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Original Research

The representation of women who have sex with women (WSW) in sexual health promotion in England: a frame analysis

ORIGINAL RESEARCH

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ABSTRACT

Background: Women who have sex with women (WSW) are a marginalised group. WSW are assumed to be at low risk of sexually transmitted infections (STIs). However, they have similar rates of STIs to women who have sex exclusively with men. A lack of accurate and relevant sexual health information for WSW has been identified and highlighted as a barrier to good sexual health in this group. This study aims to explore how WSW and their STI risk are represented in sexual health promotion in England.

Methods: Organisations that produced sexual health promotion campaigns or policy were identified using a three-step Google search. Up to three materials from each campaign were chosen for analysis alongside policy documents. Frame analysis was used to identify and develop a thematic framework that identified common themes and assumptions from the data.

Results: 47 materials were included in the analysis: 5 policy documents, 11 posters, 11 leaflets and 20 online articles. 9 frames were identified and used to discuss the two overarching themes that emerged from these: over-representation of the penis and under-representation of WSW and their relevant sexual practices.

Discussion: This study suggests an androcentric and heteronormative framing of sexual health promotion, resulting in the erasure of WSW. Erasure perpetuates false narratives of low STI risk and symbolically annihilates this group, a form of symbolic violence. To address this issue, I suggest empowering WSW by acknowledging this erasure and developing new sexual health campaigns and policy with the participation of this group.

BACKGROUND

The term women who have sex with women (WSW) is defined as any woman, regardless of sexual orientation, that has had at least one sexual encounter with women. (1–3) This is a diverse and heterogeneous group and includes a vast spectrum of sexual identities. Of these, the most commonly cited in the literature are heterosexual, lesbian/gay, and bisexual. (4–7) For the purpose of this paper, I have focussed on cisgender women as the needs of trans and non-binary people are different (8,9) and are beyond the scope of this study.

The sexual health of WSW needs to be understood in the wider social and cultural context of English society. WSW are a marginalised group that experience systemic violence, social exclusion and victimisation. (10–12) All of these factors have been shown to adversely impact health. (13,14) WSW have poorer experiences of healthcare, encountering discrimination and prejudice from staff, as well as exclusion and marginalisation from the healthcare space as a whole. (11,15,16) In addition, WSW exhibit fewer health-seeking behaviours, and have low levels of disclosure of sexuality. (5,7,11,15–17)

WSW have been excluded from sexual health discourse and have been labelled as a 'low-risk' group for contracting and transmitting sexually transmitted infections (STIs). (5,11,18) Because of this assumption, little research is conducted around WSW and their risks of STIs compared to men who have sex with men (MSM) and heterosexuals, a gap in research that extends beyond sexual health. (14,18) This gap reinforces the assumption that WSW are not at risk of STIs. The invisibility of WSW occurs not only in research but in the physical healthcare spaces and sexual health clinics and is reflected in an absence of accurate and relevant sexual health information for this group. (12,19,20)

The erasure of WSW in sexual health discourse is not reflective of their real risks of STIs. STIs such as trichomoniasis, genital herpes, human papilloma virus (HPV), and human immunodeficiency virus (HIV) are transmissible through sexual contact between women, through cervicovaginal fluid and direct mucosal contact. (5,6) Although it is often assumed that the risk of STI transmission between women is lower than between people of the opposite sex, WSW have similar rates of STIs compared to women who have sex exclusively with men (WSEM). (6,21) In addition, women who have sex with both women and men have higher rates of most STIs than WSEM. (12,21–24)

The lack of relevant sexual health information for WSW has been highlighted as a barrier to good sexual health. (12,25–27) There is an absence of relevant and targeted sexual health information for WSW; an absence that is also present in English sexual health policy. (11,22,28–30,31) The aim of this study was to explore how WSW and their STI risks are represented in sexual health promotion in England, to contribute to understanding of the visibility and representation of this group in sexual health promotion, and to guide future sexual health promotion strategies.

