about (FG3, P2, line 25)

Some participants added that being professional when building trust and respecting their clients enabled the nurse to confidently discuss sexual health with the client,

You know sometimes people are so – I’ve got to be proficient and professional, I’ve got to be the nurse...we forget that there actually needs to be a little bit of a relationship going and a rapport going before people can, especially when it’s intimate and possibly potentially embarrassing for the patient (FG2, P3, line 570)

It’s building up trust and knowing they can come to you with complete confidence (FG1, P2, line 155)

That confidentiality you know and being taken seriously, just like it’s any other problem that they may present to us (FG1, P1, line 152)

Building relationships was understood by participants as a way of building trust and confidence within the professional relationship with their clients, thus allowing a freer flow of communication,

Building the relationships, it’s very good for enabling people, ‘cause I know that, now I am known in the community as the Pacific Nurse, they just come up when they have
problems, they’ll just come up and say – can I talk to you about this problem that I’ve got? (FG2, P2, line 528)

It did feel really, really good for me as a clinician that this gentleman felt so able to talk to me about the problems that he was having...because he’s having this conversation with me that he hasn’t had with anybody else...I thought it was really right asking the question possibly but I think it was more than that. I think it was building the relationship over the next couple of months (FG2, P3, line 131)

Yeah and in any relationship that trust takes time to get to a level that you feel comfortable talking about something that your children don’t approve of ... it might be something that they can’t talk to their partner about but they’ll talk to you about it (FG3, P1, line 191).

... He’s told me that he’s a cross dresser and that he’s found that Viagra doesn’t work and that Cialis does and...it’s not until we’ve built up that rapport that he actually felt safe enough to come out to me ...(FG2, P3, line 105)

4.3.2 Privacy and a relaxed environment

Providing adequate privacy for consultations, making time to ask questions and arranging follow-up sessions on sexuality issues were all factors identified by participants as enabling sexual health conversations and increasing the comfort felt by both participants and their clients. Participants related the importance of adequate privacy in the practice and home settings,

Having somewhere private to talk so it’s not out there in open space (FG1, P2, line 62)

It’s easier in the home situation and if you are home visiting and you have the time to actually point out and ask those questions about cervical screening, are there any problems, you know, with sex or...? (FG2, P2, line 98)
4.3.3 Having time to engage

Some participants acknowledged that they worked in an environment where they were able to spend more time with clients, thus creating more opportunity to engage in a consultation around sexual health,

We [PHO nurses] are lucky we have more time and so we’re not sitting there looking at our watches with our calendar in front of us with a whole list of people who we are about to see and I think people will feel happier. I mean you can just see their stance, sitting there in the room, they’re ... more laid back, because you’ve got that time (FG2, P1, line 563)

Also having the time to you know, spend and they’ll come back again (FG1, P6, line 162)

I think possibly that’s why people approach us ‘cause they see us as having more time (FG1, P2, line 442)

4.3.4 Clients initiating conversations

If the client initiated conversations about their sexual health, participants were comfortable engaging in these conversations. Frequently clients who were in new relationships or were engaging in non-traditional sexual relationships initiated conversations,

... If they got a new partner in the relationship or in a new relationship and they want to know what to do because they have been out of that kind of scene for some time (FG1, P2, line 23)

It’s not uncommon for older people to have new partners now, that’s just the way things are now so you do actually get more enquiries (FG1, P4, line 165)

But if the patient initiates the conversation, I’m quite happy to continue with that conversation (FG3, P3, line 35).

... If they are happy to initiate then I’m happy... (FG3, P3, line 115)
Participants discussed the growth in media coverage on sexuality issues which has contributed to the normalization of sexuality in society and a greater willingness among older clients to initiate sexual health issues,

And they’ve driven past the sex toy shops and things like that and they’ve asked me “what are those things?” …publicly we are making things very sexualized… they will engage and intrigue in things (FG1, P6, line 367)

… the more it is normalized for people… the easier it becomes to initiate that conversation as well…. Viagra ads and all the rest of it, does make it easier to initiate things. People often come and bring it up more, perhaps than 10-15 years ago (FG1, P3, line 458)

4.3.5 Picking up cues and concerns in conversations with clients
Participants discussed ways to appropriately phrase questions around sexual health. Picking up on client cues triggered their initiation of sexual health conversations,

I suppose it’s like a whole lot of other things you ask patients, you sort of tailor the questioning to the person, you are trying to get to know them, open questions. You pick up on prompts from them. It wouldn’t be a leading question to start a conversation with, no (FG3, P2, line 211)

And pick up on the cues where they’re wanting obviously to say something but don’t want to say something (FG1, P2, line 68)

I think that you are open, you don’t have closed conversations that you leave the conversation open, that you’re receptive to whatever they say and you just, yeah (FG2, P4, line 533)

Having the conversation is breaking the ice, once you are having the conversation, most people, I find, actually appreciate it and quite often thank you at the end and say I had something on my mind, and thank you for asking (FG1, P4, line 485)

And that’s why I think it needs to be an issue and that’s why we need to take cues from the person eh (FG3, P2, line 318)
And that’s what I try to do, take the cues from the person and if they want to discuss, you know you can pick up on the cues and you can follow through… (FG3, P3, line 321)

I suppose I would ask more often when the cue comes from the person, rather than initiating the cue (FG3, P2, line 89)

On some occasions the nurse, as identified by these participants, has provided the cues,

But when I catheterize people or when things around incontinence are discussed, then I usually hint towards that, and if they pick up on that cue then I would take it further (FG3, P2, line 90)

I think it’s giving them the cues, giving them the triggers, whereby if they feel they would like to, trying not to appear prudish when you approach the subject (FG2, P1, line 452)

4.3.6 Using appropriate language

Using appropriate language provided greater ease to the participant’s discussions on sexual health. One participant pointed out that variation in language could make the discussion around sexuality issues more acceptable,

You know, in the community you might be scared to ask, so you’ve got to think, of course in the Pacific language – there are two languages – there’s the everyday language and there’s the oratory, polite way of asking things. So if you’re wanting a good answer you actually need to know that polite oratory language to ask the question (FG2, P4, line 146)

This participant reported that the use of humour increased the comfort and trust between self and client when discussing sexuality,

I had a wonderful 94 year old couple actually, both had heart problems so the woman’s heart was slightly worse so I turned to the man and said “you will have to
“do all the work then!” and he just said “oh I’ve got a dicky ticker too you know” (laughter) (FG2, P1, line 284)

Touch, according to this participant, increased connection with their client. She acknowledged that touch increased the ease for the client to talk about sexuality,

*Another time when I’ve done a blood pressure someone has mentioned that that’s the first time that someone has touched them since their partner died. You could tell that was really important for them to be touched* (FG3, P4, line 67)

### 4.3.7 Discussion of sexuality during episodes of care

Nurses were more comfortable initiating conversations around sexuality issues when clients presented for prescriptions, appointments or during discussions over medication changes. Conversation related to clients’ sexual health also occurred during presentation for episodes of care,

... **So that it’s [sexuality] more about a health related issue so just kind of remove that emotional or that attachment to, or “I don’t want to talk about that ‘cause I can’t do it”** (FG1, P5, line 188)

*And by applying it [sexual health discussion] to their condition is a very smart way of making it [sexuality] easier to discuss* (FG1, P1, line 233)

Participants felt that when a client presented for a sexual health related issue, this was a good starting point to initiate a conversation about sexual health,

*I actually found it easier...’cause they came in for things like the Depo or for medication or for testosterone injections or whatever, so there was actually an initiating point, there was something that started the conversation, you weren’t going in cold turkey with no starting point, so there’s always something to launch it from* (FG2, P4, line 238)

*Even better if on their medications it’s got Viagra or Cialis ‘cause you can actually start asking the question, so it’s the trigger* (FG2, P1, line 167)
I see a number of people for three monthly reviews so if they, if any of the medication needs changing that would affect that, I would have that discussion. (FG3, P2, line 23)

Sexual dysfunction was often addressed when patients were presenting for a diabetes check. Participants regarded this interaction with the client as an appropriate time for discussion on sexual health,

And certainly if it’s something like a diabetes check and you may say that sexual dysfunction can be a concern. And that may be good because then they’ll take up on... (FG1, P1, line 64)

If somebody has diabetes. They’ve given you the indication [that they have sexual health problems]... just sow the seed, they might come back (FG2, P1, line 251)

When discussing prostate-specific antigen (PSA) test results or at a follow-up appointment on prostate issues, some participants found it timely to initiate a conversation with the client on sexual health,

Like the PSA is known to be elevated and then I’d start from there so you need to find a right point to start the conversation (FG2, P4, line 162)

Sometimes we’d follow up on prostate issues, it’s an easy in (FG3, P2, line 27)

Enquiring about genital discharge or problems passing urine were leading questions which participants thought helped to open up the conversation about sexual activity,

I find that if I just come out and ask, about their sexual activities/their sexual life, they’ll just straight out say no – not doing that or no problems. Whereas if I start from asking the questions about other health problems that they may have had at that point, like are there any discharge or any problems with how they pass urine or anything like that and then they’ll open up slowly in the conversation of sexual activity (FG2, P2, line 244)
It's easier to talk about sexual health in a urology appointment because the potential for that to be an issue (FG2, P3, line 732)

Some participants identified increased ease in discussing sexual health while performing cervical smears on older clients,

They come in for the smear and as part of that conversation you kind of talk to things like dryness and other bits and pieces and actually discovered yes they are sexually active but they just weren’t going to admit it, initially, so yeah you need to have that conversation (FG2, P4, line 262)

I tend to ask questions about sexuality when doing cervical screening, that’s probably the only time when I’d bring it up myself (FG3, P3, line 34)

For women it’s much easier and they often do, when I’m doing smears, women often ask me about discharge and smell and dryness and things like that, that’s got a lot to do with their sexuality or their enjoyment in their sexual health and like same sex women? With recurrent BV [bacterial vaginosis] and having those discussions around appropriate cleaning of toys and all those. And they’re really happy to have those conversations because they’re there for that purpose (FG3, P1, line 160)

If the appointment was gynaecological related, some participants believed there was client expectation that the clinician would discuss sexual health,

There’s almost an expectation that you’re going to be talking about that area because of the department [gynaecology] that they’ve come to... you sort of have to set the scene to be able to get a more open discussion about it (P4; FG2. Line 745)

Yeah I think that’s why it’s quite easy when it’s for smear time. (FG2, P1, line 746)

I find that if someone’s got a problem they find it much easier to come. For example an older woman who’s got “something that just not right”. Then they’re quite happy coming to discuss anything at all with you. (P3; FG3. Line 113)
4.3.8 Using an assessment tool to facilitate discussion about sexual health

The use of a questionnaire or assessment tool, such as the Comprehensive Health Assessment (CHA), which was available to most participants, was used to initiate sexual health conversations. Participants described increased confidence and comfort to ask sexual health questions with older clients when using an assessment tool,

I find that having the assessment, the assessment tool does help navigate that question really or initiate the question...initiating the conversation having the assessment tool does help (FG1, P5, line 48)

I would [ask about sexual health] as part of a CHA... I think because you are asking lots of questions at that time, they seem to relax and build a rapport as you go and it’s a long appointment usually. I ask lots of questions and find what’s important to them (FG3, P4, line 40)

If you’re doing a CHA you could say to them, are you up to date with your mammograms? Are you up to date with your smear? So you can kind of bring it up that way (FG2, P4, line 53)

I find it easier, you know as I do the assessment and it just comes up, like we are just talking, and he was 89 and he was just asking about what could help, you know, make his sex more pleasurable... that it’s easier if I’m guided about, you know, like, the diabetes annual get checked, then it wouldn’t be so hard... (FG1, P6, line 346)

... Gives me a framework, because I don’t see the person more like the practice nurses do, so I have to have some sort of framework to work by. That’s my guidance asking the question (FG2, P1, line 16)

Participants also used other forms of assessments and questionnaires for initiating education to clients on sexual health issues,

But what I tend to do with clients I see, that are... have issues around erectile dysfunction... I quite often get them to do the questionnaire and then talk to the husband and wife... so by the time they see the doctor about getting the
prescription... they’re actually well versed in what they need to say and feel really comfortable about it (FG1, P2, line 260)

I’ve had occasions where people have brought it up [sexuality] as part of the assessment when you talk around pain. They sort of explain that they have pain, or you know, back pain and they have intercourse or sexual relationship with their partner or sometimes it comes up in conversation in a time that you are not necessarily expecting (FG3, P2, line 53)

[Re assessment tool] And also asking about significant relationships with people, they will, people have told me about who’s important to them and what they do, and yeah (FG3, P4, line 59)

4.4 PHC nurses willingness to discuss sexuality with older clients

Some participants were more willing than others to discuss sexual health with older clients. Factors impacting on their willingness included the age and experience of the nurse, the gender of the nurse and their clients and the nurse’s culture and client’s culture. Participants also discussed their comfort when discussing sexual health and their perception of the client’s comfort in discussing sexual health issues,

