

Draft 2

**Towards a Sexual Health Policy for the West:  
Developing consensus on the potential  
goals, objectives and actions**

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## Contents

<b>Section</b>	<b>Page</b>
<b>Acknowledgements</b>	<b>3</b>
<b>Introduction</b>	<b>4</b>
<b>Literature Review</b>	<b>5</b>
Sexual health	<b>5</b>
Sexual Health Strategies & Policies	<b>13</b>
Consensus Development	<b>21</b>
Research Aims and Objectives	<b>22</b>
<b>Methods</b>	<b>23</b>
Stage 1 Interviews	<b>24</b>
Stage 2 Questionnaire round 1	<b>25</b>
Stage 3 Questionnaire round 2	<b>26</b>
<b>Results</b>	<b>28</b>
Goals	<b>29</b>
Objectives	<b>30</b>
Actions	<b>31</b>
Additional Suggestions	<b>39</b>
<b>Discussion</b>	<b>43</b>
Consensus	<b>46</b>
<b>Appendix</b>	<b>54</b>

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## **Section 1: Introduction**

The HSE Western Area has identified the need to promote safer sexual health and to help support its population in caring for their sexual health. While, there are gaps in the HSE knowledge of the sexual health status of the regional population it has been highlighted that there are areas of unmet healthcare need in the region (Department of Public Health, HSE Western Area, 2005). For example, the numbers of sexually transmitted infections diagnosed in the area is increasing rapidly each year (Health Protection Surveillance Centre, 2003; McDaid, 2003), the numbers of crisis pregnancies including numbers going abroad for termination of pregnancy are unknown, the rates of use of emergency contraception are unknown, the provision of contraceptive services varies considerably in the region, people with psychosexual problems are poorly served and sexual behaviours are known to be changing, but these changes are poorly understood (Department of Public Health, HSE Western Area, 2005). Therefore, it has been proposed to develop a sexual health strategy in order to plan for comprehensive, accessible and confidential services to improve and promote sexual health that is relevant to service users and providers statutory, voluntary, and non-statutory within the region (Department of Public Health, HSE Western Area, 2005). This is supported by reference to the development of regional sexual health strategies in national health policy documents (Department of Health and Children, 2000a). In order to inform the development of a sexual health strategy for the Western Area, this study aims to investigate sexual health service providers and representative's views and opinions on what is important and relevant to include in such a sexual health strategy.

Initially this report presents the context for the development of a sexual health strategy for the Western Area with a review of definitions of sexual health, followed by current knowledge of attitudes, social norms and behaviours. Issues of sexual ill health, such as sexually transmitted infection are also presented. Sexual health policy regionally and internationally with comparison of common themes and inconsistencies is presented. The subsequent section describes the methods for undertaking this study followed by presentation of the results. Finally, the implications of the results are discussed and conclusions drawn.

## Section 2- Study Context

### 2.1 Sexual Health

Sexuality is considered to be a significant factor in our overall sense of wellbeing. According to Edwards & Coleman (2004), our sexuality contributes to our identity and our self-values, as well as influencing our interactions and relationships with others. The Surgeon Generals “Call to Action” (US Department of Health and Human Services, 2001) highlighted that sexuality is an integral part of human life. The report identified how sexuality can foster intimacy and bonding, as well as shared pleasure in our relationships. It also noted that sexuality could fulfil a number of personal and social needs and that we can value the sexual part of our being for the pleasures and benefits it affords us (US Department of Health and Human Services, 2001). The World Health Organisation (WHO, 2002) considers sexuality in a similar way and defined sexuality as being a central aspect of being human. It recognises that sexuality is important throughout the life span and is influenced by the interaction of biological, psychological, social, economic, political, cultural, historical, religious and spiritual factors (WHO, 2004). However, although the importance of sexuality in our lives and towards our well-being has been emphasised, it has also been recognised that our sexuality can have negative consequences for our health through the transmission of infection, unintended pregnancy or coercive and violent behaviour (US Department of Health and Human Services, 2001). Edwards & Coleman (2004) noted that to enjoy the important benefits of sexuality whilst avoiding the negative consequences, it is necessary for individuals to be sexually healthy.