METHODS

Our frame analysis explores how the framing of sexual health promotion presents WSW and their risk of STIs. Proposed by Erving Goffman, frame analysis is based on framing theory, which states that how a topic is presented to an audience (the 'frame') influences how people process what is presented. (32) Frames through which information is conveyed allows us to study the social construction of reality, which can subsequently influence peoples' choices and decision-making which is related to the information presented. (33) Although often used to study media communication and social movements, here it is applied to sexual health promotion campaigns and policy.

Data Collection

Two types of data were collected for this analysis. The first data set is sexual health promotion campaigns relating to STI transmission, treatment, and prevention. The second data set is sexual health promotion policy. Both of these were included to gain a broader understanding of sexual health promotion in England.

The search engine Google was used to find organisations that produced relevant campaigns and policy. Google was used to ensure that the data collected was the most current and accessible to the public. Data collection was divided into three steps, outlined below:

- **Step 1**: Search for sexual health campaigns. The following search terms were used: 'sexual health promotion England/UK'; 'sexual health campaign England/UK'; 'sexual health charity England/UK'; 'sexual health organisation England/UK'; 'sexual health NHS'; 'HIV campaigns England/UK'; 'HIV charity England/UK'. The organisations that produced sexual health promotion campaigns were mapped in Figure 1.
- **Step 2:** Search for sexual health promotion policy. The search terms used were: 'sexual health policy England/UK'.
- The organisations from this step were also mapped in Figure 1.
- **Step 3**: The webpages from the previous two searches were explored and any other relevant sexual health promotion organisation mentioned on these were added to the map.

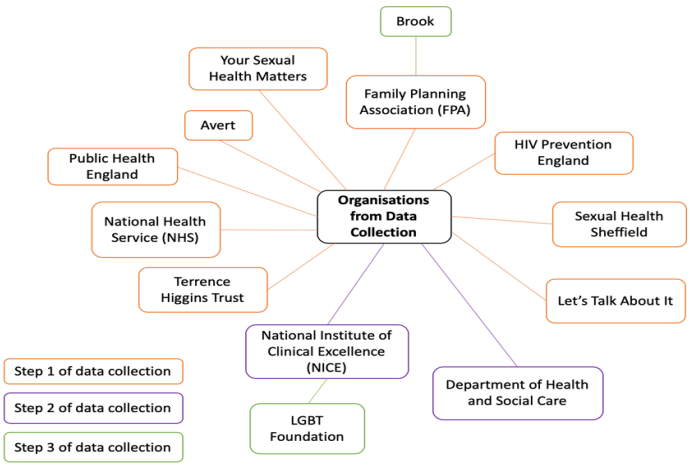


Figure 1: *Mapping of the organisations from the steps in data*

From these organisations, relevant campaigns and policy documents were identified according to the inclusion and exclusion criteria (Table 1). For each campaign, up to three materials were chosen to represent the breadth of the campaign. The full list of materials included in the analysis can be found in Appendix A.

Inclusion Criteria	Related to STIs, including HIV (testing, prevention and treatment). Ongoing campaigns, campaigns from the 3-year period prior to the start of the study (2017- February 2020), currently active policy documents. Campaigns and policy from England.
Exclusion Criteria	Focus on contraception, sexual pleasure, consent, sexual wellbeing, relationship and sex education, abortion, cervical screening, funding of services and clinic appointments, pre-exposure and post-exposure prophylaxis. Campaigns or policy from Scotland, Wales or Northern Ireland.

Table 1: *Inclusion and exclusion criteria*

The analysis of the data was conducted using the 'framework' method outlined by Ritchie and Spencer: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation. (34–37) The thematic framework was developed from a priori and from emerging themes. It was edited during the indexing and charting phases to be more representative of the data. Further details on this process can be found in Appendix B. The thematic framework was mapped as shown in Figure 3.

RESULTS

47 materials were included in the analysis. These consisted of 5 policy documents, 11 posters, 11 leaflets and 20 online articles. A total of 9 frames were identified, defined in Table 2. The frequency of each frame in the data is illustrated in Figure 2.

Two key overarching themes emerged from the analysis of the frames: the over-representation of the penis and the under-representation of WSW and their relevant sexual practices. These themes are mapped in Figure 3.

DISCUSSION

Over-representation of the penis

One key theme that emerged in the analysis was androcentrism. Androcentrism refers to the positioning of male experiences and male bodies at the centre of a world view; at the expense of female, transgender, and non-binary bodies and experiences. (38) In this context, androcentrism was apparent through condom- and penis-centric discourse.

