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Capacity Building Impact of the Foundation Programme in Sexual Health Promotion: A Multiple Stakeholder Perspective

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Foreword

by Dr. Cate Hartigan
Head of Health Protection and Improvement,
Health & Wellbeing Division, HSE

I am very pleased to welcome this report of the evaluation of the *Foundation Programme in Sexual Health Promotion (FPSHP),* a training programme designed and delivered by my colleagues in Health Promotion and Improvement Department, HSE South. Evidence-based service planning and practice are key to progressing sexual health service delivery into the future. *Healthy Ireland* and the forthcoming *National Sexual Health Strategy* set out the importance of applying evidence to inform effective decision-making and resource allocation. An evaluation report such as this is exemplary of good practice in this regard.

I would like to congratulate my colleagues in Health Promotion and Improvement Department, HSE South for developing an effective and popular training programme that meets the needs of a wide range of service providers in the area of sexual health. The findings are very positive and affirm that the FPSHP can build capacity among participants to deliver sexual health promotion in their respective organisations. I would like to thank my colleagues in the Crisis Pregnancy Programme (the Programme) for funding this piece of work and for providing expertise and guidance throughout the process. Collaborative partnerships and investment into research are key strategic goals of the Programme. The Health Promotion and Improvement Department, HSE South and the Programme have a very positive and well-established working relationship and I look forward to further strengthening the productivity from this partnership and partnerships with Health Promotion nationally into the future. I would like to thank the research team in School of Nursing and Midwifery, Trinity College Dublin, led by Professor Agnes Higgins, for carrying-out and delivering a high quality and robust piece of research.

I hope that the findings of the study will be used to inform the work of the
Health Promotion and Improvement Department, HSE South in the delivery of their work and also to inform the development and roll-out of sexual health promotion training nationally under the auspices of the National Sexual Health Strategy.

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Dr. CateHartigan
Head of Health Promotion and Improvement, HSE

Foreword

by Andy Walker

Acting Functional Manager, Health Promotion and Improvement, HSE South

The *Foundation Programme in Sexual Health Promotion* (FPSHP) is the cornerstone of the sexual health capacity-building strategy of the Health Promotion and Improvement Department, HSE South, therefore I am delighted to present this report evaluating its impact on the participants, their organisations and the community at large.

The *FPSHP* has been in operation since 2009 and is the result of collaboration between the sexual health promotion officers to increase the sexual health promotion capacity of health, education and community personnel in the HSE South region. The programme adopts a life-course approach, wherein people are acknowledged as having sexual health needs from the beginning to the end of life and it promotes a holistic and positive concept of sexual/sexuality health.

In the preparatory stage of programme design, a review of the available literature indicated that two of the major blocks to sexual health promotion were the discomfort experienced by various professional groups in addressing the topic and the conscious and unconscious impact of professionals' own attitudes on their practice. Therefore, the primary focus of the *FPSHP* is to normalise the discussion of sexual/sexuality health and to provide a safe space for participants to explore their own attitudes and values with regard to a range of sexual health issues.

From the outset, the 'end-of-course' *FPSHP* evaluations were overwhelmingly positive. However as our aim was to impact on the amount and quality of sexual health promotion carried out in the region, there was a need for an independent evaluation of the longer term effect of the training and the post-training supports, all of which were designed to assist participants to transfer the learning back into their work. The current evaluation was commissioned to fill this gap in our knowledge.

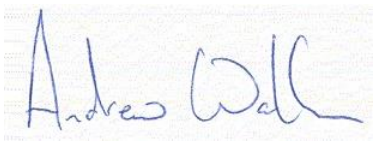
The findings of the evaluation are enormously encouraging. The level of participant and managerial satisfaction with the programme has been reaffirmed, a clearer idea of the impact of the programme on sexual health promotion in the region has been established and the recommendations give us food for thought as to the future direction of the programme.

I would like to thank the authors of the study, from the School of Nursing and Midwifery, Trinity College Dublin, for their excellent work on the evaluation and for their interest in what we are trying to achieve: Agnes Higgins (Professor), Louise Daly (Assistant Professor), Jan de Vries (Assistant Professor), Brian Keogh (Assistant Professor), Edward McCann (Assistant Professor), Danika Sharek (Researcher).

I would also like to thank the HSE Crisis Pregnancy Programme (CPP) for providing financial support. Our particular thanks to Maeve O Brien of the CPP for contributing her research expertise to the tendering process and the review of the final document.

The positive findings outlined in the report are a testament to the considerable hard work and professionalism of the Health Promotion staff who originated, developed and facilitate the *FPSHP*: Moira Germaine, Sharon Parkinson, Catherine Byrne, Maire O Leary and Martin Grogan. I would also like to acknowledge the role of our additional facilitators in the programme's ongoing delivery and development: Mary O Connor, Susan Scully, Catherine O Loughlin and Tracey Tobin. Maire O Leary, who so ably project-managed the commissioning of this report, deserves particular mention and thanks.

Finally, I offer my sincere thanks to all the past participants of the FPSHP, their managers and all the other individuals and organisations who participated in the data collection which made this report possible.



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Andy Walker
Acting Functional Manager, Health Promotion and Improvement, HSE South

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Abbreviations

CPD – Continuous Professional Development

CPP – Crisis Pregnancy Programme

FPSHP – Foundation Programme in Sexual Health Promotion: The subject of this evaluation

HIV – Human Immunodeficiency Virus

HSE – Health Service Executive: Ireland's national health service

NGO – Non-governmental organisation

RSE – Relationship and Sexuality Education Programme: An education programme for young people in Irish schools up to 6th year in post-primary school which aims to provide opportunities for children and young people to learn about relationships and sexuality in ways that help them think and act in a moral, caring and responsible way. The RSE is part of the SPHE (see below).

SPHE – Social, Personal and Health Education Programme: An education programme for young people in Irish schools from Junior infants to third year

STI – Sexually Transmitted Infections

WHO – World Health Organisation

Executive summary

Today, there is widespread agreement that investment in comprehensive sexuality education is critical if as a society we wish to promote sexual health amongst citizens. To this end, in addition to investing in sexual health education, there is an international, national and regional recognition that part of that investment must be in the area of capacity building, which is a key feature of sustainable and effective health promotion. Building capacity increases the range of people, organisations and communities who are able to address health problems, and increases critical problem solving and collaboration within and across organisations, thus multiplying health gains.

Similar to international trends, within Ireland the importance of sexual health promotion has been identified as a priority in a number of policy documents and research reports. In addition, there is a move from an issues-driven focus on unintended pregnancy, crisis pregnancy and sexually transmitted infections to a broader multi-sectoral and multidisciplinary concentration on the determinants of sexual health, other forms of sexual health promotion, and sexual health capacity building. However, despite this, there is a limited knowledge base evaluating the outcomes of education and training for those involved in sexual health promotion for capacity building, within both the national and international literature.

The focus of this report is the evaluation of the Foundation Programme in Sexual Health Promotion (FPSHP). The FPSHP was developed by staff within the southern region of the Irish Health Service Executive (HSE) in response to an identified need for a more comprehensive programme to develop the sexual health promotion capacity of health, education and community workers in this region. The overall aim of the FPSHP is to enhance participants' capacity to incorporate sexual health promotion into their work through the development of their comfort levels, confidence, knowledge and skills in relation to sexual health. The programme is comprised of ten days education, with five, two-day sessions spread over four to five months. Between 2009 and the summer of 2012, when the evaluation process began, 12 programmes had been delivered in three HSE South regions. In total, 200 participants completed the programme, drawn from a variety of health, education and social care backgrounds.

The evaluation study aimed to:

- evaluate the effectiveness of the FPSHP (and its support activities) in building capacity amongst health, education and community professionals with regard to the promotion of sexual health within HSE South; and
- establish whether the FPSHP demonstrated sufficient promise in relation to its contribution to sexual health promotion capacity building to warrant a further feasibility study regarding its extension beyond HSE South.

The main objective of the evaluation was to explore the impact of the programme on sexual health promotion capacity building at individual, organisational and inter-organisational level. The study employed a mixed-method approach, using qualitative and quantitative methods. Data were collected using surveys, focus group interviews, telephone interviews and documentary analysis. To gain an in-depth perspective, data were collected from all the key stakeholders, including past participants, their managers and facilitators of the programme. Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin.

In total, 97 surveys from past participants were returned, representing a 49% response rate. Thirty five managers returned their surveys, representing a 35% response rate. Individual telephone interviews were conducted with 22 past participants, and eight out of the nine programme facilitators participated in one focus group discussion.

Findings showed that all stakeholder groups (participants, managers, and facilitators) were highly satisfied with the aspects of the FPSHP explored in the study, including content, facilitation, and follow-up supports, as well as its impact on the sexual health promotion work of the participants. There was clear evidence that the programme had a positive impact on capacity building at an individual and organisational level, improving past participants' confidence and competence in communicating about sexual matters, and knowledge of the field. The majority of participants (61%; n = 59) who completed the survey reported that they were already engaging in sexual health promotion activities before the programme and 70% (n = 68) did so after they attended the programme. The main impact of the programme, however, was on the expansion and diversity of the activities of the participants. All of the 19 sexual health promotion activities presented to the past participants showed increases after participation, with some activities showing a dramatic increase. Raising awareness (+41%) and providing sexual health education to staff within the organisation (+31%) were activities that seemed to be impacted upon most by participating in the course. Furthermore, significant expansion was reported in: using group settings in sexual health promotion (+23%), developing services within the organisation (+26%), developing written materials on sexual health promotion (+28%), as well as engaging with further education and training (+30%). In terms of capacity building, the findings from the managers and facilitators supported those of the past participants, as they also reported a greater level of impact at the individual and organisational level.

At an inter-organisational level, all of the stakeholders involved (past participants, managers, and facilitators) provided some evidence of capacity building in terms of networking, but concrete examples of collaboration in sexual health promotion activities or exchange of services outside of the organisation that sponsored the participant were rare. While networking is an important aspect of inter-organisational capacity building and it may be too early to assess the long-term outcomes of the programme at this level, the extent of

inter-organisational capacity building was modest in comparison with the considerable impact of the programme on activities at an individual and organisational level.

The follow-up supports and communication (newsletter, email bulletins, library resources, and follow-up days) were seen by all stakeholders as instrumental in generating and nurturing a sustained impact at the individual and organisational levels, with managers particularly welcoming the support and advice they received. The managers, in turn, had supported participation in the programme, which highlights their key role in capacity building and the importance of ongoing communication with them before, during and after the programme.

Although specifically invited, few substantial criticisms were expressed. The exception was related to comments by a small number of participants that: the pace of learning was too slow for those with more advanced knowledge on sexual health, there was an overabundance of experiential learning exercises, and there were challenges in freeing up time for a ten day programme. Similarly, few obstacles to the implementation of the learning were mentioned; the main obstacles being lack of financial support, time, and for some participants, the organisational culture. The main challenge managers anticipated, into the future, was finding the financial and time resources to release staff to attend both the programme and follow-up days.

One of the objectives of the evaluation was to comment on the FPSHP against the landscape of other sexual health promotion training within Ireland. In total, 16 programmes were identified that had elements of sexual health organisational or inter-organisational capacity building as part of their remit. All of the programmes identified were aimed at those working with young people or young people themselves, thus the life course approach evident with the FPSHP was absent. Although a number of programmes included specific capacity building skills, such as a focus on participants' facilitation and teaching skills, the breadth of capacity building activities that was evident in the FPSHP did not appear to be present, such as the focus on organisational policy development and inter-organisational networking.

In establishing the value and significance of the findings of the study, there are a number of strengths and limitations to this evaluation that need to be considered. It needs to be acknowledged that this evaluation is a post design study, with a volunteer sample and not a randomised controlled trial with pre- and post-measures, which is considered the most robust design for evaluation studies. However, the diverse methodology and the inclusion of three groups of stakeholders has made it possible to compare findings from more than one source of data, thus outweighing some of the weaknesses and adding to confidence in the findings.

Overall, the findings from this evaluation demonstrate a positive impact of the FPSHP and its related support activities with regard to its creation of sexual health promotion capacity. Based on the findings, the following recommendations are made:

Expansion of the programme

In view of the positive feedback and capacity building outcomes at individual and organisational levels, it is recommended that:

- the programme in its present form is suitable to be considered for roll out in other areas beyond the HSE South; and
- a strategy is developed that addresses the preparation of facilitators, the provision of supports and other resources, and the concerns of the current facilitators in the event of a roll out elsewhere.

Maintaining the strengths of the FPSHP

- In view of the positive appraisal by participants of the FPSHP content, materials and process, it is recommended that the programme continues to:
  - use teaching methodologies that focus on active learning, reflective practice and application of learning to practice;
  - emphasise the development of participants' facilitation skills;
  - use the interview to ensure that participants are aware of the content and methodologies employed during the programme, the commitment required to achieve the expected outcomes in terms of capacity building and their organisation's sexual health promotion goals prior to coming on the programme;
  - provide follow-up days with content responding to recommendations of past participants, organisational contacts and emergent concerns in the field, while exploring ways of increasing uptake;
  - provide the ongoing supports (email contact and resource library), while exploring ways of increasing the use of the Sexual Health Resource Library;
  - provide participants with resource materials on sexual health promotion;
  - make use of skilful facilitators such as the ones presently involved; and
  - remain in contact with participants after the programme has been completed.

- In view of feedback and recommendations from participants on ways to improve the programme, the facilitators should consider:
  - amending the term 'foundation' in the name of the programme as it does not fully represent the advanced nature of the programme;
  - adding information (for instance in the newsletter) on funding opportunities available to voluntary or community groups around sexual health promotion; and
  - making available to participants good exemplars of organisational sexual health promotion policies to support participants in the development of such policies.

- In view of the research findings that suggest capacity building at an inter-organisational level could be enhanced, the facilitators should consider:
  - placing greater emphasis within the programme on the importance of building capacity at the inter-organisational level (beyond the level of networking);
  - exploring strategies to enhance collaboration and sharing of resources between individual participants and organisations during and post programme; and
  - developing additional units of study/strategies on inter-organisational capacity building for past participants and others who already have broad sexual health knowledge and experience.

- In recognition of the nature of the subject matter and the emotional demands of the programme on the facilitators, consideration should be given to:
  - providing facilitators with access to a formal system of clinical support or supervision, or peer supervision.

- In view of the feedback from past participants and the increasing challenges managers will face in releasing participants to attend both the programme and follow-up days, consideration needs to be given to:
  - developing creative strategies to address barriers in terms of individual and organisational access to and participation in the FPSHP and follow on courses;
  - diversifying the format of the programme offered to cater to different needs of participants and organisations;
  - developing and evaluating some aspects of the information as online learning resources, while maintaining the focus on process skills. Blended learning may be particularly useful for the follow-up days or other information aspects of the programme; and
  - exploring the feasibility of developing an online forum or other types of networking opportunities for those involved in sexual health promotion regionally and nationally.

Further research and evaluation

In view of the limitations of this evaluation, and the absence of evaluations of similar programmes within the literature, specific consideration should be given to strengthening the current approach to evaluation through:

- the use of robust evaluation methods (pre-post designs and randomised control trails) to study the long-term benefits and outcomes of the programme; and
- the development of research studies to compare the outcomes of different modes of delivery of sexual health promotion education such as face to face versus blended learning.

Chapter 1: Current state of evidence on training and education in the delivery of sexual health promotion

Introduction

The focus of this report is the evaluation of the Foundation Programme in Sexual Health Promotion (FPSHP). Its main emphasis concerns the impact of this programme on sexual health promotion capacity building at individual, organisational and inter-organisational level. To set the evaluation in context, and provide the reader with sufficient information to interpret the findings, this chapter reviews the landscape of sexual health promotion education and training for those involved in delivering sexual health promotion in the context of international and national evidence[1]. To help frame the subsequent issues, the literature on sexuality and sexual health is briefly overviewed at the outset. However, an in-depth exploration of sexuality and sexual health are beyond the scope of this report.

Sexuality and sexual health

Sexuality is an essential component of identity, well-being and quality of life (Crouch, 1999a; Department of Health and Children, 2000a; Layte et al, 2006; Higgins, 2009; Royal College of Physicians in Ireland, 2011). The World Health Organisation (2006, p.5) suggests that sexuality is:

> *'…a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.'*

This definition not only highlights the all-encompassing, dynamic and value laden nature of sexuality, but emphasises the social, cultural, political, legal, moral, spiritual, and

[1] A systematic search of the literature was conducted that aimed to identify: i) what is currently known about education and training for those who provide sexual health promotion; and ii) identify published reports of evaluations of staff education and training programmes on sexual health promotion. Searches were carried out in CINAHL, EMBASE, Web of Science, Pubmed, Google Scholar, Scopus and the Social Sciences Index, and the reference lists of retrieved materials were also searched. Due to the limited literature available, no date restrictions were imposed. The following keywords and terms were used to source literature written in English: sexual health promotion; staff; training; education; capacity; evaluation; and various combinations thereof. Both free text and thesaurus searches were conducted depending on the particular database being searched. Extensive efforts were made to identify relevant grey literature on the subject matter. This involved: the retrieval of sexual health promotion strategies; searching relevant government and organisational websites; and contacting Irish organisations known to provide sexual health promotion training.

psychological issues and variations that need to be taken into account in sexual health promotion (Irwin, 1997; Scottish Executive, 2005; Layte et al, 2006; World Health Organisation, 2006; Department of Health Social Services and Public Safety, 2008). Due to its often sensitive and emotive nature, education around sexuality can pose challenges for professionals and there can be a reluctance to address sexuality and sexual health issues in practice for various reasons, including lack of knowledge and skills, conservative attitudes, feelings of anxiety and discomfort, and the culture of practice which tends to deemphasise or even ignore sexuality (Higgins et al, 2008; Higgins, 2009; McCann, 2010). In Ireland, for example, sexual attitudes have been reported as more conservative in comparison to other Western European jurisdictions even though some positive change has been demonstrated in recent times (Layte et al, 2006).

Definitions of sexual health are many and the term can be understood differently by various professional groups (Bloxham, 1997; Sandfort and Ehrhardt, 2004). To provide clarity and bring consensus, a working definition of sexual health was proposed by the World Health Organisation. The definition states that sexual health is:

> *'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' (World Health Organisation, 2006, p.5).*

This definition is viewed as particularly useful because it defines sexual health in terms of its physical, emotional and social aspects, as well as being affirmative (Sandfort and Ehrhardt, 2004). Not only does it emphasise sexual well-being and the discourse of pleasure, but it also highlights that sexual health is more than reproductive health or the absence of disease. The definition also underscores the way in which sexual health and well-being are increasingly perceived as rights that are influenced by numerous determinants. These include sexual and gender identity, sexual expression, relationships and pleasure, as well as negative consequences or conditions, such as lack of education, violence, poverty, and discrminatory practices of others (World Health Organisation, 2010).

Sexual health promotion

Sexual health promotion is defined as:

> *'Any activity which proactively and positively supports the sexual and emotional health and well-being of individuals, groups, communities and the wider public and reduces the risk of HIV transmission' (Department of Health UK, 2003, p.8).*

Sexual health promotion is a global concern and the public health value of sexual health promotion is internationally recognised (Matthews and Fletcher, 2001; World Health Organisation, 2004; Department of Health and Science and Bioethics/Sexual Health, 2009). Coleman (2002) pinpoints the impetus for this increased focus on sexual health promotion to: the global sexual revolution; emergence of multiple sexual health problems leading to increased societal burden in terms of financial, social and physical and psychological morbidities; and the public health imperative. This in turn has led to a growing demand for improvements in sexual health education and services (Kong et al, 2009) and rising pressure on health ministries to invest in the development of sound sexual health promotion approaches. Similarly from an Irish perspective, Layte et al (2006, p.283) in concluding their research identify "sound understanding of the biological, interpersonal and emotional dimensions of sexual relationships [as] a pre-requisite to good sexual health".

Thompson et al. (2008) suggest that sexual health promotion incorporates activities which aim to serve a number of functions, including promoting positive sexual health, decreasing sexually transmitted infections, reducing unintended pregnancies, raising awareness, promoting sex and relationship education, and reducing prejudice, stigma and discrimination. According to the World Health Organisation (2010, p.iv)

> *'…the ability of men and women to achieve sexual health and well-being depends on their access to comprehensive information about sexuality, knowledge about the risks they face, their vulnerability to the adverse consequences of sexual activity, their access to good-quality sexual health care, and an environment that affirms and promotes sexual health.'*

Historically, sexual health promotion as a priority issue related to reproductive health and sexually transmitted infections, with a more recent emphasis on sexual abuse and violence. These issues, in turn, tended to drive policy and related activities. However, an emphasis on the need to acknowledge and improve sexual health in its more holistic and expansive sense is increasingly evident in contemporary sexual health literature (Parker et al, 2009; World Health Organisation, 2010).

Although Ireland does not, as yet, have a national sexual health strategy, from a policy perspective the importance of sexual health promotion has been identified as a priority in a

number of documents and research reports (Appendix I). Similar to International trends, the available Irish evidence suggests a move from a target driven focus, in earlier documents, on unintended pregnancy, crisis pregnancy and sexually transmitted infections (Department of Public Health, Health Services Executive Eastern Region, 2005; Duffy et al, 2011) to a broader multi-sectoral and multidisciplinary concentration on the determinants of sexual health and other forms of sexual health promotion (McKenna et al, 2004). However, despite developments to date, it is recognised that sexual health services in Ireland require continued modernisation and enhancement, and work is on-going in this regard (Department of Public Health, Health Services Executive Eastern Region, 2005).

The range of people, initiatives, services and sectors involved under the umbrella term of sexual health promotion is diverse and expanding. In recognition of this change, the World Health Organisation's (2010) Action Framework to guide the development of sexual health programmes advocates the need for a multisectoral approach to sexual health promotion planning, programming and service delivery that takes into account the need to develop complementary actions that cross the five domains of: law, policy and human rights; society and culture; education; health systems; and economics. In addition, the World Health Organisation (2004) advocates that sexual health promotion is integrated into other health promotion activities and programmes, and targets multiple levels including individuals, groups and communities. In their view, all activities need to be underpinned by the six supportive actions outlined in Table 1.

Table 1. Six underlying key principles of actions to promote sexual health

1. Awareness of the importance of gender and gender-related power dynamics influencing sexual health
2. Recognition of and respect for diversity
3. Promotion of respect for the rights of individuals
4. Participation of all, including the most vulnerable and marginalised in activities to promote sexual health
5. Awareness of the need to address both risk and vulnerability
6. Working with social norms to create an environment that supports sexual health

(World Health Organisation, 2004, p.4)

In addition, there is a growing emphasis placed on a rights-based and life course approach to sexual health promotion (Pan American Health Organisation and World Health Organisation 2000; Higgins, 2009; World Health Organisation, 2010) that encourages healthy behaviour patterns and addresses the negative effects of inadequate sexual health due to social, economic and health inequalities (Ubido et al, 2009; World Association for Sexual Health, 2011). As such, there is also a strong call for sexual health promotion initiatives that redress sexual health inequalities, with particular emphasis being placed on

the need to ensure that vulnerable and marginalised societal groups are targeted. These include: teenagers and the youth sector; older people; people with HIV; ethnic minority groups, migrants, refugees and asylum seekers; people with disabilities; those who are gay, lesbian, bisexual and transgender; mental health service users; (Jolley, 2001; Royal College of Nursing, 2001; Department of Health UK 2003; World Health Organisation, 2004; Scottish Executive, 2005; Collins et al, 2006; Kong et al, 2009); and specfically within the Irish context, the Traveller community (Department of Public Health, Health Services Executive, Eastern Region, 2005). In addition to addressing social, economic and health inequalities, there is further recognition of the need to acknowledge the cultural or religious determinants that affect sexual health and sexual health behaviours (Department of Health Social Services and Public Safety, 2008; World Health Organisation, 2010). Finally, programmes and services need to ensure that they take account of the identified needs of those to whom they are directed and take cognisance of the places and circumstances within which people live (Hicks and Thomas, 2005; World Health Organisation, 2010).

In addition to setting out five core domains for action, the World Health Organisation (2006, p.20) has also outlined a set of core principles for programmes to support sexual health promotion (Table 2).

Table 2. Core principles to support sexual health promotion

1.	Using affirmative and positive approaches to sexuality as opposed to fear, that recognises that people are sexual throughout the life cycle
2.	Promoting autonomy and self-determination in choices about sexual lives
3.	Responding to changing sexual health needs of women and men across the life cycle
4.	Planning and developing services based in a comprehensive understanding of sexuality
5.	Respecting people's rights to confidentiality and privacy, and their right not to feel compelled to share information or have information about them divulged to others
6.	Advocating for the promotion of sexual health and well-being
7.	Respecting cultural diversity and recognising the cultural practices, traditions, beliefs and values that are beneficial and promote sexual health when designing interventions and services
8.	Developing programmes and services that are based on equity and cater to needs of each sex, as opposed to perpetuating stereotypes
9.	Addressing violence, sexual violence and abuse
10.	Developing services and programmes that are based on a non-judgemental approach that respects the values of others
11.	Developing services that are accessible, affordable, confidential, or high quality, and age- and culture-appropriate
12.	The health system to be accountable and responsible for developing and implementing programmes based on the above principles

Education and training for those involved in delivering sexual health promotion

The socially constructed nature of sexuality as 'private', 'sensitive' and 'taboo' makes engaging in sexual health promotion a challenging and sensitive role that demands evidence-based knowledge and skills (World Health Organisation, 2010). At the level of delivery, the literature identifies a number of specific factors needed to support those engaged in sexual health promotion practice (Table 3).