A review of the literature has highlighted that there is no single, universally accepted definition of sexual health (e.g. Robinson *et al.*, 2002; Irwin, 1997). According to Irwin (1997), sexual health is sometimes defined in a negative manner, for example, as the absence of sexually transmitted infections (STIs) and unwanted pregnancies. However, in keeping with the WHO definition of health (1946) many conceptualisations now reflect more positive approaches to sexual health constructing it as something enjoyable, enriching and fulfilling (Ewles &

Simnett, 1999). A consensus on a definition of sexual health was achieved at a major WHO conference, by a diverse group of experts from around the world. The definition encompasses a view of sexuality in its broadest sense and sexual health is defined comprehensively.

*“Sexual health is a state of physical, emotional, social and mental well-being related 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”.* (WHO, 2002)

This definition, whilst generally accepted, has received some criticism. A review by Sandfort & Ehrhardt (2004) suggested that the definition was somewhat utopian and questioned whose sexual health was being defined and also queried, *“who would be classified as sexually healthy according to the definition”* (Sandfort & Ehrhardt, 2004; p183). However, in clarifying the definition of sexual health, the WHO reasserted the fundamental importance of sexual rights and the need for the promotion of sexual health (Edwards & Coleman, 2004).

### Sexuality in Ireland

Until the second part of the twentieth century, sex was largely a taboo subject in Ireland. The Roman Catholic Church had a strong influence over people’s views on sexual issues and people as sexual beings, and sexual intercourse was highly condemned outside the confines of marriage (Butler & Woods, 1992). The traditional culture of the Church largely linked sexuality and immorality, with sexuality and sexual issues being condemned and confined and with much that was written, spoken and taught dominated by the teachings of Roman Catholicism (Fullerton, 2004; Inglis, 1998). According to Butler & Woods (1992) over time different voices and opinions began to be aired surrounding sexual matters and the media played a significant role in conveying these issues. The culture of silence surrounding sex and sexuality began to alter conspicuously, with the

traditional linking of sex with morality giving way to far greater tolerance and acceptance with more open discussion (O' Connell, 2001).

The changing attitude to sex and sexuality was reflected in social behavioural norms, so that in the first part at least of the twentieth century, it was socially unacceptable to cohabit, have sexual relations or bear children outside marriage. However, by 1992 a survey by Lansdowne Market research found that 70% of single men and 55% of single women were sexually active and more significantly, 33% of single men had had more than one partner in the previous twelve months (Inglis, 1998). This highlighted a significant trend towards sex outside marriage. This change in attitude and behaviours in relation to non-marital sexual intercourse has been linked to a corresponding decrease in the age of first sexual intercourse (Southern Health Board, 2001). The Durex Irish Health Monitor Survey (1997) found that 50% of Irish seventeen to twenty year olds had had sexual intercourse before the age of sixteen (cited in Inglis, 1998), the average age of first sexual intercourse was found to be 15.9 years compared with 18.8 years amongst the 35 to 39 group. In a Galway based study among school children aged 15 to 18 years, 21% claimed to have had sexual intercourse and the mean age for first sexual activity was found to be 15.45 years (McHale & Newell, 1997).

### Improving Sexual Health

The WHO's first Global Reproductive Health Strategy (WHO, 2004) highlighted that together aspects of reproductive and sexual ill-health are estimated to account for nearly 20% of the global burden of ill-health for women and 14% for men. The WHO estimates that unsafe sexual practices are the second most important global risk factor for health in the world (WHO, 2004). In an Irish context a report by the South Eastern Health Board in 2000 identified that in the past decade there has been a growing recognition of the fact that sexuality plays a significant role in people's lives and that sexual problems can cause both emotional and physical distress (HSE Eastern Region, 2005). Markers of poor sexual health in Ireland have been identified including STI's, ectopic pregnancies, infertility, cervical cancer, unintended pregnancy, abortion, the psychological consequences of sexual abuse and poor educational, social and economic opportunities for teenage

mothers (HSE Eastern Region, 2005). Some of these issues will be reviewed in more detail.