The most frequent frames in the data were 'condoms as universal', followed by 'anyone as susceptible to STIs'. It is hard to know whether WSW would consider themselves included in this latter frame. Although quite broad, surely encompassing WSW, it was also regularly accompanied with sentences like 'after unprotected sex', where unprotected sex was defined as sex without a condom. For example, "Safer sex involves using condoms correctly every time you have sex" (A06) and "Sex without using a condom is called unprotected sex" (A25). Therefore, the 'anyone as susceptible' message may have been overshadowed by the framing of 'condoms as universal'.

Condoms can be used by WSW when having sex with women. They can be cut and used as a dam (also known as 'dental dams', i.e. thin pieces of latex or polyurethane that act as a barrier between the mouth and the vulva/anus) or used on fingers and sex toys. This is included in the 'condoms as useful for WSW' frame. Unfortunately, this frame was only present in 9 of the 42 (21.4%) campaign documents, and never alongside the 'anyone as susceptible to STIs' frame. This suggests an assumption that only people with penises should use condoms.

Furthermore, in the 'oral sex as posing a risk of STI transmission' frame, oral sex was sometimes framed as a risk that could be reduced by using a condom (A24, A27, A40). In the absence of information that a condom could be used as a dam, this provides an additional assumption that oral sex must be performed on a penis.

The presence of condom-centric discourse combined with the absence of information about alternative uses of condoms frames sex as an act that necessitates a penis. It also frames STIs as a risk only present in sex that involves a penis, thereby creating a false assumption that sex between women carries no risk of STI transmission. This alienates WSW and the reality of their sexual practices; and leads to misinformation regarding their risks of STIs. This narrow framing of sex erases the variety of sexual practices that people engage in outside of vaginal/anal/oral penetration with a penis. (39)

Under-representation of WSW and their relevant sexual practices

The focus on condoms and androcentric discourse has left little room for information that is targeted or relevant to WSW. WSW were under-represented in the data. The 'WSW as having specific sexual health needs' frame was present in 12 materials (25.5% of the data), demonstrating that although WSW were included to some degree, they are also excluded from a large proportion of sexual health promotion.

WSW were framed as overlooked (see 'WSW as overlooked in sexual health' frame in Figures 2 and 3). There were two manners in which WSW were framed this way. Firstly, they were ignored in favour of groups perceived as being at 'high-risk' of STI such as MSM, Black and Afro-Caribbean populations, and young heterosexuals. Notably, the two government policy documents analysed (B1 & B2) did not once mention WSW, whereas they extensively discussed these 'high-risk' groups. Secondly, women more broadly and WSW specifically were acknowledged as under-represented in sexual health.

This gap was recognised by two policy documents and one campaign material. The Terrence Higgins Trust's 'Women and HIV' report explored how women are represented in HIV policy and research. The report stated that "all women as a whole are by default assumed to be heterosexual" (B5). The Trust's other report