Nothing really shocks me or surprises me anymore and so I think that enables me to sort of ask questions in a more open way (FG2, P3, line 537)

It’s how comfortable as a clinician you are about asking the question because if you phrase it in quite a sort of closed way, you’re not going to get that open answer... (FG2, P1, line 195)

One participant outlined her concerns over consultation with older clients who had been abused and requiring more input than a normal consultation. She expressed her need to be prepared to act on the information presented, despite her reluctance and discomfort to explore the disclosure,

A lot of people in that 65 age group and over, especially females have had abusive relationship... when I worked as a practice nurse, you would have women in their
65’s – 70 year olds, who had an abusive husband, who would demand sex of them even if they didn’t want it. Who drank too much, who would beat them, who would... you had to give them the time, it’s one of those things, you open the can of worms, you have to deal with the can of worms. So yeah you have to be prepared to deal with whatever you... (FG2, P4, line 577)

Another participant described her intervention when a client disclosed personal abuse to her,

We had a conversation that went in the direction that you almost had to consider abuse prevention strategies. That was uncomfortable for the person but it took a bit of thinking on my part how best to approach that... Well this was with someone who...was diagnosed with dementia and the partner had different ideas about what the marriage was all about and she couldn’t understand it and he couldn’t see that there was anything different from her because of her mental health and dementia. I needed to get some counseling services involved with that one. So I don’t think it’s always as straight forward (FG3, P2, line 262)

4.4.1 Experience/age of nurse
Some participants thought that the experience and age of the PHC nurse was a factor in how comfortable they were talking with older clients about sexual health and how skilled they were in doing so,

When I was a new nurse I didn’t do smears and stuff, whereas yep that’s my main focus now... I spent many years in a GP practice...we saw a large culture of people and lots of transgender, so I was immersed in that quite a bit early on...a lot of them were 55, 60, 65 and above, so yeah (FG2, P4, line 227)

Experience, we’ve learnt by experience how to ask and educate our client on, you know, the sexuality (FG2, P2, line 806)

4.4.2 Gender
All participants were female and most expressed that discussing sexual health issues with women clients was easier than with men,
It’s easier, or they give more back when you’re talking to a woman when you are asking men the same question (FG1, P2, line 171)

And they [women patients] feel more comfortable bringing it [sexual health] up (FG1, P1, line 174)

It’s a little bit easier with a female that because we get them for cervical screening and stuff like that, you can kind of ease into that sexual health stuff whereas the men... it’s a bit harder to bring it [conversations about sexuality] up (FG2, P5, line 205)

However, one participant found discussing sexual health issues with male clients easier than with women,

I feel much more comfortable talking to the male patients than I do to the female patients...I’ve got more experience talking to the men (FG2, P1, line 213)

4.4.3 Cultural similarities and differences

Pacific and Māori participants discussed the ease and comfort felt when having conversations about sexuality with clients from the same ethnic group as them. A Pacific participant stated she was comfortable having discussions about sexual health with Fa’afafine (Samoan men who behave in a range of feminine-gendered ways),

There’s quite a lot of them [Fa’aafafine] but they’re more open to those kind of questions. I’d have no problems talking to Fa’aafafine about their sexuality (FG2, P2, line 652)

Another participant found discussing sexual health with Māori clients easier when both partners were present and if it was discussed as part of a health issue rather than a relationship issue,

...From the Māori world...it’s the balance of both men and women ... having the conversation with their partners is easier... to make it less about, to remove it of, the inability of “you”, so that it’s more about a health related issue so just kind of
remove that emotional or that attachment to, or “I don’t want to talk about that ‘cause I can’t do it...” (FG1, P4, line 185)

4.5 Summary

Participants described a range of factors which enabled conversations about sexual health ranging from the age, gender and ethnicity of the RN to the use of an assessment tool to open up a dialogue. Participants also discussed barriers in discussing sexual health with over 65 year old clients. Barriers to conversations are the next major theme.

4.6 Barriers to conversation about sexual health between PHC nurses and clients

Some barriers about discomfort discussing sexual health with the older client were related to personal and societal views of the older adult. Other barriers included the participant’s working practice, lack of preparedness and situational issues present at their place of work.

4.6.1 Perception of discomfort with sexuality

Participants discussed both their comfort and discomfort when discussing sexual health with clients and their perception of the client’s comfort in discussing sexual health issues,

There certainly has to be an aspect of self-awareness, so how comfortable do I feel about asking that and how do I work through that... just to be aware that we know this is a generation that have different perspectives certainly of my own, so how to kind of have that self-awareness of you know, how do I... (FG1, P5, line 359)

There are only a couple of people that I would feel comfortable in having that conversation with, so the rest of them...(FG2, P5, line 199)

Following the focus groups, one participant reflected that in her view PHC nurses perceive that the older adult is embarrassed when discussing sexual health, which may or may not be the case depending on the person.

Participants discussed societal and their own views of sexuality and how these views affect their conversations with clients,
They [clients over 65 years] are still the generation where sexuality and things weren’t discussed very openly, so you’ve got a lot of those sort of barriers to break down as well (FG1, P3, line 135)

And having quality information for them so it dispels those myths…it’s about letting them know this is really common and you haven’t got a tattoo on your head. They say you’re a loser ‘cause you can’t get it up, or you’re frigid…’cause that’s what a lot of these people in the older age group, that’s the kind of head stuff they carry, so it’s about breaking that down (FG1, P2, line 269)

Participants described difficulty initiating and continuing conversations around sexual health when they perceived the client was uncomfortable with the topic,

Those women that went through that thing of “oh if I have sex I won’t get my period and there’ll be another baby” [in the past], you know, they are all those kind of worries (FG1, P3, line 284)

No [I don’t ask] most people just shrug it off and say nothing (FG2, P6, line 187)

Sometimes it can be a really tricky question to ask, even if you’ve got all the skills in the world (FG2, P3, line 41)

Some participants were unsure how they felt about asking older adults about their sexual health. A level of uncertainty and tentativeness emerged in respect to asking clients about their sexuality, questions which participants interpreted as being disrespectful,

I always ponder over, is the 65 year old spinster who has led a very pure life, is to instigate the conversation…I feel uncomfortable from the point of view; am I being suggestive to them that they may have done something out of wedlock?…I hesitate because I have to think about how I’m going to phrase it, that’s the only [patient] group that I kind of hesitate with (FG2, P1, line 397)

Sometimes it’s hard to know the right language to use with these people. You know like it’s all well for us and it’s all very well for the younger age group but when you’re
Some participants on the other hand wanted to have more in-depth conversations with clients who identified having sexual health problems. This participant expressed her difficulty in dealing with a particular situation,

The ones that probably I have the most difficulty with are the prostatectomy guys....they felt inadequate to their wives...their sexual prowess had been taken away surgically and it’s quite difficult for them... I would see his wife and she kept saying “I keep reassuring him, I keep saying, that you know, it’s fine, it doesn’t matter, it doesn’t change our relationship, he was just adamant that she was going to leave him and go and find somebody else (FG2, P1, line 317)

4.6.2 Discussing sexual health with clients who are lesbian, bisexual, gay, transgender or questioning (LGBTQ)
Older clients identifying as LGBTQ were perceived by participants as a group who lacked acceptance by society and were missing out on appropriate sexual health assessment,

I think perhaps as health professionals we need to slightly change our view a little bit... I was asked to check someone for delirium ‘cause he was on respite care and he came to the dining room in a dress and scarf... it was his normal attire... I’ve seen a number of people who were in same sex relationships who go into care, who talk about finding it really difficult to fit in with the masses...they feel like it is like ‘coming out’ all over again and I’m not always sure about how to best help people in... (F3, P2, line 134)
In primary health care, in GP land is the assumption that people are straight [heterosexual] and the minute you start assuming that someone is straight, you’ve wiped out any opportunity for having that conversation...you say even something as simple as to a lesbian woman “what does your husband do? They’ve got to then make a decision, am I going to come out today, is this a safe place, is this what I want to do, and if the answers no...? (FG2, P3, line 624)

4.6.3 Lack of rapport

Some participants wanted more than one consultation to establish a rapport with their clients to feel sufficiently comfortable to discuss their sexual health. Initiating a conversation around sexual health with their clients seemed inappropriate in this situation,

Most people I see I have a relationship with, I’ve known from before, so I would approach it different with different people really and I know some people would find it really difficult... sometimes it needs to come in the second or third consultation with people because it’s not, they don’t find it easy to talk about (FG3, P2, line 25)

But not sort of like bringing up something that could be potentially offensive to the person. You don’t know, particularly if you don’t know somebody, you don’t know what’s going to upset someone... (FG3, P3, line 321)

Other participants considered it too difficult to initiate conversations about sexual health during the first consultation,

If it was the first presentation that you were having with the patient I think it would be more difficult to initiate that conversation than if you already had that relationship with them (FG1, P1, line 44)

...I don’t tend to bring it up very often at all, when it’s not initiated by the patient, unless it’s to do with an appointment that they’ve already got (FG3, P3, line 35)

When I do the Comprehensive Health Assessment (CHA) I don’t finish it on the first visit, so by the third visit I’d know the person quite well, then I’d bring out the last question, ‘cause it’s the last question in the CHA (FG2, P2, line 32)
4.6.4 Episodes of care not involving sexuality or sexual health

Some participants thought it inappropriate to initiate discussion of sexual health with clients, other than in a consultation where sexual health was relevant to the presenting health condition,

*It’s fine to ask that kind of question in a consultation where it’s kind of relevant, like enhanced care plus where you are doing a CHA [Comprehensive Health Assessment], or a smear but if they’re coming in for their B12, or a wound dressing, or an acute clinic when they’ve got a cold, it’s not the sort of thing...*(FG2, P5, line 92)

*It’s got to be appropriate to the consult – yeah* (FG2, P4, line 103)

The discomfort experienced when approaching a sexual health discussion under the surmise that the client might not see it as appropriate for the PHC nurse to be questioning, was relayed as,

*Whereas, as part of the CHA you throw out this question about sexual health and they’re going “where in the blue blazers did this come from?!” and although we understand it as part of our holistic review of the patient, the patient is then going “really, you’re going to ask me this?* (FG2, P3, line 732)

One participant stated that she had never asked a client about sexual health during a consultation for a more regular health problem,

*I don’t think I’ve ever asked anyone actually about their sexual health in a consultation, like for a more mundane thing, like a blood pressure – I don’t think I’ve ever had that conversation with anyone to be fair* (FG3, P1, line 14)

Another participant would not initiate a conversation about sexual health in non-related consultations,

*With smears, that’s easy ‘cause you need to talk about that and people will expect it then, but I don’t bring sexuality up in any other consultations outside of something that’s got to do with that* (FG3, P1, line 75)
For this participant asking about sexual activities led to a negative response from the client,

*I find that if I just come out and ask, about their sexual activities/their sexual life, they’ll just straight out say no – not doing that or no problems* (FG2, P2, line 244)

4.6.5 Not knowing the appropriate language to use when discussing sexual health

Participants expressed a need for appropriate language to be used when discussing sexual health. There was a sense of discomfort and lack of confidence to speak openly with their older clients and a need to have education available to facilitate discussions about sexual health with older clients, especially those who are (LBGTQ), those with intellectual disability and for whom English is a second language,

*That question never comes with a crib bit [explanation] about how to phrase it and I think that’s the reason why people get upset asking it, is that they don’t know how to ask it* (FG2, P1, line 155)

*If we think someone is gay or lesbian, if we ask the same questions in the same way or if we kind of really do start avoiding it or make them think that we’re not approachable enough to talk about it based on how we present?* (FG2, P3, line 133)

*And how do you ask the intellectually handicapped? There are times where you would actually be asking the carer? ...there’s a lot of 50 and 60 year old people with Down’s Syndrome now...* (FG2, P3, line 424)

4.6.6 Using interpreters to communicate

Participants discussed the barriers they faced in communicating respectfully with older clients for whom English was a second language and the issues they had when using interpreters. Many interpreters were family members, who attended appointments with their parents or spouses,

*You often have translators for smears and they’re 60 plus...other nationalities...they don’t speak English* (FG2, P5, line 299)
I have had a Chinese gentleman who translated for his wife and I found that a very strange experience...He spoke very good English and she spoke none (FG2, P4, line 311)

We used to have a lot of Somalians and we used to do lots of refugees...and if they had had translators who had grown up in NZ...they seemed to be a lot more open...they were able to ask the questions, whereas the ones that had come from overseas...were too shy to ask the questions, didn’t want to ask the questions...I think it was a cultural thing, whereas the ones growing up in NZ had a more broad, open-minded opinions (FG2, P4, line 707)

Interpreting for Pacific clients in a respectful way and using family members was difficult for some participants,

When you’ve got your son or daughter translating for you, the parent themselves is going to be very reluctant to tell their son or daughter anything...(FG2, P3, line 664)