### Sexual Health Problems in Ireland

#### *Sexually Transmitted Infections*

Sexually transmitted infections remain one of the greatest global health challenges (WHO, 2004). Ireland has not escaped that challenge, and the threat of STI's in the Irish population has escalated in recent years. The impact of STI's on health has been long recognised due to the long-term morbidity attached to infections both physically and psychologically. Apart from the initial symptoms and discomfort, STI's may result in long-term health problems such as infertility, ectopic pregnancies and genital cancers (McMillan, 2000).

The Health Protection Surveillance Centre's (HPSC) most recent report (2003) stated that:

- ❖ Over 90,000 STI's have been reported nationally since 1991
- ❖ Since 1994 STI's have been steadily increasing in Ireland
- ❖ The increase in all notified STI's between 1994 and 2003 is 173.8%
- ❖ The most commonly notified STIs are:
  - Ano-genital warts
  - Chlamydia Trachomatis
  - Non-specific urithritis
- ❖ 61.6% of all infections occurred in the 20-29 year age group
- ❖ Heterosexual women are the most likely group to contract STIs

(HPSC, 2003).

The HPSC report identified that of all total infections reported in 2003, 9.2% of these cases were in the Western Area (HPSC, 2003). A report on sexually transmitted infections in third level students by the Western Health Board in 2003 identified that STI cases in the region reflect national trends with significant and continuous increases each year (McDaid, 2003). This is supported by data reported by the Health Protection Surveillance Centre (HPSC, 2003). These data highlighted a significant increase in patients from all socio-economic groups and

genders attending the Genito-urinary medicine (GUM) clinic and services in the region (McDaid, 2003).

### *HIV/AIDS*

At the start of the 21<sup>st</sup> century HIV/AIDS remains a communicable disease of major public health importance in Western Europe. The National AIDS Strategy Report (Department of Health and Children, 2000b) highlighted that although Irish statistics indicate that there is a relatively low incidence of HIV seropositivity with approximately 150 new cases per year per population of 3.6 million (0.4 per 1000), there is still an increasing concern that overall transmission rates have not yet begun to decline (HPSC, 2003). Concern is also expressed in relation to the changing pattern of transmission with increasing heterosexual spread. The health effects of HIV/AIDS are widely recognised. Apart from HIV/AIDS being an incurable illness, the potential to infect others with the disease is life-long and the stigma of infection can have serious psychological consequences (Hammers & Downs, 2004). Moreover, McMillan (2000) reported that large numbers of people remain unaware of their infection and therefore neither benefit from treatment nor take steps to reduce the risk of passing the infection on.

### *Pregnancy and Reproductive Health*

Changes in Irish society can be discerned with the rise in non-marital births since the 1960's and especially during the 1990's (Inglis, 1998). Fullerton (2004) highlighted that the importance of marriage in family formation in Ireland is less dominant and clear cut than previously. The Central Statistics Office (1996) reported that in 1980 one in twenty births took place outside marriage, and this figure had risen to one in four by 1996 and one in three by 2005 (cited by HSE Eastern Region, 2005). Fullerton (2004) noted that whilst pregnancy and parenthood are positive choices for some people regardless of marital status, for others pregnancy and parenthood, especially in the young, can be associated with negative social and psychological consequences, such as incomplete education, poverty, social isolation and low self-esteem.