Table 3. Key factors needed to support staff in sexual health promotion work

Specific training, education and continuous professional development
Membership of a community of sexual health promoters – collegiality
National and local policy
Designated resources
Specific competency skill set
Multi-agency working
Management and organisational support

(Royal College of Nursing, 2001; Department of Health UK, 2003; Scottish Executive, 2005)

Sexual health promotion and sexual health services are provided by a wide range of professionals working in statutory and non-governmental organisations across various sectors. Indeed, the current Health Services Executive Crisis Pregnancy Programme strategy (2012, p.7) advocates, as one of its five key objectives, "the development of strategic partnerships and alliances to increase the participation, resources and collective commitment in improving sexual health in Ireland and the reduction of crisis pregnancy". To support sexual health promotion practice and services, health workers, teachers, social workers, youth workers, and other key professionals have been identified as needing sexual health and sexual health promotion education and training (World Health Organisation, 2004). However, there is wide agreement in the literature that sexual health education and practitioner training is insufficient (Irwin, 1997; Jolley, 2001; Collins et al, 2006; McCann et al, 2008; Kong, Wu and Loke, 2009) and that a "good route map" can be lacking for those engaged in sexual health promotion (Department of Health UK, 2003). The World Health Organisation (2004) have specifically identified a need for knowledge, skills and an ability and willingness to address sexual health related issues stating that overall at least one of these pre-requisites is absent in sexual health promoters. For example, primary care health professionals in Northern Ireland have reported delivering sexual health promotion in an ad hoc manner, describing a lack of time to conduct sexual health promotion activities, a lack of proper training to do so, and feelings of embarrassment and discomfort around the area (McCann et al, 2008; Thompson et al, 2008).

The lack of curricular input on sexual health promotion and related skills in many professional programmes has led to calls for the establishment of core sexual health

curricula, continuous curricular review, and on-going development of training materials in this regard (Matthews and Fletcher, 2001; Oye-Adeniran et al, 2004; World Health Organisation, 2006; World Health Organisation, 2010; Royal College of Physicians in Ireland, 2011). In addition, there is also an emergence of organisations and professional bodies identifying core competencies and competency frameworks for practitioners working in the area of sexual health and sexual health promotion (Royal College of Nursing, 2009; Australasian Sexual Health and HIV Nurses Association Incorporated, 2011; Society of Sexual Health Advisers, 2013) and producing toolkits to assist those working in the area of sexual health promotion (Department of Health UK, 2003).

The purpose of sexual health education and training for those involved in delivering health promotion is to facilitate the acquisition of the requisite knowledge, skills, values and competencies to "deliver sensitive and appropriate sexual health advice, education, information, services and support" (Department of Health UK, 2005, p.2). Best practice sexual health education and training should according to the Department of Health, UK (2005) achieve the outcomes identified in Table 4.

Table 4. Principles of best practice in sexual health education and training

Prepare staff to support individuals and groups to manage their own sexual health in ways that are enjoyable, safe and consensual
Develop and promote an understanding of individual and collective rights and responsibilities in relation to sexual health
Play a part in the reduction of inequalities, particularly in relation to sexual health education and sexual health service provision and delivery
Support and promote partnership, multi-agency and multi-disciplinary approaches where appropriate
Highlight evidence-based guidelines and best practice where appropriate
Challenge discrimination, stigma and prejudice. This includes striving to provide equality of opportunity, valuing diversity and creating safe, co-operative, yet challenging training environments in which people can feel motivated and supported to change

(Department of Health UK, 2005, p.3)

It is also suggested that education and training should reduce anxiety and difficulties related to sexual care, advance knowledge, develop self-awareness, challenge discrimination and prejudice, develop understanding of sexual rights and responsibilities, and well as developing tolerance for sexual diversity and its expression (Surgeon General, 2001; Department of Health UK, 2003, 2005; Braeken et al, 2006). Some of the core issues that need to be addressed within programmes include self awareness, exploration of values and attitudes, communication skills, and the provision of information on: sexual orientation, relationships, cultural differences, and the needs of those with a disability (Department of Health Social Services and Public Safety, 2008). Other writers stress the importance of

education and training which emphasises the development of teaching, facilitation and personal development skills to support and build participants confidence and ability to implement sexual health promotion (Ahmed et al, 2006; Murphy-Lawless et al, 2008). (Appendix II presents an overview of suggested education and training content, collated from the literature, necessary for those involved in sexual health promotion).

In terms of the attributes of an effective sexual health educator/promoter, it is suggested that in addition to having evidence based knowledge on sexual health, people who engage in sexual health promotion need to be comfortable with their own sexual identity and have the confidence to discuss sexuality issues in an open and relaxed manner (Allen, 2009; Higgins et al, 2009). In addition, facilitators need an acceptance of sexual thoughts and desires as natural, a comfort with sexual issues, a sense of humour, a non-judgmental and non-moralistic attitude, a tolerance of ambiguity, and an awareness of limitations as educators and sexual health promoters (Minister of Public Works and Government Services Canada, 2003). Within the literature there is general agreement that best practice approaches to developing these skills and attributes involve participatory and active approach to learning underpinned by adult learning philosophy and experiential methodologies (Department of Health, 2005; Ahmed et al, 2006; Mayock et al, 2007). In recognition of the dynamic and emergent nature of evidence in the field, others suggest that education relating to sexual health should also be underpinned by a commitment to life-long learning and continuous professional development (Royal College of Nursing, 2001). Competence assessment has also been suggested for those in the field (Royal College of Physicians in Ireland, 2012). For example, Hicks and Thomas (2005), although writing in relation to the provision of sexual health education for specialist community sexual health services and not sexual health promotion per se, advocate for the conduct of an educational needs analysis and audit of local staff skills as a first step in programme design. The quality of education and training is a pivotal concern, as it is recognised that insufficient quality could result in substandard practices (Zamboni, 2009). Indeed, Ahmed et al (2006), writing in relation to adolescents, suggest that the quality of sexuality and sexual health programmes rests on the quality of their implementation as well as the programme itself. It is suggested that training should also be accredited and suitable for participants work settings, as well as being tailored to the assessed learning needs of participants and their clients (Cooper, 2007; Department of Health Social Services and Public Safety, 2008; Fronek et al, 2011; Royal College of Physicians in Ireland, 2012).

In recognition of the differing education requirements for those involved in sexual health promotion, the Royal College of Nursing (2001) outlined a spectrum of educational opportunities:

- Short study opportunities
- Short certified courses
- Diploma/degree pathways in sexual health
- Advanced specialist studies in aspects of sexual health
- Higher degrees

Mapping the evidence base on education and training in sexual health and sexual health promotion

Despite the plethora of views expressed on the nature and purpose of sexual health promotion education, there is a dearth of published international empirical research exploring the nature and impact of education and training programmes for staff whose remit involves the promotion of sexual health. The picture is similar in Ireland, with the Royal College of Physicians of Ireland (2012) recently stating that there has been no evaluation of curricula in terms of medical sexual health education. The literature that is available tends to evaluate education and training on sexuality and sexual health for health care practitioners and not specifically education and training for those engaged in sexual health promotion (see Appendix II). Evaluation studies of education for health practitioners provide evidence of the effectiveness of uni-disciplinary education in enhancing practitioners' knowledge, skills and comfort in responding to patients' concerns (Walker and Harrington, 2002; Post et al, 2008; Byrne et al, 2006), with some studies highlighting the effectiveness of sexuality training delivered in an inter-professional context (Tepper, 1997; Simpson et al, 2006; Fronek et al, 2011; Higgins et al, 2012).

Walker and Harrington (2002) in the USA, pilot tested a sex and sexuality training programme in a long-term care setting based around four programme modules of which participants attended one or more. Pre and post-test survey evaluations, observation and interviews with instructors demonstrated improved knowledge of, and attitudes towards, sexuality, although this was not consistent across the four modules. The researchers identified the need to revise module content to address this finding. In a later study involving ten HIV clinic nursing staff, Byrne et al (2006) delivered a training package to enable participants, in England, to address the sexual health needs of clients. The training package involved content relating to motivational interviewing, behaviour change and counselling skills and was delivered over one day. Knowledge and confidence in using motivational interviewing and addressing sexual health issues were evaluated at the time of, and six months post, the intervention. The findings demonstrated the greatest increase in knowledge and confidence in using motivational interviewing in the context of sexual health promotion.

In the Netherlands, Post et al (2008) implemented training for rehabilitation professionals (n=283) aiming to improve knowledge, attitudes and enhance comfort with discussing matters relating to sexuality. Training was supported with a 170 page participant reader. Of note, this training was discipline specific and each discipline was trained separately. This approach differs to the inter-disciplinary approach now recommended in the wider literature and used in the programme which this report evaluates. Pre and post-test questionnaires were used at the time of training and 3-4 months following, based on a Dutch adaptation of Kendall et al's (2003) Knowledge, Comfort, Approach and Attitudes towards Sexuality (KCAASS) scale. While self-perceived sexological competence was demonstrated, inter-professional competence was found to differ. More recently, in Australia, Fronek et al (2011) conducted a two year follow-up of a randomised controlled trial to examine the effectiveness of a sexuality training programme for interdisciplinary practitioners in spinal cord injury rehabilitation using the KCAASS scale and a focus group in the service within which training occurred. The findings demonstrated that training did have a prolonged effect on participants' knowledge, comfort and attitudes to addressing issues of sexuality within practice. Similar improvements in knowledge, comfort, approach and attitudes were reported among multidisciplinary practitioners working in neurological rehabilitation in New Zealand by Simpson et al. (2006) following a two day workshop and by Tepper (1997) in the USA following participants' (n=18) attendance at a three day programme.

While the previous research derives mainly from the health and social care perspectives, literature from the education sector also offers some relevant understanding of training for those engaged in sexual health promotion. For example, internationally, Ahmed et al (2006) conducted a process evaluation of a teacher training programme relating to sexuality and AIDS prevention in South Africa. The training intervention involved four full days delivered over two consecutive Fridays and Saturdays followed by two refresher days; one delivered at two months and the other at five months after the initial programme. The purpose of the teacher training was to enable teachers to develop the requisite knowledge and skills to deliver a set 16 lesson curriculum to 14 year olds. The teacher training programme addressed factual information, facilitation skills, self-awareness, values and beliefs relating to sexuality education, as well as aiming to encourage ownership of the curriculum. Open ended questionnaires were distributed before and after the initial four days, as well as after each of the refresher days. These were thematically analysed and participant observation was also used during the delivery of the training. Similar to the findings reported previously, increased confidence and comfort were reported by participants. However, factual knowledge was found to be problematic after the refresher days and participants reported challenges with the translation of sexual reproductive knowledge and facilitation methods into the classroom. The study concluded by contextualising the findings within the cultural situation which the study was located and the researchers recommended the need for on-going support and professional development in the subject areas included in the training.

Wight and Buston (2003) reported on the outcome of an evaluation of the teacher training component of SHARE (Sexual Health and Relationships – Safe, Happy and Responsible), a theoretically grounded behavioural sex education programme for 13 to 15 year olds in Scotland. Participants in this study also found that the training increased their confidence and comfort to deliver sex education and their readiness to deliver the programme. Peer support was again referred to in this study, as participants identified the peer support offered during the programme as a particular benefit. However, the introduction of interactive skills based exercises to classrooms following the programme was the least successful aspect of the training for teachers.

The literature that evaluates education programmes focused on sexual health promotion within Ireland is equally sparse. From an Irish perspective, Higgins et al (2012) explored the provision of sexuality education for 29 staff working with people with an acquired physical disability. Similar to the previous study, education was inter-disciplinary. A one day programme based on the PLISSIT model (P-LI-SS-IT stands for Permission, Limited Information, Specific Suggestions and Intensive Therapy) was provided exploring sexuality as a multi-dimensional concept and how acquired disability impacts on sexuality. A mixed method approach (pre and post-test questionnaires and interviews) was employed to evaluate the outcome of the programme. Statistically significant increases were demonstrated in participant knowledge, skills and attitudes using a questionnaire again derived from the KCASS scale. A shift in participant comfort was identified, although this was not as significant as the other items evaluated. Participants particularly described having a greater awareness of clients' sexual needs. However, as the course was one day long, this limited the depth and breadth of content addressed and the scope for developing significant knowledge in areas relating to specific issues. This finding could suggest the need for longer programmes in order to maximise the opportunity to address related issues and might also facilitate greater outcomes in terms of participant comfort. This is supported by Fronek et al (2011) who hypothesise that the greater amount of exposure to discussion on sexual issues, the more that comfort will increase.

Sex education in Irish schools also remains a challenging issue, and the full implementation of the Relationships and Sexuality Education programme in schools has been slow (Mayock et al., 2007). As part of a wider evaluation of the Relationships and Sexuality Education programme, Mayock et al (2007) explored the barriers and facilitators to its optimum implementation for post-primary school students. In relation to the training of teachers for the introduction of the programme, there were some reports that the extent and coverage of training was comprehensive. However, some participants reported that the amount of time allocated to training was inadequate to meet the programme demands. There were also suggestions that the one-off approach to training and the amount of follow-up support might be inadequate to meet teachers' training needs, again suggesting a need for longer training programmes and ongoing follow-up supports.

In a departure from the studies that focus on health and social care practitioners and teachers, the following study involved 58 women from or in disadvantaged settings. Murphy-Lawless et al (2008) reported on WiSE UP, a pilot programme on sexuality education delivered by the Irish Family Planning Association. The objectives of the programme included improving women's access to sexual health education, training and employment and increasing their capacity to engage in sexual health decision-making with relevant statutory and non-statutory organisations. The programme addressed a variety of subjects, including sexually transmitted infections, sexual health services, prejudices and myths about sexuality, minority groups, and the relationship between alcohol, drug use and sexual health. Participants also explored the values that influence sex and sexuality and acquired strategies to "challenge these and manage difficult situations in sex education" (p.6). A particular strength was that the programme supported the development of teaching, facilitation and personal skills so participants could act as educational resources within their families and local communities. A mixed method approach (questionnaire, individual and focus group interviews with participants, attendance at training sessions and presentation days and interviews with staff members) was employed to evaluate the programme. The study found that the women reported an increased knowledge base and enhanced confidence, personal development and related skills. Participants also felt that access to the course should be available to more individuals from within their communities.

In conclusion, there is limited evidence of evaluations of education and training programmes that focus on building capacity in sexual health promotion at both an International and National level, a point highlighted by other writers as an issue of some concern (Department of Health UK, 2003; Department of Public Health HSE Eastern Region, 2005; Wight and Buston, 2003). Despite considerable variability in the contexts, length, content and evaluation of programmes, which limits the ability to compare findings, what is available provides preliminary evidence that education and training programmes improve participants' knowledge, confidence and competence. However, it cannot be assumed that the findings are directly related to sexual health promotion training specifically, and the question of how participants use their new found knowledge and skills within practice to promote sexual health remains unanswered.

Mapping the literature on sexual health education in the context of building of capacity to engage in sexual health promotion

Within Ireland, the Department of Health and Children have stated a national and regional commitment to building the capacity of a health promotion workforce (McKenna et al, 2004). Capacity building has been defined as "an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over" (Hawe et al, 1999, cited by New South Wales Health Department, 2001, p.i). According to the New South Wales Health Department (2001, p.1), "Building capacity to improve

health is an important element of effective health promotion practice", as it increases the range of people, organisations and communities who are able to address health problems, and increases critical problem solving and collaboration within and across organisations, thus multiplying health gains many times over, which is particularly important in times of limited resources (Hawe et al, 1997).

While the focus of capacity building is on sustainability and sustained change, to be effective capacity building needs to work at a number of levels. Crisp et al. (2000) outline four main approaches to or levels of capacity building, including the bottom-up organisational approach, top-down organisational approach, partnerships approach, and community organising approach. Within the bottom-up approach the focus is on the importance of the expertise of individuals and on providing training at the level of the individual. The knowledge and skills required will not just benefit the individual but the organisation and community. The top-down organisational approach focuses on changing the policies and practices at the organisational level, including providing training programmes, restructuring the organisation, developing quality assurance mechanisms, and appropriately organising resources. Both of these approaches are focused within the organisation. The third, the partnership approach involves improving the relationships between organisations. In this approach, the focus is on strengthening the relationships between organisations so that they can work together to address common health challenges and goals. This approach emphasises moving away from 'silo' behaviour and thinking, whereby organisations work on similar problems but in isolation to each other. Described as the most 'ambitious' approach, the community organisation approach aims to empower community members to move beyond passive recipients of health care service and become active participants in community change and development. The underlying belief of this approach is that the most successful healthcare promotion programmes are those which are developed by community members. However, it must be acknowledged that change at one level or approach will no doubt impact on all levels. Other writers support the use of levels of capacity building, for example, Hawe et al (1997) identifies three levels: firstly, building health infrastructure, services, resources and skills within the organisation; secondly, delivering programme change through a network of organisations; and thirdly, developing problem-solving capability of organisations and communities.

In terms of capacity building, the literature explored in the previous section tends to focus on capacity building from a bottom-up organisational approach (Crisp et al 2000) or at the level of building services, resources and skills within the organisation (Hawe et al 1997). Clearly, to be effective, workforce and training capacity building is a pre-requisite for building a critical mass of practitioners and advancing sexual health promotion practice (Department of Health UK, 2005; World Health Organisation, 2010). However, in terms of a capacity building strategy, education and training of the individual is only one of a number

of necessary approaches to the building, maintenance and sustainability of sexual health promotion.

Summary

- There is a global impetus for action in the area of sexual health promotion that acknowledges a whole person approach and addresses the personal, social, emotional and spiritual, as well as the physical aspects of sexuality.
- Sexual health promotion should be underpinned by national level strategic direction, a co-ordinated interagency approach with an explicit values set, strong leadership and educational preparation, including inter-professional education and training.
- Sexual health promotion capacity building needs to take place at a number of levels, including individual, organisational and inter-organisational.
- The range of people, initiatives, services and sectors involved under the umbrella term of sexual health promotion is diverse and expanding.
- There is a limited knowledge base evaluating the outcomes of education and training for those involved in sexual health promotion for capacity building at an international and national level.

Chapter 2: Evaluation methodology

Introduction

In this chapter, the details of the research methodology employed in this evaluation are described, including participant recruitment, data collection, and data analysis strategies. This is followed by an overview of the demographic profile of the sample.

Foundation Programme in Sexual Health Promotion programme design

Although the HSE South had a history of delivering short sexual health courses, the Foundation Programme in Sexual Health Promotion (FPSHP) was developed in response to the need for a more comprehensive programme to develop the sexual health promotion capacity of health, education and community workers. This programme is now delivered in three HSE South regions annually, including Waterford and Clonmel (the southeast), Kerry, and Cork. The programme that was evaluated comprised of ten days education, with five, two-day sessions spread over four to five months. The programme has accreditation from Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 60 credits of CPD, the Irish Association of Social Workers for 20 credits of CPD, and the Irish Association of Counselling and Psychotherapy for 70 hours of CPD. At present, the HSE Health Promotion and Improvement Department does not charge a course fee, however participants and their organisations cover travel and subsistence costs.

Aims and learning outcomes of the programme as described in the documentation

The overall aim of the FPSHP is to enhance participants' capacity to incorporate sexual health promotion into their work, through the development of their comfort levels, confidence, knowledge and skills in relation to sexual health.

The learning outcomes described within the programme documentation were as follows. To provide participants with the opportunity to:

- increase their knowledge around sexual health issues;
- increase their comfort levels to address sexual health issues;
- increase their understanding of sexual health in an Irish context;
- understand how their sexual socialisation impacts on their values and attitudes to sex;
- be aware that people are sexual beings through their life cycle;
- develop skills to facilitate workshops on sexual health topics; and
- understand the need for organisational sexual health policy development.

The programme content of the ten days is outlined in Table 5.

Table 5. Overview of content

Introduction to the programme
Sexual health promotion in the Irish context
Sexual health: A life course approach
Physical sexual health (contraception and Sexually Transmitted Infections)
Self-esteem and sexual health
Sex, society and culture
Irish law and sexual health
Power and sex
Policy development
Facilitation skills

Throughout the programme, there is an emphasis on personal development and awareness of the participant's own values and beliefs about sexuality and sexual health. Consequently, the curriculum design favoured an experiential approach with teaching methods that focus on process-orientated outcomes. In line with the programme's strategy of capacity building, other elements such as a library service, follow-up days, email updates, a bi-annual newsletter and ongoing support from the facilitators were implemented to support the participants following completion of the course. A full description of the Foundation Programme in Sexual Health Promotion provided by the facilitators is located in Appendix IV.

Evaluation study objectives

The objectives of the evaluation study reported here were:

- to evaluate the impact of the FPSHP (and support activities) with regard to its creation of sexual health promotion capacity within individual participants and their organisation;
- to assess the FPSHP's approach with regard to sexual health training as a capacity building measure;
- to complete an overview of sexual health promotion training within Ireland and to comment on the FPSHP against this landscape;
- to make recommendations regarding potential future directions within HSE South with regard to sexual health training as an element of capacity building; and
- to draw a conclusion as to whether the FPSHP showed sufficient promise to warrant the feasibility study with regard to its expansion beyond the HSE South.

Research design

The study employed a mixed-method approach, using qualitative and quantitative methods. Mixed method research is defined as the use of two or more research methods within a single study (Creswell and Plano Clark, 2011). As described below, the varied methods of data collection allowed for different aspects of the research aim and objectives to be examined. Data was collected using surveys, focus group interviews, telephone interviews, and documentary analysis.

Data collection instruments

To meet the objectives of the study, two survey instruments were designed by the Trinity College research team to evaluate the programme from the perspectives of the participants and managers. Telephone interviews were conducted with a sample of the programme participants and a focus group was convened to elicit the views of the FPSHP facilitators. In addition, curriculum and other documentation were analysed and a scoping of similar sexual health promotion education provision within Ireland was conducted.

Past participant surveys

A 37 item survey was designed to capture the perspectives of past participants on the programme. The survey focused on: participants' knowledge, confidence, comfort; problem solving; application and integration of the programme content into sexual health promotion practice; barriers and enablers to its application; and ratings of programme supports (e.g. newsletter, library, and resources within participants' organisations). The survey was designed for easy completion, taking approximately 15 minutes to complete, and was divided into five sections:

- Section A: Biographical information
- Section B: Experience of the impact of the programme on knowledge, skills, comfort and confidence
- Section C: Impact of the programme on capacity building activities (individual, organisational and inter-organisational level)
- Section D: Sustainability of the impact of the programme (factors that facilitated and hindered application and sustainability)
- Section E: Overall views on the content of programme

Most of the questions required a response on a Likert scale. In addition, several open-ended questions were included to allow participants to describe their perspectives in their own words. Most importantly, participants were asked to provide examples of opportunities provided and taken to build capacity at several levels, including within their own practice (changing own and colleagues' practice), within their own organisation (e.g. change in policy and priorities), and within the wider community (enhanced relationships between

organisations). In addition, participants were asked to make recommendations for improvements of the programme.

Manager survey

A 21 item survey was designed to capture managers' perspectives on issues, such as overall views of programme, impact of the programme on the organisation and work practices, resources and supports, and factors influencing future decisions to release staff to attend programmes. Again, it was designed for easy completion, taking approximately 15 minutes to complete.

The survey was divided into 4 sections:

- Section A: General information
- Section B: Impact of the programme on your organisation
- Section C: Organisational resources and support
- Section D: Sustainability and looking ahead

As with the past participant survey, most of the questions required a response on a Likert scale. In addition, several open-ended questions were included to allow the managers to describe their expectations for the programme and whether these were met. They were also asked to provide examples of changes in practice of the staff members who they released onto the programme, as well as any changes within the organisation or between other organisations. Finally, participants were asked for any suggestions for changing or improving the programme and its supports.

Past participant interviews

Interviews were conducted with a sample of past participants of the programme in order to learn about their experiences and the impacts, benefits and challenges encountered in using the knowledge and skills gained to build capacity within their own practice, within their organisation and within the wider community. All interviews were semi-structured and guided by an interview schedule, which was developed by the research team and informed by the available literature. Given the short timeframe, the interviews were conducted as telephone interviews and lasted between 15 and 30 minutes.

Facilitators' focus group interview

The aim of the focus group with the facilitators was to learn about their aspirations for the FPSHP in terms of capacity building, to explore their experiences of facilitating training and to gather their views on sustainability and future expansion of the programme. The focus group was semi-structured in nature, utilised a topic guide developed by the researchers, and lasted just over two hours. The topic guide was used in a flexible manner to enable facilitators to convey their perspective, whilst simultaneously addressing the study purpose.

Documentary analysis

A number of documents were collected from the facilitators, including outlines of the programme and relevant Microsoft Powerpoint presentations. These were analysed to formulate a background understanding of information pertaining to structure, content and processes involved in the programme.

Scoping of sexual health promotion capacity building education in Ireland

In order to learn more about the landscape of sexual health promotion programmes for those involved in sexual health promotion in Ireland, local and national organisations were contacted to request information about whether they had any training for trainers available within this remit. In addition, websites of organisations involved in sexual health were examined for documents on sexual health promotion training programmes and their evaluation. By their nature, all training and education, irrespective of focus, duration or academic level, are aimed at building capacity at the individual level. For the purpose of the scoping exercise for this study, the researchers chose to include only programmes which were aimed at the higher levels of capacity building: organisational and inter-organisational.

Sample

All past participants, facilitators and managers were eligible to participate in this study. The sample was drawn from those participants and managers that the FPSHP facilitators, who acted as gatekeepers, had contact addresses or emails for. This excluded some potential participants for whom up to date contact information was not available.

Recruitment and survey distribution

Survey distribution

Both the past participant survey and manager survey were distributed in the same way. They were available for completion both online and via hard copy. Hard copy survey packs containing an introduction letter, information sheet and copy of the survey were sent to the HSE facilitators who acted as gatekeepers and forwarded on the survey packs to the past participants and the managers who released participants for the programme. The introduction letter also contained a link to the online version of the survey. In addition, the facilitator gatekeepers sent email links of the survey to past participants and to managers for whom they had email addresses in order to facilitate those who wished to complete the survey online.

Telephone interviews

In order to recruit past participants for the telephone interviews, participants were asked at the end of the survey to indicate by signing an opt-in form if they were willing to participate in an interview. If participants indicated their wish to take part in the interview, they were asked to return the form online or by post. All participants who opted in to complete an interview before January 21st 2013 were contacted about participation and asked about

whether they preferred to participate in an in-person or telephone interview. Each interview was digitally audio-recorded. Those who opted in to be interviewed after the deadline were contacted, thanked for their participation in the survey and their interest in the interview, and were told they would be contacted at a later date should the need for more interview participants arise.