Table 2
Description of frames with example from the data

Frame	Description of frame with example
Condoms as universal	Condoms portrayed as either the only method of preventing STI transmission, or as the best option. This also included mentions of vaginal/female condoms. *"Safer sex involves using condoms correctly every time you have sex" (A06)*
Anyone as susceptible to STIs	The statement or implication that anyone is at potential risk of contracting and transmitting STIs and the assertion that therefore everyone should get tested for these. *"Anyone who has sex can get an STI, you don't need to have lots of sexual partners. Anyone can get and pass on STIs" (A23)*
Oral sex as posing a risk of STI transmission	Oral sex, either with a penis or on a vulva, positioned as a risky sexual activity that could result in STI transmission. This included mentions of condoms used for oral sex and mentions of dams, as these imply possible STI transmission. *"Yes, you could be at risk of an infection if a partner has licked, kissed or sucked your penis, vulva, vagina or anus." (A07)*
Dams as a safer sex option	Any mention of dams (also referred to as 'dental dams' or as a latex or polyurethane square). *"A dam (sometimes called a dental dam) is a latex or polyurethane (soft plastic) square, about 15cm by 15cm, which you can use to cover the anus or female genitals. It acts as a barrier to help prevent sexually transmitted infections passing from one person to another." (A07)*
Diverse sexual practices as posing a risk of STI transmission	Any mention of diverse sexual practices. Diverse sexual practices were defined as any sexual practice that was not penetrative sex with a penis or oral sex. *"Sharing sex toys has risks, including getting and passing on infections such as chlamydia, syphilis and herpes." (A18)*
WSW as able to reduce STI risk when having sex with women	The implication that there are methods to reduce STI risks between women, such as the use of dams, gloves, or condoms on sex toys. *"You should always clean your sex toys before and after each use […] We recommend always putting a condom on a sex toy and changing the condom between partner(s), and holes, to avoid infection." (A22)*
WSW as having specific sexual health needs	Materials that were targeted to WSW, mentioned WSW as being at risk of STIs or having needs or barriers that might impact their sexual health. *"Lesbians and bisexual women are not immune from sexually transmitted infections (STIs), yet can be complacent about getting tested for them" (A28)*
WSW as overlooked in sexual health	The implication that WSW have an unmet need or are under-represented in sexual health. This included a statement of this, as well as the more subtle framing of WSW as under-represented by either emphasising other groups above WSW (e.g. MSM and young heterosexuals), and simply the absence of WSW in this discourse. *"There are very few sexual health services specifically for lesbians or bisexual women. Partly, this has been due to the epidemiology of HIV among gay and bisexual men, but it also reflects a wider invisibility of the needs of lesbian/ bisexual women in all aspects of health." (A28)*
Condoms as useful for WSW	A statement that condoms can be used by WSW when having sex with women, such as being used as a dam or used on fingers and sex toys. *"You can also make your own dams from condoms, by rolling the condom out, cutting off the tip and the ring, and then along its length to create a rectangle" (A11)*

Figure 2

Frequency of frames in the data (n=47)