It’s when there’s no words to translate what they’re trying to say actually that’s the difficult bit...for a Pacific parent, you cannot ask a daughter or a son to actually translate those kind of things, you may need to go out to find another professional or another nurse or someone else who understands that language to get your questions through (FG2, P3, line 666)

And the problem with translating for another person, is that you can’t ever actually be certain that the question you asked and the answer you’ve been given are actually the same (FG2, P3, line 673)

And sometimes that’s the other challenge or difficulty of trying to translate from the simple everyday language to the polite oratory language to actually get the message through, sometimes using the oratory or polite way of explaining to your patient doesn’t quite get the meaning across (FG2, P1, line 673)
4.6.7 Inexperience, age and gender of the PHC nurse

Some participants considered that the age and experience of the PHC nurse was a factor in how comfortable and skilled they were talking to older clients about sexual health and the receptiveness of their clients,

*I do think some people will skim over that question because they’re uncomfortable themselves to ask the question...if you placed me in this position when I was first qualified, I would have been horrified by the thought of having to ask the question (FG2, P1, line 60)*

*Definitely some of the practitioners may not be as comfortable as others are... some younger people may find it more difficult to ask a 65 year old (FG2, P3, line 69)*

*Until you’re really confident in your role it’s a lot harder to broach the more difficult topics... what’s the point in asking a question if you’re not, don’t know what you’re going to do with that information and until you’re a bit more experienced, you don’t actually know how to handle that (FG2, P5, line 77)*

*If a 60, 65 plus year old man turned up and came into the clinic and it was a 20, 23 year old girl [RN], how likely is he to bring up the problem and in comparison to talking to his GP, to talking to you, to talking to me... (FG2, P3, line 985)*

*If you had talked to me when I was first trained I would have gone puce red... I’m not sure if I would have felt very comfortable talking about it. Because you don’t know what you are supposed to do with that information (FG2, P1, line 216)*

The gender of clients made a difference to how most participants approached discussions on sexual health with their clients. Some participants felt more uncomfortable talking with their male clients,

*It’s a little bit easier with a female that because we get them for cervical screening and stuff like that you can kind of ease into that sexual health stuff whereas the men... it’s a bit harder to bring it up (FG2, P5, line 205)*
Mostly they refuse to see us (FG2, P6, line 209)

...yep they don’t want to see a female about that (FG3, P5, line 211)

I think I’d be more comfortable asking the females than the males, with my clients, especially the over 65s (FG2, P2, line 392)

Some participants who worked as practice nurses believed that male clients mostly preferred to discuss their sexual health problems with a male doctor,

Most of the time they ring and ask for a male doctor (FG2, P6, line 461)

I had a patient booked in with me…. He wouldn’t tell us what it was about, he came and saw me and refused to talk to me… had a meltdown about that too because he wanted to see a male doctor but he didn’t say that to begin with…(FG2, P6, line 991)

4.6.8 Lack of adequate privacy
Participants related the importance of adequate privacy in the practice and home settings,

Having somewhere private to talk so it’s not out there in open space (FG1, P2, line 62)

Quite often we see the husbands and wives together…when you go to somebody’s home, you see both of them together…. if you’ve had problems asking the question in the first place because the partners in the room then you’re going to continue to have problems asking that question…it’s not always possible when you go to somebody’s home is it? (FG2, P3, P3; line 410)

With the under 65s I don’t find it harder to ask both of them while they are there ‘cause then I can kind of spin up the sex stories before I ask them…but with the over 65s I find that quite difficult or challenging to ask (FG2, P2, line 419)

Participants were less willing to discuss sexual health issues with clients when family members were present,
If their husband or wife was in the room it can be really, really incredibly difficult to ask the question and they’re probably not going to answer in a way that is as useful as it might be, especially if things aren’t going the way they want them to go (FG2, P3, line 294)

Discussing sexuality while having others present, in this case a student nurse, was noted by this participant as being too confronting for older clients,

*People are often quite happy if you take somebody along (student nurse) and you do a chest examination to hear and see and but by the time you go into more in depth questions and you look at other parts of the body they, that’s often a bit too much for older people* (FG3, P2, line 100)

Talking to clients about sexual health issues over the phone was according to this participant inappropriate due to privacy,

*Occasionally you will get just a script request or that sort of thing but we don’t really discuss it if it’s something they’ve had before. We will just give them the repeat prescription, over the phone you don’t really go into it* (FG2, P5, line 463)

4.6.9 Lack of time
Some participants felt that asking a sexuality-related question was like “opening Pandora’s box” which could lead to a time-consuming consultation, involving referring and dealing with arising problems,

*And it’s also a time thing as well... the phrase is, you are going to ‘open Pandora’s box’, are you going to have the time to then close it again?... if there is an inkling that there may be an issue that is going to require more conversation, are you likely to go down that avenue if you know you’ve got five minutes till your next person?* (FG2, P1, line 85)

*In GP land, it’s so hard to get through the list of patients with the problems that they come in with, you don’t really have time to then bring up another topic that’s potentially going to be bigger than all the ones that they already brought in* (FG2, P4, line 588)
And with those health assessments and those you know the questions that we are doing at the moment about the alcohol status, all that sort of stuff, it can lead into so many things. And it’s not a tick box exercise…but that’s what it turns into with the time pressure and like the health assessments, that’s only a very limited number of the patients we see that we are doing a full health assessment on. Most of them are acute patients that we see that have come in with an acute problem that we have…

(FG2, P5, line 591)

4.6.10 Cultural barriers
Participants discussed the difficulties they had discussing sexual health with different cultural groups,

They might interpret it as me being rude if I do ask these questions. That’s my experience of Pacific culture anyway (FG1, P6, line 97)

For Pacific it’s always been a taboo subject to talk about those issues for sexuality, you know open up about it, they kinda like put it in the back burner and unless they have problems with their prostate, or their smears…they will not open up about those things in that age group (FG2, P2, line 1008)

Some participants found the client’s culture to be a barrier to working with them, even if the clients were from their own cultural community,

With Pacific people I will struggle with this because of my relationship, you know, within the community…. With non-Pacific people it’s not so much of a struggle to have the conversation about sex (FG1, P6, line 80)

The status of the client within the Pacific community was also viewed as a barrier to Pacific nurses asking a sexual health related question of Pacific clients,

Culturally it’s the status of the person, ‘cause I wouldn’t be able to initiate the conversation with a church minister, if I know them as well or even if I don’t know them. If I know they are a church minister I wouldn’t be able to…and the same with
yeah the chiefs or those people. I would probably go around them and ask the wives but I wouldn’t directly initiate the conversation (FG2, P2, line 376)

Some participants perceived that Asian women were not open to having conversations about sexual health,

*I’ve never raised the issue about it with Asian women* (FG1, P3, line 390)

Another participant used humour to deflect her discomfort or her prejudice when discussing sexual health with her client,

*I was told by an old Indian lady... she said “that’s locked up [her sexual organs], cobwebs over it”, I said “you are not interested in having another sexual relationship?” and she said “definitely not, my husband did more than enough for me, and I don’t want to trust anybody else”* (FG1, P2, line 392)

Another participant stated that having a young nurse who was not born in NZ accompanying her when seeing clients for sexual health appointments would be a clash of cultures for her older clients. The participant shared her discomfort conducting a consultation with her clients with a younger nurse present,

*The other thing that would prevent me from starting a conversation is that as part of my role I often take other nurses along, especially when I go to aged care facilities and often those are overseas trained nurses and although I always ask if the patient is ok that the nurse is present when I doing a physical examination, often I get the sense but never really verbally explored it with residents or patients that having a young, overseas woman standing there is most likely a clash of cultures so I will either go back if I feel there is something further that needs to be discussed* (FG3, P2, line 92)

One participant provided feedback following the focus groups recommending the development of cultural guidelines or cultural training to address the sensitive nature of sexual health assessment with Pacific clients. This participant noted the need for caution
with using interpreters from the family, stressing that family members should be of the same gender to appropriately interpret sexual health concerns for Pacific clients.

4.6.11 Lack of educational preparation to have sexual health discussions

Most participants discussed their lack of education on sexual health of the older adult, at both undergraduate and postgraduate levels or through ongoing professional development,

*It’s certainly nothing that we were ever were prepared in any way to ask about* (FG1, P1, line 108)

*In the Bachelor of Nursing [programme], very little and very restricted [education about sexual health assessment] and even when you admit patients to hospital there are questions you are supposed to ask and nobody talks to you about how to ask these questions, it’s just – you’re a nurse, you must know how to do it… my experience of my general nursing training was that it’s as taboo in your general nursing training as it is out in the community asking the questions unless it’s for a specific reason* (FG2, P3, line 771)

*But preparation/education, not really, there isn’t really anything specific* (FG2, P5, line 804)

*And I mean, going back to the education, even in the specific training, there’s nothing about how to talk to gay or lesbian people or Fa’afafine or transgender people about their sexuality and how not to be offensive, even if it’s unintentionally offensive and how to deal with… I don’t think there’s any real training anywhere for people on how to deal with gender and sexuality issues…* (FG2, P3, line 828)

*Even in those specific trainings like the smears and the sexual health course, it’s all very general, there’s nothing really about the different ways to approach somebody in the over 65 age group to have those conversations, because it is a different topic from a 25 year old to a 65 year old* (FG2, P5, line 784)

*There’s very little formal training for the generic nurse in the older adult… very little about how to talk about sexual relationships, but yes there are specifics like the*
smears and the pelvic floor exercises for example, but actually entering into the conversation of how the sex therapists talk, no, there is very little (FG2, P1, line 820)

I’m taking a paper on sexual health at the moment, and none of this came up. It was just about like sexually transmitted diseases and what they look like and what you do about it, not how you talk about it and nothing about 65 plus (FG2, P3, line 900)

So you’re doing a post grad paper in sexual health and nobody’s talking to you about how you should be talking to the patients and what the options are. That’s just bizarre (FG2, P5, line 904)

4.6.12 Lack of evidence-based practice to lead effective nursing provision
Some participants questioned whether any research had been undertaken to establish how well the sexual health needs of the older adult were being met,

I’m not sure whether or not we do sexuality and sexual health with older people particularly well as a health issue. I don’t actually know (FG3, P1, line 346)

Any of these issues that we’ve just been talking about that we’re having difficulty talking to our patients about – is the research out there about it? Well actually there isn’t a lot of research about how you go about discussing it...but, like I said it’s difficult because it’s not seen as a sexy subject (FG2, P1, line 890)

How important it is to the 65+ age group because I actually have a basic idea that probably it’s quite important. I don’t know what the statistics are. There must be some information out there. I wonder (FG1, P1, line 404)

Yeah it’s hard to know what people actually want, what they expect about sexuality and sexual health in the older age group. Do they want more input? (FG3, P2, line 350)

4.6.13 Lack of sexual health services and available resources
Participants described a lack of affordable and suitable services for referral of older clients with sexual health problems. They recognised that many of the sexual health services in this region were mainly suitable for younger people or those in child rearing years,
Not in this age group... it is hard to find somebody...and somebody that’s free for relationships for couples (F1, P3, line 312)

No we don’t have an Aged Concern now, but they only do the elder abuse... (FG1, P3, line 327)

I have no idea if the rest homes have any focus on anything like that [discussing relationship services] (FG1, P2, line 330)

Two particular men who said they go to Indonesia...I said, you know “are you going over there because, your, for sexual reasons?”...I said “do you get checked before you go and when you come back? Do you know where to go and get checked?” And they didn’t have any idea...I thought, how many other patients are going that we don’t know about that are taking unnecessary risks (FG1, P2, line 425)

There is a rising number of 55-60, 65 going towards 70 year olds who are having STI checks (FG4, P5, line 473)

We don’t actually get that many people coming in for STI checks, I wonder where they all go? (FG4, P6, line 473)

... There’s sort of a gap between what can be done and what is available for a lot of people and also the diagnosis and really in depth of erectile concerns is probably not available around here (FG3, P4, line 128)

4.6.14 Summary
Participants identified a range of barriers to having conversations with their clients around sexual health. These barriers were related to personal and societal views of sexuality and the older adult, as well as those barriers relating to participants’ working practice and situational issues. Nursing education and knowledge of sexual health for PHC nurses and clients also emerged from the data. In the following section, these findings are described.
4.7 Education and knowledge of sexuality for PHC nurses and clients

Participants discussed the lack of sexual health education available for them, including the limitation of education and health promotion available for older clients. In many instances educational resources, health promotion and services provided in sexual health were inadequate, or not appropriate for clients over the age of 65 years.