Focus group interview

The project facilitators were aware of the evaluation from the outset and had agreed in principle to participate in a focus group. However, to recruit them to the focus group, they were all sent an electronic introduction letter and information sheet inviting them to participate and giving them an option not to participate. If they were willing to participate they were asked to indicate their intent by emailing written consent to the research team.

Data analysis

Quantitative data

Statistical analysis of participants' responses to the survey was performed using the Statistical Package for the Social Sciences (SPSS), version 20 (IBM Corp, 2011). Frequency distributions and descriptive statistics were generated to document participants' scores on each measure to establish the extent to which key objectives of the project had been achieved. Inferential statistics (ANOVA and Multiple Regression Analysis) were used in order to establish the relationships between the perceived sustained impact of the programme and the other variables in the evaluation, including demographic variables. This was done to determine the core factors in predicting capacity building around sexual health promotion following participation in the programme.

Qualitative data

An independent transcriber transcribed the interview data and a conventional thematic analysis was used to analyse the qualitative data from the telephone interviews and focus group. For the telephone interviews, data analysis began by reading each transcript several times to achieve immersion. Text that described participants' experiences and perceptions was noted (open coding). Following open coding of six transcripts by two researchers, a coding guide of preliminary codes was developed by each researcher. These were compared and a final coding framework agreed which was used to guide the coding of the remaining transcripts. New emergent codes were incorporated into the framework as analysis proceeded. Once all of the data was coded, each code was examined and overlapping codes collapsed to form larger more inclusive categories. This process also made explicit the links between themes, enabling a hierarchical structure to emerge, showing themes and their subthemes. A similar process of analysis was used for the facilitator focus group interview with two researchers independently coding the transcript and coming together to compare and agree meaning of codes before the final analysis and write up. The computer software package, NVivo 8, was used to assist in the organisation, management and retrieval of the

qualitative data (QSR International, 2009). Open-ended questions from the participant and manager survey were analysed using a similar process and coding framework and both sets of data were then merged.

Ethical considerations

Ethical approval was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. All those involved with the study were bound by national and international codes of good practice in research and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. Informed consent was viewed as an ongoing process which required negotiation throughout all aspects of the study. An information sheet outlining the aims and objectives of the study was sent to all potential participants. The voluntary nature of participation was emphasised throughout the data collection process and participants were free to withdraw from the study at any time without fear of penalty. Return of the survey was taken as evidence of implied consent. As the survey was anonymous, no identifying information was requested; however, when this did occur, any identifying information was removed prior to analysis. Both written and verbal consent were obtained before the interviews. All identifying information was removed from the qualitative data and interview participants (individual interviews and focus group) were assigned a code number.

Demographic profile of participants who participated in the FPSHP

Profile of survey participants who completed the programme

Since 2009, 12 courses have been run between Cork, Kerry, Waterford and Clonmel. In total, 200 participants completed the course. Analyses of completion rates suggest they were very high with 93% of those starting the programme going on to complete it. However, due to the absence of contact details only 197 surveys were distributed to past participants from the programme and 97 were returned, representing a 49% response rate (Table 6). The vast majority of participants were female (92%), with only a small percentage of males (8%). The age range was between 25 and 59 years, with the mean age being 42 years (SD = 9.05).

Table 6. Response rates for past participant survey by location

Location	Participants starting programme	Participants completing programme	Completion rates	Surveys Sent	Surveys returned	Response rate	% of sample (n=97)
Kerry	73	69	95%	68	**30**	44%	31%
Waterford	73	71	97%	66	**38**	58%	39%
Clonmel	18	16	89%	16	**10**	63%	10%
Cork	51	44	86%	47	**19**	40%	20%
Total	**215**	**200**	**93%**	**197**	**97**	**49%**	**100%**

Nearly half of the participants worked in health (46%; n = 45), and one-third with youth (34%; n = 33) or within community services (32%; n = 31). Just over one-quarter were involved in education (26%; n = 25) and a smaller percentage worked in disability services (11%; n = 11). Other areas (15%; n = 15) participants reported working in were child protection, counselling, psychotherapy, family support, intellectual disability nursing, HIV support, residential care, rape crisis, sexual health, social work, substance misuse, and voluntary work.

Analysis of participants who returned the survey against the overall population of people who completed the FPSHP indicated that they were representative in terms of gender, location and year of attendance, with oversampling among participants who attended the follow-up training days. However, having taken part in follow-up training was not a significant factor in how satisfied participants were with the course and or how they perceived its impact (see Appendices XI and XII for further details).

Previous and current sexual health promotion activities

The majority of participants (61%, n = 59) who completed the survey reported engaging in sexual health promotion activities before the programme and 70% (n = 68) did so after they attended the programme. Twenty-five people indicated that they started their activities after attending the programme, 16 participants ceased their sexual health promotion activities since attending, and 43 participants were involved both before and after. Just over half of the participants (52%, n = 50) were still engaged in sexual health promotion activities at the time of the survey. Just 5 participants reported no engagement with sexual health promotion activities at any time. Table 7 provides further details.

More than 80% (n = 79) of the sample was involved in sexual health promotion solely as part of their job and 3% (n = 3) solely as part of their volunteer activities, with 9% reporting they were involved in sexual health promotion activities in both. People reported other areas of involvement, including education, fertility counsellor, student counsellor, sexual health centres, research, rape crisis, and working with young people.

Table 7. Engagement of past participants with sexual health promotion activities

Time of engagement in sexual health promotion activities* (n = 97)	
Before I attended the programme	61% (59)
During the period I attended	52% (50)
After I attended the programme	70% (68)
At present	52% (50)
Capacity in which engaged in sexual health promotion activities* (n = 97)	
As part of my job	81% (79)
As part of my volunteer activities	3% (3)
Multiple or other areas of involvement	16% (15)

Profile of interview past participants

Twenty seven past participants opted to take part in the telephone interviews by the closing date and 22 interviews were completed. Five people who completed the opt-in form did not participate due to a variety of reasons, including inability of the team to contact the person by phone or the person was unable to identify a suitable date or time before the cut off point for completion of interviews. Of the 22 participants who completed the telephone interviews, 4 were male and 18 were female. Their average age was 43.6 years, with a range from 28 to 59 years. Participants had completed the programme in all fours areas, including Waterford (n = 8), Kerry (n = 6), Cork (n = 6), and Clonmel (n = 2). Participants had completed the programme in the previous four years, including 2009 (n = 2), 2010 (n = 9), 2011 (n = 2), and 2012 (n = 6)[2]. The telephone interview participants were asked where they worked from a list of 5 possible responses. While the majority worked in health, many gave more than one response to describe their professional activities (e.g. health and disability). Details of the interview participants' work sector are provided in Table 8.

Table 8.Telephone interview participants' work sector

Work Sector	Response 1	Response 2	Response 3
Health	12	-	
Education	2	5	2
Youth	2	7	
Community	6	-	4
Disability	-	2	
Other	-	-	
Total	22	14	6

Profile of managers

In total, 101 surveys were sent to managers and 35 were returned, representing a 35% response rate. Managers worked in a variety of areas, including community, health, youth, disability, and education. Other areas of work described by participants included counselling, domestic violence, humanitarian NGO, psychotherapy, and sexual health services. Most (76%, n = 26) were currently the direct line manager to the staff they released and were also the direct line manager at the time of releasing staff onto the programme (73%, n = 25). The managers (n = 29) reported having sponsored up to four staff to attend the programme, with most having sponsored either one (59%, n = 17) or two (24%, n = 7) staff members. However, one manager did indicate that the staff within that organisation did the programme '*on own time and using own money*', as opposed to being given time by the organisation to attend.

[2] Two participants could not remember the exact year when they did they programme. Data was missing for one participant.

Profile of FPSHP facilitators

In total, eight out of the nine programme facilitators participated in the focus group which represented 89% of the facilitators involved. Of these, all of the participants were between the ages of 32 and 52 and the majority were women. There were 3 health promotion officers, 4 senior health promotion officers (2 with a sexual health remit), and 1 public health nurse. They had varied educational backgrounds with diplomas and degrees in health promotion, counselling and psychotherapy, nursing, education, radiography, nutrition and management, and professional qualifications in nursing, midwifery, and teaching. In addition, four of the facilitators had attended programmes in Social, Personal and Health Education at varying academic levels (certificate to Master's level). All reported having previously received training on facilitation and teaching skills and had facilitated a varying number of courses ranging from 1 (n = 2) to 6 (n = 2), with the remaining falling somewhere in between. They also had experience facilitating programmes in the rollout areas (Kerry, Cork, Clonmel and Waterford) and over all the years of rollout from 2009 to 2012.

Profile of services involved in sexual health promotion education in Ireland

In order to map the landscape of sexual health promotion programmes for those involved in sexual health promotion in Ireland, a list of voluntary and statutory organisations or groups that could potentially be involved in sexual health promotion activities was compiled (Appendix V). The list of organisations to be contacted was compiled by the research team in association with the facilitators of the FPSHP. In addition, people who were involved in the area of sexual health were asked to add names to the list if omissions were noted. Compiling the list of organisations or groups that could potentially be involved in sexual health promotion activities with a capacity building focus proved quite challenging, as there is no national database of organisations and groups involved in sexual health education and no database of sexual health education programmes being delivered.

In total, 36 organisations and groups were identified[3] (see Appendix V) and all were contacted by phone or email to request information about whether they had any training on sexual health promotion with a capacity building agenda or remit for those undertaking the training programme (see Appendix VI for data collection template). In addition, websites of organisations involved in sexual health were examined for documents on sexual health promotion training programmes, again with a capacity building agenda. In a small number of cases, despite repeated attempts, contact with the relevant person or group was not achieved as phone calls or emails were not acknowledged or returned.

Although a high number of the organisations and groups contacted did offer education and training, in a number of situations the education programmes provided did not fulfil the criteria for inclusion as they were not focused on sexual health promotion capacity building

[3] In the absence of a national database the list identified by the researchers may not be complete.

at an organisational or inter-organisational level, but were focused more on: providing the individual with updates on sexual health, including STIs, cervical screening, and contraception; building competence in performing a single skill, such as smear taking; or involved staff within organisations providing brief, ad hoc information sessions into school or youth based programmes. In addition, a number of the organisations or groups stated that in the past they offered sexual health education with an organisational capacity building agenda but had ceased providing as it was no longer their remit or they had to prioritise resources in another direction. In total, 16 programmes were identified that could be considered to have an element of sexual health organisational or inter-organisational capacity building as part of their remit[4] (Appendix VII).

The majority of the programmes identified within Ireland that have an organisational or inter-organisational capacity were aimed at those working with young people or young people themselves. The focus of the programmes varied and included general training on sexual health, learning how to develop healthy relationships, and encouraging young people to make positive choices around sexual health and delaying sexual activity. Several of the programmes had a specific focus on developing participants' facilitation skills and increasing their comfort in talking about sexual health so that participants could then go on to deliver training to various client groups. Two of the programmes were aimed at developing peer facilitation skills of young people. The duration of the programmes varied from one day workshops to multi-day training sessions to a full university course schedule. Many of the programmes were free of charge, with a few notable exceptions. Most of the programmes offered a certificate of attendance for completion of the programme and a few were certified with Continuous Professional Development (CPD) points or other levels of accreditation.

In contrast, the underlying focus of the FPSHP is on the life course approach which emphasises the sexual health needs of people from birth to death and, given the fact that the majority of the programmes identified are youth-oriented, the life span approach to sexual health promotion evident within the FPSHP is not present within these programmes. Furthermore, while some of these programmes do have quite a general sexual health promotion capacity building remit and some span over a rather lengthy duration, it does not appear that any of these programmes encompass the breadth or holistic depth of the FPSHP. In conclusion, it appears that the FPSHP is a unique programme in that offers an in-depth and holistic approach to sexual health promotion capacity building that is tailored to address the needs of different client groups and a number of different work sectors.

[4]Given the lack of a national database and the limited time frame available to complete this aspect of the project, the list provided may not be complete.

Summary

- This evaluation study employed a mixed-method approach, using qualitative and quantitative methods. Data were collected using surveys, focus group interviews, telephone interviews, and documentary analysis.
- In total, 97 surveys from past participants were returned, representing a 49% response rate and telephone interviews were conducted with 22 past participants. Thirty five managers returned the survey, representing a 35% response rate. Eight out of the nine programme facilitators participated in the focus group discussion. In addition, local and national organisations were contacted and websites of organisations involved in sexual health were searched.
- All qualitative data was thematically coded and quantitative data were statistically analysed.
- Ethical approval was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin.
- In total, 16 programmes were identified that could be considered to have an element of organisational or inter-organisational sexual health capacity building as part of their remit. The majority of the programmes identified were aimed at those working with young people or young people themselves; thus, the holistic nature of the FPSHP appears to be unique in the landscape of sexual health promotion programmes in Ireland.

Chapter 3: The facilitators' perspective on the FPSHP, its impact and future expansion beyond the HSE South

Introduction

To set the wider evaluation in context, this chapter of the report presents an in-depth analysis of the FPSHP programme based on the curriculum documents provided to the researchers and findings from the focus group conducted with the eight facilitators. The facilitators' aspirations for the programme in terms of capacity building, and the strategies they used in programme design, delivery, and follow-up supports to increase the potential of the programme to support and sustain capacity building are discussed. The chapter concludes with an outline of the facilitators' perspectives and recommendations for programme expansion beyond the HSE South.

Facilitator aspirations for the programme's ability to build capacity

Facilitators explained that their overarching intent was to build sexual health promotion capacity at individual, organisational and inter-organisational level. Their drive to develop the FPSHP arose from their awareness that sexual health promotion is a sensitive, value and culturally laden topic that historically within Ireland has been shrouded in silence and fears:

> *'There's generations [of people] who never had any sex education, so you ask people [participants] what was your experience, nothing, nobody had anything [education]…so silence was the message…So you're trying to get beyond silence…and that's huge…This [sexual health] doesn't have to be ignored anymore.'*

In addition, the facilitators aimed to move away from the more historical medical model and issue-based approach to the field, which focused on, for example, sexually transmitted diseases, pregnancy, fertility, and/or sexual violence, to normalise sexuality and sexual health as a dimension of life and living, as well as broadening understandings and approaches to sexual health and its promotion:

> *'Actually, [it's about] taking it right back to the beginning, and saying, 'From the very start of life, you're a sexual being…to the very end of life, whether you're in a relationship or not…you are a sexual being.''*

Facilitators were conscious that while sexual health information abounds, a void exists between the availability of sexual health information and resultant actions/behaviours of people working in the area of health promotion. Facilitators explained that this void relates to the less tangible aspects of comfort and confidence to speak of sexuality and sexual health. Thus, a central intent was to enhance participants' personal and professional

knowledge, skills, comfort and confidence in the inter-connected components of sexual health and sexual health promotion:

> *'We have people who have loads of information and the piece they're coming [onto the course] for is the ability to talk about sexual health in a normal everyday way, [so] that they'll feel supported and they can support their clients.'*

> *'We know between the information and the actions, there is this gap and this course is about this gap. [It is about] your feelings, your attitudes, your values, your skills, your confidence...'*

In addition to enhancing individual capacity building, the facilitators envisaged that the programme would offer the potential to enhance organisational sexual health capacity building in a number of ways. Firstly, when programme participants returned to their respective organisations, they would nurture capacity at a team level by role modelling the integration of sexual health promotion into their own role, developing local sexual health and sexual health promotion policies, and engaging in sexual health promotion education with colleagues and service users. At a wider organisational level, facilitators spoke of the potential to impact on managers' understanding and outlook:

> *'Participants are coming onto [the programme] and going back to them [managers] and presenting this different scenario to them, we're hopeful … that the manager would be open enough to say, 'Oh, good, yeah, I hadn't thought about it [sexual health and sexual health promotion] like that.''*

There was less mention of capacity building at an inter-organisational level although some facilitators hoped that the networking part of the programme would assist in building networks across organisations, as the following comments suggests:

> *'When they [have] finished the course, it's not just over…They now are part of a network...so we're driving [participants] to keep going and promoting sexual health at a wider level. So it continues...that gives more strength to the capacity building.'*

Having clearly articulated their aspirations in terms of capacity building, facilitators explained the strategies used within the FPSHP to enhance this end.

Strategies used within the programmes to enhance capacity building

In view of the desire of the facilitators to build capacity at individual, organisational and inter-organisational levels, it is not surprising that when designing the programme, capacity building foregrounded all decisions in relation to educational philosophy, structure and design, teaching strategies, follow-up supports, and recruitment strategies:

> *'We actually did quite a lot of thinking about capacity building...we actually did spend a lot of time thinking about how do we actually give this the best chance of translating into something concrete, in [the areas of] education, community or the health service.'*

Educational philosophy

The facilitators spoke of underpinning the programme with educational theory and adult learning principles and designing the programme using Kolb's (1984) experiential learning cycle as the basis:

> *'The methodology wasn't accidental...we chose Kolb's learning cycle, we chose that deliberately...the slow development of capacity building, and slow development of comfort levels...and participants tell us that [this] methodology is really supporting … them moving on from where they were [at prior to coming on the programme].'*

According to Kolb (1984, p.38), 'Learning is the process whereby knowledge is created through the transformation of experience.' The theory presents learning as a cyclical process involving the following four stages: concrete experience (CE), reflective observation (RO), abstract conceptualisation (AC) and active experimentation (AE). Although the learner can enter that cycle at any point, an important feature of the theory is its emphasis on reflection and feedback, which becomes the basis for new action, and further reflection and evaluation of the consequences of that action:

> *'It's the reflective piece and all of that empowering piece, ... they're not on their own, they're in this together and they're vulnerable together, they're knowledgeable together, they're exposing together, so there's a journey for them in the collective piece.'*

Programme structure and design

In keeping with Kolb's (1984) experiential learning cycle, which emphasises the need for a period of 'concrete experience' followed by reflection and subsequent action or experimentation, the facilitators purposefully spaced the delivery of the ten days. As a result the programme comprised five two-day sessions spread over a number of weeks. It was anticipated that this strategy would, firstly, enable participants to develop relationships

within the group over time and, as a consequence, they would be less reluctant to expose their vulnerabilities, more open to hearing feedback from fellow participants, and more likely to maintain ongoing networking with participants once the programme finished. Secondly, it was hoped that the spaced delivery would enable participants to return to their work environments, reflect on their sexual health promotion practice in the light of learning, make changes to practice or engage in capacity building activities within their organisation and return to the group for feedback, support and suggestions for moving forward:

> *'I think this course is very different from many other courses...because number one, people have time to … process the information, to think about it, to kind of maybe apply it to their practice and then get … feedback as well or kind of I tried X, Y and Z.'*

Programme content

In deciding on the content for the programme, the facilitators were mindful of trying to move away from the traditional medical approach to sexual health promotion, which tended to 'pathologise' sexuality by its focus on sexually transmitted infections (STIs), sexual violence or avoidance of pregnancy. In addition, they were attempting to develop a programme that had a focus on sexuality and sexual health across the life course. Consequently, in designing the content for the programme, there was a clear focus on issues such as sex, society and culture, self-esteem and sexual health and the life course approach to sexual health. Secondly, in an attempt to help participants understand the social contexts in which meaning is constructed and sexual practices enacted, and to enable them to locate and contextualise their sexual health promotion activities within the Irish context, the curriculum included sessions on understanding sexual health and sexual health promotion in the Irish context and the Irish Law and sexual health. In addition to the more traditional sessions on STIs, contraception, fertility and sexual dysfunction, there was also time dedicated to exploring the area of organisational policy development.

Teaching and facilitation strategies

In addition, to framing the FPSHP on an experiential learning cycle, the facilitators selected a range of teaching and learning strategies that enabled participants to think critically about sexual issues, explore their attitudes and beliefs, share their wealth of personal experience, and to consider the relevance of the educational material to their own practice. From the outset of the programme, there was an emphasis on learning as an active rather than a passive process and on promoting participant involvement. Facilitators spoke of using a combination of individual and group activities, ongoing journaling, reflection and opportunities to practice skills in a safe setting and receive feedback from colleagues, as the emphasis was clearly on the transfer of knowledge and skills to practice.

The focus of the journal was to enable participants to reflect on the content of each session in terms of their own practice**:**

> *'They have the journal...if they're carrying something out of the group, carrying it home, they can sit down, write it...they can put all this stuff that maybe is in their head, that they're afraid to put in the group [into the journal].'*

Similarly, the emphasis with all group activities was on reflection and application:

> *'After we've done any exercise, we say 'How can you apply this in your work?'…what relevance does it have for your work?'*

> *'Many of the activities are done…individually, people are kind of thinking about their own attitudes…thoughts, beliefs, and then you move [them] into smaller groups and have discussion…and then into the bigger group…you're giving individuals time to reflect on how they feel about different topics but you're bringing it back to the work space and how is this applicable, how can they incorporate it into their work.'*

In addition, participants were encouraged to create a learning community within the group to share the challenges they encountered in applying learning and using co-participants as 'critical friends' to get feedback and new ideas:

> *'There is…continuous feedback from participants in that they will feed back what they've actually done [between sessions]…as part of their small group work.'*

The facilitators also strove to create a safe educational space that combined challenge with emotional support, and modelled the skills of empathy, reflective listening, self-care skills as well as giving participants the right to choose not to participate in exercises. While these strategies served to create a safe space for participants to explore their own vulnerabilities, the facilitators were also conscious that from a capacity building perspective they were also modelling and mirroring in a parallel process, many of the skills that participants would require within their own practice:

> *'So there's never a thing that they have to stay and participate...it happens in every course...there is something triggered [within the participant] and then it's just handled where one person might leave the room with the person, or they get to sit out of that exercise...those things [permission not to participate] are built in from the outset for people. It's actually...very powerful...saying 'no' in sexual health…is a key piece. So you have the right to say 'no', and that's a powerful piece and your clients have the right to say 'no', so we knit that in.'*

In addition to building skills for practice, the facilitators hoped that this form of learning would help build relationships that would assist with ongoing networking and capacity building into the future, and across disciplines and organisations:

> *'There's I suppose a lot of capacity being built among each other in that they're networking continuously while they're…here.'*

Post programme supports

In an attempt to sustain and nurture changes accrued during the programme, the facilitators designed a number of systems of follow-up and supports for participants, including an email newsletter that keeps participants up to date on sexual health promotion policy and practices, access to library facilities with sexual health promotion materials, and the provision by the facilitators of ongoing telephone/email support and advice on issues, such as developing local policies and responding to challenging work situations:

> *'We do our best to have an ongoing relationship with people...we say talk to us if you're devising programmes, talk to us if you're devising policies. We do the newsletter which keeps them in touch and updated of anything we hear.'*

The other two post programme strategies included the encouragement of participants to maintain contact after programme completion and the provision of what facilitators referred to as 'follow-up days' on sexual health issues not addressed during the ten day programme. To enhance capacity and make the 'follow-up days' feasible in terms of numbers attending, the days were open to people who had not attended the ten day programme, but who had an interest in the topic. These days also provided past participants with an opportunity to meet and network face to face.

Recruitment strategies

The recruitment strategy for the programme was also a critical aspect of the capacity building approach. Recruitment to the programme consisted of a written application, followed by a telephone interview. Within the application form, participants were required to highlight how they anticipated using the information in their own work; thus, minimising the likelihood that people would come on the programme with little opportunity or commitment to apply learning to practice:.

> *'We gave a lot of thought to how do we do the recruitment?...There are some courses if you put your name down...you apply and you say you're interested in doing a course, that's it you're on the course. Whereas we have a two-step process where we shortlist on the basis of their applications and we tell them fill in the applications with as much detail as you can because we're going to be using it and then…we have a telephone interview...'*

The telephone interview served a number of purposes. Firstly, it provided an opportunity to explore in greater depth applicants' capacity for applying learning in practice; thus, screening out those who didn't appear to have any potential or motivation to engage with changing practices:

> *'We're clear about, 'What use do you think you can make of it [programme]?' and sometimes it is about a two way process of us helping them see what use they can make of it...We have actually not taken people on the course because they may not have the capacity at the present time to actually do the work. So we talked about the recruitment and then we talked very much about what happens afterwards.'*

The second function of the interview came from what could be called the facilitators' 'ethical stance' and their sensitivity to the potential that the methodologies being used could open up past experiences and emotions for the participants. Consequently, the facilitators highlighted the importance of discussing the personal nature of the process work involved with the applicants and the level and depth of participant engagement required:

> *'We try to let them know on the phone…about the methodology...We try to say to them 'you know issues may [come up], you're likely to know if there's a significant serious issue in your life around abuse or domestic violence, [but] it's other small things that will catch them by surprise'.'*

> *'We would have a telephone interview where we really are really clear about the type of course we're running…'This is how we're running it'...because some people want to come and do a lecture so this is not the course for them.'*

In addition to the above, applicants are asked about the degree of managerial support they had for their application. The facilitators were conscious that for change to occur at organisational or inter-organisational level, managers needed to be on board, supportive and committed to nurturing change when the person returned from the programme:

> *'We've had people who come on their [own] time and that's really good and we don't always turn them down, but it's more that if they get the time and support of the manager, it's more likely to build capacity back within the organisation...'*

The final consideration that facilitators take into account when making decisions around places on the programme is the mix of participants, with priority given to people working with disadvantaged or minority groups:

> *'We prioritise people who are working with those who … have social or cultural disadvantage, so they would be prioritised for a place on the course...people working in more difficult circumstances.'*

Examples of the impact of the programme

Thus far, the account of the focus groups with facilitators has highlighted their aspirations for capacity building and the programme strategies chosen to achieve this end. However, facilitators also talked about their impressions of the impact of the programme based on their continued contact with the participants. These accounts as narrated during the focus group represent illustrations of the impact of the programme, and corroborate the participants' and managers' findings presented in Chapters 4, 5 and 6.