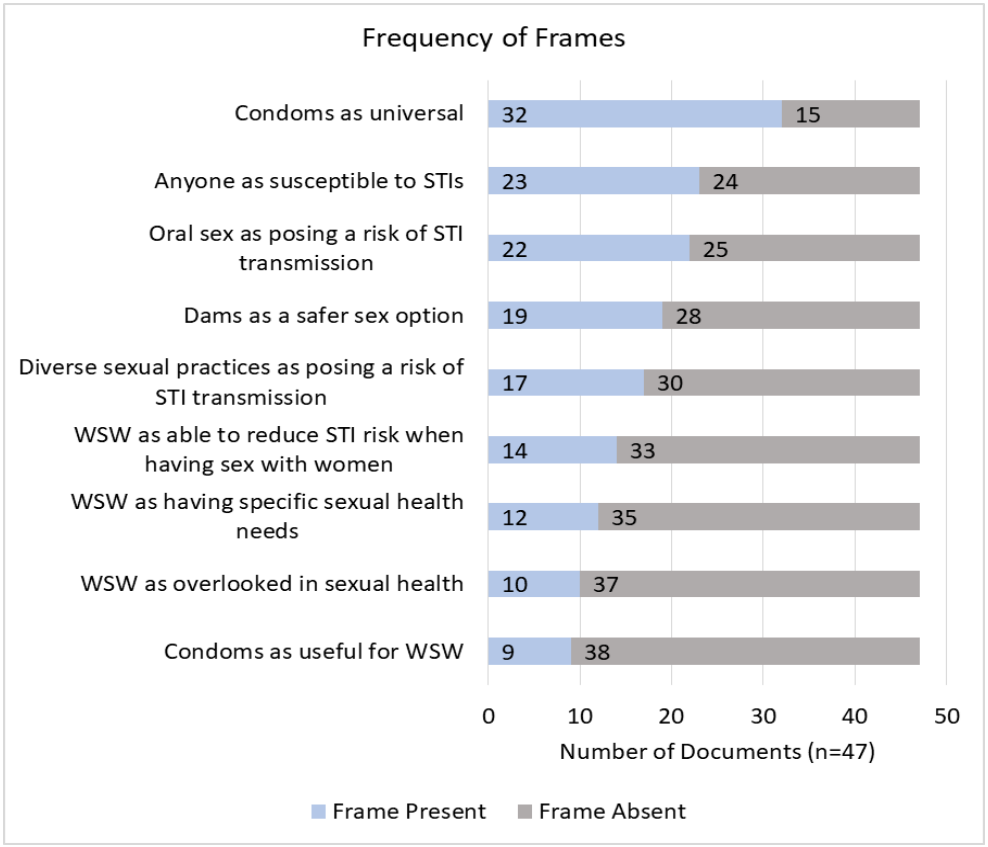
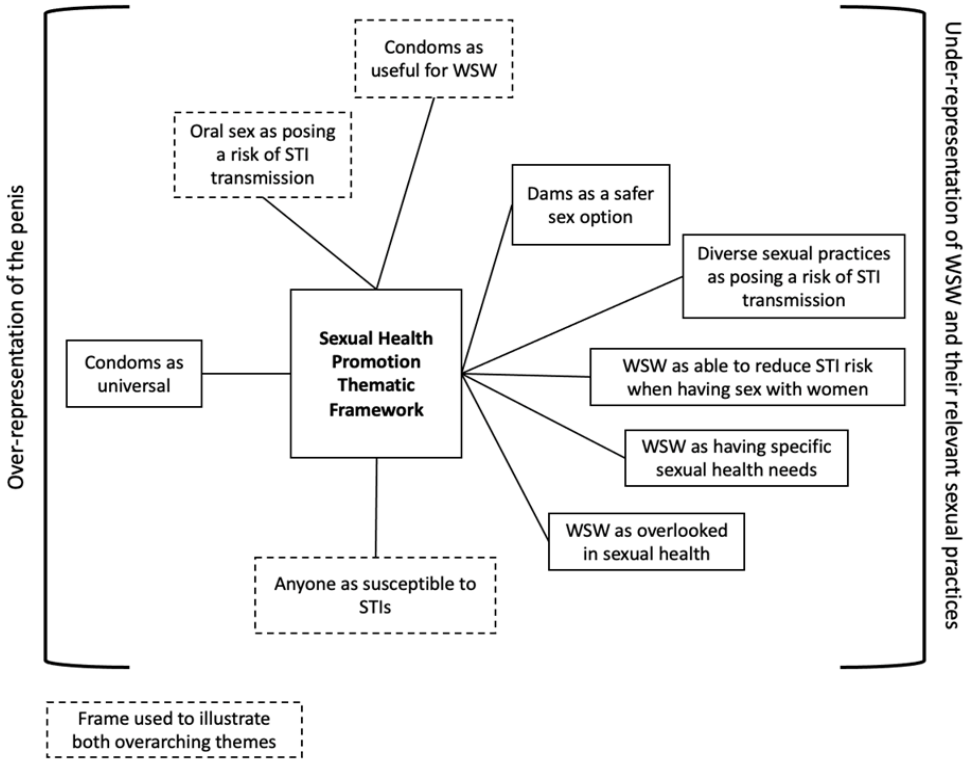


Figure 3

Thematic framework and overarching themes



entitled 'State of Nation' explored the burden and prevalence of STIs in England, and acknowledged the gap in STI data for WSW, going one step further to express that "these gaps highlight the erasure of identities" (B4). Bisexual women stated that the lack of sexual health services for this group "reflects a wider invisibility of the needs of lesbian/bisexual women in all aspects of health" (A28). Women as a whole were framed as under-represented, and a man's perspective was prioritised. The 'State of the Nation' report described a "huge gap" in research on women and STIs and in the 'Women and HIV' report, the Trust stated that "women's voices are not heard, and their experiences and needs are not sufficiently recognised, prioritised and met" (B5). This highlights the double burden that WSW face as both women and non-heterosexual.