4.7.1 Sexual health education for PHC nurses

The participants expressed the need for continuing education in sexual health of the older adult for PHC nurses,

Nobody else is talking about it [LGBTQ], and so how do we encourage people to learn and to change and to support our populations if we’re not actually talking about it in the first place. And how to talk about it and how to make sure you’re being safe for both yourself and your clients (FG2, P3, line 854)

Some education in how to do it [discuss sexual health] and things that have worked for people, things that haven’t worked for people and especially hearing from, you know patient stories, what’s worked for them and what hasn’t worked for them could be really beneficial for everybody (FG2, P3, line 962)

... I do think some more education on sexual health perhaps across the lifespan but particularly for older people would probably help health professionals because often you see people coming with preconceived ideas or there are cues from the person but the health professional sort of push it aside and don’t want to talk about...(FG3, P2, line 327)

Education in how I respond to that, without being inappropriate would be awesome (FG1, P6, line 372)

I do hope that out of this research some education packages might be developed (FG3, P2, line 343)
4.7.2 Health promotion and services

Participants discussed the scarcity of products, services and health promotion activities for the older adult and ways in which clients could benefit from the availability of such amenities,

...And products aren’t aimed at this age group like looking at lubricants and things like that which the older people tend to need to use they are not available. Condoms are so more different for the older men to use than when they were young men, they are much more malleable and thinner and just quite different (FG1, P4, line 473)

Unless it’s something curative you don’t see a lot of general advertising around the health issues of sexuality and stuff that involve an older person, like when we have all these same sex discussions or promotions or debates in public, it tends to be the focus on younger people and forgetting that a huge cohort of people who are approaching 65 now have been in same sex relationships for most of their life (FG3, P1, line 290)

All the advertising is based on young people (FG3, P4, line 290)

...The discussion like around contraception and disease prevention is all targeted to young people and there’s a whole group of people who’ve lost their partners due to death, divorce or you know that might need that exact same education, support and equipment (FG3, P1, line 293)

4.8 Chapter summary

In this chapter, four major themes emerging from the data have been identified; factors enabling the primary health care (PHC) nurse or the client to initiate conversations about sexual health, willingness of PHC nurses to discuss sexuality with older clients, barriers to sexual health discussions occurring between the PHC nurse and their clients and the education and knowledge of sexual health for PHC nurses and their clients.

There was a strong expression of comfort and discomfort for the PHC nurse and the client around discussion of sexual health. Sexual health discussions were enhanced by the development of the professional relationship and the willingness of the PHC nurse to initiate
and continue these conversations. Effective communication was seen to be an important part of enhancing this relationship. Culture and sexual orientation were considerations that made interactions more complex and introduced societal influences.

Using an assessment tool and discussion of sexual health during episodes of care was discussed as both barriers and enablers to initiating and continuing sexual health discussion. Participants expressed the need for further education and resourcing in the sexual health of the older adult. The findings will be discussed in depth in the following chapter, discussion.
Chapter Five: Discussion

5.1 Introduction

This chapter builds on and extends the results from the study as set out in the previous chapter. The three themes which emerged from the data showed that there were identifying factors which enabled sexual health related conversations between primary health care (PHC) nurses and clients. There were also barriers that prevented such conversations between PHC nurses and the older clients. The third theme revealed that PHC nurses required more education and knowledge on ways to assess sexual health of older clients and appropriately refer them to services that could adequately meet their needs. This discussion chapter is based on the themes identified in the previous chapter which will be contextually analysed against existing literature to highlight new or extended insights. There has been very little research undertaken in New Zealand on sexual health from a PHC nursing context. This study could add to any existing knowledge on sexual health communication with older clients from a PHC nursing perspective.

5.2 Conversations with clients about sexual health

Effective therapeutic relationships rely on open conversations, the ability of the nurse or the client to initiate conversation about sexual health and the willingness of both the nurse and the client to continue the conversation (McCabe, 2002). In the current study, PHC nurses were more willing to initiate conversations about sexual health with older clients when conversations were part of an episode of care or if related to a question within an assessment tool. To initiate conversations about the client’s sexual health, a trusting relationship needed to be formed between the PHC nurse and the client. Additionally, the PHC nurse has to be alert to cues and concerns raised by the client and appropriately respond to the client.

When discussing conversations they had with older clients about sexual health, the participants frequently used the words ‘comfort and discomfort’. The participants were eager to be open in their conversations with their clients about sexual health related issues, but were undecided on who should initiate the conversation, the PHC nurse or the client.
Fileborn et al. (2015) suggests that the initiation of sexual health discussion is the role of the health practitioner. The initiation of sexual health conversation is a nursing responsibility, more so if the client is too shy to raise the conversation themselves (Saunamaki & Engstrom, 2014) or appear hesitant (Tsai, 2004). Bauer et al. (2007) notes that when clients are tentative to initiate sexual health conversations it is usually due to embarrassment, shame, self-belief that their problem is a normal result of ageing, or anxiety at how the health practitioner will react to their sexual health issue. Most of the participants agreed that sexual health related conversations with clients were the responsibility of the nurse but they were more inclined to initiate the conversation as part of an episode of care.

5.2.1 As part of an episode of care
The participants were comfortable to discuss sexual health concerns with their older clients when the discussion was incorporated into the health consultation. A useful starting point, according to the participants was to initiate the conversation around sexual health when the client presented for a sexual health related issue. The participants also considered the use of a health assessment tool as a means to prompt a conversation about sexual health.

For some participants sexual health conversations were pursued with clients when conversation was related to medications prescribed for sexual health problems, often resulting from a long term health condition. Zeiss and Kasl-Godley (2001) confer that long term health conditions present as particularly useful starting point for discussion of sexual issues. Older clients are more likely to present with long term health conditions which are known to contribute to sexual dysfunction owing to disease and medical intervention (Zeiss & Kasl-Godley, 2001). Participants explained that sometimes discussions with clients about their sexual health occurred when the client discussed concerns related to erectile dysfunction. The availability of drugs for erectile dysfunction alongside marketing and education resources that are available to general practices were regarded by participants as a partial reason for clients to seek sexual health consultation with the PHC nurse. According to Bauer et al. (2007) the introduction of the drug ‘Viagra’ to enhance erectile response for men is revolutionary to the sex life for the older adult and suggests that the medication may redefine the meaning of sexuality in older age.

The discussion of sexual health other than during a consultation when it is relevant to the presenting health condition was considered by several participants as inappropriate and could be perceived by the client as being confrontational. One such example was when a
participant asked a client about their sexual health issues during a general health assessment, which led to an affirmed “no” from the client. Tsai (2004) noted that nurses could be fearful of a firm negative response to questioning. In studies by Saunamaki and Engstrom (2014) and Rowntree and Zufferey (2015), nurses considered discussion regarding sexual health with patients to be a “non-topic” or “taboo”, with sexual health having no place in nursing care.

All participants considered that an appropriate time to initiate a conversation about sexuality occurred when a client presented with a sexual health related concern. Some participants claimed that when undertaking diabetes checks with older clients, they were more at ease to raise the topic of sexual dysfunction as part of the consultation. Presenting with health issues related to the genito-urinary system, discussion of prostate-specific antigen (PSA) test results, requests for prescriptions and medication changes were ideal opportunities to initiate sexual health discussion. If the appointment was gynaecological-related, participants perceived an expectation by the client that the nurse would discuss sexual health. Gynaecological-related consultations led the PHC nurse to ask the client questions related to vaginal discharge or problems passing urine. The questions provided an opportunity for further enquiry into sexual health issues. Some participants identified increased ease with discussing sexual health with female clients when performing cervical smears. This is consistent with the literature which shows that discussion of sexual health is deemed appropriate by the nurse when aligned to a consultation related to sexual health (Gott et al., 2004a; Gott & Hinchliff, 2003a; Zeiss & Kasl-Godley, 2001).

5.2.2 Using a framework or assessment tool
The use of an assessment tool allowed some participants greater confidence and comfort to initiate a discussion about sexual health with their older clients. Participants explained that an assessment tool provided them with a framework for assessment and care. Participants also acknowledged the importance of including client’s sexual health as a part of their nursing assessment, especially for those clients with complex long term health needs, and if the condition has an impact on their sexual health and performance. This finding is consistent with Bauer et al. (2007) who describe the effect of long term health conditions on the older persons’ sexuality and how sexual health issues can affect their general enjoyment of life.
The use of a questionnaire or assessment tool, such as the Comprehensive Health Assessment (CHA) (Lovelock, Cumming, & Gauld, 2014), which was available to most study participants, was used to initiate conversations but did not provide any detailed framework for sexual health assessment nor guidance on the implementation of care. It is a responsibility under the RN scope of practice for RNs “to provide comprehensive assessment to develop, implement, and evaluate an integrated plan of health care…” (Nursing Council of New Zealand, 2012). Comprehensive assessment of clients in PHC is a nursing responsibility to ensure holistic nursing care (Saunamaki & Engstrom, 2014; Tsai, 2004), and assessment is an opportunity for a detailed and open appraisal of the client’s sexual health, sexual history and beliefs (Tsai, 2004). An assessment tool permits PHC nurses to integrate questions about sexual identity into the health assessment and provide the opportunity for clients to disclose identity in an appropriate and safe manner (Neville & Henrickson, 2006). However when using the assessment tool, some participants found that they tended to ask closed-ended questions which did not allow clients to speak freely about their sexual health problems.

The concept of client sexual health “needs” as described by Rowntree and Zufferey (2015) emphasizes that sexual expression and intimacy should be included into client assessment and care planning. There are no known tools for a comprehensive sexual health assessment suitable for use on the older adult in New Zealand, which was underscored by the study participants. However, there is a guide available to obtain a sexual history (not specific to the older client) within PHC services designed by bpacNZ (Best Practice Advocacy Centre New Zealand) (bpacNZ, 2013) which none of the participants made reference to in this study.

Participants reported that sexual health assessment is a nursing responsibility and acknowledged its use in practice, however they used cursory questioning into their client’s sexual health.

5.2.3 Clients and PHC nurses responding to, or avoiding cues and concerns
Participants recognized the direct or indirect comments made by the clients within the context of their general health discussions as cues to further their discussions. Cues can be described as, “statements that imply, but do not explicitly state, the patient’s concerns” (Lang, Floyd, Beine, & Buck, 2002, p. 325). Using cues and identifying client’s concerns during consultations was identified by participants in this study as an important tool for initiating and continuing sexual health conversations.
The recognition of client cues can offer the nurse the chance to connect with the client and provide an opportunity for an enhanced therapeutic relationship and improved clinical outcomes (Levinson, Gorawara-Bhat, & Lamb, 1999). Zimmerman, Del Piccolo and Finset (2007) highlight the importance of picking up on cues and concerns during health consultations in order to identify emotional issues in this study, responding to client cues triggered the initiation of sexual health conversations between the participants and clients, which were viewed as “setting the scene” or “sowing the seed” to prompt conversation regarding client sexual health. However, it was generally the client who signaled the cues to instigate the conversation on sexual health rather than the participants. Accordingly, Zimmermann et al. (2007) concurs that client initiated cues were three times more likely to occur than those initiated by a health professional.

5.2.4 Clients and PHC nurses avoiding cues and concerns

Although participants in this study noted the importance of identifying client’s cues, there were times when they evaded the cues to avoid engaging in deeper conversation owing to their own discomfort or because of time constraints during patient consultations. Zimmerman et al. (2007) describe this pattern of evasiveness by health practitioners as minimising, dismissing, interrupting and ignoring.

Cues from either the client or the PHC nurse presents as a trigger to open up a conversation on sexual health issues that are of concern to the client. Figure 2 (over) highlights the relationship between the client and the PHC nurse, demonstrating that when cues are neither acknowledged nor followed through, a circling effect occurs. The PHC nurse may wait for the client to give the cue before actively engaging in a conversation on sexual health. On the other hand, the client may wait for the PHC nurse to respond or give cues to prompt a conversation on sexual health. If neither occurs, discussion of the client’s sexual health issues or concerns that should occur between the client and the PHC nurse will be ineffective, as has been found in this study.
5.2.5 Establishing a trusting relationship

The client/nurse relationship is a crucial element of effective communication (McCabe, 2002). Knowing the client and having a professional relationship with the client was perceived as of high importance to the majority of participants. Words the participants used to describe relationship building with their clients included: trust, professionalism, confidentiality, familiarity, approachability, being non-judgmental and having time.

It was important for some participants that a professional nurse-client relationship be established before initiating a conversation and/or responding to cues from the client about their sexual health. Being professional and respectful to the client’s needs when building trust was reported to improve the confidence of PHC nurses’ assessment of their clients’ sexual health, which some participants perceived could potentially become an uncomfortable conversation.

Practising in a large primary health care practice made it difficult for some participants to form ongoing trusting relationships with clients because the large number of enrolled clients did not allow for care continuity. Continuity of care was seen as an important factor by clients in the study by Bastiaens, Van Royen, Rotar Pavlic, Raposo, and Baker (2007) in
allowing therapeutic and caring relationships to be established between the health care practitioner and the client. Relationships described by clients as open, trusting and responsive allowed clients to feel engaged in a comfortable conversation (Bastiaens et al., 2007; Bentrott & Margrett, 2011). Older adults strongly value PHC providers with good communication skills and being trustworthy and supportive (Bastiaens et al., 2007).