At the level of the individual participant, facilitators spoke about participants who had come with the intent of going back to practice and starting sexual health promotion but who had, in the course of the programme, learned that in advance of doing so, they needed to develop a policy to frame the organisation's sexual health promotion work. This type of example also demonstrates the importance of the follow-up supports offered in terms of capacity building:

> *'There would be a number of people who would have come [onto the programme] with no policies within their organisation and that would be a huge shift for them and they would have…written policies…and would have incorporated sexual health in some way in their work as well.'*

> *'A lot of the people [past participants] come back around policy. They…want to either talk about the process whereby they were going to start or want you to look at a draft and give them some feedback on that.'*

One facilitator gave the particular example of an allied health professional, who now incorporates sexual health into her therapy practice. This participant, who prior to completing the programme did not address sexual health or its promotion in great depth, reported that as a consequence of addressing sexuality and sexual health, she now also refers clients on appropriately where the need arises:

> *'It's led her to…referring clients on...it might be an older person about abuse or different things that have come up. So she's incorporated that into her work on a day to day basis since the programme...'*

In terms of participants who work with marginalised communities, one facilitator spoke about the positive impact of working with members of the Travelling community who had completed the programme. It was viewed as a success that women and men from the Travelling community had completed the programme and continue to actively promote sexual health within the community. Another facilitator provided an example of a past participant who is now working with new communities or new nationalities within Ireland and there were references to participants who work in the youth sector and in the intellectual disability setting, who it was said were:

> *'Cascading stuff back to their teams in work, you know, even before the course had ended and now are writing a policy and they've sent it me to have a look at and they've been to other things since, you know there was a seminar on trans in Kilkenny which they wouldn't have thought was anything to do with them and now they're realising, 'Yes, it has'…and then other groups have developed programmes and within the youth service that have actually pulled back on some programmes that [name of another facilitator] was talking about earlier and are re-directing towards a more holistic notion of sexual health rather than just STIs and contraception and that piece.'*

Taken alongside the individual impact outlined earlier, the above example appears to suggest that the programme may enable participants to achieve the aim of normalising sexuality and adopting an expanded and redefined understanding of what sexual health promotion can and should involve. It further suggests that understanding can translate into changed sexual health promotion behaviours and activities.

At a broader level, it was shown that the programme also contributed to making system level differences. The example provided related to a branch of a national service. Here, a facilitator spoke about how a change introduced to a recruitment orientation package had been picked up and was being considered for inclusion nationally:

> *'We had two [participants] from the [name of national service]…and they came to look at sexual health within the context…but sex is never really mentioned [in induction pack]…there wasn't really real sexual health piece… But these two particular [participants]…came in to look at that and how to change that approach and they had their policy and everything in place, but they looked about changing the induction pack and there was a little bit of resistance…but they presented to their [local managers] to the point of now they were, … the last time I spoke to the [participants], they had been invited to put the same pitch to the national piece because they saw the benefit of it.'*

Views on future development and expansion of the FPSHP beyond HSE South

The previous section focused on the facilitators' aims and aspirations for the FPSHP the strategies they employed to achieve these and their views on the impact of the programme. This section focuses on their perspectives and recommendations for future programme development, and expansion beyond the HSE South.

Overall, the facilitators were supportive of the idea of expanding the programme beyond the HSE South but were clear that expanding the programme was not as simple as taking the curriculum and *'powerpoints*' off the shelf and implementing them in a wider context. They were clear that a number of issues need to be considered to ensure that the programme had *'a quality mark'* and *'consistency in its delivery'*. Facilitators were particularly concerned that the current emphasis within the programme on spaced learning, face to face learning, process and process orientation skills, reflection on practice and meaningful participant exchange in a safe and supportive space not be changed.

Facilitators were further concerned that the current economic climate could negatively impact on future resources and the willingness of managers to release staff to attend a ten day programme. Consequently, they feared that within an expansion context, a decision would be made to reduce the contact time. While acknowledging the challenges, the facilitators were adamant that time is needed to build participants' knowledge, confidence and comfort and enable them to acquire the skills necessary to effectively engage in sexual health promotion in practice. In addition to being concerned that the programme may be shortened, they were also concerned about a move to a blended learning approach, which would combine face-to-face learning with online activities. While the facilitators were not opposed to this in principle, they were cautious about this form of development and were of the view that blended learning requires careful development within an overall coherent framework:

> *'I hear blending [learning] as diluting, so you take out a little bit, we'll miss attitudes or you take out a little bit where we won't get the skill of delivering the workshop, or we leave out policy because we just stay with the personal. Like I think it's very good…that's the truth.'*

> *'I would have some worry around...who would do it [the roll out] and would it [programme] be taken and done in a perfunctory way that actually didn't pay attention to the sensitivities and the need for the support for the participant.'*

> *'The actual process piece…it might actually change, mightn't look like what they thought at the beginning. So that's the piece I think is more vulnerable.'*

It was acknowledged that some of the success of the programme was in part due to effective facilitation, the peer supportive culture that had developed within the facilitator group, and the sexual health promotion focus that existed within the geographic regions in which the programme was delivered. Therefore, to ensure the integrity of the programme and its delivery, facilitator preparation and supports were identified as key issues that needed to be considered in any expansion. All facilitators spoke about the emotional impact of the programme on themselves and acknowledged the demanding nature of facilitation. Consequently, they were mindful that without skilled facilitators who were comfortable and confident with the subject matter, and supports for facilitators, the quality of the programme may be compromised in any expansion:

> *'One thing that I think we've [facilitators] talked about…is how exposing ten days is for the facilitator. You can go in and do one or two days and be brilliant because you don't have to give as much of yourself, so it's not just a challenge to the participants to do a ten day course. It's a real challenge for the facilitator because you are so seen as a person.'*

There was some discussion about the realities and challenges of ensuring that facilitator competence was maintained, particularly as programmes may not be running frequently enough in each region to ensure that facilitators have the opportunity to co-facilitate a significant number to maintain their competence. One facilitator explained:

> *'I suppose we don't have the same opportunity in [name of region] to co-facilitate…because three other facilitators need to be slotted in, so…in my situation…there's a two year gap, because [name of person] does it next year and then I do it...I suppose from that point of view I find that [maintaining competence] that's difficult, because it's not my core area of work.'*

Strategies to support the strengthening and expansion of the FPSHP programme

Based on their experience the facilitators made a number of suggestions and recommendations to overcome the challenges identified. The facilitators recommended the appointment of a national co-ordinator who would plan and guide the roll out, source the resources required, oversee the on-going implementation of the programme, and develop systems and processes to maintain quality. Facilitators also recommended a core group or steering group, with responsibility for the ongoing curriculum development and updating of programme content and materials be established, so that each programme delivered would be based on best available evidence. It was suggested that materials needed to be updated at least every three years to avoid materials and approaches becoming dated. Indeed, the facilitators indicated that they had already commenced developing a manual that would outline the philosophy of the programme, the aims and objectives of the programme, provide guidance to facilitators on teaching methodologies, use of teaching material, and

follow-up supports. The facilitators hoped that once completed the manual would help maintain the process orientation and provide some consistency in the delivery of the programme.

Having spoken about the needs for knowledgeable and skilled facilitation, as well as support for future facilitators, the FPSHP facilitators made a number of suggestions that they perceived as necessary to sustain the capacity and well-being of individual facilitators to continue in the roll out over time beyond HSE South. These included the need for facilitators to be given:

- support in the form of a formal system of supervision as well as the establishment of ongoing local peer support forums for facilitators within the region;
- training in core facilitation skills including, inter-disciplinary co-facilitation, adult learning approaches, experiential learning, and fundamentals of health promotion;
- training in knowledge and skills to support people in distress within a group and individual context;
- opportunities for individual facilitators to complete the FPSHP prior to undertaking its facilitation; and
- an opportunity to facilitate at least one/two programmes per year to maintain competence.

In addition to education, training and support, the facilitators also made the following two recommendations.

- In addition to the ten days required to deliver the programme, the time required by facilitators to plan and prepare the programme for delivery needs to be acknowledged in their workload.
- A minimum of two facilitators per programme, with both facilitators having an established background in facilitation and one facilitator with a background in sexual health and sexual health promotion, should be continued.

When questioned about the potential for exploring academic accreditation or award for the FPSHP, facilitators were of the opinion that the preferred option would be for a system of CPD credits in contrast to a formal academic award. There was some concern that the process orientation within the programme, which they viewed as critical for participants personal and professional growth, might be minimised if the programme was to achieve a formal academic accreditation.

Cognisant of the need for cost effectiveness, facilitators spoke of the need to open the follow-up days out to non-programme participants to ensure their viability, as well as the need to ensure that future participant recruitment and selection is inclusive of multiple

disciplines and those who work with minority and vulnerable groups. The need for designated administrative support to support recruitment and other aspects of the programme was also highlighted.

Finally, the facilitators were very clear that in the current climate there was an urgent need for the national sexual health strategy to be finalised and published so that sexual health promotion would be recognised as a national priority and the mandate of those involved in sexual health promotion could be cemented:

> *'The national strategy…I'd like to say something on it. We know that there's going to be no [additional] budget, so there are loads of limitations and so I suppose from health promotion…I [still] think it's really important because it actually states, for the first time, that sexual health is a national priority…it gives us a mandate..'*

Summary

- While participants described their overarching aspirations for the programme in terms of individual, organisational and inter-organisational sexual health promotion capacity building. In particular, facilitators placed the greatest emphasis on the following capacity building aims:
    - the normalisation of sexuality and the adoption of a life-course approach to sexuality and sexual health promotion;
    - the development of programme participants' knowledge, skills, competence and confidence to engage in sexual health promotion; and
    - the building of capacity within organisations though influencing organisational policy, practice and managers' understanding of sexual health promotion.
- The desire to build capacity foregrounded all decisions in relation to educational philosophy, structure and design, teaching strategies, follow-up supports, and recruitment strategies.
- To enhance the potential of the programme as a vehicle of capacity building the facilitators:
    - designed the programme based on Kolb's reflective cycle;
    - selected content that moved beyond the traditional medical approach to sexual health;
    - included experiential teaching methodologies;
    - capitalised on the use of follow–up supports;
    - developed a critical mass of facilitators to deliver the programme; and
    - selected participants onto the programme that had the motivation and opportunity to engage in sexual health promotion and the support of the organisation they worked for.

- The provision of managerial support was viewed by facilitators as a key factor in the building of local organisational capacity both in terms of release to attend the programme and the nurturance of an environment of sexual health promotion.
- In seeking to establish an evidence base for the success of the programme, facilitators provided a number of exemplars illustrating the impact of the programme.
- In looking to the future and the potential for expansion of the FPSHP, facilitators were concerned about a number of issues that needed to be addressed to ensure faithfulness to the purpose and process of the programme.
- The facilitators identified a number of strategies, which they perceived to be integral to support the expansion of the FPSHP programme into the future. These included the appointment of a national co-ordinator and development of a steering group, regularly updated and high quality materials, the development of a FPSHP manual, and ongoing training and support for facilitators.

Chapter 4: Survey results from past participants on the FPSHP

Introduction

This chapter reports on the quantitative results of the survey of the past participants (n = 97). These findings provide a quantification of how participants have experienced the programme and its impact. Although some qualitative comments from the survey are cited, the majority are merged with the data from the interviews with participants reported in Chapter 5. The following aspects from the survey are addressed here:

- overall satisfaction with the programme;
- usefulness of the content and follow-up supports;
- impact of the programme on the participants' sexual health promotion activities;
- factors that helped and hindered implementation of learning;
- sustainability of the impact of the programme; and
- predictors for sustained impact of the programme.

Overall satisfaction with the programme

Participants were asked to rate their satisfaction with the programme in terms of overall satisfaction, satisfaction with content, delivery, and overall learning. Each of these aspects was presented in the survey in the form of a 0-10 Likert scale (0 indicating low satisfaction and 10 high satisfaction). Overall the findings suggest high satisfaction with the programme, with mean ratings clustered between 8.5 and 9 out of 10 with 'satisfaction with the delivery of the programme' (M = 9.0, SD = 1.4) being the highest of all aspects. See Table 9 for further details.

Table 9. Overall satisfaction with the programme

Variable (n)	Range (observed)	Mean (SD)
Satisfaction variables: How satisfied were you with …?		
the programme overall (n = 97)	1-10	8.8 (1.3)
the content of the programme (n = 97)	1-10	8.7 (1.3)
the delivery of the programme (n = 96)	1-10	9.0 (1.4)
your own learning from the programme (n = 97)	1-10	8.5 (1.4)

Usefulness of the content of the programme

Participants were asked how useful they found each aspect of the programme Table 10. Overall, the majority of the participants found each aspect very useful or quite useful, with 9 out of the 13 aspects listed considered useful by over 90% of participants. In addition, the very low number of negative responses suggests a high extent of perceived overall utility of the different elements of the programme for the participants.

Table 10. Usefulness of each aspect of the programme

	Very or quite useful % (n)	Neutral % (n)	Not very or not at all useful % (n)	Did not attend or do not remember % (n)
Sexual health promotion in the Irish context (n = 94)	98% (92)	1% (1)	1% (1)	0% (0)
Understanding of sexual health in the Irish context (n = 93)	97% (90)	3% (3)	0% (0)	0% (0)
Sex, society and culture (n = 94)	96% (90)	4% (4)	0% (0)	0% (0)
Self-esteem and sexual health (n = 94)	95% (89)	5% (5)	0% (0)	0% (0)
The life course approach of sexual health (n = 93)	94% (87)	6% (6)	0% (0)	0% (0)
STIs (n = 94)	94% (88)	5% (5)	0% (0)	1% (1)
Irish law and sexual health (n = 92)	91% (84)	6% (5)	1% (1)	2% (2)
Contraception (n = 94)	91% (86)	9% (8)	0% (0)	0% (0)
Skills practice workshop (n = 94)	91% (85)	4% (4)	2% (2)	3% (3)
Facilitation skills (n = 93)	86% (80)	11% (10)	2% (2)	1% (1)
Fertility (n = 94)	81% (76)	16% (15)	1% (1)	2% (2)
Sexual dysfunction (n = 94)	78% (73)	15% (14)	1% (1)	6% (6)
Policy development (n = 93)	69% (64)	24% (22)	5% (5)	2% (2)

Usefulness of the follow-up supports

Participants were asked about the usefulness of each of the follow-up supports offered by the facilitators of the FPSHP. Those who responded to this question, and had used the support services, overwhelmingly indicated that they found them useful, especially the follow-up emails and support from the facilitators, and the Sexual Health Newsletter (Table 11). While more than half of the participants reported finding the Sexual Health Resource Library and follow-up days useful, a greater number of participants reported not using these supports. It is also worth noting that the total number of people responding to this question is lower than the total number of participants. This might suggest that those not responding did so because they had not made use of any of the follow-up supports.

Table 11. Usefulness of each support factor in sustaining the impact of the programme

	Very or quite useful % (n)	Neutral % (n)	Not very or not at all useful % (n)	Did not use % (n)
Emails from the sexual health team with updates of interest (n = 87)	94% (82)	5% (4)	0% (0)	1% (1)
Sexual Health Newsletter (n = 89)	88% (78)	9% (8)	2% (2)	1% (1)
Ongoing support from the sexual health team (n = 87)	77% (67)	16% (14)	0% (0)	7% (6)
Sexual Health Resource Library (n = 87)	68% (59)	18% (16)	2% (2)	12% (11)
Follow-up training days (n = 83)	58% (48)	16% (13)	1% (1)	25% (21)

The satisfaction with the supports offered was also reflected in the comments written in the open-ended follow-up question, with high numbers expressing gratitude for the *'very supportive and excellent team'* who they felt they could contact at any time for information and advice. Where participants requested more support, it was in the form of ongoing education and continuous professional development days. Other suggestions made included the need for information on any grants available to voluntary or community groups around sexual health promotion and good exemplars of sexual health promotion policies available. The final suggestion was the need to develop a formal network of sexual health promoters as the following survey comments suggest:

> *'Maybe meeting with others who have carried out the programme to hear how they have used their learning in practice, create a community of sexual health promoters'*

> *'A support type group may have been useful, where new ideas for community sexual health projects could be planned and organised'*

Impact of the programme on the participants sexual health promotion activities

Participants were asked to rate their views on the impact of the programme on knowledge, comfort and confidence, skills, and awareness and attitudes**.** Each of these aspects was presented in the survey in the form of a 0-10 Likert scale (0 indicating a very negative rating and 10 a very positive rating). Overall, the findings suggest a high impact of the programme on participation, based on ratings for all aspects included.

Mean ratings clustered between 8 and 8.5 for the majority of items (see table), with the exception of 'problem solving around sexual health issues' (M=7.4, SD =1.8), 'facilitation skills around sexual health' (M= 7.9, SD= 2) and 'the ability to develop policies' (M = 6.6, SD = 2.1), which were slightly lower than the other aspects. See Table 12 for further details.

Table 12. Self-reported effects of programme

Knowledge, comfort and confidence variables: How did the programme affect your…?	**Range (observed)**	**Mean (SD)**
knowledge of issues of sexual health (n = 97)	1-10	8.2 (1.6)
comfort in relation to issues of sexual health (n = 97)	2-10	8.3 (1.7)
confidence in relation to issues of sexual health (n = 97)	3-10	8.4 (1.5)
motivation to engage with sexual health promotion activities (n = 96)	3-10	8.5 (1.3)
Skills variables: How did the programme affect your…?		
sexual health promotion skills (n = 97)	1-10	8.1 (1.4)
problem solving skills around sexual health issues (n = 97)	1-10	7.4 (1.8)
ability to communicate about issues of sexual health (n = 97)	0-10	8.3 (1.9)
ability to develop policies around sexual health (n = 92)	1-10	6.6 (2.1)
facilitation skills around sexual health (n = 96)	0-10	7.9 (2.0)
Awareness and attitudes variables: How did the programme affect your…?		
self-awareness in relation to sexual health issues (n = 97)	0-10	8.2 (2.0)
understanding of your own values and attitudes towards sexuality (n = 97)	0-10	8.2 (2.0)

To assess the impact of the programme on change in practices, participants were asked about what sexual health promotion practices they engaged in before the FPSHP training and which sexual health promotion practices they engaged in post-training. Overall, there was a doubling of the number of activities participants engaged in (from 3.77 to 7.60; paired-samples t-test, t (42) = - 6.25, p = .000***), which is a significant increase.

As Table 13 shows, out of the 19 activities presented to the participants, three were already engaged in to a considerable extent before the programme (assessing sexual health promotion needs of clients (60%), referring people to sexual health services (56%), and providing sexual health education to clients or service users in a one to one setting (63%)), while sixteen were only engaged in by some. All showed increases after participation, with some activities showing a dramatic increase. Networking (+ 40%), raising awareness (+ 41%) and providing sexual health education to staff within the organisation (+ 31%) are activities

that seem to be impacted most by participating in the course. Furthermore, significant expansion was reported in developing services within the organisation (+ 26%), developing written materials on sexual health promotion (+ 28%), using group settings in sexual health promotion (+ 23%), as well as engaging with further education and training (+ 30%).

In terms of evidence of capacity building it can be concluded that while a number of sexual health promotion practices were being conducted by staff prior to the programme, these practices expanded following the programme. In addition to the increasing number of participants engaging in sexual health promotion activities, the range of activities also diversified after the programme, which is likely to have promoted capacity building. While networking seems to have been strongly affected by the programme, the extent of inter-organisation capacity building is still modest in comparison with the considerable impact on activities taking place within organisations.

Table 13. Engagement in activities related to sexual health promotion of the survey sample

*Only participants who had been involved in sexual health promotion both before and after the programme were included in these calculations. See Appendix VIII for a version including all participants.

Practice (n = 43)	**Before programme**	**After programme**	**Difference**
Individual capacity building practices			
Attending training or education on sexual health promotion (CPD – Continuous Professional Development)	10 (23%)	23 (53%)	+ 13 (30%)
Providing formal sexual health education to clients or service users in a group setting	14 (33%)	24 (56%)	+ 10 (23%)
Referring people to sexual health services	24 (56%)	33 (77%)	+ 9 (19%)
Assessing sexual health promotion needs of clients	26 (60%)	33 (77%)	+ 7 (17%)
Providing sexual health education to clients or service users in a one to one setting	27 (63%)	33 (77%)	+ 7 (14%)
Organisational capacity building practices			
Raising awareness of sexual health promotion needs within your organisation	14 (33%)	32 (74%)	+ 18 (41%)
Providing formal sexual health education to staff within your organisation	1 (2%)	14 (33%)	+ 13 (31%)
Developing written information materials related to sexual health	4 (9%)	16 (37%)	+ 12 (28%)
Developing sexual health services within your organisation	6 (14%)	17 (40%)	+ 11 (26%)
Auditing sexual health promotion practices within your organisations	4 (9%)	12 (28%)	+ 8 (19%)
Assessing sexual health promotion education needs of staff within your organisation	5 (12%)	13 (30%)	+ 8 (18%)
Developing sexual health policies/guidelines within your organisation	5 (12%)	12 (28%)	+ 7 (17%)
Engaging in research on sexual health	5 (12%)	13 (30%)	+ 8 (18%)
Adapting administrative practice to include sexual health items, e.g. developing/changing assessment forms to include sexual health	2 (5%)	7 (16%)	+ 5 (11%)
Inter-organisational capacity building practices			
Networking about sexual health with other individuals or organisations	10 (23%)	27 (63%)	+ 17 (40%)
Publishing articles on sexual health	2 (5%)	7 (16%)	+ 5 (11%)
Developing sexual health policies/guidelines outside of your organisation	0 (0%)	3 (7%)	+ 3 (7%)
Providing formal sexual health education to staff outside your organisation	2 (5%)	5 (12%)	+ 3 (7%)
Developing sexual health services outside your organisation	1 (2%)	3 (7%)	+ 2 (5%)
Sum of activities (means / sd)	**3.77 (2.60)**	**7.60 (3.99)**	**+ 3.83 (sig ^)**

^ Difference between sum of activities before and after programme :(t (42) = - 6.25, p = .000*)** (* p < .05; ** p < . 01; *** p < .001)

Factors that helped and hindered implementation of learning

Participants were asked to identify from a list of personal, practical and human factors, which ones helped them in the implementation of what was learned in the programme. Similarly, they were asked to identify factors that hindered them. The response to these two related questions is compiled in Table 14.

In terms of what had helped participants in implementing their learning, the vast majority reported increased confidence in their knowledge and skills (87%) and personal autonomy (80%). In terms of practical supports, the content of the programme (98%), the availability of sexual health promotion materials (82%) and the availability of time (61%) were identified as key enablers. More than 60% of participants also felt that networking with other participants, supportive colleagues, and follow-up support from facilitators helped them implement learning. Interestingly, only 20% reported that an availability of financial resources was an enabler.

In response to the question what hindered them, the majority of participants reported that the factors presented to them had not affected them. Only lack of time (39%) and financial resources (38%) were deemed to hinder the implementation of their learning by more than one third of the participants. And only just over 20% felt they were hindered by an unsupportive organisational culture, or unsupportive management within their organisation. While this question had the potential of identifying bottlenecks in the implementation phase, the response suggests mostly that this was not the case for any of the factors presented. The response to the question what hindered the implementation of learning was consistent with the response to the question of what helped.

Overall, it would seem that participants perceived they were helped rather than hindered in the implementation of what they had learned in the programme. Their personal autonomy was not considered hindered and the environment in which participants implemented the outcomes of their sexual health promotion training was seen as supportive of their sexual health promotion activities. Furthermore, the knowledge, skills and materials received in the programme were regarded as helpful supports rather than a hindrance.

Table 14. Factors that helped or hindered in the implementation of learning

Factor	Helped % (n)	Did not affect % (n)
Personal factors		
Increased confidence in knowledge/skills (n = 91)	97% (88)	3% (3)
Personal autonomy to implement change (n = 82)	80% (66)	20% (16)
Practical resources		
The content of the programme (n = 91)	98% (89)	2% (2)
Availability of sexual health promotion materials (n = 87)	82% (71)	18% (16)
Availability of time (n = 83)	61% (51)	39% (32)
Availability of physical space (n = 81)	43% (35)	57% (46)
Availability of financial resources (n = 79)	20% (16)	80% (63)
Human resources		
Follow-up support from facilitators (n = 84)	77% (65)	23% (19)
Supportive colleagues or team (n = 86)	76% (65)	24% (21)
Networking with other participants (n = 87)	64% (56)	36% (31)
Supportive management/supervisor(s) within your organisation (n = 84)	58% (49)	42% (35)
Supportive organisational culture (n = 79)	57% (45)	43% (34)
Supportive outside organisation(s) (n = 80)	36% (29)	64% (51)
	Hindered % (n)	**Did not affect % (n)**
Personal factors		
Lack of sexual health promotion materials (n = 81)	11% (9)	89% (72)
Lack of personal autonomy to implement (n = 84)	8% (7)	92% (77)
Lack of confidence in knowledge/skills (n = 85)	5% (4)	95% (81)
The content of the programme (n = 85)	1% (1)	99% (84)
Practical resources		
Lack of time (n = 85)	39% (33)	61% (52)
Lack of financial resources (n = 80)	38% (30)	62% (50)
Lack of physical space (n = 81)	17% (14)	83% (67)
Human resources		
Unsupportive organisational culture (n = 82)	23% (19)	77% (63)
Unsupportive management/supervisor(s) within your organisation (n = 81)	21% (17)	79% (64)
Unsupportive outside organisation(s) (n = 79)	16% (13)	84% (66)
Unsupportive colleagues or team (n = 81)	15% (12)	85% (69)
Lack of networking with other participants (n = 86)	10% (9)	90% (77)
Lack of follow-up support from facilitators (n = 85)	2% (2)	98% (83)

Sustainability of the impact of the programme

Participants were asked to consider the impact of the programme on:

- their own work;
- their perception of whether the programme had a sustained impact on their work; and
- if they anticipated the continuation of this impact into the future.

Each of these questions was presented in the form of a 0-10 Likert scale, with 0 representing 'not at all' and 10 representing 'to a very great extent'. The outcome suggests an overall positive perspective on all three questions (see Table 15). The similarly high mean scores (M = 7.6, SD = 2.1; and M = 7.5, SD = 1.8) for present, sustained impact and anticipated sustainability are an indication that participants are confidently looking to the future in this respect. The high correlations between the three variables also suggest a perception among participants of the impact of the programme as mostly stable over time.