Furthermore, sexual practices relevant to WSW were under-represented. WSW engage in both penetrative and non-penetrative sex, most commonly using sex toys and fingers for vaginal and anal penetration, oral sex on the genitals or anus and genital to genital contact. (6,22,25) These are referred to as 'diverse sexual practices', with the exception of oral sex which in this report is discussed separately as it appears more frequently in the data. The frames 'oral sex as posing risk of STI transmission' and 'diverse sexual practices as posing risk of STI transmission' inform us of how practices relevant to WSW are represented. Oral sex was discussed in 22 materials (46.8%); this does not reflect the prevalence of this practice. According to the National Survey of Sexual Attitudes and Lifestyle 3, the prevalence of oral sex on a partner of the opposite sex in a year is as high 80% in 25 to 34 year olds. (39) In addition, diverse practices were present in a relatively small proportion of the data compared to more 'mainstream' practices (oral sex and penetrative sex with a penis). These sexual practices are not unique of WSW and are carried out by heterosexual couples, and the under-representation of these may point towards a lack of interest or awareness of the diversity of sexual practices and as a lack of interest in WSW. (39)

There was a gap in information available for WSW to reduce their STI risks. The frames 'dams as a safer sex option', 'WSW as able to reduce STI risk when having sex with women' and 'condoms as useful for WSW' were often not found in the data (see Figure 2). 'Dams as a safer sex option' was the most frequent of these, but detailed information about the dam was only found in 6 documents. In comparison, the other 13 only mentioned the dam by name. This is significant as dams are infrequently used by WSW due to limited access, not knowing how to use them or how to negotiate their use. (27,30,40,41, 42) These issues could be addressed by providing more information in sexual health promotion.

To summarise, WSW and their relevant sexual practices were not included in the data to the same extent as men and heterosexuals, leading to the erasure of their identities in sexual health promotion.

Erasure of WSW in Sexual Health Promotionp

This study highlights heteronormative and androcentric assumptions of sex in sexual health promotion and supports previous criticism that WSW are not adequately represented in sexual health discourse. (10,11,26,28,43–45)
The justification for under-representing WSW in sexual health promotion has been an epidemiological one. The 'high-risk' groups mentioned above represent a significant burden of STIs, and dominate sexual health discourse. (10,11,26,43,44, 46, 47) Although WSW have lower rates of STIs than MSM and other 'high-risk' groups, they still carry a significant burden. It is estimated that over 1 in 10 women have had sexual contact with other women, a number that is rising over time. (39) WSW also have similar STI rates compared to WSEM, demonstrating that the sexual health needs of this group are not negligible. (12,21–24)

Furthermore, the epidemiological argument ignores the wider systemic impact that heterosexism and sexism have in the lives and health of WSW; the role that invisibility and erasure play in this. Symbolic annihilation is a term that has been used to describe the absence of socially disenfranchised groups from media representation. (45,48,49) Language and representation have the power to shape the social construction of reality, and therefore the representation of WSW in sexual health promotion can shape perceptions of this group. (48,50) The underrepresentation of WSW both constructs false assumptions of low STI risk and symbolically annihilates WSW and their experiences. (28,45,51) The representation of some groups and the erasure of others creates a dichotomy between 'normal' or 'acceptable' and 'abnormal' identities and behaviours. (49,52) The symbolic annihilation of WSW places this group in the latter category, facing social marginalisation and exclusion, while heterosexual identities are presented as desirable. This is a form of symbolic and structural violence that denies legitimacy of this group and socially disempowers them. (53,54)

Symbolic and structural violence are exerted on WSW as a result of heterosexism and patriarchal structures. Heterosexism is used to describe "the cultural ideology that perpetuates sexual stigma by denying and denigrating any nonheterosexual form of behaviour, identity, relationship, or community, "where sexual stigma refers to society's antipathy towards non-heterosexual individuals. (55) In effect, heterosexism is the imbalance of power between heterosexual and non-heterosexual, where non-heterosexual identities are inferior and disempowered. Enforced invisibility of sexual minorities is one of the systems for enacting sexual stigma, and therefore enforcing heterosexism. (55) WSW face a double burden of discrimination due to both their sexuality and gender. They face the additional oppression from sexism, which refers to the subjectively unfavourable and favourable attitudes that enforce gender inequality, patriarchal beliefs and male domination of power and resources. (56) Both heterosexism and sexism stem from the same heteropatriarchal mechanisms of oppression working together to subordinate, disempower and control WSW. (56–60) The result of this oppression is marginalisation, social disenfranchisement, stigma and discrimination, which affect the health of this group, from assumptions of STI risk to experiences within the healthcare system. (13,30,61,62)

Erasure and invisibility are an actively harmful form of violence. The under-representation of WSW in sexual health promotion

as revealed in this study demonstrates a complicity in these heteropatriarchal power structures. In order to address the underlying and systemic inequalities and marginalisation faced by WSW, we must improve and prioritise the representation of this group and directly challenge these power structures.