There is strong evidence that supports quality time spent with clients is important in building stronger relationships and improving communication between the client and health provider (Bastiaens et al., 2007; Lang et al., 2002; Maes & Louis, 2011; Magnan et al., 2006; McCabe, 2002; Ridd, Shaw, Lewis, & Salisbury, 2009; Street, Makoul, Arora, & Epstein, 2009). The participants viewed the time taken during consultations as being valuable and essential to gain trust and build rapport with older clients before attempting to initiate or continue conversations related to the client’s sexual health. Tsai (2004) considers the establishment of a therapeutic relationship as essential to successful communication. Likewise, older adults welcome the development of a trusting relationship being formed between self and the health practitioner (Bastiaens et al., 2007). Once a trusting relationship was built with their clients, the participants were more at ease to pursue sexual health conversations which they perceived to be uncomfortable.

5.3 Discomforting conversations about sexual health

The perception of comfort was engendered by having a trusting relationship, where both the PHC nurse and client felt able to discuss a topic that may be seen by the nurse and client as difficult to initiate and follow through. Discomfort experienced by the participants in this study when discussing sexual health issues was mirrored in a study by Magnan et al. (2006) in which nearly half of the hospital-based US nurses described their discomfort initiating conversations with clients about their sexual health.

Some participants described feelings of uncertainty, tentativeness and a sense of disrespect when considering a discussion with clients on their sexual health. The participants’ fear and avoidance was based on their assumption that the enquiry would be interpreted by the client as being confrontational or an invasion into the older client’s privacy. This is supported by Saunamaki and Engstrom (2014) whose participants described fear and embarrassment when having discussions with clients about their sexual health and concern they may offend the client by initiating this conversation.
The gender of clients made a difference to the way most participants approached discussions on sexual health with their clients. Some participants were hesitant with clients of the opposite gender, a behavior also noted by Tsai (2004) and Maes and Louis (2011). The participants in Tsai’s (2004) study were female and most believed that discussing sexual health issues with female clients was easier than with men. Nurses are more comfortable having sexual health conversations with clients who are of the same gender (Maes & Louis, 2011).

5.3.1 PHC nurses’ attitudes and beliefs

Some participants described their own attitudes and beliefs which did not always support successful sexual health consultations with their clients. The participants’ personal attitudes and convictions relating to sexual health enquiry of others affected their decision and approach to conversations on the subject with their older clients, which is also reflected in the literature (Moreira et al., 2005; Pangman & Seguire, 2000; Saunamaki & Engstrom, 2014; Snyder & Zweig, 2010; Tsai, 2004; Zeiss & Kasl-Godley, 2001).

Participants in this study were influenced by their personal assumptions, as well as by societal influences on sexuality. The media including news reports, television, film and advertising portrays a stereotypical view of the older adult with connotations that the older adult is in general physically incapable of sexual activity and mostly heterosexual (Bauer et al., 2007). According to the participants, the media is more overt in recent times, on their coverage relating sexuality issues which contributes to the normalisation of sexuality in society. Some participants were of a view that the increased media coverage on sexuality could inspire older clients to initiate discussions about their sexual health. Participants also noted attitudes and beliefs evident in society of the older adult not being sexually active which mirrored the viewpoint of participants in the study by Saunamaki and Engstrom (2014) who admitted that they often held stereotyped views of their older clients and their sexual health. These views can be interpreted as ageism (World Health Organisation, 2012 para. 3).

Society’s negative perception of ageing, especially in regards to sexuality impacts on the attitude of the older adult and health care professionals (Snyder & Zweig, 2010). Nurses who embrace a positive attitude towards their own sexuality are more likely to engage with and have positive sexual health conversations with their older clients (Snyder & Zweig, 2010).
Likewise, nurses who are able to accept their own sexuality are far more likely to create a comfortable environment which encourages the older client to freely express their concerns of ageing, long term conditions and sexuality (Pangman & Seguire, 2000). Participants in this study acknowledged that ageism exists in society and within the health system, and self reported that they were not discriminating or stereotyping in their views of their older clients and sexuality. The participants however, reported infrequently engaging in sexual health conversations with clients in the over 65 years age group and often only if part of an episode of care. The disparity between the participants’ apparent openness to age and the lack of sexual health assessment of the older client may in part be attributed to negative attitudes and beliefs about sexuality held by the PHC nurses in this study.

Neville and Henrickson (2006) state that clients identifying as LGBTQ are mainly ignored by PHC providers beyond issues concerning HIV, AIDS and other STIs. However, the participants in this study showed concern for older clients who identified as LGBTQ, who could potentially miss out on appropriate sexual health assessment because of societal ostracism. Neville and Henrickson (2006) and Munson (2014) established that nurses frequently assumed clients are heterosexual and did not always give clients an opportunity to disclose their sexual identity. Non-disclosure of sexual identity during health interventions leads to poor patient outcomes including increased incidence of suicide, depression and other mental health illness (Neville & Henrickson, 2006). Although participants in this study did not express negative attitudes towards LGBTQ clients, they did note the lack of available sexual health education, training and research for PHC nurses.

5.3.2 Using appropriate language
Using appropriate language techniques to describe and discuss sexual health with older clients was perceived by participants as an important skill to initiate and engage with the client. Some participants identified the need to explore a more in-depth conversation with clients who had obvious sexual health problems but felt unprepared on how to approach the conversation even though the nurses had greater than 10 years of nursing experience and was above 45 years of age. Participants identified a number of ways to create a sense of ease when discussing sexual health issues with clients. They were respectful and considerate of their clients’ attitudes, beliefs and sensitivity before engaging in conversation related to sexual heath. The participants reported being particularly mindful in their use of appropriate language, suitable terminology and also took cognizance of the older client’s cultural affiliation, as well as rank or position within the community.
An opportunity to have had prior education and training in sexual health would have been advantageous for the participants to initiate effective discussions with older clients, especially those who identify as LBGTQ; with intellectual disability, who disclose sexual abuse and for whom English is a second language. Participants considered more experienced nurses to be more comfortable and confident than less experienced nurses to have sexual health conversations with clients. However, they were of one opinion that all PHC nurses needed further education and training on language techniques suitable for engaging older clients into sexual health discussion.

Several participants explained the barriers they faced in communicating effectively with older clients with limited English fluency or proficiency, including issues they had to access interpreters. Older clients with limited English proficiency needed family members who accompanied them on visits to act as interpreters. There was concern raised by the participants about the appropriateness of using family members to interpret, especially when the topic was related to sexual health. A study in the UK by Gerrish, Chau, Sobowale and Birks (2004) demonstrates the importance of PHC nurses being educationally prepared in the use of interpreters. When nurses have not received education in the use of interpreters, they are more likely to use family members to interpret with the result of less effective communication with their clients (Gerrish et al., 2004). Notably, none of the participants raised the issue of using a professional interpreter to improve the dialogue, however this question was not proposed within this study.

Some participants voiced their concerns when older clients had disclosed abuse. Despite their unease during the consultation, the participants felt a sense of responsibility to persevere and follow through with the conversation. Saunamaki et al. (2014) study participants described their actions as ‘doing the right thing’, when they delved deeper into their enquiry to find out more about the patient’s situation and experiences.

5.3.3 Cultural considerations
Factors that impacted on the willingness of participants to discuss sexual health with older clients included the age, experience and gender of the nurse, as well as the cultural differences that may have existed between the nurse and client. Cultural diversity is an important variable that influences the way nurses proceed in their interactions with clients (Dayer-Berenson, 2011).
Participants highlighted the existing diversity of ethnic and cultural groups within the region of this study and ways in which clients’ culture influenced their approach to discussing sexual health with clients. The Ministry of Health (2009) recognises the diversity of culture and ethnicity in New Zealand and stress the importance for PHC nurses to work in partnership with their clients and communities.

Initiating and discussing sexual health issues with clients whose cultural affiliation was different to their own posed some difficulty for the study participants. Even though the participants understood that it was up to them to adjust the way they approached clients when discussing sensitive issues related to the clients’ sexual health, a level of personal unease remained apparent. Cultural sensitivity especially related to sexuality and sexual health when dealing with older clients whose beliefs and behaviours were different to their own deterred some participants from pursuing related conversations. Accordingly Gott et al. (2004a) found that cultural differences between the client and the nurse reduced the likelihood of discussion related to clients’ sexual health issues.

Participants in this study who identified themselves as of Pacific or Māori ethnicity commented on their discomfort having conversations about sexual health with clients from the same ethnicity as themselves. A Pacific participant stated she was more at ease and felt comfortable to have discussions on sexual health with Fa’afafine. However, if the older Pacific client had a significant position of status within the Pacific community, the Pacific nurse was uncomfortable and less likely to pursue a sexual health conversation with the client. Pacific participants perceived older clients who were religious ministers or those who had chiefly authority as persons requiring greater respect and dignity. Hence, conversations about sexual health with them would be carefully calculated using, ‘formal’ Pacific expressions and terminology.

One participant found discussing sexual health with Māori clients easier when the client and their partner were both present and when the discussion was health related rather than a relationship issue. The importance for this participant was to ensure the client’s comfort by balancing the physical (sexual) health discussion within an acceptable emotional framework for her client (having the partner present). This balance between the physical and emotional

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15 Samoan men who behave in a range of feminine-gendered ways and who are integrated into the Samoan Community
realm for Māori is described by Mark and Lyons (2010) as a connectedness between mind, body, spirit and family which is essential to consider when delivering health care.

5.4 Inhibitors and facilitators to conversations about sexual health

Participants explained that the practice environment had a significant impact on the way PHC nurses engaged older clients in conversation on sexual health. The main issues highlighted by participants were time constraints, lack of privacy and being able to provide home visit consultations, all of which affected the quality of conversations on sexual health both for nurses working in general practice environments and the PHO nurses.

5.4.1 Time pressure

Participants considered sexuality-related questioning was like “opening Pandora’s box” which could potentially lead to time-consuming consultations, involving referring clients on to other health professionals and spending a large portion of the consultation time dealing with sexual health problems. Practice nurses were time-restricted for consultations which resulted in them being less likely to engage in sexual health consultations with their older clients. When nurses are rushed to complete sexual health conversations because of time constraints, stress and discomfort increases for both the nurse and client (Saunamaki & Engstrom, 2014). The PHO nurses in this study were advantaged to spend more time than practice nurses with their clients. Improved length of time spent with clients created opportunities for PHO nurses to engage in sexual health consultations, however even with extra time, the nurses infrequently asked clients about sexual health nor did they undertake adequate sexual health assessment. Magnan et al. (2006) verify that even in quieter times of work, nurses are less likely to engage clients in conversation about sexual health. Providing a holistic and comprehensive assessment of a client’s sexual health requires a significant amount of time over several consultations (Maes & Louis, 2011; Taylor & Gosney, 2011; Tsai, 2004). Furthermore, older clients place high value on sufficient time for PHC consultations (Bastiaens et al., 2007; Ridd et al., 2009).

5.4.2 Lack of privacy

Participants described the importance of adequate privacy for clients while having sexual health consultations in general practice and in their home settings. Participants were less willing to discuss sexual health issues with clients when other people were present, such as
family members or students even when informed consent was granted, reporting that the lack of privacy was particularly confronting for older clients.

The working environments of participants in both general practice and PHO settings had issues related to privacy which affected their consultations with their older clients. Practice nurses needed to share clinical treatment areas and offices that were not always private, even for telephone consultations. PHO nurses reported that family members were often present at home visit appointments which made sensitive consultations difficult. The reluctance of health professionals to discuss sexual health issues with older clients in places with no privacy was confirmed in studies by Bentrott and Margrett (2011) and Saunamaki and Engstrom (2010).

5.4.3 Home visits
Participants employed by a PHO frequently visited clients in their own home. They discussed both the advantages and disadvantages to both the client and themselves in discussing sexual health issues while in the home environment. For some participants the home setting was described as being a more comfortable environment to discuss sexual health. However, there were also concerns about privacy in the home setting especially when family members were present resulting in less opportunity for discussing sexual health concerns with clients.

Most participants found it desirable to have effective conversations with their older clients about sexual health, yet there were inhibiting factors which affected this occurring. Participants reported that their lack of knowledge and education on managing older clients with sexual health issues inhibited them to pursue these conversations with their clients.

5.5 PHC nurses’ lack of knowledge of sexual health issues
Despite the majority of the participants (62%) being educated at postgraduate or higher levels, which was significantly higher than the national RN workforce (38.1%) (Nursing Council of New Zealand, 2015), the participants reported that they were inadequately prepared to deal with sexual health issues of their older clients.

5.5.1 Education in sexual health
Participants gained academic knowledge of sexual health issues from a variety of sources including postgraduate courses, professional development, their health professional colleagues, the internet, drug companies and from practice experiences. However, most
participants viewed their knowledge and understanding of the topic from the perspective of the older clients to be minimal despite some having a postgraduate education.