Table 15. Overall ratings of impact and sustained impact of the programme

Variable (n = 94)	**Range**	**Mean (SD)**	**Pearson Correlations (Sig 2-tailed)**
1) To what extent has attending the programme affected **your work** on sexual health promotion?	1-10	7.0 (2.1)	with 'sustained impact': r(92) = .70 (.000***) with 'anticipate': r(92) = .63 (.000***)
2) Overall, from your perspective has your participation in the programme had a **sustained impact** on sexual health promotion practices in your work (or volunteer work)?	1-10	7.6 (2.1)	with 'your work': r(92) = .70 (.000***) with 'anticipate': r(92) = .86 (.000***)
3) Do you **anticipate** that you can sustain the impact of the programme?	2-10	7.5 (1.8)	with 'sustained impact': r (92) = .86 (.000***) with 'your work': r(92) = .63 (.000***)
(* p < .05; ** p < . 01; *** p < .001)			

Predictors for sustained impact of the programme

It is important to establish whether the sustained impact of the programme can be predicted from demographic factors, the perceived usefulness of specific elements of the programme, the engagement with different sexual health promotion activities, and factors that helped or hindered the implementation of learning. On the basis of such findings, the most relevant factors for sustainable impact can be identified. Subsequently, it can form a basis for adjustments to the programme and/or its targeted participant base.

While there are a variety of statistical procedures that provide insights into the relationship between predictors and outcome variables, the chosen method here, *Multiple Regression*, provides a particularly powerful way of highlighting the most distinctive predictors. The outcome of this procedure, in which all relevant quantified independent variables were entered as potential predictors, provides an equation representing the extent to which all of these factors together, and each separately, predict the outcome for the dependent variable. The choice for the dependent variable would be between focusing on the impact on participants' own work, sustained impact, or anticipated impact. Considering that participants are probably more reliable in estimating present 'sustained impact', it was decided to use this variable as the preferred outcome variable (see Appendix IX) for this procedure. All quantifiable variables (scales and yes/no variables) were entered into the model and consequently considered in terms of their predictive value. The procedure was performed in so called '*Stepwise'* mode to isolate the impact of variables with a significant predictive value from those that did not predict the outcome variable in a meaningful way.

The outcome suggests that several variables are significant predictors of the outcome variable, together predicting 89% (Adjusted R^2 = .894) of variance in sustained impact. This is a high degree of explained variance. The emerging equation is also highly significant (F (8,26) = 36.676, p = .000***). The equation was achieved in ten iterations in which the strongest predictors were identified first and additional variables were added 'stepwise' to the equation until no more significant predictors could be included. The outcome includes the following variables in order of appearance (see Appendix IX for statistical detail):

- the impact of the programme on the motivation to engage (explained variance 38%; R^2 = .38; $\beta = .31$, t(88) = 4.53; p = .000***);
- overall satisfaction (added explained variance 21%; R^2 = .59; $\beta = .48$; t(88) = 6.94; p = .000***);
- attending continuous training or education (CPD) on sexual health promotion (added explained variance 8%; R^2 = .67; $\beta = .22$; t(88) = 3.54; p = .002**);
- implementation of what was learned in the programme was helped by supportive organisational culture (added explained variance 4%; R^2 = .71; $\beta = .34$; t(88) = .5.22; p = .000***);
- engaged in sexual health promotion as part of my job (added explained variance 4%; R^2 = .75; $\beta = .26$; t(88) = 4.01; p = .000***);
- engaged in sexual health promotion as part of voluntary work (added explained variance 6%, R^2 = .81; $\beta = .27$; t(88) = 4.48; p = .000***);
- implementation hindered by lack of financial resources (added explained variance 6 %; R^2 = .87 $\beta = -.36$; t(88) = -5.59; p = .000***); and
- engaging in research on sexual health after attending programme (added explained variance 3%; R^2 = .89; $\beta = .18$; t(88) = 2.73; p = .011*).

To conclude, this suggests that first and foremost the degree of *motivation* participants reported following the programme was by far the most potent factor in predicting *sustained impact,* followed by *overall satisfaction* and *attending further training.* Those participants that reported higher motivation and satisfaction and had engaged in further training were more convinced of the *sustained impact* of the FPSHP programme. Those participants that reported lower motivation and satisfaction, and had not engaged in further training, perceived a lower degree of sustained impact of the programme.

As evidenced by the decreased extent of the added explained variance, the other variables included in the equation have considerably less predictive value. Their minor impact can be summarized as follows. If the implementation was helped by a supportive organisational culture and not hindered by lack of financial resources, higher sustained impact was reported. If participants engaged in sexual health promotion activities as part of their job or as part of voluntary work, they rated the sustained impact higher in comparison with those who were not involved in SHP activities through their job or voluntary activity. Furthermore, those engaging in research after attending the programme, reported higher sustained impact ratings than those who did not.

Finally, it is important to highlight what was not found. These findings suggest no meaningful differences in sustained impact ratings predicted by any of the other demographic variables, the perceived usefulness of specific elements of the programme, the engagement with the other sexual health promotion activities, and other supports or obstacles encountered. In some cases, this may be because the variable is unrelated to the sustained impact rating, in other cases the lack of variance in the variables made them unsuitable as a predictor of differences in sustained impact rating. For instance, the consistently high satisfaction with the facilitation of the programme will have ensured that this variable does not help predict higher or lower degrees of sustained impact.

Summary

- The outcomes of the survey of participants suggest a very positive evaluation of all aspects of the FPSHP explored (content, facilitation, own effort, supports) and high degrees of satisfaction with the programme overall and its impact on the participants.
- Participants perceive more supports than obstacles in implementing what was learned and are positive about the sustained impact now and in the future, and the extent to which participating in the programme is part of their capacity building efforts around sexual health promotion.
- Participants diversified considerably after participating in the programme in the sense that they doubled the number of sexual health promotion activities they engaged in.

- A salient detail is that while many participants reported that the programme had made them network with other sexual health professionals, this does not seem to have led to much inter-organisational capacity building.
- The motivational aspect, satisfaction and efforts to engage in further training were demonstrated to be the main predictors of how participants rated the sustained impact of the programme.
- Barriers to sustained impact were related to lack of financial resources, lack of time and unsupportive organisational culture.

Chapter 5: Qualitative analysis of interviews with past participants on the FPSHP

Introduction

This chapter presents the findings from the qualitative analysis of the 22 telephone interviews held with the past FPSHP participants integrated with the qualitative comments from the surveys reported in the previous chapter. As there was much overlap between the two data sets, they are presented together. The findings are supported by quotations from the interview transcripts or extracts from the survey. The code assigned to the participant, their age and gender are also given with the quotation from the interview.

Participants' prior expectations of the programme

While many of the participants came to the programme with an open mind, some had definitive expectations of the programme, such as developing greater knowledge about sexual health and sexual health promotion. The majority of the expectations came from the participants' previous work practices or emerged in response to difficulties encountered in their daily experience with clients or individuals. Many of the participants worked with young people and were keen to increase their knowledge, comfort and confidence in talking about issues of a sexual nature. The following participant's expectations exemplified these types of comments:

> *'I was hoping [for] more skills on how to work in a one-to-one basis with teenagers…how to grasp the more woolly areas of sexual health, like communication, assertiveness, intimacy, relationships, boundaries, those kind of things that are...really, really important but a little bit harder to kind of, to work with.' (Interview 8, age 36, Female)*

Other participants had specific learning needs or areas of interest that they wanted addressed. For example, some participants wanted specific education on sexual health for people with an intellectual disability, while another participant wanted to develop knowledge in the area of HIV. Others were very keen to develop their facilitation skills and were looking for materials and new methods of teaching in the area of sexual health and sexual health promotion.

Participants' views of the FPSHP: Content and process

In the main, the participants were highly positive about the programme and many found it difficult to think of any negative issues. Throughout the interviews and surveys, they used words like *'amazing,' 'brilliant,' 'stimulating,' 'nuanced,'* and *'informative,'* to describe the programme. For some, the word 'foundation' proved to be a misnomer as they perceived that the knowledge they gained far exceeded foundation level and was

'beyond basic'. This finding is important as facilitators highlighted the importance of understanding the meaning of the term 'foundation' for the purposes of the FPSHP course as meaning a strong basis for sexual health promotion practice and not 'basic'. For others, the information presented built on, augmented and complemented their existing knowledge and skills. Others described the foundation programme as a starting point and planned to use it as a gateway to further education and training. Irrespective of their level of prior knowledge and skills, the vast majority of participants spoke very positively about both the content and process orientated nature of the programme and valued the wealth of knowledge that they gained from attending the programme:

> *'I've done courses before, they're fairly kind of...tick the boxes, but this was like doing a college course…there was loads of information, loads of practicing…standing up in front of a group and everything. It was brilliant'. (Interview 11, age 28, Female)*

> *'I found the content and delivery of this programme to be of an exceptionally high standard. I come from an academic background and have completed a number of courses/qualifications across the National Framework of Qualifications. This programme was incredibly well planned, researched and delivered using a variety of media and activities to ensure learning outcomes of participants were met. This course offered me, as a participant, new and current fact based knowledge/material that I can utilise in my own work, in supporting clients and families.' (Survey participant)*

Many were of the view that the programme helped to bring sexual health to the forefront and helped them to look at sexual health and sexual health promotion in a different and more holistic way and in so doing minimised and removed some of the taboos around sexuality. Indeed, some participants underestimated the level of the content, believing it would be more basic, while others felt that it was *'all going to be about sexual dysfunction'*. Consequently, many participants spoke of being surprised by the broad nature of the content and the range and number of different professionals attending, and involved in sexual health promotion. This finding provides further evidence that facilitators' aspirations to normalise sexuality and sexual health as a dimension of life and living, and broaden understandings and approaches to sexual health and its promotion, were achieved (see Chapter 3).

While all the participants said that they had enjoyed the programme, they spoke about it as *'challenging'* and '*heavy going'* at times:

> *'Just partaking in group work at all, the very first morning we went in we were told like 'Right, stand up there on the white board', you know, and 'write your name, a bit about yourself and things', and from day one it was challenging.'*
> *(Interview 13, age 55, Male)*

The participants strongly valued the interactive and experiential nature of the workshops, which they considered was critical to confidence building and skill development. Many of the participants did not have any prior experiences of facilitating or presenting information to a group of people, and commented how their confidence had grown as a result of being given an opportunity to practice the skills within a safe environment:

> *'The experiential nature, it was very interactive...personally speaking, that's my favourite thing, to be able to do the stuff and then incorporate into workshops yourself...the very obvious expertise [of the facilitators] and relaxed attitude and [they] being comfortable with the subject...the facilitators really gave you confidence.' (Interview 19, age 43, Female)*

> *'Do you know, you just get confidence from standing up in front of people. Before I would have never kind of volunteered to stand up in front of [people]...so it gave me reams of confidence, even around facilitation...in all aspects of facilitation not just sexual health.' (Interview 11, age 28, Female)*

In addition, the open dialogue within the programme helped to 'normalise' sexuality and sexual health as a component of physical and mental health. This assisted the participants to talk more freely about issues of a sexual nature within their work practices and perhaps further appreciate the holistic nature of the subject:

> *'I feel because the quality of the programme, the length of time, it was over four or five months...my comfort level in discussing sex and sexuality with people has increased, it [sexuality and sexual health] was been normalised for me. So it's not an area I'm afraid to touch on with people.' (Interview 1, age 43, Female)*

The participants recognised the difficulties and complexities of delivering a programme on sexual health and genuinely praised the facilitators for their skills and sensitivity in creating a positive and safe learning environment, which was essential to the open exchanges of a personal nature that took place between participants.

One participant described the learning environment:

> *'I suppose the facilitators put a lot of work in to the comfort levels in the group and thinking back because it's such a sensitive area they worked quite well in making sure that everybody got involved and participated, no matter what their comfort level was, so they were quite good in that respect.' (Interview 15, age 33, Female)*

This finding provides a justification for facilitators' deliberate intent to create a safe and supportive learning environment within the context of the FPSHP (Chapter 3).

Participants also spoke of the learning they experienced as a result of listening to each other, and especially listening to people who worked in very different contexts or with different client groups:

> *'I think the first day…people looked to be quite uncomfortable because it was getting to the bare bones of sexuality, but actually over the ten days I really found I probably got as much out of the group as I did out of the content, because there was people there from very different professions in life and also peoples personal experiences.' (Interview 3, age 37, Female)*

The fact that the facilitators did not end their contact, but continued their support when participants completed the programme, was appreciated and highly valued by the participants. This contact gave the participants a sense of connection to a hub of information and advice, which they could tap into when necessary:

> *'I am on the mailing list and the networking aspect is wonderful because I get notification for stuff that I wouldn't have normally heard of in the past, such as ongoing training. It's excellent because there are networks made and connections set up which are still in place.' (Interview 17, age 59 Female)*

Individual capacity building: Confidence and comfort with sexual health and sexual health promotion

Most capacity building was completed on an individual level where the participants spoke about utilising the skills and knowledge within their own practice as a result of increased levels of confidence and comfort in discussing issues of a sexual nature. All examples of capacity building activities that interview participants indicated that they engaged in after participation in the FPSHP are included in Appendix X, and many of the activities mentioned supported the findings from the surveys.

In terms of confidence, this appeared to operate on two levels. Firstly, attending the programme increased the participants' levels of confidence with the knowledge they had.

This meant that they were confident that the information and advice they were giving others was accurate and up to date:

> *'Yes, certainly I gained more knowledge…I certainly was more knowledgeable, while I would have had a level of knowledge prior to the training, certainly more up to date knowledge that I learnt through the programme and so more confident in having that information, in relation to my own work.' (Interview 2, age 49, Female)*

> *'I think it affected me in a positive way...I suddenly learned newer and more contemporary information and research, which unfortunately sometimes when you don't get on training as often as you should you can be working from older, older information…the programme was strong in that sense, in that it was based on up to date and current research.' (Interview 6, age 46, Female)*

Secondly, the participants reported an increase in their levels of confidence in terms of being able to discuss issues of a sexual nature with individuals and groups. Participants gave a number of examples of how their new found confidence enabled them to create an open dialogue around sexuality, whereas before it might have been perceived as taboo:

> *'We would constantly deal with masturbation issues, thirty times a day, and you know after doing the sexual health course it gave me the confidence to remove any taboos I had about talking about sex or sexual health or masturbation, or trying to explain where to masturbate or how to masturbate properly, if they [clients] are having problems masturbating...So it gave me the skill and the personal self-confidence to openly talk about all that kind of stuff.' (Interview 9, age 35, Male)*

> *'My participation in the programme allowed me to discuss sexual matters with individuals directly; prior to the course I would have avoided the subject. Further, I became aware of my personal discriminations and realised where these came from.' (Survey)*

As well as confidence, most of the participants reported an increased level of comfort when discussing issues of a sexual nature. Prior to attending the course, many of the participants reported a level of discomfort in discussing issues of a sexual nature within their work practices. This discomfort was marked in areas where traditionally issues of a sexual nature were not always at the forefront, for example, in the disability sector. Increasing levels of comfort was often one of the key goals of attending the programme:

> *'I work in the disability area and it [sexual health promotion] was something that was hugely lacking in our area, comfort levels around talking to any service users*

about it. So, yeah, I kind of wanted to know what was general practice out there or how it was dealt with in other organisations.' (Interview 15, age 33, Female)

Comfort was seen by the participants as a key requisite for successful engagement with individuals and groups. The space for and level of self-reflection afforded by the programme assisted the participants to become comfortable with open discussion. One of the participants suggested that this was facilitated by creating an awareness of the participants' attitudes and beliefs and allowing them to acknowledge and 'own' them. Even participants who felt that they had a good level of comfort, reported increased comfort levels following the programme**.** In the following comment, the participants suggest that their improved level of confidence led to the inclusion of sexual health in the youth programme that they operate:

'In general, I am more comfortable in a group situation with young people discussing sexual health. I have included sexual health in some youth programmes. A colleague and I ran a programme for teenagers specifically around issues of sexual health. I have also used some of the facilitation techniques we used [on the FPSHP].' (Survey)

Some of the participants revealed how attending the programme helped them to discuss sexual health in the context of general health and the wider implications that it has. For example, in the quotation below, the participant suggests that she was able to look at health in a more holistic manner, using what she describes as a 360-degree process:

'Its [FPSHP] changed my attitude towards how I work with young people, in the holistic nature that I would approach mental health, sexual health, drug awareness, lifestyle choice, peer education, you know all across the board. The implications of one choice has a knock on effect and can be understood through looking at, you know all, you know the 360-degree kind of experience.'
(Interview 18, age 43 Female)

In addition, some participants reported that they were now considered 'champions' in practice and their knowledge and skills were perceived as a valuable resource. Others described how they had used the programme as a gateway to further education. For example, in the quotation below, this participant had completed an additional course and become a specialist practitioner in sexual health in the area of disabilities:

'I now facilitate a relationships and sexuality course with people with disabilities because I've gone on further [education] after the foundation programme to be trained up in that area.' (Interview 14, age 33, Female)

In some of the interviews, participants described how they incorporated sexual health and sexual health promotion into their work practices within their organisations. For example, prior to attending the programme, they did not cover sexual health promotion in their workplace but after they programme they included it. This often involved tailoring the programme to meet the specific needs of people within their organisations. These innovations often resulted in changes in practice. This is highlighted in the following quotation:

> *'We didn't do much around sexual health. We always had sexual health leaflets around, stuff like that, but we never did specific things. Whereas now we do, we actually have a week where we sit down with our young people that come in and we ask them, what do you know about this, you know, what do you know about that.' (Interview 11, age 28, Female)*

Organisational capacity building: Educational delivery and policy development

The most common method of developing capacity at the organisational level was through the provision of education and training to other members of staff. This occurred both informally or formally. Participants spoke about creating awareness about sexual health and sexual health promotion within their organisation by creating informal opportunities to discuss issues related to sexual health. This dialogue often motivated people to become more engaged in the subject and fuelled people's interests in the area. These actions were seen as empowering and meant that people were able to be open and expressive about sexual health while also embedding it within their work practices.

The second way people built capacity within organisations was through more formal channels of education. In the quotation below, the participant discussed how he had introduced sexual health and sexual health promotion within his organisation:

> *'I've conducted maybe eight or nine workshops since I've returned from the sexual health course. I've introduced it to our staff here, the staff team of twenty-three so I would have done one workshop a month at the start, half day a month at the start of every staff meeting.' (Interview 9, age 35, Male)*

As well as educational initiatives, some of the participants became involved in organisational policy formation and had actually written a local policy. In some areas, this policy was being used to orientate new staff and volunteers in a particular area. In other services, they were waiting for policy approval before implementation. Often, writing the policy meant that other staff members within an organisation needed to be involved in the process that would enable the 'buy in' for changes in practice. In the following quotation, the participant explains that a 'sea-change' was possible because the critical mass required for change was available because five people from the organisation had attended the programme.

The participant describes:

> *'Because five of us from the staff team went and did the training and it was enough to push through a sea-change that was in the wind…We went ahead and consolidated our sexual health policy from doing the course because there were five of us and we were on the same page.' (Interview 18, age 43 Female)*

Another way that organisational capacity was developed was through the participants building up resource files for use by the staff in their work places. This meant that not only were they themselves a resource, but there was also information that could be shared in their absence.

Inter-organisational and community capacity building: Networking and education

The main ways that the participants discussed capacity building at a community or inter-organisational level was through their contact with other organisations where they shared information about sexual health and sexual promotion. This often involved facilitating workshops in other localities, as well as developing informal networks. Many of the participants spoke about keeping in touch with one another and informal networks were further developed in this way. In addition, some of the participants became involved in other organisations and became advisors in the statutory and non statutory sector. For example, one of the participants became a member of a national strategy group and was involved in policy formation at a national level:

> *'I've gotten a lot more involved…I've pushed myself since I came off that course, I'm on the [names committee] of Ireland, as well where there's GP's and there's, sometimes the Minister for Health is there and everything and…I found I used to be very nervous before I did that course, going to these meetings and now I find…I have knowledge behind me, you know.' (Interview 12, age 55, Male)*

Other examples of how the participants built capacity are detailed in the following quotations:

> *'After the training…I organised a week event…This was a series of workshops for young people and their families. The organisation also attempted to run workshops for professionals outside the organisation, however [the] take up was slow. I also ran workshops for staff involved in the organisation and wrote a piece for the newsletter. In the year after, I covered leave in the [names organisation]. The post was a 'sexual health project worker'. In this position, I gained significant experience in terms of facilitation. I worked with a variety of difficult groups, such as sex workers, homeless people, young people, young mothers, and LGBT people.' (Survey)*

'As I am a volunteer worker with [names a group], it can be hard for me to push new initiatives, but the course has made me more confident in putting forward new ideas, , I have given talks to students in [name University]. I also helped to set up and present forums in [names cities in Ireland], I also set up a programme with the [names hospital]. Before I did the course, I did not have the confidence to do a lot of this work but the course helped me to be really comfortable talking about myself and others.' (Survey)

Other people talked about wanting to contribute an article to the Sexual Health Newsletter that was produced periodically. Others wanted to take this further by completing a piece of research in this area. For example, the participant in the following quotation was looking at the provision of providing sexual health education in schools:

'One of the groups that I facilitate is doing a sexual health survey that looks at the quality of sexual health education in schools.' (Interview 18, age 43, Female)

Barriers to capacity building

Despite the many capacity building activities and opportunities, the participants referred to some obstacles to the development of sexual health promotion either on an individual, organisational or community level. For some participants, due to their working practices, there were limited opportunities for capacity building activities. For example, this was the case for participants who were not working in areas where there was a sexual health context and sexual health promotion was not a remit within their work practices (e.g. working in administration). Other participants mentioned that there was no scope for capacity building within their organisation or service and although they found the programme useful on a personal level, it was difficult for them to develop or change practice.

One of the major obstacles was the inability of organisations to *'free up'* people to attend the training. This was mainly due to financial constraints. This was seen as detrimental to capacity building as the participants felt that there needed to be a critical mass in each organisation in order to develop and sustain sexual health promotion activities in practice:

'I suppose the main problem with the organisation at the moment is I know there'll be no more people sent on it…because of cutbacks and funding and stuff. They can't afford to release the staff, you know. Our manager did want to send another few people but it's just not going to happen with cut backs.'
(Interview 14, age 33, Female)

Another barrier that was perceived by the participants was the lack of support from senior management. This meant that the infrastructure required for capacity building was

sometimes lacking. In order to achieve the necessary buy in, the participants felt the 'people of influence' or clinical leaders needed to attend the programme:

> *'Most of the girls who have done the course, it's enhanced their performance in dealing with patients, but if the [medical] consultants went on the training it would be great, but I can't see that ever happening.' (Interview 20, age 42 Female)*

Suggestions for improvement and consideration

Notwithstanding, the overall positive experiences expressed by the participants, a number of reservations were apparent. One issue centred on the length of the programme where some participants felt that the ten days was too long or too extensive. This view tended to be held by people who had a pre-existing strong foundation in sexual health knowledge as a result of prior professional education. Consequently, they were of the view that the programme content could have been covered in less time. The mixed ability of the participants was also commented on by some of the study participants, who were of the view that including people from diverse backgrounds meant that the pace of the course was slower than it may otherwise have been. In this instance, suggestions were made about perhaps delivering programmes to individuals from similar background and levels of knowledge. This would mean a course of shorter duration for individuals who had prior knowledge and experience in the area. There was also some commentary around the use of role play, games and quizzes in the sessions. In relation to the length of the programme, some of the participants felt that if there were less of these types of activities, then the content could be delivered more efficiently or over a over a shorter number of days.

> *'I had the foundation knowledge but what I was looking for, yes it was provided on the course, teaching techniques and things like that, but I felt it was very long and drawn out. I could only attend seven days, out of the ten…what we achieved in that we could have achieved in two days if we had been put into a course where people of the same ability were, you know, I felt there was a lot of time wasted doing role playing...it was just too much really from the point of view that we were in with people that didn't have the same level of knowledge that we had and we were held back with it.' (Interview 13, age 55, Female)*

As stated, some participants mentioned that the duration of the programme made it difficult for them to attend all of the training days due to employment constraints. In this instance, they suggested that online content would make some aspects of the course more accessible. In addition, some of the participants felt that the break between sessions made it difficult for them to get back into the course and some were of the view that time was wasted catching up and revisiting material that had been covered already. There was some suggestion by a small number of participants that by having people from different geographical locations they would learn more about the services in other areas. In this vein,

they also suggested that there should be a greater gender mix within the groups, although it was acknowledged that this might be difficult to achieve. There was also mention of the timing of *'refresher or follow-up course'.* One participant explained how she had attended a follow-up day but they felt it was too soon after the end of the programme.

A number of people made suggestions around topics that they would like to have seen addressed during the programme or addressed in a different way. While participants felt that the lecture on Irish law and sexuality was important, they were of the view that it was not 'applied' and presented in a '*complicated*' and '*confusing'* manner. Several participants felt that a more practical approach, perhaps using case law, would be more interesting and applicable. In addition, people who worked in the disability sector wanted the programme more streamlined to meet the needs of people with a physical or intellectual disability. Other suggestions for content made by interview and survey participants are presented in Table 16[5].

Table 16. Overview of suggested content

Dimensions of sexual health
Relationships and self esteem
Pregnancy and birth
Contraceptives and influence on medication
Sexuality and spirituality
Breastfeeding
Postponing sexual behaviour/Abstinence
Visits to STI clinics
Sexual dysfunction
Menopause
Sexual harmful behaviour/Sexual deviance

[5] It should be noted that each of the suggestions made in Table 16 were made by only one or two participants.

Summary

- Overall the participants were highly positive about their experiences on the FPSHP.
- As well as increases in knowledge and skills, the participants reported a general increase in their levels of confidence and comfort when discussing issues of a sexual nature.
- The participants praised the facilitators for their skills and sensitivity in creating a positive learning environment where the participants felt safe and comfortable to openly discuss issues that were often of a personal nature.
- While the participants' were aware of the need to develop capacity as one of the outcomes of the foundation programme, and reported examples of capacity building at an individual and organisational level, building capacity at an inter-organisational level was more informal and ad hoc.
- There were some criticisms of the programme; some participants perceived it to be too long while others were critical of the breaks between sessions.
- Participants had some suggestions as to content that they would like to see developed or included in future programmes or follow-up days.