Patricia Hill Collins proposes a two-step process from erasure to empowerment: to recognise the process of erasure and to create space for new knowledge to be produced. (63) In the context of sexual health promotion, this may constitute directly acknowledging the gaps in sexual health promotion for WSW like in the Terrence Higgins Trust's reports 'State of the Nation' and 'Women and HIV', as well as Sexual Health Sheffield's lesbian and bisexual sexual health leaflet. This should be combined with a participatory approach to developing sexual health campaigns. Listening to the voices of the target audience is imperative to create a destigmatising, inclusive and successful campaign. (64)

An example of good representation is the LGBT Foundation's 'sex guides' that provide sexual health information for vaginal, anal and oral sex (A20, A21 and A22 respectively). These documents outline diverse sexual practices, multiple uses for condoms and include extensive and thorough information on how to reduce risks of STI transmission. This goes beyond the restrictive definitions that equates safe sex with condom use, and in addition is delivered with inclusive and gender-neutral language. The LGBT Foundation has developed these guides working with members of the LGBT community to empower them. (65)

Limitations and future research

This study provides insight into how WSW and their STI risk are represented in sexual health promotion, supporting conclusions from previous studies looking at WSW in sexual health discourse in England. (31) However, it has several limitations. The three-step Google search used for data collection was chosen as it gives a good indication of the materials that are easily accessible and available to the general public. This is particularly pertinent to WSW who may have limited access to sexual health information elsewhere. However, a Google search is not a systematic method of obtaining scientific literature and for this reason does not generate reproducible results. The full list of data analysed was therefore supplied in Appendix A.

A further key limitation of this study was that it does not explore the impact that sexual health campaigns have on peoples' perception of WSW and their STI risk, as well as the relative impact of each campaign. This would be useful to understand in order to contextualise the message of these as it is likely that bigger campaigns, such as Public Health England's Campaign "Protect Against STIs" (A14, A15 and A16) have a greater impact and scope compared to smaller campaigns such as Sexual Health Sheffield's campaigns (A26, A27 and A28).

CONCLUSION

This study demonstrates that developing sexual health promotion for WSW that is inclusive and relevant is both possible and desirable. However, the issue of erasure of WSW goes beyond health promotion and impacts the wider healthcare space. WSW face prejudice in clinics and have lower rates of health-seeking behaviours. (5,7) As such, attempts to tackle the invisibility of WSW should be wide-ranging. As future healthcare workers we must educate ourselves on the erasure of WSW and the social structures that contribute to this. With this knowledge, we can act as advocates for WSW not only in the field of sexual health, but in all health and social care. (66,67)