The lack of nursing education on sexual health issues related to older clients was concurred by Saunamaki and Engstrom (2014) whose study participants identified insufficient knowledge and training to effectively discuss sexual health with their clients. Snyder and Zweig (2010) underscore the deficiency in nursing education regarding sexual history taking and training in sexual health counseling. There is limited PHC nurse education available in conducting sexual health assessment (Maes & Louis, 2011). It was important to participants in this study to be confident in their delivery of quality information imparted to their clients and to be professional in their interactions with clients. Education programmes which target sexual health assessment and intervention can increase both nurse’s and client’s knowledge and encourage more permissive attitudes towards sexuality (Zeiss & Kasl-Godley, 2001).

One participant in this study who was enrolled in a postgraduate sexual health paper noted that sexual health of the older person or processes to communicate sexual health with clients was not a learning outcome in the course. Education which increases the awareness of nurse’s values and beliefs of sexual health will encourage the normalization of sexual expression and more open conversations with clients (Rowntree & Zufferey, 2015; Snyder & Zweig, 2010). Tsai (2004) contends that knowledge of sexual health is not sufficient; there also needs to be education in effective communication in sexual health which supports similar education needs identified by participants in this study.

5.5.2 Using evidence based practice

Participants discussed evidence-based practice and questioned if there was research which supported the assessment, communication and management of sexual health of clients. Some participants enquired whether research had been conducted to establish how well the sexual health needs of the older adult were being met and if the older clients were interested in being assessed about their sexual health. Pangman and Seguire (2000) and Maes and Louis (2011) stress the need for more nursing research in the ageing population and sexuality. Bentrott and Margrett (2011) points out the lack of research into older adult sexual health, especially associated with long term condition assessment and management.
5.6 Lack of sexual health resources

Participants highlighted the lack of affordable and suitable services for referral of older clients with sexual health problems, noting that sexual health services in the region where this study was conducted were only suitable for younger people or those in child rearing years. Some participants reported reluctance to initiate conversations or to continue with sexual health conversations with older adults due to the lack of sexual health services available for the older client. Researchers have noted the scarcity of both private and funded sexual health services as a reason for nurses to avoid sexual health conversations (Maes & Louis, 2011; Tsai, 2004).

Participants in this study identified colleagues, including GPs, as a source of information used to improve their knowledge in sexual health. Professionals with expertise in sexual health can act as a knowledge resource and provide mentor support (Tsai, 2004). Saunamaki and Engstrom (2014) noted that registered nurses (RNs) regarded the doctor as the health professional with greater experience than the RN to discuss sexual health problems with their clients. In the current study, participants accessed the GP as a resource for information and if a more expert opinion was needed. Conversely, some participants were of a view that the GP had less skill and time to communicate with clients about sexual health.

Participants were inclined towards the use of a framework for assessment of sexual health with their older clients to increase facilitation of such conversations. The only assessment tool used by some of the participants was the CHA and this was not available to all the participants in the study. This tool is presently only used in the region where this study took place. The use of professional guidelines to support sexual health assessment and care was recommended by Saunamaki and Engstrom (2014). A guide for health assessment has been published by bpmc (2013) but participants in this study did not have knowledge of this guide. There are some tools available for sexual health assessment, such as the Permission, Limited Information, Specific Suggestions, Intensive Therapy (PLISSIT) model (Mitty & Rheaueme, 2008; Wallace, 2004), none of which were mentioned as being used by this study’s participants.

Participants discussed products, services and health promotion currently being marketed, but not for the older adult. PHC nurses in this study described rarely seeing clients over 65 years for STI checks. Conversations on the increasing incidence of chlamydia diagnosed in
aged care facilities prompted discussion about available and suitable services for older clients in the region of this study. Participants suggested the need for health promotion strategies to raise awareness of sexual health risk and to encourage conversation in safe sexual health practices among the older adult. Globally there are increasing numbers of adults over the age of 65 years diagnosed with later progression of STIs (Minichiello et al., 2012). This could suggest that older adults with STIs are not being diagnosed early or have limited access to the primary prevention programmes available which are generally targeted for youth, reproductive, maternal and gynaecological interventions (Fileborn et al., 2015).

Statistics in the region of this study indicates the incidence of chlamydia is higher than the national average (Institute of Environmental Science and Research Limited, 2015). National statistics of STI incidence in older age groups is scant. Institute of Environmental Science and Research (ESR) surveillance data is given only for the 40+ age group (Institute of Environmental Science and Research Limited, 2015). The 40+ age group has a very low incidence of STI cases tested and diagnosed, demonstrating low rates of STI’s in the 40+ age group in New Zealand. Possibly older age groups are not reporting STIs or are not being screened by health providers, while worldwide statistics show an increase in STIs in the older age groups (Minichiello et al., 2012). Despite this increasing trend of STIs in the older adult population there is no targeted education for this age group (Fileborn et al., 2015). Kirkman (2015) suggests the lack of targeted education may be due to baby boomers being perceived as having more liberal views and knowledge about sexuality, thus not requiring sexual health education (Kirkman, 2015).

5.7 Chapter summary
Feelings of comfort and discomfort were major influences that affected the PHC nurses’ decision to initiate or continue conversations in sexual health. Mostly participants were more comfortable to pursue the conversation when it was a part of an episode of care. Participants believed that building trusting relationships and establishing private and comfortable environments for sexual health consultations increased their ease to have sexual health conversations. Attending to clients of the same gender and cultural group as their own made it easier for the participants to speak freely to clients on sexual matters. Participants were in unison in their belief that further education, ongoing professional development and research was the way forward for them to become skillful and comfortable to meet the holistic needs of older clients’ sexual health within PHC services.
The following chapter, Conclusions, will review the key findings and detail implications and recommendations for nursing education, nursing practice and research.
Chapter Six: Conclusion

6.1 Introduction

This chapter highlights the key research findings and the resulting recommendations for nursing education, nursing practice and research. The limitations of the study are outlined and reflections made on the use of the method. The aim of this study is to gain an understanding of the way PHC nurses engage older clients to discuss issues related to their sexual health. The experiences and attitudes of PHC nurses have been investigated to identify factors that either facilitated or inhibited their discussion of sexual health with their older clients. Evidence from the literature shows a lack of research pertaining to sexual health assessment and communication between PHC nurses and the older adult, particularly from New Zealand.

The following questions arose during the review of literature:

- what facilitates PHC nurses’ discussion around aspects of sexual health with their older clients?
- do PHC nurses feel comfortable and prepared to ask clients about their sexual health, or do they wait for the client to initiate the conversation?
- do PHC nurses want to include sexual health as part of their provision of holistic care to their clients?

These initial questions influenced the decision to use qualitative methodology with focus groups as the exploratory descriptive method and directed the formation of the topic questions (Appendix 4) used in the focus groups.

6.2 Key findings

Comfort and discomfort were words used frequently by participants during the study and these terms were used within the themes identified in the discussion chapter: conversations with clients about sexual health, discomforting conversations about sexual health, inhibitors and facilitators to conversations about sexual health, PHC nurses’ lack of knowledge of sexual health issues and lack of sexual health resources.

PHC nurses in this study showed increased comfort when initiating conversations about sexual health with the older client when the consultation was part of an episode of care or
when using a health assessment tool. Participants believed that sexual health conversations with clients were the responsibility of the nurse but were more comfortable initiating these conversations when the conversation was part of an episode of care. The discussion of sexual health anywhere other than during a consultation where there was relevance to the presenting health condition was considered by several participants as inappropriate which they thought could be perceived by the client as confrontational.

Using an assessment framework such as the CHA inspired participants with greater confidence, comfort and ease to raise sexual health questions with their older clients. Participants explained that an assessment tool provides them with a framework for assessment and care. Participants were focused on the importance of including the client’s sexual health as a part of their nursing assessment, especially for those clients with complex long term health needs, or if their condition had an impact on their sexual health.

Participants used cues in their conversations which they referred to as “setting the scene” or “sowing the seed” to prompt conversation with the older client into discussing sexuality and sexual health. Generally, PHC nurses were hopeful that the client would respond to the cues. Yet there were instances when participants evaded cues given by the client to avoid getting into deeper conversation. Their avoidance was based on their personal discomfort talking about sexual health issues, their lack of education and preparation on how to facilitate the conversation when raised by the client or due to time constraints. Effective communication occurred when the nurse or client had given cues and the client or the nurse responded to these cues. When the client or PHC nurse did not give cues, were unwilling to discuss sexual health or showed discomfort with sexual health conversation, the outcome was ineffective discussion, as noted in Figure 2.

Study participants perceived that knowing the client and having a long-term professional relationship with the client was an important component of successful sexual health discussions. Some participants proposed that a professional nurse-client relationship should be established before initiating conversation and/or responding to cues from the client about sexual health. Adequate time for consultations and establishing the relationship was essential to build sufficient trust and rapport with older clients to initiate or continue conversations in sexual health.
Participants’ description of their attitudes and beliefs did not always support successful sexual health consultations with their clients. Personal biases and beliefs related to sexual health affected their decision and approach to achieve effective conversations with older clients on related matters. Uncertainty, tentativeness and feelings of being disrespectful prevented participants from assessing and exploring the sexual health needs of older clients in PHC, with some participants suggesting that such conversations could be interpreted as being confrontational and invasion of a client’s privacy.

The attitudes of the PHC nurses in this study were influenced by the stereotypical views of society towards sexuality of the older adult. These attitudes influenced not only the way they approached the client but whether or not the client felt comfortable to approach the nurse to discuss their sexual health. Discussing sexual health with clients of the same gender was more comfortable for PHC nurses in this study.

Older clients who identify as LGBTQ were considered by participants to be ostracised by society and be easily overlooked by PHC nurses thus missing out on appropriate sexual health assessment. Participants noted the lack of education for nurses working in PHC in discussing sexual health and how to communicate effectively with this group of clients.

Using language to appropriately describe and discuss sexual health with older clients was perceived by participants as an important skill to initiate and engage clients in discussion of sexual health. Some participants wanted to have more in-depth conversations with clients who identified having sexual health problems but felt insufficiently prepared to know how to approach the conversation, even though most participants were experienced nurses with postgraduate qualifications.

Many participants discussed the barriers they faced in communicating effectively with older clients with limited English fluency or proficiency and the issues they had when using interpreters. Family members who happened to be attending appointments with their parents or spouses often acted as the interpreters. There was concern raised by the participants about the appropriateness of using family members to interpret, especially when the topic was related to sexual health. Participants highlighted the increasing diversity of ethnic groups within the region of this study and found initiating and discussing sexual health issues with clients who were of a cultural group different to their own more difficult.
than having the same conversations with clients they identified as belonging to their own cultural group.

The need to build a non-threatening conversational space where clients felt supported was important to participants especially when addressing potentially sensitive topics of conversation. The practice environment influenced the quality of the communication PHC nurses had with their clients when discussing sexuality and sexual health. Sexual health assessment although acknowledged by participants as part of a holistic assessment of a client, was described as “opening pandora’s box” which could lead to time-consuming consultations; this affected their decisions whether to start the discussion. PHO nurses described having more time than practice nurses during consultations to enable initiating sexual health discussions. Privacy was a barrier for sexual health consultations both in the practice environment and during PHO nurse home visiting, although if family members were not present, the PHO participants noted that home visiting was a more comfortable and relaxed environment for many clients and participants.

There was a reluctance to discuss sexuality and sexual health with the older client when there was a perceived lack of sexual health services oriented towards the needs of the older client in the region of this study. This also pertained to products, services and health promotion, not marketed to the older population.

6.3 Implications of the study and recommendations

6.3.1 Implications for education

Even though the majority of the participants (62%) were educated at postgraduate or higher levels, which is significantly higher than the national RN workforce, 38.1% (Nursing Council of New Zealand, 2015), there was a noted lack of knowledge reported by participants in assessing the sexual health of the older adult. Education was reported by participants to be needed at undergraduate, postgraduate and as the on-going professional development of the PHC nurse. Attitudes and beliefs of the PHC nurse affect the course of all sexual health interactions and consultations. These beliefs and attitudes did not always support successful sexual health consultations with clients. Participants were not always able to respond to cues and concerns from the client in sexuality and sexual health.
6.3.2 Recommendations: education

- Sexual health education programme development for PHC nurses must include the effects of long term conditions on sexual health, effective communication of sexual health between older clients and PHC nurses, appropriate assessment and management of sexual health and where to appropriately refer the older client for sexual health treatment.

- Sexual health education needs to be included into undergraduate and postgraduate nursing programmes, encompassing attitudes and beliefs of society and nurses toward the sexual health of the older adult with the aim of developing confidence and communicating effectively with the older client.

- Education for PHC nurses needs to include information on LGBTQ lifestyle, understanding the barriers LGBTQ face in accessing PHC and how to provide nursing care which is accepting and appropriate to LGBTQ clients while providing opportunity for disclosure of sexual identity.

- Education needs to include communication about sexual health with clients who are of a different age, gender or culture to the nurse. Including clients from different cultures in the education of PHC nurses may help to increase understanding and influence positive attitudes to discussing sexual health with cultures different to the PHC nurse.