Chapter 6: Findings from the Managers' survey

Introduction

This chapter reports the findings from the manager's survey. In total, 101 surveys were sent to managers who released staff to attend the FPSHP and 35 were returned, representing a 35% response rate. The managers' expectations, views on the impact of the programme on capacity building, supports provided to participants and willingness to sponsor other staff to attend the programme are presented. In addition, written examples of capacity building activities described by managers as occurring in their organisations as a result of the programme are included. These exemplars provide evidence as to the impact of the FPSHP at individual practitioner and organisational level.

Managers' expectations of programme

Managers were asked to indicate what their expectations were when they agreed to release a staff member. Only one manager indicated that they '*didn't have any expectations, as didn't know what to expect.'* Analysis of the other written responses suggested that the managers' expectations were primarily focused on building capacity at an individual level, with some expectations of capacity building at an organisational level. There did not appear to be any expectation that the programme would give participants the knowledge and skills to strengthen relationships between organisations or work on sexual health promotion capacity building at a community level.

Individual capacity building

Similar to the facilitators, the managers were aware of the sensitive and taboo nature of sexual health promotion. Consequently, the majority of them indicated that their primary motivation for sponsoring staff was to build capacity at an individual level. Consistent with facilitator perspectives, capacity building at an individual level was conceptualised as enhancing knowledge, comfort and confidence of staff to engage in sexual health promotion and *'talk about sexual issues'* to people across the life course, including children and young people. Some managers had an expectation that staff would acquire knowledge on all aspects of sexual health promotion, including sexual orientation, contraception, legal and policy issues. Depending on the service, managers expected staff to acquire a range of skills, including communication, counselling, problem solving, facilitation, education, and skills in policy writing. For a small number of managers, this included an expectation that the staff member would get the skills *'to deliver RSE and SPHE to a higher standard'.*

The managers' expectations in relation to capacity building at an individual level can best be summed up by the following two quotes:

> *'[My desire is] for staff to be able to respond to issues in a professional, non-judgmental approach, have the knowledge to inform our service users and to support them to make positive choices.'*

> *'[My expectation was] that the staff would be very clear on facts and law of sexual health, and would have new ideas on how to deliver the programme to young people who find talking about sex difficult.'*

Organisational capacity building

The second reason managers sponsored staff was in the hope that staff would return and work on building sustainable sexual health promotion skills within the organisational team and sponsoring organisation. In the words of the managers, there was an expectation that staff attending the programme would share their learning with their colleagues and *'gain the knowledge and skills to pass on to other individuals'*. In addition to building capacity within the organisational team, the managers wrote of the need to build on current sexual health promotion to include work with various groups, such as people living in Direct Provision Accommodation, the Traveller community, transition year and leaving certificate students, parents/carers/foster parents, teens and young people's groups within the community. Interestingly, only one manager wrote of an expectation that the participants would return and work to '*produce a sexual health policy for the service'.*

While a small (n = 3) number of managers wrote of an expectation for networking, the described purpose of networking did not appear to be about building relationships for the purpose of inter-organisational and community capacity building. For most, it was more about information sharing and support for the participants, and to enhance participants working within their own organisation. This is best summed up by the following quote from a manager:

> *'[I expected the staff member] to help with networking which would lead to the person becoming more confident in the subject and be better able to support people who use our services.'*

Managers' views on the extent to which their expectations were met by the FPSHP

Managers were asked to indicate on a scale of 0 (expectations not at all met) to 10 (expectations were met to a great extent) whether their expectations were met. The mean response for this question was 7.6 (SD = 2.3; n = 31) indicating that overall managers were satisfied that their expectations for the programme were met. One of the managers who indicated that the programme did not meet his/her expectations felt that the person

attending was experienced in her area and found the *'course too basic for her needs'.* Another manager wrote that the:

> *'Person attending was on placement for a defined period and has now left the organisation, so didn't get a chance to use the programme.'*

A third manager commented that:

> *'One worker trained in the programme over a year ago with little development within the community, and [the] other two only just completed it, so still may not know the impact of it.'*

Managers' views on the impact of the programme on capacity building

Using a similar type scale, managers were also asked to report on whether they felt participation in the programme had a sustained impact on:

- the person(s) who completed the training;
- the practices of other staff within the organisation; and
- inter-organisational networking related to sexual health promotion.

All responses ranged from 0 'not at all' to 10 'to a very great extent'. Managers were of the view that the programme had the strongest sustained impact on the sexual health promotion practices of the person (M = 7.5, SD = 2.4, N = 34). The mean responses for the impact on the organisation (M = 5.5, SD = 3.2, N = 32) and inter-organisational networking (M = 4.7, SD = 3.2, N = 32) hovered more around the middle, representing the perception that the programme had somewhat of a sustained impact in these areas (see Table 17).

Table 17. Managers' views on the impact of the programme on capacity building

Variable (n)	**Range (observed)**	**Mean (SD)**
Overall, from your perspective, has participation in the programme had a sustained impact on the sexual health promotion practices of……		
the person(s) who completed the programme? (n = 34)	0-10	7.5 (2.4)
other staff within your organisation? (n = 32)	0-10	5.5 (3.2)
inter-organisational networking related to sexual health promotion? (n = 32)	0-10	4.7 (3.2)

In order to explore the capacity building activities the programme had most impact on, managers were also asked to indicate, using a yes, no, don't know response, whether the programme affected 19 sexual health promotion activities. The activities crossed the

individual, organisational and inter-organisational levels of capacity building and reflected the aspirations of facilitators when designing the programme (see Table 18).

Individual capacity building

In terms of activities at the level of individual capacity building, between 45% and 82% of the managers were of the view that five individual staff activities were changed as a result of them participating in the programme. The majority of managers indicated that participants' activities were changed in the areas of assessing the sexual health promotion needs of clients (82%, n = 28) and providing sexual health education to clients or service users in a one-to-one setting (82%, n = 8). Sixty nine percent (n = 24) reported impact on the activity of referring people to sexual health services, with less that 50% reporting impact on providing formal sexual health education to clients or service users in a group setting (47%, n = 16) and attending further sexual health training or education (45%, n = 15).

Organisational capacity building

At the level of organisational capacity building, between 15% and 67% of managers were of the view that participants' practices were affected in the nine activities described (Table 18). The areas that managers indicated the greatest change in were: raising awareness of the need for sexual health promotion within the organisation (67%, n = 22), assessing sexual health promotion education needs of staff within the organisation (42%, n = 14), developing written information on sexual health (41%, n = 13), and developing sexual health services within the organisation (39%, n = 13). The areas that were least affected by the programme were: auditing sexual health promotion practices (19%, n = 6), engaging in research on sexual health (18%, n = 6) and adapting administrative practice, such as assessment forms to include sexual health items (15%, n = 5). The provision of formal sexual health education to staff and the development of sexual health policies/guidelines were in the managers' views only moderately affected by the programme, with only 32% and 23% of managers indicating a change in participants' practice.

Inter-organisation capacity building

At the inter-organisational level, the results were less positive, with just about 13% of managers' being of the view that the programme impacted on the five inter-organisational activities identified (Table 18). The exception was networking about sexual health with other individuals or organisations, which according to the managers, 73% (n = 25) of participants engaged in after the programme. However, the other areas identified were rated very low: developing policy guidelines (12.5%, n = 4), publishing articles (9%, n = 3), providing formal sexual health education outside organisation (6%, n = 2), and developing sexual health services outside organisation (6%, n = 2). Perhaps, this suggests that the exchange of sexual health promotion information and activities between organisations is more difficult to achieve and that the programme is not impacting as greatly on inter-organisational capacity building.

Table 18. Managers' views on whether the programme affected participants' practices

Practice	Yes % (n)	No % (n)	Don't know or N/A % (n)
Individual capacity building practices			
Assessing sexual health promotion needs of clients (n = 34)	82% (28)	3% (1)	15% (5)
Providing sexual health education to clients or service users in a one to one setting (n = 34)	82% (28)	12% (4)	6% (2)
Referring people to sexual health services (n = 35)	69% (24)	14% (5)	15% (6)
Providing formal sexual health education to clients or service users in a group setting (n = 34)	47% (16)	44% (15)	9% (3)
Attending further sexual health training or education (CPD – Continuous Professional Development) (n = 33)	45% (15)	52% (17)	3% (1)
Organisational capacity building practices			
Raising awareness of need for sexual health promotion within your organisation (n = 33)	67% (22)	27% (9)	6% (2)
Assessing sexual health promotion education needs of staff within your organisation (n = 33)	42% (14)	52% (17)	6% (2)
Developing written information materials related to sexual health (n = 32)	41% (13)	56% (18)	3% (1)
Developing sexual health services within your organisation (n = 33)	39% (13)	58% (19)	3% (1)
Providing formal sexual health education to staff within your organisation (n = 31)	32% (10)	58% (18)	10% (3)
Developing sexual health policies/guidelines within your organisation (n = 34)	23% (8)	68% (23)	9% (3)
Auditing sexual health promotion practices within your organisation (n = 32)	19% (6)	75% (24)	6% (2)
Engaging in research on sexual health (n = 33)	18% (6)	76% (25)	6% (2)
Adapting administrative practice to include sexual health items, e.g. developing/changing assessment forms to include sexual health (n = 33)	15% (5)	73% (24)	12% (4)
Inter-organisational capacity building practices			
Networking about sexual health with other individuals or organisations (n = 34)	73% (25)	21% (7)	6% (2)
Developing sexual health policies/guidelines outside of your organisation (n = 32)	12.5% (4)	75% (24)	12.5% (4)
Publishing articles on sexual health (n = 33)	9% (3)	82% (28)	9% (3)
Providing formal sexual health education to staff outside your organisation (n = 33)	6% (2)	82% (27)	12% (4)
Developing sexual health services outside your organisation (n = 33)	6% (2)	85% (28)	9% (3)

Examples of new capacity building activities that managers have seen after the FPSHP

To set the above quantitative data in context, managers were asked to provide examples of capacity building activities they had seen as a result of the person attending the programme. Analysis of the written responses identified six areas of changes in practices: incorporating learning into own practice, development of staff within the organisation, enhancing existing or developing new sexual health education programmes, providing new sexual health information resources, development of new policies and services, and networking with other services.

Managers indicated participants incorporated the learning into their own practice and were more mindful on a day to day basis of the sexual dimension of the clients/service users. Comments included:

> *'I found that the course helped her [past FPSHP participant] considerably in her counselling [on a one-to-one basis] and in making her very at ease in working with sexual and sexual health issues.'*

The second set of capacity building activities related to the development of staff within the organisation, with comments mainly centring on raising awareness within the team of sexual health through the sharing of knowledge and skills or as one manager wrote *'keeping sexual health on team's radar/agenda'.* This appeared to be undertaken through both formal and informal education and support. Some participants clearly returned and engaged in what managers called *'more formal in-service education with staff'*, while others educated staff through sharing insights on a day to day basis. Irrespective of the format, the majority of managers wrote about staff being: *'More confident in their knowledge base of sexual health'* and *'more confident and competent in dealing with issues as they arise'.*

Some managers gave examples of outcomes of this increased knowledge and skills. Comments included:

> *'Staff are advising parents/carers on sexual health/relationship advice for their children and provide them with resource materials…advising parents on the availability of services regarding relationship/sexual difficulties they may be experiencing.'*
>
> *'[Names participant] has shared her sexual health knowledge on language with co-workers and they use it with clients where appropriate.'*
>
> *'Staff developed broader perspective addressing different areas of sexual health.'*

One manager indicated that the outcome of this level of capacity building was clearly evident with the audits being conducted in one aspect of practice within their organisation. This manager wrote:

> *'The information acquired from the programme and information passed on to their [participant's] colleagues is definitely shown in recent [names area of practice] audit.'*

The third set of capacity building activities were within the realm of enhancing and updating existing programmes and the development of new sexual health education programmes. Managers wrote of staff's changed practices:

- 'delivery of sex education during SPHE';
- 'providing sexual health programme to all 2nd year students in community college';
- 'delivery of new programmes, e.g. Before U Decide';
- 'providing sexual health talks to local young group - aged 18-25';
- 'developing training for foster carers, to raise their awareness';
- 'providing information/education on individual basis to young parents'; and
- 'runs men's group focusing on sexual health issues and women's group weekly.'

Some managers spoke of future changes in practice, such as plans to do *'more training with [names a youth organisation] this year and other agencies and plan to do a programme on healthy relationships and sexual health this year also.'*

The outcomes of these activities were more informed clients/service users as indicated by the following manager:

> *'[Our clients are] better informed and more open to seeking sexual health services….Many originate from countries where HIV/AIDS is prevalent…Women support each other and pass down correct information to young women and girls.'*

The fourth set of capacity building activities fell within the theme of updating or providing new written sexual health information materials or other resource materials. Three managers wrote that:

> *'We are adapting sexual health information given to groups that we run.'*

> *'We now have sexual health demonstration box available in youth cafe for staff to use.'*

The fifth capacity building activity related to the development of new policies and services. Only two managers mentioned that the person was 'developing a new sexual health and relationships policy' for the organisation. In addition, one manager wrote of a participant developing a nurse-led smear clinic and integrating the service with current services:

> *'[Names participant] runs nurse-led smear clinics as part of the [names specialist] service. She educates and counsels patients regarding sexual health in these clinics. As a result of the course her confidence in doing so has grown.'*

The final capacity building activity mentioned by managers was in the area of networking with other services. Although managers did not have an expectation for capacity building activity at this level, their written comments indicated that some participants were now combining resources and were starting to work in partnership with people from other organisations. The following are the two examples provided:

> *'Joint facilitation of sexual health promotion stand at the Traveller health event with HSE health promotion officer'*

> *'This staff member is now delivering the programme in association with the health promotion colleague who previously had given her the course.'*

Managers' views on factors that hindered staff making changes

The managers were asked whether they felt any factors hindered staff in making changes within or outside the organisation in relation to sexual health promotion (Table 19). More than 20% of the managers felt that five of the six factors listed were a hindrance, with the greatest proportion identifying competing demands on organisational resources (53%) as an obstacle. Between 23% and 29% were of the view that organisational factors such as: lack of prioritisation of sexual health promotion (29%), a lack of policy supporting its development (26%), and an inability to release staff for education in sexual health promotion (24%) hindered change. Only 6% of managers were of the view that lack of support from colleagues was a barrier to staff in making changes. Three managers provided comments on 'other' factors that may hinder staff in making changes, including that sexual health promotion is not the only area of remit for staff, that timing restricted developments, and that the person they had released onto the programme was no longer with the organisation.

Table 19. Managers views' on factors that hindered staff in making changes in relation to sexual health promotion

Factor	Yes % (n)	No % (n)	Don't know or N/A % (n)
Competing demands on organisational resources (n = 34)	53% (18)	41% (14)	6% (2)
Other (n = 6)	33% (2)	50% (3)	17 %(1)
Sexual health promotion not a key priority for the organisation (n = 34)	29% (10)	65% (22)	6% (2)
Lack of policy supporting sexual health promotion development (n = 34)	26% (9)	59% (20)	15% (5)
Inability to release staff for ongoing education in this area (n = 34)	24% (8)	67% (23)	9% (3)
Sexual health not a priority for in-service education (n = 34)	23% (8)	65% (22)	12% (4)
Lack of support from colleagues (n = 34)	6% (2)	82% (28)	12% (4)

Managers' views on organisational resources and support that enabled change

The development of sexual health capacity building requires organisations to be willing to invest in resources and supports, other than sponsoring a person to attend education. To ascertain the level of supports offered to participants, managers were asked to indicate whether certain resources were made available to participants after the programme. The most common form of supports made available were at a practical level, with interpersonal forms of support, such as mentoring being less common (Table 20). More than half of the managers reported making the following practical resources and supports available: designated time for sexual health promotion activities (65%), physical space (61%), and opportunities for additional training (53%). Less than half reported providing administrative supports (47%), technological support (36%), and financial support (26%). Interestingly, despite the fact that the facilitators of the programme frequently highlighted the emotional and personal nature of engaging with sexual health promotion activities, only a small percentage of managers indicated that they provided interpersonal/emotional support to staff in the form of mentoring within (38%) or outside the organisation (18%). Six managers provided commentary on 'other' resources they made available, with one indicating that the staff member did not ask for any of the supports. Other supports described were a supportive philosophy of the organisation which has a strong focus on sexual health, supportive management and supervisor, allocated time given to deliver the course, and support given to attend other courses and feedback to other staff members.

Table 20. Managers' views on factors that enabled staff in making changes in relation to sexual health promotion

Factor	Yes	No	Don't know or N/A
Practical supports			
Designated time for sexual health promotion activities (n = 34)	65% (22)	20% (7)	15% (5)
Availability of physical space (n = 33)	61% (20)	27% (9)	12% (4)
Opportunities for additional training (n = 34)	53% (18)	35% (12)	12% (4)
Administrative support (n = 34)	47% (16)	41% (14)	12% (4)
Technology support (n = 33)	36% (12)	52% (17)	12% (4)
Availability of financial resources (n = 34)	26% (9)	65% (22)	9% (3)
Interpersonal /emotional supports			
Mentor available within the organisation (n = 32)	38% (12)	50% (16)	13% (4)
Mentor available outside of the organisation (n = 34)	18% (6)	67% (23)	15% (5)
Other			
Other (n = 10)	50% (5)	20% (2)	30% (3)

Awareness of supports offered by the HSE Sexual Health Promotion Team

Managers were asked whether they were aware of the supports offered by the HSE Sexual Health Promotion Team to support the implement of sexual health promotion by past participants. Between 60% and 81% of the managers were aware of each of the supports offered, indicating that the managers are engaged with the programme and the staff they agreed to sponsor. Table 21 provides further details.

Table 21. Awareness of the additional supports offered by the HSE Sexual Health Promotion Team

Support	Yes % (n)	No % (n)
On-going support from the sexual health team (n = 32)	81% (26)	19% (6)
Sexual Health Newsletter (n = 33)	79% (26)	21% (7)
Emails from the sexual health team with updates of interest (n = 32)	75% (24)	25% (8)
Sexual Health Resource Library (n = 32)	69% (22)	31% (10)
Follow-up training days (n = 30)	60% (18)	40% (12)

Releasing additional staff for training

Managers were also asked whether they would release additional staff for the FPSHP programme. The majority reported that they would (73%, n = 24) or might (12%, n = 4) release additional staff for the training; however, 15% (n = 5) reported that they would not release additional staff for the training. Qualitative comments from the managers suggest that the feedback they received from staff participants, together with the changes they observed within their services positively influenced their decision to release staff. Typical comments included:

> *'Team members who attended and who I supervise stated that they thoroughly enjoyed and benefited personally and as a staff member on the training. So based on the feedback, I would be open to releasing more staff members who wanted to attend.'*

> *'All three staff who attended the training found it excellent...engaging and challenging. All brought back to the team ideas and information from the training. The time commitment involved is a problem for a very small team. However, all were pleased they persevered and completed the training.'*

Those who reported they would not release additional staff for the training programme indicated a number of reasons. In addition to the reasons listed in Table 22, one manager indicated that the course '*is too basic and more advanced training is needed',* and another commented, '*that the organisation has since developed its own staff sexual health promotion training programme'*.

The impact of the changing health care environment on managers' willingness to release staff to attend future programmes was also reflected in the qualitative comments, with managers writing comments such as:

> *'In the present funding climate, it is impossible to begin planning new initiatives. All energy and effort is put towards maintaining current services on less funding.'*

> *'It is impossible to release staff due to limitations on non statutory training days. If the team could come to us, it would only be possible then.'*

Table 22. If no, what factors would influence your decision not to release additional staff for FPSHP training programmes?

Factor	N
There was no impact or a limited impact on sexual health promotion practices within the organisation following return of the person(s) from the FPSHP programme.	3
We do not have the financial resources to release staff.	2
The organisation is unable to support the development of sexual health promotion practices within the organisation after a person completes the FPSHP programme.	2
The programme offers poor value for money.	2
The time commitment for the programme is too demanding.	2
No staff are suitable for the programme.	1
No staff are interested in the programme.	1
We no longer have a need sexual health promotion training for staff within my organisation.	0
The location of the training programme is not suitable for staff.	0

Managers' views on how the HSE sexual health promotion staff could improve FPSHP

Managers were asked to provide any recommendations they had for improving the FPSHP and to indicate ways that the facilitators could provide ongoing follow-up support. The quality of the programme and supports offered was clearly evident from the managers' comments. The majority of the managers used this question as an opportunity to compliment the sexual health promotion team on what they considered a quality educational programme facilitated in a professional manner with excellent follow-up and support for staff participants and organisations. The following is a reflection of some of the comments made:

> *'We feel that the current level of support being received from HSE, sexual health mentor is very supportive and sufficient.'*

> *'They are doing a great job at present. I don't believe I require additional supports.'*

> *'Good resource from HSE. Always on email/phone if needed, very quick to reply. It was a fantastic programme with great supports.'*

> *'I would recommend that many disciplines should avail of this course.'*

In terms of improvements, managers did not make any suggestions for improvements within the current programme, but did request that facilitators give consideration to developing other programmes that advance staff knowledge and confidence to address a number of issues.

Areas that managers requested more advanced training included:

- sexual health for teens and teens post-delivery of baby;
- educating parents in talking with their children;
- training in areas of pornography;
- grooming of teenage, young girls using sex for money/favours/a way out;
- strategies for responding to inappropriate sexualised behaviour; and
- education on the impacts of female genital mutilation, fistulas, rape, and sexual exploitation through trafficking.

In addition to advanced education, managers also requested that facilitators assist them in developing written sexual health materials targeted particularly towards children and adolescents, such as:

- 'quality leaflets for 12 year olds, designed for young people (not adults or parents) with diagrams';
- 'a specific booklet on sexual health for children in care, who are often without their own parents to guide them'; and
- 'information for adolescents on sexual health, and sexual health services.'

Some managers requested specific assistance with *'developing organisational policies re: sexual health promotion'* and with *'strategies to overcome barriers and resistance'* to implementing change.

Finally, the managers urged the facilitators to continue their ongoing email communication and support with participants and themselves, to keep them aware of any future courses on offer in the area of sexual health or related areas, such as courses on family support and child protection. One manager suggested that facilitators consider opening the course to administrative staff as in the manager's view:

> *'Many aspects of it [course] could relate to administrative staff and assist in enhancing their understanding of clients.'*

Summary

- Thirty five managers responded to the survey, representing a 35% response rate. They worked in a variety of areas, including community, health, youth, disability and education.
- Managers' expectations were primarily focused on building capacity at an individual level, with some expectations of capacity building at organisational level, and generally they felt satisfied that their expectations had been met by the programme.

- In terms of capacity building at the three levels, managers reported a greater level of impact on practices at the individual level, with some impact at organisational level. However, there seems to be a limitation to the free flow of what was learned in the course to benefit anyone outside of the organisation that sponsored the participant.
- The FPSHP was perceived by managers to have the most impact on activities involving people skills, such as one-to-one education (82%), raising awareness (67%) and networking (73%); and evaluation skills, such as assessments (82%) and making referrals (69%). It was reported to have the least effect on activities involving writing skills, such as research (18%), writing articles (9%), and policy development (23%). Most likely this is related to the activities of the organisations the participants are from.
- The majority of managers reported that they would or might release additional staff for the training; however, 15% reported that they would not release additional staff for the training, and identified financial resources as the main barrier.

Chapter 7: Discussion, strengths, limitations and recommendations

Introduction

This chapter concludes the report by discussing the findings from the evaluation of the effectiveness of the FPSHP in the context of the objectives of the study. This includes consideration of the literature and the scoping exercise carried out to review the landscape of education and training for those involved in sexual health promotion within Ireland. The final sections in this chapter outline the strengths and limitations of the research, and the recommendations that arose from the study.

The objectives of the study were to:

- evaluate the impact of the FPSHP (and support activities) with regard to its creation of sexual health promotion capacity within individual participants and their organisation;
- assess the FPSHP's approach with regard to sexual health training as a capacity building measure;
- complete an overview of sexual health promotion training within Ireland and to comment on the FPSHP against this landscape;
- make recommendations regarding potential future directions within HSE South with regard to sexual health training as an element of capacity building; and
- draw a conclusion as to whether the FPSHP showed sufficient promise to warrant the feasibility study with regard to its expansion beyond HSE South.

Discussion

Sexual health promotion capacity building requires a holistic, multifocal, multi-sectoral and interdisciplinary approach (World Health Organisation 2010) that needs to be underpinned by particular knowledge, skills and competencies. In terms of sexual health capacity building, the FPSHP is an example of a programme that sets out to develop sustainable skills, organisational structures, and commitment of staff in health, social care and education sectors to multiply sexual health gains at the individual, organisational and inter-organisational level. In the context of Hawe et al's (1997) three levels of capacity building, the overall conclusion of this research is that the evaluation of the programme supports its effectiveness in terms of capacity building in sexual health promotion, in particular at the personal and an organisational levels through the building of resources, skills and services within organisations. Evidence of capacity building at a personal level is based on the fact that participants in the programme reported an increased effectiveness and substantial broadening of their sexual health promotion activities. At an organisational level, participants' impact on colleagues and organisational culture was emphasised and further acknowledged by their managers and facilitators who provided evidence to corroborate the findings from participants. At an inter-organisational level, the stakeholders involved in the

study (participants, managers, and facilitators) provided some evidence of capacity building in terms of networking, but concrete examples of collaboration in sexual health promotion activities, or exchange of services were rare.