O'Keeffe (2004) identified that there is great difficulty in determining the true levels of crisis pregnancy presently in Ireland and that research and understanding

of the concept is presently limited. Few studies appear to have been conducted in the area of crisis pregnancies. A study by Greene *et al.* (1989) found that 20% of Irish married women had not planned their pregnancies compared with 89% of the single women surveyed. However, the authors did not examine the extent to which these unplanned pregnancies were considered as crises situations (O’Keeffe, 2004). As the HSE Eastern Region (2005) emphasised, at present in Ireland there are no available figures for crisis pregnancy, and proxy indicators are widely employed, including those based on abortion figures, adoptions and survey estimates.

Abortion rates for Irish women are estimated using figures for women giving Irish addresses at UK abortion clinics. These rates have been seen to increase substantially over the last two decades (O’Keeffe, 2004).

- ❖ In 1991 there were 4154 abortions reported to women giving Irish addresses
- ❖ In 2002 this figure had risen to 6485.
- ❖ The greatest number of abortions occur for women aged between 20 and 24 years.

(O’Keeffe, 2004).

O’Keeffe (2004) indicated that very limited Irish data exists on abortion rates for Irish women and argues that this problem needs to be rectified and an up to date analysis of the geographical spread of women seeking abortion is required.

### *Teenage Pregnancy*

Some controversy appears in the literature regarding the rates of teenage pregnancy. Maycock & Bryne (2004) note that rates of teenage pregnancy in Ireland cannot be considered high in comparison to other Western European countries. However, the Department of Health and Children have highlighted that Ireland has one of the highest teenage birth rates in Europe, with 8.2 births per 1000 women (HSE Eastern Region, 2005). The teenage pregnancy rate (births in women under nineteen years of age) has been increasing significantly in the last decade in Ireland although a plateauing in this increase has been seen in recent

years (Department of Health and Children, 2000a). However, despite these clearly conflicting opinions most of the available literature agrees that teenage pregnancy is an issue of public health priority and is a major subject of concern and debate in society at large, especially among health care providers and policy-makers (HSE Eastern Region, 2005; Maycock & Byrne, 2004; Fullerton, 2004).

The health and social outcomes of teenage pregnancy have been well documented. Teenage parents have been shown to suffer adverse health consequences. International evidence has indicated that compared to 20-35 year old mothers, teenage mothers have a higher risk of complications in childbirth. Dempsey *et al.* (2000) reported evidence that teenage mothers and their babies have an increased risk of anaemia, hypertension, pre-eclampsia, urinary tract infections and low birth weight (Rundle *et al.*, 2004). The Department of Health and Children report (2001) noted that teenage pregnancy is a health concern because teenage parents tend to have poor antenatal health, lower birth weight babies and higher infant mortality rates. These problems are proposed to arise because pregnancies in this group may be unplanned and poorly managed (Department of Health and Children, 2001).

Hannan & Ni Riain (1993) suggested that teenagers who become parents at an early age can be faced with a host of multiple disadvantages including low educational attainment, early school leaving, low income and poverty. O' Riordan (2002) noted that teenage pregnancy is often considered to be a cause and consequence of social exclusion (cited in Fullerton, 2004). McCashin (1997) found that 25% of teenage lone parents had either no qualifications or only primary level qualifications. However, this has been disputed by Berthoud & Robson (2001) who questioned whether this was in fact a cause-effect relationship; it is unclear whether low educational attainment leads to higher rates of teenage pregnancy or whether teenage pregnancy leads to school drop out.

#### *Contraceptive Services*

High levels of STI's and the ongoing problem of crisis and teenage pregnancies have been highlighted as jeopardising the health of the Irish population and as priority health issues. Research has indicated that a lack of use of contraception is

one of the reasons why these sexual health problems are rising and a cause for concern (Mason, 2004). A review of studies in the 1990's found that approximately 30% of sexually active Irish women did not use contraception, with single women more likely to use contraception than married women (Mason, 2004). The SLAN surveys in 1998 and 2002 showed an increase in regular contraceptive use by women over the four year period of study. However, there was a fall over the same period of sexually active men who said that they always used contraception from 35.6% to 26.3% (Kelleher *et al.*, 2003). The role of alcohol has been highlighted in the use of contraception, particularly barrier methods of contraception. Research has suggested that while those who drink more are more likely to have multiple sexual partners they are also less likely to use condoms consistently (Thompson *et al.*, 2005; Graves, 1995; Leigh *et al.*, 1994). Contraception types follow international trends with the oral contraceptive pill and condoms consistently being reported as the most commonly used methods (Mason, 2004).