6.3.3 Implications for nursing practice

Insight into the sexual health discussions between PHC nurses and older clients has been gained by this qualitative study. This study has found the importance to the PHC nurse of establishing a strong client/PHC nurse relationship to initiate and continue conversations in sexual health. Relationship is seen as the foundation for trust and rapport. Restricted time for PHC consultations was noted as a barrier to providing comprehensive and holistic sexual health assessment to clients. The lack of an appropriate sexual health assessment tool or history-taking framework to use with the older client hinders the ability to provide holistic assessment of the older client.
6.3.4 Recommendations: nursing practice

- Professional guidelines developed to ensure quality sexual health assessment and management is provided in PHC.

- When designing the workforce and structure of the larger PHC practices, ways of increasing the ability of clients and nurses to build therapeutic relationships must be taken into account, such as nurses working in smaller teams within the larger practice, providing opportunities for nurses to act as lead providers, to be able to visit the client at home (if more appropriate) and the ability to book consecutive appointments with clients.

- Sufficient time for sexual health consultations must be allowed for when planning for staffing and models of PHC.

- Planning of PHC practice environments and home visiting consultations must also include measures to ensure privacy for sexual health consultations and the promotion of comfort to encourage therapeutic conversation.

- The development of a sexual health assessment tool suitable for use with the older adult, either a stand-alone tool, or development into existing assessment models. Sexual health assessment for the older client should occur when the client presents for an initial assessment or for a sexual health related concern. This may be an appropriate time to be assessing the client’s sexual identity, sexual expression and intimacy and incorporate this into the client’s long term condition needs management.

- Within general PHC practice, health promotion and conversation about sexual health must be emphasized with an aim of early diagnosis and treatment of STIs among the older client population.

6.3.5 Implications for research

Education in sexuality and sexual health of the older adult is underpinned by the strength of evidence in research. This study highlights the lack of research conducted in this topic in New Zealand. This study has added to local and global knowledge of sexual health of the older adult and added to PHC nursing practice in New Zealand. Research into the attitudes
and beliefs of clients over the over 65 years and how they regard the communication of
sexual health of PHC providers will provide a basis for recommendations of sexual health
PHC services for the older adult.

Participants questioned existing research: PHC nurses knowledge of older adults’ sexual
health; what gaps exist and what education is needed in research of sexual health of the
older adult in NZ across the PHC nursing workforce; where do PHC nurses obtain information
on sexual health of the older adult; and how reliable and trustworthy is this information.

Research into the attitudes and beliefs of PHC nurses and society towards sexuality of the
older adult including the visibility of older people and the experiences of those older people
identifying as LGBTQ may influence national policy, development of guidelines and the
provision of health promotion that is applicable to sexual health of the older adult. With the
increasing population of older adults in NZ, providers of sexual health services and products
should be researching what is appropriate for this group of consumers and targeting
resources more effectively.

6.3.6 Recommendations: research
Further research areas identified by this study include:

• How well are PHC sexual health services provided to diverse cultural groups in NZ?

• Are existing sexual health services appropriate to the needs of the older adult?

• What do older clients in NZ want in the way of sexual health assessment and
  services?

• What interpreter services are available in NZ and what is their appropriateness for
  sexual health consultations?

• What are the barriers and effectiveness of nurse/client communication during home
  visiting consultations?
6.4 Limitations of the study

Limitations and strengths of the research are recognised. This study was conducted in one region in New Zealand with small numbers of PHC nurses and can only be regarded as a snapshot of the PHC nursing service in New Zealand. The results of this study may not be transferable to other regions in New Zealand or with participants who are employed in other areas of PHC nursing. Recommendations are based on the PHC services available within the region of the study. It is difficult to know if the sensitive nature of the topic prevented some of the participants from speaking as openly as they would have in an individual interview.

Participants may have felt more able to disclose their experiences, which they may otherwise have not offered, to the researcher due to the researcher’s background as a PHC nurse in the region of the study. As a PHC nurse there was potential for the researcher to be regarded as part of the group of participants and for participants to provide responses they think the researcher may have been seeking. Potential bias is identified in the background of the researcher who was a PHC nurse, NZ European, female, heterosexual and of middle class socioeconomic status.

6.5 Reflection on the use of the method

The use of focus groups, while applicable for an exploratory descriptive method has limitations as identified previously. Despite reasonable consistency in the data from all three focus groups, the results still may not represent the experience of other PHC nurses. A mixed methods study with individual interviews of PHC nurses and quantitative data showing the quality and numbers of sexual health consultations would contribute data on the provision of sexual health assessment by PHC nurses. Focus groups hold the risk of participants not contributing fully due to shyness or hesitation with a potentially sensitive subject such as sexual health. In this study participants did not show any signs verbally or non-verbally of discomfort with the subject but individual interviews would be an alternative if this is seen to be a potential problem with further such studies.

6.7 Concluding comments

This research has contributed insight into communication between PHC nurses and the older adult as well as identifying key recommendations. With the rising numbers of older people in the New Zealand population (Statistics New Zealand, 2006), appropriate provision of health services becomes increasingly important to policy makers and the nursing profession.
Providing holistic nursing assessment is vital component of PHC nursing care and part of this care should entail the provision of sexual health assessment and management for older clients. To ensure sexual health care is available to older clients, PHC nurses need to be supported to provide this care, with evidence-based undergraduate, postgraduate education and professional development.

This exploratory study encourages further research to be undertaken in the sexual health of the older adult, especially within New Zealand, with the expectation of increased visibility, improved resourcing and improved health outcomes of the older adult.
References


Appendices

Appendix 1: EIT Approval of Research Proposal Progression

EASTERN INSTITUTE OF TECHNOLOGY

APPROVAL OF RESEARCH PROPOSAL PROGRESSION - MN9.490 MASTERATE RESEARCH

Details of candidature

Student Name: Brenda Moana
Principal Supervisor: Ruth Crawford
Associate Supervisor: Dorothy Isaac

Thesis working title: Primary Health Care Nurses discussing sexual health with older clients

Approval to progress

The Faculty approves your Research Proposal for progression to the EIT Research Ethics and Approvals Committee.

Please follow the Thesis Guidelines in completing the appropriate forms for submission to the EIT Research Ethics and Approvals Committee, and consider any additional research approval submissions you may have to make for locality approval or to relevant external bodies.

On receipt of approval to commence research from the EIT Research Ethics and Approvals Committee please upload a copy of your approval to EIT Online.

Sign off

Head of School signature ________________ Date 07 July 2015

Programme Co-ordinator signature ________________ Date 07 July 2015

Course Co-ordinator signature ________________ Date 07 July 2015
Appendix 2: Letter of Approval Research and Ethics Committee

Reference Number 13/15

3 August 2015

Brenda Moana
Masterte Student
C/- School of Nursing
EIT

Dear Brenda

Thank you for responding to and providing further clarification to your research application “Primary Health Nurses discussing sexual health with older clients”, which are accepted by the Reviewers.

I am pleased to inform you that your research project was approved by the Research and Ethics Committee at their meeting held on 31 July 2015.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wishes you well for the project.

Yours sincerely

[Signature]

Dejette Fifield
Secretary – Research Ethics & Approvals Committee
## Appendix 3: Locality Approval

### HEALTH APPROVAL FORM FOR RESEARCH ACTIVITY

**Research Practice Title:** Primary Health Nurses discussing sexual health with older clients  
**Principal Researcher:** Brenda Moena  
**Designation:** Master of Nursing Thesis student (EIT)  
**Service Area:** Taradale  
**Research Practice Experience:** Masterate Research Candidate, Eastern Institute of Technology (EIT)  
**Other Researchers involved:** EIT thesis supervisors: Dr Ruth Crawford, Dorothy Isaac

#### Brief Description of Research Practice Purpose and Methodology:

The purpose of this study is to gain a better understanding of the way Primary Health Care nurses engage older clients (over 66 years) to discuss issues related to their sexual health. Data collection will be three focus groups with 4-6 primary health care nurses in each group. Two focus groups will be held in and one in Focus groups will allow open discussion and will generate information from the participants on their experiences and perspectives on assessment of sexuality with the older client. It is an appropriate method to use with this group of participants as they all work in the PHC setting and are likely to have similar experiences to share about their consultation with the older client, which will encourage them to participate.

#### Section A: Initial Registration and Approval of Research Practice

<table>
<thead>
<tr>
<th>Documented evidence:</th>
<th>Research purpose and parameters</th>
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<tbody>
<tr>
<td>Consultation with all involved parties</td>
<td>Risk and indemnity cover</td>
</tr>
<tr>
<td>Resources required e.g. staff, equipment, other service involvement</td>
<td>Approved research budget</td>
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**Operations Director's signature to proceed:**  
**Date:**

**Professional approval gained, where applicable (e.g. Professor of Nursing):**

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<th>Not applicable</th>
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**Designation:**  
**Signature:**  
**Date:**

**External approval gained, where applicable (e.g. Regional Ethics Committee, Educational Institution):**

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<th>Not applicable</th>
</tr>
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</table>

**State where from:** EIT Research Ethics & Approvals Committee (REAC)  
**Documented evidence (where applicable):**

- National application form for ethical review of a research project (NAF-2005-v1)
- Participants who are unable to give informed consent to participate form (NAF-Part 7)
- Locality assessment form
- Use of human tissue form (NAF-Part 5)
- Genetic research form (NAF-Part 6)

#### Section B: Final Operations Director Approval to Proceed

**Final contractual agreement completed**

**Proposed start/end dates of research:**  
**Start date:** 10 August 2015; **end date:** 22 November 2015

---
Operations Director signature
Service Line: __________________________ Date: __________________________

This submission has been considered to meet ethical and professional requirements, and clearly
demonstrate potential clinical, professional and/or strategic benefit to the organisation.

Clinical Board Acknowledgement of Registration
Signed: ___________________________ Designation: Chief __ Date: 14/3/2015

Copy to be retained by Chief Medical Officer’s office and details entered onto Register.

To be completed by Principal Researcher and Operations Director. The Operations Director is to forward a copy of
the form to the ith Clinical Board, via Quality & Clinical Risk. All relevant supporting documentation is
to be included.

Consultation with all involved parties:

Proposal for Research granted from EIT on 24 June 2015
Ethical Approval obtained from EIT Research Ethics & Approvals Committee (REAC),
reference number 13/15 on 3 August 2015
Te Tihi Health Maori Health Team

Resources Required:

Staffing: Brenda Moana is the research facilitator and moderator of the focus groups

Equipment: Meeting room required a and at for use after working hours
Appendix 4: Information for Research Participants

Date: 16 June 2015

Project Title: Primary Health Nurses discussing sexual health with older clients

To: Registered Nurses working in a primary health care setting

Researcher: Brenda Moana

Affiliation: Masterate Research Candidate, Eastern Institute of Technology (EIT)

Description of the research:
The purpose of this study is to gain a better understanding of the way nurses in primary health care discuss sexual health with older clients (over 65 years).

What will participating in the research involve?

You are invited to participate in a focus group with up to five other nurses. The focus group will be held in a lunch time or after work. In the focus group there will be a general discussion of the ways nurses in primary health care discuss sexual health with clients over 65 years. You will be asked to share your experiences to identify factors which facilitate or inhibit discussions with older clients about this topic.

What are the benefits and possible risks to you in participating in this research?
Potential benefits are a greater awareness and understanding of facilitating discussing sexual health with older clients in your nursing practice. There are no possible risks, however some participants may find this topic sensitive. Counselling support is available if this should be required through the DHB EAP programme.

Your rights:
- You do not have to participate in this research if you do not wish to.
- If you are a student at EIT and decide to take part, you can withdraw from the research at any time and this will not affect treatment or assessment in any courses at EIT.
- If you are a patient or under the care of students or staff from EIT, you can withdraw from the research at any time and this will not affect your treatment or assessment in any way.
- You are welcome to have a support person present (this may be a member of your family/whanau or other person of your choice)
- You may request a summary of the completed research

Confidentiality:
The venues for the focus groups will be a private quiet space in a PHO. Participants are asked to maintain anonymity of others in the focus group. Digital recordings of the groups, consent forms, transcriptions and field notes will be stored in secure manner in a password protected computer and...
held for five years, for audit purposes and then destroyed.

- If you wish to participate in this research, or if you wish to know more about it, please contact

<table>
<thead>
<tr>
<th>Contact Person:</th>
<th>Brenda Moana</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIT School/Section:</td>
<td>School of Nursing, Faculty of Education, Humanities and Sport Science</td>
</tr>
<tr>
<td>Work phone #</td>
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</tr>
<tr>
<td>Mobile phone #</td>
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<tr>
<th>Supervisor Name(s): (if applicable)</th>
<th>Dr Ruth Crawford</th>
</tr>
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<tr>
<td>Work phone #</td>
<td># 5401</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:rcrawford@eit.ac.nz">rcrawford@eit.ac.nz</a></td>
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<th>Head of School/Manager:</th>
<th>Associate Professor Thomas Harding</th>
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<td>Email address</td>
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- For any queries regarding ethical concerns, please contact: Chair, Research Approvals Committee, EIT. Ph. 974 8000

- This study has been approved by the EIT Research & Ethics Committee on 3rd August 2015, reference number 13/15
Appendix 5: Consent Form

CONSENT FORM

Project Title: Primary Health Nurses discussing sexual health with older clients

Researcher: Brenda Moana

I have read and I understand the Information for Research Participants sheet dated 16 June 2015 for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my employment.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

I agree to take part in this research

☐ Yes  ☐ No

I consent to my interview/activity being audiotaped

☐  ☐

I wish to receive a summary of the results

☐  ☐

Signed: _______________________________________________

Name: ________________________________________________

Signature of Research Participant’s Support Person (if applicable)

________________________________________________________________________

Date: __________________________

Witness: __________________________

I/We as researcher(s) undertake to maintain the confidentiality of information gather during the course of this research.