The limited international and national research available concludes that sexual health promotion training experiences can enhance the knowledge, skills and confidence of participants (Byrne et al, 2006; Walker and Harrington, 2002; Post et al, 2008; Higgins et al, 2012). Education and training are also suggested as a means of providing support and assistance to sexual health promotion workers who might feel isolated in their sexual health promotion work, in addition to helping them develop a cadre of 'key allies' (Department of Health UK, 2003; Higgins et al, 2012). Byrne et al (2006) also indicate the importance of providing education and training in sexual health promotion to non-specialist practitioners, particularly where sexual health clinics are in high demand but have restricted resources. In the context of the FPSHP, it is clear that the success of the programme in capacity building at the individual and organisational level is linked to its emphasis on 'communication' at every stage and with all stakeholders. At its core, participants are trained to overcome obstacles to effective communication and develop comfort and confidence to communicate with clients and groups. Programme facilitators teach and model these skills in various ways and communication between participants is promoted. Thus, upon returning to practice, participants build on and expand their sexual health promotion activities not only within their own zone of practice, but by extending their sexual health promotion activities within the wider organisation.

In addition to the emphasis on communication within the training programme, the facilitators also communicated with the participants and their managers before, during and after the programme. Previous researchers who have evaluated sexual health education programmes which were aimed at the level of individual capacity building, comment on the challenge of maintaining and supporting any changes accrued from the initial educational programmes and many suggest the need to develop supports to sustain change following programme completion (Ahmed et al, 2006; Mayock et al, 2007; Fronek et al, 2011). The follow-up supports and communication in the FPSHP were not just a formalised process through a newsletter or official email bulletins but also operated at a personal level. Again, these forms of communication were seen by all stakeholders in this evaluation as instrumental in generating and nurturing a sustained impact at the individual and organisational levels, with managers particularly welcoming support and advice on issues, such as developing local policies and responding to challenging clinical situations.

While communication between participants is promoted within the programme, and findings demonstrate that this has led to increased networking across organisations, as stated previously, examples of inter-organisational capacity building were less evident. While inter-organisational collaboration may not have been a primary aim of the FPSHP, it is

desirable that capacity building at this level be expanded. In Ireland, "partnership working is now perceived as being integral to the health promotion function" (McKenna et al, 2004, p.viii). In particular, collaborations may be an economical way of optimising the effective yield of the programme in terms of minimising the resources required, sharing organisational learning and avoiding needless duplication of service. Welfare and Lighton's (2011) study highlighted the value of information and best practice sharing, and the combining of resources for service development and evaluation in sexual health promotion. This can lead to the sharing of expertise and best practice models, as well as sharing knowledge and information relating to emergent developments in sexual health promotion. Evidently, in today's climate of scarce resources, and the importance placed by managers and participants on financial restrictions and time as a barrier to further capacity building, measures to build inter-organisational capacity are worthy of exploration in the future development of the programme.

Of course, the position can be taken that networking is a preliminary phase in building inter-organisational capacity and as such it may be too early in the dissemination of the programme to expect further collaboration. Nonetheless, the programme facilitators may wish to consider its communication model. Perhaps, the 'Hub and Spokes' model which seems to be the dominant way of interacting with participants can be expanded by putting more emphasis within the programme on how the 'spokes' and their organisations can better communicate and collaborate (Bryan and O'Kelly, 1999; Rogers et al, 2009). Respondents in Welfare and Lighton's (2011) study highlighted the value of information and best practice sharing, and the combining of resources for service development and evaluation in sexual health promotion. This can lead to the sharing of expertise and best practice models, as well as sharing knowledge and information relating to emergent developments in sexual health promotion (Department of Health UK, 2003). The World Health Organisation (2010, p.vi) similarly promotes "a holistic, multi-sectoral and interdisciplinary approach" to sexual health. Collaborative working is clearly a key component of capacity building and a review from the wider health promotion literature has also emphasised the beneficial effectiveness of strategic networking and alliances (Gillies, 1998).

One of the objectives of the evaluation was to assess the FPSHP's approach against internationally recommended best practice with regard to sexual health training. The Department of Health UK (2003) advocates for interdisciplinary training and development among professionals and organisations involved in sexual health. Similar to others, they view this form of learning as a means of forging strategic alliances and building interconnections between disciplines and organisations. While a small number of participants were critical of the interdisciplinary mix in terms of knowledge differences, findings from the evaluation of the FPSHP clearly demonstrate that the programme is attracting participants from an array of disciplinary backgrounds and organisations and is in

keeping with best practice in this regard. This points to the potential for alliance formation, however to affect this outcome, perhaps more emphasis is required on building and supporting interconnections within the programme. Similar to the findings of this evaluation, the recent Healthy Ireland, Framework for Improved Health and Wellbeing 2013-2024 (Department of Health, 2013) also explicitly recognises the importance of building partnerships across sectors and communities to affect health and well-being in the population. The facilitators' suggestion to establish localised participants supports where a critical mass of individuals has completed the FPSHP is one measure towards this end. However, the organisational cultures and history of collaboration, or absence thereof, may need to be considered, as organisational structures may prohibit a more elaborate joining of forces. There is also a need to explore the nature and type of collaborations and cross-fertilisation which would be beneficial for the organisations involved.

In relation to the programme structure and processes, findings from the evaluation suggest that the FPSHP is contemporary in its educational philosophy and 'critical' pedagogical approach. It is now recognised that to be effective, capacity building within sexual health education must engage participants as cognitive, emotional and reflexive beings, and provide participants with opportunities to socially transform their views and beliefs (Kippax and Stephenson, 2005). It is also recognised that this is best achieved through the use of participatory and experiential teaching methods. Findings from both facilitators' and participants' interviews clearly demonstrated that in addition to framing the FPSHP on Kolb's (1984) experiential learning cycle, the facilitators viewed learning as an active rather than a passive process. Facilitators referred to selecting a range of teaching and learning strategies that enabled participants to think critically about sexual issues, to explore their attitudes and beliefs, to share their wealth of personal experience, and to develop the comfort, confidence and skills necessary to transfer and attend to the relevance of the educational material to their own practice. Having said this, there is a growing body of literature on the use of Interactive Computer-Based Interventions (ICBI) for sexual health promotion. For example, Bailey et al's (2010) systematic review of 15 randomised controlled trials of ICBI found them effective tools for learning about sexual health. While the review did not include studies that were focused on people involved in sexual health promotion, given the current drive towards e-learning and the e-health agenda, the possibility of developing and incorporating aspects of online learning into the programme (blended learning) should be explored. Online learning has previously been advocated as a potential means to innovatively promote sexual health in the Irish context by Layte et al (2006) and may offer the potential to decrease facilitator and participant burden. It could also offer a flexible, more sustainable approach to the continuance and expansion of the FPSHP without compromising on the emphasis on active and participatory learning.

In addition to attending to contemporary thinking on teaching methodologies for capacity building, the findings of this evaluation demonstrated that facilitators were very aware that engaging in sexuality and sexual health promotion education was more than a cognitive endeavour. Similar to other writers, they recognised that sexual health promotion education has the potential to 'evoke a variety of emotional responses and reawaken past hurts and painful memories in the participants' (Murphy-Lawless et al, 2008, p.62). Consequently, the facilitators spoke of creating a safe educational space that combined challenge with emotional support, and modelled the skills of empathy, staying with silence, and self-care skills, as well as giving participants the right to choose not to participate in exercises.

Another objective of this evaluation was to comment on the FPSHP against the landscape of other sexual health promotion training within Ireland. In total, 16 programmes were identified that had elements of sexual health organisational or inter-organisational capacity building as part of their remit. The programmes identified were varied in terms of target audience, duration, cost and capacity building focus. The majority of the programmes were aimed at those working with young people or young people themselves, as opposed to the life course approach evident in the FPSHP. Although a number of programmes included specific capacity building skills, such as focusing on how to deliver workshops or talks, the breath of capacity building activities that was evident in the FPSHP did not appear to be present, such as the focus on organisational policy development and inter-organisational networking. However, without an in-depth evaluation of these programmes, this interpretation needs to be treated with caution and any further comments or comparisons are not possible.

In the context of such training it is clear the FPSHP is a unique programme. No similar programme with a sexual health capacity building focus was found in the literature or through contact with individual organisations. What does exist appears to be information oriented programmes that are topic oriented or focused on the needs of a particular age group, such as young people as opposed to taking a life course approach.

In terms of the various stakeholders' satisfaction with the programme, findings from the participants and managers show that they were very satisfied with the programme, its facilitation and follow-up activities, as well as its sustained impact on their sexual health promotion work. The interviews with FPSHP participants and qualitative comments in surveys demonstrated a positive perspective on what the programme meant for the participants, in particular their enhanced confidence and competence in communicating about sexual matters, and knowledge of the field. Although specifically invited, few substantial criticisms were expressed, with the exception of comments on the challenges in maintaining the pace of learning for those with more advanced knowledge on sexual health and some comments on the amount of experiential learning exercises. Similarly, few

obstacles to the implementation of the learning were mentioned: the main obstacles being lack of financial support, time, and for some participants, the organisational culture.

The surveys of the managers were also positive and affirmed the beneficial impact of the programme on the participants and the organisation. Furthermore, the managers' surveys confirmed what had been found in the participants surveys and interviews that financial matters are a core factor in limiting participation in the programme and capacity building. The managers also substantiated their role in supporting participation in the programme, which reinforces the importance of ongoing communication with them before, during and after the programme. The findings from the participants and managers also confirmed what the facilitators emphasised within the focus groups as core aims of the programme, such as confidence building, communication skills, personal awareness, as both groups referred to or praised the same aspects of the programme.

In summary, findings from this evaluation demonstrate the positive impact of the FPSHP and its related support activities with regard to its creation of sexual health promotion capacity within individual participants and their organisation. The programme is in line with the limited international evidence and recommendations on best practice with regard to sexual health promotion training and is unique as a capacity building measure within the Irish context. According to Healthy Ireland, "Basing Ireland's health promotion policies and programmes on robust evidence means that interventions will be in line with international best practice, cost-effective, integrated with service delivery and more likely to make an impact" (Department of Health, 2013, p.7). Although the evaluation has a number of limitations, which will be discussed in the next section, this evaluation is a step in the right direction by providing empirical evidence to ensure that Healthy Ireland's aspirations are achieved.

Strengths and limitations of the study

In establishing the value and significance of the findings of the study, the following strengths and limitations need to be considered.

Strengths

- The diverse methodology (survey, interviews, and focus groups) has made it possible to compare findings from one source of data with the other. This has added considerably to the strength of the evidence, in particular because findings were to a large extent concurrent across the different methodologies.
- The involvement of three groups of stakeholders in this study (participants, managers, and facilitators) has enabled the researchers to include three different perspectives on the FPSHP programme and its impact.

- The size of the survey sample is one of the main strengths of this evaluation. Only a little less than half of the people who completed the FPSHP programme (n = 200) participated in the survey (n = 97).

Limitations

- The development and execution of the evaluation study took place post-hoc. With a more integrated evaluation methodology, the study could have been strengthened in the following ways: a more reliable pre-measure could have been used instead of the retrospective questions on the participant's activities and perspectives; a control group could have been added with sexual health professionals who did not take part in the FPSHP programme; and participants who did not complete the programme could have been included in the study. A full randomised controlled trial (RCT) with pre- and post-measures was not feasible for the present study. However, future efforts to evaluate the FPSHP programme should aim for such an approach.
- While unavoidable, the voluntary basis of participation may have led to a bias towards interested participants who had positive memories from their participation in the course and found it enjoyable to be reminded of this. The same issue around the representativeness of the sample is that participants who sought further training through the programme were overrepresented in the survey sample. The latter factor was found to contribute to the extent of the perceived sustained impact of the programme, but overall did not show significant correlations with satisfaction and other ratings. In short, this did not seem to have affected the overall evaluation.
- It must also be recognised that part of the selection process onto the programme included screening out people who had limited opportunity or motivation to use their learning in practice; thus, the participant group could be said to be positive-oriented from the outset.
- A relatively low response rate of 35% was achieved from the managers' group. Although this is not an unusual response rate for survey research, it did limit the array of statistical tests that could be performed.

On balance, the strengths outweigh the weaknesses and the support participants have expressed for the programme should be seen as a genuine reflection on the quality of the programme and its impact.

Recommendations

In light of the findings and limitations, the following recommendations are proposed.

Expansion of the programme

In view of the positive feedback and capacity building outcomes at individual and organisational levels, it is recommended that:

- the programme in its present form is suitable to be considered for roll out in other areas beyond the HSE South; and
- a strategy is developed that addresses the preparation of facilitators, the provision of supports and other resources, and the concerns of the current facilitators in the event of a roll out elsewhere.

Maintaining the strengths of the FPSHP

- In view of the positive appraisal by participants of the FPSHP content, materials and process, it is recommended that the programme continues to:
  - use teaching methodologies that focus on active learning, reflective practice and application of learning to practice;
  - emphasise the development of participants' facilitation skills;
  - use the interview to ensure that participants are aware of the content and methodologies employed during the programme, the commitment required to achieve the expected outcomes in terms of capacity building and their organisation's sexual health promotion goals prior to coming on the programme;
  - provide follow-up days with content responding to recommendations of past participants, organisational contacts and emergent concerns in the field, while exploring ways of increasing uptake;
  - provide the ongoing supports (email contact and resource library), while exploring ways of increasing the use of the Sexual Health Resource Library;
  - provide participants with resource materials on sexual health promotion;
  - make use of skilful facilitators such as the ones presently involved; and
  - remain in contact with participants after the programme has been completed.

- In view of feedback and recommendations from participants on ways to improve the programme, the facilitators should consider:
  - amending the term 'foundation' in the name of the programme as it does not fully represent the advanced nature of the programme;
  - adding information (for instance in the newsletter) on funding opportunities available to voluntary or community groups around sexual health promotion; and
  - making available to participants good exemplars of organisational sexual health promotion policies to support participants in the development of such policies.

- In view of the research findings that suggest capacity building at an inter-organisational level could be enhanced, the facilitators should consider:
  - placing greater emphasis within the programme on the importance of building capacity at the inter-organisational level (beyond the level of networking);
  - exploring strategies to enhance collaboration and sharing of resources between individual participants and organisations during and post programme; and
  - developing additional units of study/strategies on inter-organisational capacity building for past participants and others who already have broad sexual health knowledge and experience.

- In recognition of the nature of the subject matter and the emotional demands of the programme on the facilitators, consideration should be given to:
  - providing facilitators with access to a formal system of clinical support or supervision, or peer supervision.

- In view of the feedback from past participants and the increasing challenges managers will face in releasing participants to attend both the programme and follow-up days, consideration needs to be given to:
  - developing creative strategies to address barriers in terms of individual and organisational access to and participation in the FPSHP and follow on courses;
  - diversifying the format of the programme offered to cater to different needs of participants and organisations;
  - developing and evaluating some aspects of the information as online learning resources, while maintaining the focus on process skills. Blended learning may be particularly useful for the follow-up days or other information aspects of the programme; and
  - exploring the feasibility of developing an online forum or other types of networking opportunities for those involved in sexual health promotion regionally and nationally.

Further research and evaluation

In view of the limitations of this evaluation, and the absence of evaluations of similar programmes within the literature, specific consideration should be given to strengthening the current approach to evaluation through:

- the use of robust evaluation methods (pre-post designs and randomised control trails) to study the long-term benefits and outcomes of the programme; and
- the development of research studies to compare the outcomes of different modes of delivery of sexual health promotion education such as face to face versus blended learning.

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Appendices

Appendix I: Examples of Irish strategy/policy and research documents that address sexual health and/or sexual health promotion

Title	Organisation
A National Health Promotion Strategy - Making the Healthier Choice the Easier Choice	Department of Health (1995)
The National Health Promotion Strategy 2000-2005	Department of Health and Children (2000a)
AIDS Strategy 2000: Report of the National AIDS Strategy Committee	Department of Health and Children (2000b)
Get Connected. Developing an Adolescent Friendly Health Service	National Conjoint Child Health Committee (2001)
Quality and Fairness - A Health System for You	Department of Health and Children (2001)
Southern Health Board Strategy to Promote Sexual Health 2001-2011	Southern Health Board (2001)
Sexual Health of the Irish Adult Population: findings from SLÁN	Shiely et al (2004)
The SAVI Report: Survey of Sexual Abuse and Violence in Ireland	McGee et al (2002)
Strategy to Address the Issue of Crisis Pregnancy 2004-2006	Crisis Pregnancy Agency (2003)
Review of the National Health Promotion Strategy	Department of Health and Children (2004)
Irish Contraception and Crisis Pregnancy Study (ICCP). A Survey of the General Population	Rundle et al, (2004)
Sexual Health Strategy Promoting Sexual Health and Well-being in the Midland Area	Health Services Executive (2005)
The Sexual Health Strategy (HSE Eastern Region)	Department of Public Health, Health Services Executive Eastern Region (2005)
Surveillance of STIs. A Report by the Sexually Transmitted Infections Subcommittee for the Scientific Advisory Committee of the Health Protection Surveillance Centre	Sexually Transmitted Infections subcommittee for the Scientific Advisory Committee of the Health Protection (2005)
Irish Study of Sexual Health and Relationships	Layte et al (2006)
Strategy Leading and Integrated Approach to Reducing Crisis Pregnancy. 2007-2011	Crisis Pregnancy Agency (2007)
National Women's Strategy 2007-2016	Department of Justice, Equality and Law Reform (2007)
Relationships and Sexuality Education (RSE) in the Context of Social, Personal and Health Education. An Assessment of the Challenges to Full Implementation of the Programme in Post-primary Schools	Mayock et al (2007)
Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010). A Survey of the General Population	McBride et al (2012)
National Strategy. Participating in a National Approach that Promotes Good Sexual Health, Informed Decision-making, Evidence-Based Practice and Access to High Quality Services. 2012-2016	Health Services Executive Crisis Pregnancy Programme (2012)
Healthy Ireland. A Framework for Improved Health and Wellbeing 2013-2025	Department of Health (2013)

Appendix II: Literature review grid

Name/Country	Sample	Intervention	Description of Intervention	Evaluation Methodology	Outcome Measures Used	Benefits/Findings
Walker and Harrington (2002) USA	109 staff from four long-term residential care settings	To pilot test a training programme of Sex and Sexuality in long-term care.	Participants attended one or more training sessions based around four programme topics: 1.Need for sexuality and intimacy 2. Sexuality and dementia 3. Sexuality and ageing 4. Family and personal issues	Pre-test, post-test questionnaire design before the intervention & at the completion of each module. Programme evaluations by participants. Training observation & instructor interviews.	Knowledge and Attitudes Towards Elderly Sexuality Scale (KATES) developed by the researchers. Nine item participant evaluation form. Observation of training by researchers and interviews with instructors.	Training modules were found to improve staff knowledge and attitudes towards sexuality. However, improvement was not the same across all modules. A need to revise the content of the modules and the KATES instrument was identified.
Wight and Buston (2003) Scotland	81 teachers (divided between intervention and existing programme)	Teacher training programme, to enable teachers to implement the SHARE curriculum. Training aimed to enhance comfort and confidence to delivery sex education; prepare participants to deliver SHARE; improve understanding of the theoretical rationale for the methods involved in the programme.	Module 1 delivered over 2 days. Module 2 delivered over 2 days. Module 3 – follow-up date	Cluster randomised trial. Twenty-five schools in Easter Scotland (12 intervention, 12 existing programme). 1 School did not participate in training. Participant observation, in-depth interviews (n =15), Self-complete questionnaires before, on completion of year one training and prior to the final day of training, observation of lessons.	No detail proved on the questionnaire design etc.	Findings demonstrated that perceived comfort and confidence to deliver sex education and the programme were achieved. Programme benefits included colleague support, familiarisation with the programme and experiencing the exercises as a pupil themselves. While the ability to conduct classroom discussions was enhanced, the introduction of skills based exercises to classrooms following the programme was the least successful aspect of the training for teachers.
Byrne et al. (2006) England	10 HIV clinic nursing staff	Training package to enable nurses to address sexual health needs of people living with HIV	Development and delivery of a training package including: motivational interviewing; counselling skills; &Models of Behaviour Change (Prochaska and Di Clemente 1982) which was delivered over 1 day with a follow-up 6 months later	Four item questionnaire and qualitative feedback obtained before, immediately after and at six months post the intervention	Knowledge and confidence in using motivational interviewing and knowledge and confidence in dealing with sexual health issues.	Greatest benefit was an increase in knowledge of & confidence in using motivational interviewing in the context of sexual health promotion.

Ahmed et al. (2006) South Africa	24 teachers	Process evaluation of a 6 day programme for Grade 8 (14 year olds) teachers to provide them with knowledge and skills to deliver sexuality education. Programme addressed factual information, facilitation skills & self awareness, values & beliefs relating to sexuality education.	Four full days delivered over 2 consecutive Friday and Saturdays. Followed by 2 refresher days, 1 delivered at 2months and the other at 5 months after the initial days.	Process evaluation. Anonymous questionnaires using open ended statements and questions at four time periods: before, on completion of the four day training & after each of the refresher days. Participant observation by a clinical psychologist during the training.	Open ended questionnaires and were analysed using thematic analysis. Questions before training included: expectations for training; values and beliefs in relation to sexuality; comfort with teaching the subject to youth; areas of discomfort and teaching skills. Questions on completing training included: understanding of and feelings about the curriculum, comfort and confidence in teaching the curriculum, foreseeable challenges. Questions following refresher days included: experience of the curriculum; student engagement; skills and knowledge used from training or lacking; comfort, confidence and support needs.	Increased confidence and comfort were reported in relation to teaching sexuality in the curriculum. Knowledge deficits were identified following refresher days. Difficulties were encountered with transferring sexual reproductive knowledge and facilitative education methods to the classroom. The researchers highlight a need for ongoing support and engagement with teachers.
Post et al. (2008) The Netherlands	283 interdisciplinary rehabilitation professionals	Discipline-specific sexological training for rehabilitation professionals. Aim was to improve knowledge and attitude to enhance ease at discussing sexuality matters.	Physicians, psychologists and social workers underwent 3 units of learning of 3 hours each. All other disciplines underwent 2 units of three hours each. A 170 page reader was designed and supplied to all participants. Each discipline was trained apart.	Pre-test, post-test questionnaire design. Measurements were taken at the start and end of training and 3-4 months following training.	Dutch adaptation of the Knowledge, Comfort, Approach and Attitudes towards Sexuality Scale (KCAASS)	Sexological competence of rehabilitation professionals differed. The training demonstrated improvement in self-perceived sexological competence in participants.

Murphy-Lawless et al. (2008) Ireland	58 women	WiSE-UP pilot programme on sexuality education designed by the Irish Family Planning Association for Women from communities experiencing social exclusion. One of the course aims was to enable participants to develop teaching, facilitation and other skills to enable them to act as educational resources.	The course incorporated a wider range of sexual health issues, focused on exploration of values and strategies for managing difficult situations in sex education.	Mixed method evaluation using a quantitative questionnaires, individual and group interviews with participants	Evaluation questionnaire was developed by the research team for the purposes of the study. Interview guides were used for the individual and group interviews.	Participants reported increase knowledge and understanding in relation to the course content. They also reported enhanced confidence, the development of personal skills and expressed the view that the course should be made available to more people from their communities.
Fronek et al. (2011) Australia	37 multidisciplinary practitioners previously randomized to experimental and control groups. (These 37 were from the original 89 participants)	2-year follow-up to a randomized controlled trial examining effectiveness of a sexuality training program for practitioners in spinal cord injury rehabilitation.	1 day training programme developed based on a local needs assessment (Fronek et al 2005) and the Permission, Limited Information, Specific Suggestions and Intensive Therapy model (PLISSIT)	Questionnaires completed at 3 months and 2 years post the intervention. Open questions on attitudes, training benefits & future needs. Focus group within the service involved in the trial on benefits and challenges of training.	KCASS questionnaire completed by the control and experimental groups	
Higgins et al. (2012) Ireland	29 interdisciplinary staff completed questionnaires & 12 staff interviews	Sexuality Education Programme for staff working with people with an acquired physical disability	1 day education programme using the (PLISSIT) Model (Anon 1976). Content included sexuality as a multi-dimensional concept and the impact of acquired disability on sexuality	Sequential mixed method design using pre-test post-test questionnaires and interviews	Knowledge, skills and attitudes measured using a questionnaire based on Kendall et al.'s (2003 Comfort, Approach and Attitudes Sexuality Scale	Statistically significant increases in knowledge, skills and attitudes demonstrated. Level of comfort did increase but not as statistically strong. Participants felt they were more aware of clients sexual needs.

Appendix III: Examples of sexual health education content in relation to capacity building recommended in the literature

Draw on models of sexual health that are positive and affirmative, and not a deficit model emphasising disease and dysfunction	Atkins et al (2004)
Family planning	RCPI (2012)
Sexual and reproductive health, and HIV	IPPF (2006), Ahmed et al (2006)
STI screening and management	RCPI (2012)
Sexual violence	Ahmed et al (2006)
MDT approach	RCPI (2012)
Sexual decision-making	Ahmed et al (2006)
Continuous Professional Development	RCPI (2012)
Knowledge of human sexuality and sexual health from biological, physical, psychological, social, spiritual and emotional perspectives, sexual health needs of specific groups	Department of Health UK (2001), Southern Health Board (2001),PAHO/WHO (2002), Department of Health UK (2005), Department of Public Health, Health Services Executive (2005), IPPF (2006)
Promote sexual health and well-being, sexual rights, sexual citizenship	Department of Health UK (2005), IPPF (2006), World Health Organisation (2006), IPPF (2006)
Relationships	Department of Health UK (2001), IPPF (2006), Department of Health Social Services and Public Safety (2008)
Gender	IPPF (2006)
Educational knowledge to enable programme design, implementation and evaluation	PAHO/WHO (2002)
Teaching, facilitation and personal skills	Ahmed et al. (2006), Higgins et al (2008)
Attitudes towards and values relating to sexuality	Department of Health (2001), PAHO/WHO (2002), Atkins et al (2004), Ahmed et al (2006)
Skills to identify issues relating to sexual health and facilitate appropriate referral	PAHO/WHO (2002)
Knowledge of different sexual orientations and practices	PAHO/WHO (2002)
Awareness of cultural differences/cultural competence	Department of Health UK (2001), Hicks and Thomas (2005), Department of Health Social Services and Public Safety (2008)
Knowledge of and ability to work with diversity	Department of Health UK (2005), IPPF (2006)
Inter-personal and communication skills	Department of Health UK (2001), Department of Health UK (2005), Hicks and Thomas (2005)
Education should enable participants to acquire skills to implement the knowledge acquired	World Health Organisation (2006),
Information	Department of Health UK (2001)
Needs of those with a disability	Department of Health Social Services and Public Safety (2008)
Pleasure	IPPF (2006)

Appendix IV: Description of the Foundation Programme in Sexual Health Promotion

The FPSHP was developed in response to the need for 'training for trainers' course of sufficient breadth and duration to develop the sexual health promotion capacity of health, education and community workers. The course aims to "To enhance participants' capacity to incorporate sexual health promotion into their work through the development of their comfort levels, confidence, knowledge and skills in relation to sexual health". Each course has two facilitators from a current pool of 9 facilitators and one external presenter supports the sexuality and law day. In acknowledgement that training is only one facet of capacity building, participants and their organisations are offered ongoing support and access to resources. These include:

- follow-on sessions for past participants;
- the publication of a biannual newsletter;
- support to organisations on policy and intervention/programme development; and
- the provision of a sexual health resources and literature library service.