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APPENDIX A

LIST OF DATA ANALYSED

Number	Material Name	Campaign	Organisation
A01	Condom Flyer	Safe sex and an inclusive sexual health service.	Your Sexual Health Matters
A02	Own the Moment Poster	Safe sex and an inclusive sexual health service.	Your Sexual Health Matters
sA03	Could it Be Chlamydia? poster	Could it be Chlamydia?	Your Sexual Health Matters
A04	Summer Leaflet	Good Time Guide	Your Sexual Health Matters
A05	Freshers Leaflet	Good Time Guide	Your Sexual Health Matters
A06	STIs Overview	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A07	Oral Sex and Sexually Transmitted Infections	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A08	How to Use Condoms	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A09	Sexually Transmitted Infections (STIs) Handout	Relationship and Sex Education Handouts	Brook
A10	Condoms Handout	Relationship and Sex Education Handouts	Brook
A11	Dental Dams webpage	STI Information	Brook
A12	Do I Have an STI? webpage	STI Information	Brook
A13	Six Reasons Why You Should Get Tested webpage	STI Information	Brook
A14	You Can't Always Tell Who's Got an STI poster	Protect Against STIs	Public Health England
A15	You Only Need to Have Unprotected Sex Once poster	Protect Against STIs	Public Health England
A16	Not all STIs Have Symptoms poster	Protect Against STIs	Public Health England
A17	Sexual Health webpage	NHS Live Well	National Health Service (NHS)
A18	Sex Activities and Risk webpage	NHS Live Well	National Health Service (NHS)
A19	Sexual Health for Lesbian and Bisexual Women webpage	NHS Live Well	National Health Service (NHS)
A20	Vaginal Sex	Sex Guides	LGBT Foundation
A21	Oral Sex	Sex Guides	LGBT Foundation
A22	Anal Sex	Sex Guides	LGBT Foundation
A23	Preventing an STI webpage	Let's Talk About It Website	Let's Talk About it
A24	HIV – The Facts webpage	Let's Talk About It Website	Let's Talk About it
A25	Young Person's Advice Guide webpage	Let's Talk About It Website	Let's Talk About it
A26	Preventing STIs webpage	STIs Info and Advice	Sexual Health Sheffield
A27	Getting Checked for STIs webpage	STIs Info and Advice	Sexual Health Sheffield
A28	Sexual Health for Lesbian and Bisexual Women	STIs Info and Advice	Sexual Health Sheffield
A29	Get It On Condom Card Scheme webpage	Get It On	Let's Talk About It
A30	What is a C-Card?	Young & Free	Terrence Higgins Trust
A31	Only 19% of People are Aware image	Can't Pass it On	Terrence Higgins Trust
A32	Charity quote image	Can't Pass it On	Terrence Higgins Trust
A33	Sadiq quote image	Can't Pass it On	Terrence Higgins Trust
A34	Oral Sex webpage	Improving Your Sexual Health	Terrence Higgins Trust
A35	Unprotected Sex webpage	Improving Your Sexual Health	Terrence Higgins Trust
A36	A Healthy Sex Life webpage	Improving Your Sexual Health	Terrence Higgins Trust
A37	I Use a Condom	It Starts with Me	HIV Prevention England
A38	When to Test Quiz webpage	It Starts with Me	HIV Prevention England
A39	Give HIV the Finger image	It Start with Me / National HIV Testing Week	HIV Prevention England
A40	HIV & Sexually Transmitted Infections leaflet	Fact Sheets	Avert
A41	HIV Transmission leaflet	Fact Sheets	Avert
A42	HIV and women who have sex with women leaflet	Fact Sheets	Avert
B1	A Framework for Sexual Health Improvement in England	Policy Document	Department of Health and Social Care
B2	Health Promotion for Sexual and Reproductive Health and HIV: Strategic Action Plan, 2016 to 2019	Policy Document	Public Health England
B3	C-Card Distribution Schemes: Why, What and How?	Policy Document	Brook and Public Health England
B4	State of the Nation	Policy Document	Terrence Higgins Trust
B5	Women and HIV: Invisible no Longer	Policy Document	Terrence Higgins Trust

APPENDIX B

STAGES OF DATA ANALYSIS

Familiarisation

I immersed myself in sexual health promotion available online. This gave me insight into recurring themes in these materials so that I could start to develop the thematic framework and enabled me to narrow down and focus my data collection methods.

Identifying a thematic framework

I reviewed the final selection of data, making a note of each theme that was present in each source. I initially wrote down the themes and issues that I knew would be relevant based on previous research and background (a priori issues) and then identified and added themes that emerged when reviewing the data. The themes were all developed with the research question in mind.

Indexing

After reviewing the data again, I cross-referenced each theme against the data to identify whether it was present. If it was, I inputted the relevant textual passage, imagery or data from that material into a Microsoft Excel spreadsheet with any relevant comments so that the passage would still be considered in the context of its source.

Charting

The data from the indexing stage was summarised into tables of themes (the frames) and cases. I included in this step all relevant quotes and imagery from the data from the indexing stage so that I could refer back to it more easily and facilitate interpretation. This allowed me to see the similarities and variation within the frames.

Mapping and Interpretation

This stage was guided by the research question. I explored the relationships between frames and the similarities and differences within and between these to try to understand the meaning, context and assumptions behind how WSW and their STI risk were represented.

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