Signed_________________________________________Dated____________________

This study has been approved by the EIT Research & Ethics Committee on 3rd August 2015, reference number 13/15
Appendix 6: Topic Guide

What facilitates primary health care nurses’ discussing sexual health issues with older clients?

**Topic Guide**

**Questions used to guide the Focus group**

Please share your experiences discussing sexual health with clients older than 65 years, in the primary health setting.

What enables you to initiate conversations with your older clients about sexuality and their sexual health?

What prevents you initiating conversations with your older clients about sexuality and their sexual health?

What do you think enables older clients to approach you about their sexuality and their sexual health?

What preparation and education have you had about sexuality and sexual health?
Appendix 7: Supplementary Participant Information

Supplementary Participant Information

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<th>Age</th>
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How many years/months have you worked in primary health care?  
______________________________________________

Current primary healthcare service ie medical centre/PHO/nurse-led  
______________________________________________

Years/months in current service  
______________________________________________

First nursing qualification?  
☐ Hospital Certificate  
☐ Diploma of Nursing  
☐ Bachelor of Nursing  
☐ Other (specify)  
|                   |       | __________________ |

Postgraduate qualifications?  
☐ Yes (specify the qualification)  
_________________________________________________________________

☐ No
Appendix 8: Focus Group Checklist

Focus Group Checklist

Text to ensure coming – stress importance of being on time – can’t start till everyone is present
Charge recorder and phone

Check venue and someone to open with security card
Pens, whiteboard marker

Food – order pita pit/fruit pick up 4.30pm
Drink – white red soda juice
Write up research questions on whiteboard
Recording equipment
Consent Forms/Information and Supplementary Forms
Questions for Whiteboard

As they come in welcome and ask to fill in supplementary form and any consent forms still to do

Mihi/welcome/Thanks/toilets, refreshments – usefulness of information and research
Please turn your mobile phones off
Importance of confidentiality – not to discuss the conversation outside of the group
Openness
My role – as a facilitator of the focus group only
Being recorded and transcribed
Promise the discussion will be stopped at the one hour mark
Round the room – briefly your name and where you are currently practicing

Then start recording

At the end
“Before we close, I want to look again at the question on the board – is there anything else you would like to add”
Thank the group
Appendix 9: Mihi

Mihi

Kiaora

He maunga rongo ki te whenua
He whakaaro pai ki na tangata katoa
Kia piki te hauora ki a katoa

(peace upon the earth, goodwill to all mankind and the blessings of wellbeing be upon you).

Tena kotou Tena kotou ko Brenda Moana ahau
Appendix 10: Māori Team Approval Letter

8 Whiringa-a-nuku 2015

"He aha te mea nui o te ao?
Māku e ki atu, he tangata, he tangata, he tangata".

Kei te kalpānui, tēnā koe

RE: Proposal from Brenda Moana
Primary Health Care Nurses discussing Sexual Health with Older Clients

He whakatau whakatūturu tēnei kua oti kē ia māua ko Brenda Moana te wetewete i ngā kōrero mō te kaupapa i runga ake nei mō “Te Taeratanga o te Hunga Kauheke”, arā, a tūnohungohu mā, a pēperekōu mā.

Ki te hiahia koe ki ōtehi atu kōrero, tēnā, me whakapā mai ki ahau.

Noho ora mai i roto i ngā manaakitanga a te mea ngaro. Nāku noa nei, nā

Māori Health Manager

Translation: What is the greatest thing of the earth, it is people, it is people, it is people.

I confirm that Brenda and I have discussed the topic of primary health care nurses discussing sexual health with older clients thoroughly and approve the research into this area. If you would like to discuss this further, do not hesitate to contact me.

Best Regards, Maori Health Manager
Appendix 11: Summary of Results for Participants

Participants described the ability to connect and communicate effectively with their clients as an important step in relationship-building and increasing the feeling of comfort between the client and the nurse when discussing sexual health issues. Successful conversations about sexual health with the older client are dependent on a number of factors: having a trusting relationship, privacy and a relaxed environment; having time to engage and allowing clients to initiate the conversation; nurses responding to cues/concerns about sexual health; using appropriate language and discussing sexuality during context of care. Using an assessment tool to facilitate discussion; nurses’ willingness to discuss sexual health; experience, age and gender of nurse and cultural similarities and differences as identified by participants were also enabling factors.

Knowing the client and having a professional relationship with the client was perceived as very important to the majority of participants who felt a professional nurse-client relationship should be established before initiating conversations about sexual health. If the client initiated conversations about their sexual health, participants were comfortable engaging in these conversations. Participants discussed ways in which to appropriately phrase questions around sexual health. Responding to client cues triggered participants’ initiation of sexual health conversations. Cues and concerns from either the client or the PHC nurse present as a trigger for conversation on sexual health with the older adult. Although participants in this study noted the importance of identifying client’s cues, there were times where they evaded the cues to avoid engaging in deeper conversation due to their own discomfort or time constraints during client consultations.

Figure 1 (below) highlights the relationship between the client and the PHC nurse, demonstrating that discussion about sexual health occurs when the nurse or client has given cues and these are responded to. When the client or nurse do not give cues, are unwilling to discuss sexual health or show discomfort with sexual health conversation, there becomes a circling effect with the result of ineffective or no discussion about sexual health.

Figure 2: Nurse and client response to cues

Nurses were more comfortable initiating conversations around sexual health when clients presented for prescriptions, appointments or during discussions over medication changes.
Conversation related to clients’ sexual health also occurred during presentation for episodes of care. Participants felt that a good starting point to initiate a conversation about sexuality occurred when a client presented for a sexual health related issue. Some participants described around the appropriateness of raising questions about sexual health as a part of the client’s general medical assessment.

Some participants wanted more than one consultation to establish a rapport with their clients to feel sufficiently comfortable to discuss sexual health. Other participants considered it too difficult to initiate conversations about sexual health during the first consultation. The use of a questionnaire or assessment tool, such as the Comprehensive Health Assessment (CHA), which was available to most participants, was sometimes used to initiate sexual health conversations. Participants described increased confidence and comfort to ask sexual health questions with older clients when using an assessment tool.

Participants discussed societal and their own views of sexuality and how these views affect their conversations with clients. There was discomfort attached to asking about sexual health of older clients with STIs. A level of uncertainty and tentativeness emerged in respect to asking clients about their sexual health, questions which participants interpreted as being disrespectful to the client. Another participant implied that she would not be comfortable if a client disclosed sexual health issues, so she asked about sexual health in a dismissive way, which suggested that she did not want to discuss this issue further.

Participants discussed the burgeoning media coverage on sexuality issues which has contributed to the normalization of sexuality in society and a greater willingness among older clients to discuss sexual health issues. Older clients identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ) were perceived by participants as a group who lacked acceptance by society and were missing out on appropriate sexual health assessment.

Participants expressed a need for appropriate language to be used when discussing sexual health. There was discomfort and lack of confidence to speak openly with older clients and a need to have education available to facilitate discussions about sexual health with older clients, especially those who are LGBTQ, those with intellectual disability and those for whom English is a second language. Participants discussed the barriers they faced in communicating respectfully with older clients for whom English was a second language and the issues they had when using interpreters. Many interpreters were family members, who attended appointments with their parents or spouses.

The status of the client within the Pacific community was also viewed as a barrier to Pacific nurses asking a sexual health related question of Pacific clients. Interpreting for Pacific clients in a respectful way and using family members was difficult for some participants. Using appropriate language provided greater ease to the participant’s discussions on sexual health. One participant pointed out that variation in language could make the discussion around sexual health issues more acceptable. Pacific and Māori participants discussed the ease and comfort felt when having conversations about sexuality with clients from the same ethnic group as them. Another participant stated that having a young nurse who was not born in NZ accompanying her when seeing clients for sexual health appointments would be a clash of cultures for her older clients. The participant shared her discomfort conducting a consultation with her clients with a younger nurse present.

Some participants considered that the age and experience of the PHC nurse was a factor in how comfortable and skilled they were talking to older clients about sexual health and the receptiveness of their clients. The gender of clients made a difference to how most
participants approached discussions on sexuality and sexual health with their clients. All participants were female and most expressed that discussing sexual health issues with women clients was easier than with men. Some practice nurse participants believed that male clients mostly preferred to discuss their sexual health problems with a male doctor.

Participants related the importance of adequate privacy in the practice and home settings. Participants were less willing to discuss sexual health issues with clients when family members were present. Discussing sexual health while having others present, in one case a student nurse, was noted by a participant as being too confronting for older clients. Providing adequate privacy for consultations, making time to ask questions and arranging follow-up sessions on sexual health issues were all factors identified by participants as enabling sexual health conversations and increasing the comfort felt by both participants and their clients.

Some participants felt that asking a sexual health-related question was like “opening Pandora’s box” which could lead to a time-consuming consultation, involving referring and dealing with arising problems. Some participants acknowledged that they worked in an environment where they were able to spend more time with clients, thus creating more opportunity to engage in a consultation around sexual health.

Participants described a lack of affordable and suitable services for referral of older clients with sexual health problems. They recognised that many of the sexual health services in this region were mainly suitable for younger people or those in child rearing years. Participants discussed the scarcity of products, services and health promotion activities for the older adult and ways in which clients could benefit from the availability of such amenities.

Some participants questioned whether any research had been undertaken to establish how well the sexual health needs of the older adult were being met. Participants discussed the lack of sexual health education available for PHC nurses, including the limitation of education and health promotion available for older clients. In many instances educational resources, health promotion and services provided in sexual health were inadequate, or not appropriate for clients over the age of 65 years. Most participants discussed their lack of education on sexual health of the older adult, at both undergraduate and postgraduate levels or through ongoing professional development. More education about sexual health discussions with clients over 65, at undergraduate, postgraduate and professional development was required.

I welcome your feedback on these findings.

Brenda Moana, MN student
May 2016
Contact details:
bdmoana@gmail.com
mobile 0274587478
Email to Participants:

Re: Primary health care nurses discussing sexual health with older clients

Thank you very much for participating in this study.

On the consent form for this research you requested to receive a summary of the results.

The research question is:

**What facilitates primary health care nurses discussing sexual health issues with older clients?**

I would appreciate you as a participant in this study, reviewing these preliminary findings and responding to three questions:

1. Do the findings reflect your understanding of what facilitates primary health care nurses discussing sexual health issues with older clients?
2. Is there anything more that you think should be added to the findings?
3. On reflection, is there anything else you would like to have added in the focus group?

This further feedback will add another layer to the data already collected.
Please respond to this email by **13th May 2016**.
Appendix 13: Feedback from Participants

Replies from six participants

1. **Do the findings reflect your understanding of what facilitates primary health care nurses discussing sexual health issues with older clients?**

   P1: Yes it does
   P2: It all looks great I concur with the findings
   P3: Yes, I feel it’s reflective
   P4: It reads beautifully, content is wonderful and I love the picture, being very visual
   P5: I am in general agreement with the findings.
   P6: Thank you for the summary of results. I think the summary reflects what we discussed accurately. I don’t have anything too add to this

2. **Is there anything more that you think should be added to the findings?**

   No I think you have captured everything we discussed.

   Discussion about intimacy rather than always sexual activity

3. **On reflection, is there anything else you would like to have added in the focus group?**

   For some Pacific cultures, there maybe protocols to follow when a clinician needs to ask the sexual health questions and to clients especially those with important status in the community; e.g. For Samoan Matai or Church Minister, a clinician may need the polite oratory language to initiate (clear the way shall we say) for the questions to be comfortably asked. I guess this can come under using the appropriate language response; Clinicians should not use certain family members to interpret for some Pacific older members; e.g Clinicians should refrain from using daughters to translate for their fathers when asking sexual health questions (speaking from Samoan culture perspective – it’s inappropriate); probably safer to use a son and visa versa with mother and son – it would be safer to use a daughter for mothers. Consider cultural training on Guidelines to assessing these sensitive parts of the assessment tools.

   I do think that having a male component would provide another element. This would reflect balance particularly for Māori world view.

   Quite often the comprehensive health assessment (CHA) is a useful tool to initiate discussion, especially with older diabetic males. Generally I find that the older person is not embarrassed by the discussion at all so the barrier is probably a perceived one in the mind of the practice nurse.