Philosophy which underpins the FPSHP: The FPSHP takes a positive and holistic life course approach to sexual health, working from the premise that people are sexual beings from before birth until death. It acknowledges that individuals have different needs and wants related to their sexuality and sexual health throughout their life course which include, but are not restricted to, those associated with sexual activity. The FPSHP promotes sexual wellbeing with due regard to the prevention and treatment of sexual ill-health

Approach, content, and methodology: The approach of the FPSHP is informed by the criteria set out in the document 'Recommended quality standards for sexual health training' (U.K. Dept. of Health, 2005) and the choice of topics was influenced by practitioner experience and documentation from the International Planned Parenthood Federation (IPPF, 2006). The course teaching methodologies incorporates individual reflection, paired sharing, small group work and large group processing. As the FPSHP puts a particular emphasis on the exploration of participants' own attitudes and values with regard to sexual health, it is of paramount importance that the methodologies and facilitation create a safe learning space.

Duration of the course: The FPSHP is a 10 day programme run over 4-5 months. The length of the course was decided with reference to international experience and to a regional feasibility study (O Leary, 2008), which was carried out before the design of the programme.

Ongoing Evaluation: Prior to the start of each programme, participants complete a self assessment with regard to their knowledge, skills and personal awareness in relation to sexual health and then reassess themselves on completion of the course. In addition they fill in an 'impact and satisfaction' evaluation form. The information discerned from these by the facilitators feeds into future deliveries of the course

Cost: Currently the main costs of the FPSHP are those associated with administration, course preparation and delivery time. These costs are met within the core budget of Health Promotion with the exception of one facilitator who is based in Public Health Nursing. Where possible the course utilises free venues (however attention has to be paid to the suitability of such venues for a 10 day programme with sensitive content and processes). At present, the Health Promotion and Improvement Department does not change a course fee, however participants and their organisations cover travel and subsistence costs.

Target participants: The FPSHP seeks to integrate sexual health promotion into the core work of diverse disciplines within the health, education and community sectors. Thus participants are drawn from these sectors and the recruitment policy favours those working with disadvantaged groups. By Sept 2012, 200 people from the following disciplines completed the programme:

HSE: Social work (Children and Disability focus), Nursing (Public Health, Mental Health), Psychology, Colposcopy /Gynaecology, Midwifery/Antenatal care, SATU, Substance misuse awareness and prevention, Youth and Disability Residential Care.

Non-HSE : Practice Nursing, Family Support, Lone Parent Support, Youth work, Sexual and Domestic Violence agencies, Disability organisations (physical and intellectual), Community workers, Lactation Consultants, Counselling and Psychotherapy, School Completion, 2nd and 3rd level education inc: School nursing, School Counselling , SPHE teaching, lecturing.

Application Process: There is a two step application process whereby applicants are short-listed on the basis of their application form and then are invited to have a phone conversation with facilitators to ensure that the course is suitable for their preferred learning style and that the learning can be applied to the benefit of their client group. The training group (max of 20) is then formed based on the relevance of the training to the applicant's core work, the suitability of the content and methodology for the applicant and a mix of HSE and non-HSE staff. Priority is given to those who work with marginalised, at risk or vulnerable groups

International Planned Parenthood Federation. (2006). *IPPF Framework for Comprehensive Sexuality Education.* Retrieved April 2009, from International Planned Parenthood Federation:www.ippf.org/NR/rdonlyres/CE7711F7-C0F0-4AF5-A2D5-1E1876C24929/0/Sexuality.pdf

O'Leary, M. (2008). *A Feasibility Study for a Comprehensive Foundation Sexual Health Promotion Training Programme for Health, Youth and Community Professionals Working in Sexual Health in the Health Service Executive (HSE) South Area*. (Unpublished, Submitted to University of Limerick as part fulfilment of Certificate in HealthCare Management July 2008)

U.K. Dept. Of Health (2005). *Recommended Quality Standards for Sexual Health Training.* London: U.K. Dept. Of Health.

Appendix V: List of organisations/groups that were to be contacted

Aids Care Education and Training
AIDS West
An Bord Altranais
Belong To
Center for Nurse and Midwifery Education in Ireland
HSE Crisis Pregnancy Programme
Dublin Aids Alliance
Foroige
Here2Help
HSE
Irish Association for Counsellors and Psychotherapists
Irish Association Social Workers
Irish College of General Practitioners
Irish Country Women's Association
Irish Family Planning Association
Letterkenny Women's Centre
Irish Foster Care Association
LINC
National Parents Council
National Youth Council of Ireland
National Youth Health Programme
Newbridge Community Training Centre
NUI Maynooth
NUI Galway
Nursing/Midwifery Practice Development Units
Pavee Point
Red Ribbon
Royal College of Physicians Ireland
Sexual Health Centre Cork
Southern Gay Men's Health Project
Social, Personal and Health Education (SPHE) Support Service / Post-Primary
Waterford Institute of Technology (SPHE)
Squashy Couch Waterford
Sexual Health Clinics in hospitals (eg GUIDE Clinic, St. James's Hospital)
The Wheel
Youth Health Service Cork

Appendix VI: Template for scoping of sexual health promotion education in Ireland

Evaluation of Foundation Programme in Sexual Health Promotion Education and Training Template	
Name of organisation	
Address/web page	
Name of the programme	
Who should attend?	
Cost of attending	
Start and end dates	
Programme duration/structure	
How often does it run?	
Aim of the programme	
Mode of assessment (if any)	
Indicative Content	
Enrolled and completed (N)	
CPD or accreditation points	
Funding bodies	
Facilitators	
Facilitator preparation	
Building networks (Capacity)	
Evaluation	

Comparison of FPSHP with other Sexual Health Promotion Courses			
	Yes	**No**	**Don't Know**
Day 1 – Introduction and group formation			
Day 2 – Sexual health context			
Day 3 – Sexual health through the life cycle			
Day 4 – Female fertility, contraception & STIs			
Day 5 – Self esteem and sexual health			
Day 6 – Diversity and attitudes to sexuality			
Day 7 – Law and power in relation to sexuality			
Day 8 – Facilitation skills workshop			
Day 9 – Presenting/workshop skills			
Day 10 – Capacity building/action planning/policy formation			

Appendix VII: Sexual health promotion programmes identified in Ireland with an organisational/inter-organisational capacity building remit

Name of organisation	Name of programme	Target audience	Length of programme	Cost	Aim	Accreditation	Funders
BeLonG To	Peer education health promotion	Open to the LGBT community age 14 - 23 years	Varied	Free	They offer different programmes and sexual health is weaved through each programme and takes consideration of participants age, needs, and wants. Therefore, the aim of the programme depends on the needs and age of the individuals attending the course. Participants are encouraged to engage in capacity building activities, including peer education.	None	Dept of Child & Youth Affairs, HSE, North Inner City Partnership,Pobail, Dept of Education, Other European & philanthrophy funding
Dublin AIDS Alliance	Safer Sex Negotiation Skills Training for Trainers	Youth and Community Workers	8 Days	€220	Develop and enhance skills to deliver sexual health training to client groups. Participants are encouraged to use their training with their client groups, particularly for young people.	FETAC Level 5 Cert	HSE and North Inner City Drugs Taskforce
Dublin AIDS Alliance	Sexual Health and Drug Awareness Training for Trainers	Youth and Community Workers	8 Days	€220	Develop and enhance skills to deliver sexual health and drug awareness training. Participants are encouraged to use their training with their client groups, particularly for young people.	FETAC Level 5 Cert	HSE and North Inner City Drugs Taskforce
Dublin AIDS Alliance	One day Sexual Health Workshops	Youth and Community Workers	One day	€50	Provide basic information on sexual health - focus on STIs. Participants are encouraged to use their training with their client groups, particularly for young people.	None	HSE and North Inner City Drugs Taskforce
Foroige	REAL U Training: Relationships Explored and Life Uncovered	Aimed at anyone working in the out of school youth sector	2 days	Free	To facilitate the development of key competencies in relation to decision making and critical thinking to promote positive well being and confidence in relationships. Participants are trained to deliver a programme within their own areas of practice.	None	HSE Crisis Pregnancy Programme

Here2Help	Here2Help	Students in secondary school settings	80 minutes	Free	The workshop covers the Relationships and Sexuality (RSE) part of the SPHE curriculum. It is hoped that all teachers and principals alike, take the content from the workshop and the delivery and incorporate this into their daily teachings about RSE with their students.	Unknown	HSE Crisis Pregnancy Programme
Irish College of General Practitioners	Masterclass in contraception for tutors	For those who wish to become a contraception tutor for the purpose of certifying candidates for the Basic Certificate in Contraception	Full day or half day	€150.00 for full day €75 for half day	Teach doctors who wish to become a contraception tutor for the purposes of certifying candidates for the Basic Certificate in Contraception. Participants should use the programme information to teach other medical practitioners and within their work	Full Day: 5 CPD credits / Half Day: 2.5 CPD credits	Self-funding
Irish Family Planning Association	Sexual Health Training	Health promotion workers, teachers, carers, youth workers and HSE staff	1 day	€80	To provide participants with the information, skills and confidence to talk to young people about sexuality issues.	None	Self-funding
Irish Family Planning Association	Speakeasy	Parents and carers	8 Weeks, 3 hours per session	Free	To provide parents and carers with the information, skills and confidence needed to talk to their children about relationships and sexuality. A peer contact sheet is completed by participants. Some participants have gone on to develop their own sexual health programmes.	FETAC accredited Level 4 Credits are available to health professionals	HSE Crisis Pregnancy Programme
National Youth Council of Ireland	Delay/b4UDecide	Designed for anyone working with young people in a youth work, out of school or non formal setting.	2 days	Free	Aimed at delaying early sex among young people. Participants are trained to deliver a programme within their own areas of practice.	None	HSE Crisis Pregnancy Programme
National Youth Health Programme	Good Practice in Sexual Health Promotion	Youth workers with an interest in promoting sexual health	3 days	Free	To strengthen the organisational environment for the delivery of sexual health programmes.	None	HSE and Department of Education and Youth Affairs

Newbridge Community Training Centre	REAL DEAL	Peer Educators, Young People	10 days	Free	To equip participants with the necessary skills and knowledge to deliver the REAL DEAL - Live Life B4 U Give Life Peer Led Sexual Health Education Programme. Following successful completion of the Training of Trainers, the Peers go on to deliver the REAL DEAL in various education settings.	Participants encouraged to complete the FETAC Level 5 in Peer Education Certificate	HSE Crisis Pregnancy Programme
Pavee Point	Sexual Health Promotion for Young Travellers	Travellers working with young people or in primary health	5 days	Free	To meet the information needs of Travellers in the area of sexual health. Participants are trained to deliver a programme within their own areas of practice and to create awareness of sexual health. Facilitators are available for follow-up support.	None	Unknown
Social, Personal and Health Education (SPHE) Support Service / Post-Primary	Relationships and Sexuality Education	Primary school teachers who are involved in the development and delivery of relationship and sexuality education	1 day or 2 days	Free	To educate teachers how to support the personal development, health and well-being of young people and helps them create and maintain supportive relationships.	None	HSE and the Department of Education & Skills
Squashy Couch Adolescent Health and Information Project	Adolescent Sexual Health Programme Training for Trainers	Anyone working with young people	3 days	€100 for 3 days For group of 14, €600 plus travel expenses	To help young people make informed choices about their sexual health. Participants are required to deliver sexual health education within their own organisations and are educated on policy development.	None	HSE Crisis Pregnancy Programme and some self funding
Waterford Institute of Technology	Higher Dip. In Social, Personal and Health Education	Teachers, Youth Workers, Social Workers, Health Professioanls, Pre-school workers, Community Workers, Child Care Workers, Gardai	2 semesters, 15 weeks each	University fees	To develop facilitation skills. During the programme, participants design and deliver experiential workshops.	Higher diploma	Self-funding

Appendix VIII: Engagement in activities related to sexual health promotion of the survey sample including all FPSHP participants (n=95)

Practice	Before programme	After programme	Difference
Assessing sexual health promotion needs of clients	N = 46	N = 64	+ 18
Referring people to sexual health services	N = 42	N = 59	+ 17
Providing sexual health education to clients or service users in a one to one setting	N = 39	N = 64	+ 25
Providing formal sexual health education to clients or service users in a group setting	**N = 22**	**N = 53**	**+ 31**
Assessing sexual health promotion education needs of staff within your organisation	N = 5	N = 31	+ 26
Providing formal sexual health education to staff within your organisation	N = 2	N = 28	+ 26
Auditing sexual health promotion practices within your organisations	N = 4	N = 25	+ 21
Raising awareness of sexual health promotion needs within your organisation	**N = 20**	**N = 67**	**+ 47**
Developing sexual health policies/guidelines within your organisation	N = 6	N = 28	+ 22
Adapting administrative practice to include sexual health items, e.g. developing/changing assessment forms to include sexual health	N = 2	N = 26	+ 24
Attending training or education on sexual health promotion (CPD – Continuous Professional Development)	**N = 16**	**N = 47**	**+ 31**
Developing written information materials related to sexual health	**N = 4**	**N = 37**	**+ 33**
Developing sexual health policies/guidelines outside of your organisation	N = 1	N = 12	+ 11
Networking about sexual health with other individuals or organisations	**N = 13**	**N = 62**	**+ 49**
Providing formal sexual health education to staff outside your organisation	N = 3	N = 16	+ 13
Engaging in research on sexual health	N = 6	N = 22	+ 16
Publishing articles on sexual health	N = 3	N = 13	+ 10
Developing sexual health services within your organisation	N = 7	N = 34	+ 27
Developing sexual health services outside your organisation	N = 2	N = 13	+ 11

Appendix IX: Multiple Regression

All scale variables, interval variables, and nominal variables (coded as dummy variables with 0= value absent; 1= value present) entered as independent variables in the procedure. The dependent variable in the procedure is: Overall, from your perspective has your participation in the programme had a sustained impact on sexual health promotion practices in your work (or volunteer work)? The responses ranged from: 0 = not at all to 10 = to a very great extent. The procedure was performed in STEPWISE mode. Excluded from the analysis were the other two possible dependent variables (*To what extent has attending the programme affected your work on sexual health promotion? (0 = not affected at all; 10 = very greatly affected); Do you anticipate that you can sustain the impact of the programme? (0 = not at all; 10 = to a very great extent*)) because for this analysis the relationship between outcome variables was not the focus of interest. Also, their high inter-correlations would have dominated the outcome and have obscured the regression of the independent factors of interested here.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.630[a]	.397	.378	1.638
2	.783[b]	.613	.589	1.332
3	.834[c]	.695	.666	1.201
4	.858[d]	.737	.702	1.135
5	.885[e]	.783	.745	1.048
6	.909[f]	.826	.789	.955
7	.923[g]	.853	.814	.895
8	.948[h]	.898	.867	.759
9	.946[i]	.895	.868	.754
10	.958[j]	.919	.894	.678

ANOVA[k]

Model		Sum of Squares	df	Mean Square	F	Sig.
10	Regression	134.798	8	16.850	36.676	.000[j]
	Residual	11.945	26	.459		
	Total	146.743	34			

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
10	(Constant)	-12.660	1.570		-8.063	.000
	Affect - motivation to engage	.513	.113	.307	4.526	.000
	Overall satisfaction	1.199	.173	.475	6.940	.000
	Attending training or education on sexual health promotion	.924	.261	.218	3.543	.002
	Supportive organisational culture	1.448	.277	.336	5.223	.000
	Engaged - job	3.208	.799	.261	4.013	.000
	Engaged - voluntary	2.376	.531	.269	4.478	.000
	Lack of financial resources	-1.543	.276	-.364	-5.591	.000
	Engaging in research on sexual health	.933	.342	.182	2.729	.011

a. Dependent Variable: Sustained impacted on SHP practice?

a. Predictors: (Constant), Affect - motivation to engage

b. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction

c. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion

d. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture

e. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job

f. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job, Lack of time

g. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job, Lack of time, Engaged - voluntary

h. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job, Lack of time, Engaged - voluntary, Lack of financial resources

i. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job, Engaged - voluntary, Lack of financial resources

j. Predictors: (Constant), Affect - motivation to engage, Overall satisfaction, Attending training or education on sexual health promotion, Supportive organisational culture, Engaged - job, Engaged - voluntary, Lack of financial resources, Engaging in research on sexual health

k. Dependent Variable: Sustained impact on SHP practice?

Appendix X: Overview of interview participants' capacity building activities following FPSHP

Individual
Increased motivation, knowledge, comfort and confidence to talk about issues of a sexual nature.
Increased interest in pursuing further education.
Incorporating principles into everyday working practices.
Organisation
Raising awareness about sexual health and sexual health promotion needs within organisation.
Using facilitation skills.
Conducting workshops/training with organisational staff.
Conducting workshops/training with clients within organisation.
Discussing sexual health concepts with staff.
Developing guidelines.
Developing new sexual health policy and changing existing policies within the organisation.
Inter-organisational
Writing articles for publication.
Conducting sexual health workshops in other organisations.
Providing sexual health promotion training to volunteers.
Formal and informal networking with other individuals and organisations.
Contributing to, and membership of national committees involved in sexual health.
Contributing to national policy formation.

Appendix XI: Analysis of sample in terms of representativeness of overall population

This section establishes the representativeness of the sample of the survey (n = 97). This involves a comparison between the participants who returned the survey and the overall population (n = 200) who completed the FPSHP programme up to the date when this evaluative study was started and the sample taken. Representation was almost entirely dependent on returning the survey. Almost the whole population (n = 197; 98.5%) received the survey. Only those for whom no up to date address was available were not included.

Before we make the comparison it needs to be noted that the size of the sample (n = 97) which covers 48.5 % of the total population is more than adequate for a study of this type (Table 23). Nonetheless it needs to be established to what extent the sample is representative of the total population. A general issue of import here is that evaluative surveys may contain an overrepresentation of participants who have valued their participation and see returning the survey as an act of reciprocation. It is also not uncommon for recent participants in ongoing programmes to be overrepresented because they remember the material better and are more confident that they can contribute in a meaningful way to the study. Both of these aspects may constitute a bias. In addition, a practical issue like changes of address not communicated to the programme team may have affected the sample, in particular for those who have taken the programme longer ago. None of these impacts can be avoided, but it follows that responses to an evaluative survey are almost never entirely random.

In many studies this issue is then left alone. However, in this evaluation the access to both population and sample demographics (gender, location of participation, year of participation, and whether follow-up training was done) makes it possible to investigate the representativeness issue in more detail. Table 23 provides further details.

Table 23: Representativeness of survey sample

Variables / values	**Participants who completed the programme: population (n = 200)**		**Survey Participants: sample (n = 97)**	
	n	**%**	**n**	**%**
Gender				
women	182	91%	88	91%
men	18	9%	8	8%
missing	0	0%	1	1%
Location				
Kerry	69	34.5%	30	31%
Waterford	71	35.5%	38	39%
Cork	44	22%	19	20%

Clonmel[6]	16	8%	10	10%
Year of attendance				
2009	54	27%	12	12%
2010	48	24%	26	27%
2011	65	32.5%	34	35%
2012	33	16.5%	21	22%
Multiple years*	not available	--	4	4%
Attending follow-up training	69	34.5%	62	64%

* Participants may have started the programme in one year and completed it in the next, which they indicated in their response to the survey. Population data did not include this distinction.

The findings in the table suggest the following:

Gender representation in the sample was on a par with the population.

Location representation from the four years in which the programme was run shows some minor discrepancies between sample and population, but the overall pattern is the same. Most participants in the sample had taken part in Waterford, followed by Kerry, Cork and much fewer in Clonmel.

For **Year of attendance** representativeness of the sample was fairly good, however with recent years (in particular 2012) somewhat overrepresented and 2009 underrepresented. This is not surprising. As already indicated in the above, while address changes may have played a role, motivation to participate may also have been somewhat reduced due to the inevitably diminished recall of earlier events. It would have been unrealistic to expect equal representation from each year. The results of the Multiple Regression procedure in Chapter 4 suggested no major impact of this demographic variable. A somewhat unequal representation in year of attendance will therefore not have had a significant impact on the outcomes.

Attending follow-up training was the variable that showed the most significant discrepancy between sample and population. With 64% of the sample attending follow-up training but only 34.5% in the population – close to half that ratio – it would seem that there is a distinct level of oversampling in regard to those who sought follow-up training. It needed to be examined whether this affected the response, in particular in regard to how favourably

[6] The course run in Clonmel only began in 2011. By the time of the survey was launched, only one group had completed the course and was, therefore, eligible to participate in the survey.

disposed towards the programme the segment of the sample that took part in follow-up programmes was in comparison with those who did not.

The following two evaluative variables were initially selected to test this:

- Satisfaction rating
- Sustained impact (Overall, from your perspective has your participation in the programme had a sustained impact on sexual health promotion practices in your work (or volunteer work)?

The findings suggest that whether participants had taken part in follow-up training was not a significant factor in how satisfied they had been with the course and how they had sustained its impact. Differences in the observed means are very small. For *satisfaction*: no follow-up (m = 8.80); follow-up training (m = 8.77). For *sustained impact*: no follow up (m = 7.77); follow-up training (m = 7.51). None of the F-values is significant. Additional F-tests on all other impact variables in the survey further confirmed that no significant differences emerged elsewhere. Therefore, we may conclude that the discrepancy between sample and population regarding the factor additional training does not seem to impact the survey outcomes. It follows that on the basis of the available information there is no reason to suspect that the participants in the survey sample are not representative of the overall population. Appendix XI provides further details.

Appendix XII: Representativeness of the survey sample – ANOVA comparing participants who took part in follow-up training with those who did not

		N	Mean	Std. Dev.	Std. Error	Min.	Max.
Overall satisfaction	No follow-up	35	8.80	1.279	.216	5	10
	Follow-up training	62	8.77	1.348	.171	1	10
	Total	97	8.78	1.317	.134	1	10
Sustained impacted on SHP practice?	No follow-up	30	7.77	2.192	.400	2	10
	Follow-up training	61	7.51	2.118	.271	1	10
	Total	91	7.59	2.134	.224	1	10

ANOVA: Independent Variable Follow-up Training

		Sum of Squares	df	Mean Square	F	Sig.
Overall satisfaction	Between Groups	.015	1	.015	.009	.927
	Within Groups	166.439	95	1.752		
	Total	166.454	96			
Sustained impacted on SHP practice?	Between Groups	1.343	1	1.343	.293	.590
	Within Groups	408.613	89	4.591		
	Total	409.956	90			

ANOVA: Independent Variable Follow-up Training

		Sum of Squares	df	Mean Square	F	Sig.
Satisfied - content	Between Groups	.017	1	.017	.010	.921
	Within Groups	163.014	95	1.716		
	Total	163.031	96			
Satisfied - delivery	Between Groups	2.312	1	2.312	1.269	.263
	Within Groups	171.313	94	1.822		
	Total	173.625	95			
Satisfied - your own learning	Between Groups	1.136	1	1.136	.583	.447
	Within Groups	185.091	95	1.948		
	Total	186.227	96			
Affect - Knowledge	Between Groups	1.090	1	1.090	.439	.509
	Within Groups	235.920	95	2.483		
	Total	237.010	96			

Affect - Comfort	Between Groups	.017	1	.017	.006	.939
	Within Groups	273.014	95	2.874		
	Total	273.031	96			
Affect - Confidence	Between Groups	.122	1	.122	.055	.815
	Within Groups	210.765	95	2.219		
	Total	210.887	96			
Affect - motivation to engage	Between Groups	.626	1	.626	.360	.550
	Within Groups	163.332	94	1.738		
	Total	163.958	95			
Affect - sexual health promotion skills	Between Groups	1.270	1	1.270	.658	.419
	Within Groups	183.246	95	1.929		
	Total	184.515	96			
Affect - problem solving skills	Between Groups	.177	1	.177	.056	.813
	Within Groups	298.462	95	3.142		
	Total	298.639	96			
Affect - ability to communicate	Between Groups	2.846	1	2.846	.815	.369
	Within Groups	331.711	95	3.492		
	Total	334.557	96			
Affect - ability to develop policies	Between Groups	3.537	1	3.537	.802	.373
	Within Groups	397.071	90	4.412		
	Total	400.609	91			
Affect - facilitation skills	Between Groups	2.780	1	2.780	.727	.396
	Within Groups	359.377	94	3.823		
	Total	362.156	95			
Affect - self-awareness	Between Groups	.636	1	.636	.166	.685
	Within Groups	364.724	95	3.839		
	Total	365.361	96			
Affect - understanding of your own values and attitudes towards sexuality	Between Groups	.344	1	.344	.089	.766
	Within Groups	367.017	95	3.863		
	Total	367.361	96			
Affected - your work on SHP	Between Groups	3.738	1	3.738	.828	.365
	Within Groups	415.166	92	4.513		
	Total	418.904	93			
Anticipate that you can sustain the impact of the programme?	Between Groups	4.177	1	4.177	1.237	.269
	Within Groups	300.570	89	3.377		
	Total	304.747	90			