A review of Women's Health Care Services documented the nationwide availability of contraceptive services and indicated that service provision predominantly by General Practitioner's (GP), Pharmacists and Family Planning Clinics, had improved significantly since the 1980's (Ni Riain & Canning, 2000). However, the Crisis Pregnancy Agency (CPA) highlighted that the provision of contraceptive service varies widely within each health board (Mason, 2004). The CPA in 2003 carried out an audit of contraceptive services in Ireland and it was found that urban areas generally provided a good range of contraceptive services with General Practitioner's (GP) and family planning centres being the main service providers (Mason, 2004). However, only a minority of women have access to family planning centres due to them being primarily located in large urban centres (Mason, 2004). The provision of family planning centres in Ireland has been described as patchy, thus rendering it difficult for women in smaller urban towns and rural areas to access them. This finding is significant, as international research has identified that younger women prefer using family planning centres (Mirza *et al.*, 1998). This may be due to such centres being perceived as providing specialist services that are anonymous, confidential, and convenient (Smith & McElnay, 1994).

It has been identified that good sexual health is essential for physical and social well-being and a clear relationship between sexual ill-health, poverty and social exclusion has been established (Department of Health, 2001). Therefore, it is necessary to support and promote the sexual and emotional well-being of individuals in order to achieve the state of positive sexual health identified by the WHO (2002). With the clear relationships between sexual ill-health and overall health has come the need for Irish people to care for and protect their sexual health and also a responsibility for society to support people in doing so (Southern Health Board, 2001). This can be achieved through sexual health promotion. Sexual health promotion has been described as any activity that positively or proactively supports the sexual and emotional well-being of individuals, groups, communities and the wider public (Medical Foundation for AIDS & Sexual Health, 2005). An integral part of health promotion, and some would claim its distinguishing feature (Tones & Tilford, 1994) is the explicit development and use of policy to promote health, including sexual health. Policy initiatives can foster the conditions under which people can be healthy and provides a guide for coherent activity across diverse public and private institutional systems (Milio, 2001). The importance of policy to promote sexual health has been recognised in various national health policy documents.

## **2.2 Sexual Health Strategies & Policies: Regional, National and International**

The National Health Promotion Strategy 2000-2005 (Department of Health and Children, 2000a) emphasised the need for sexual health to be recognised as a key health issue in Ireland. The strategy identified that there is a need and responsibility in Ireland to help combat growing sexual health related problems and also to promote positive sexual health amongst our population. (Department of Health and Children, 2000a). The strategy also highlighted the need for a National Sexual Health Strategy and recommended that each health region produce a strategy to meet the specific needs of their respective populations. This was supported in a document 'Get-Connected' which proposed the development of an adolescent friendly health service (National Conjoint Health Committee, 2001). Similarly, the National Health Strategy 'Quality and Fairness: A health system for you' stated that "*measures will be taken to promote sexual health and*

*safer sexual practices*” and emphasised that “*an action plan for sexual health will be developed*” (Department of Health and Children, 2001; p22).

### Regional and national sexual health strategies compared

To date, Ireland has yet to produce a National Sexual Health Strategy, although recommendations have been put forward for such a development. However, a number of health regions have published such strategies, (eg. HSE Eastern Region, 2005; Southern Health Board, 2001) and a number of areas are in the process of developing strategies. A review of various national policies (e.g. New Zealand, UK, Scotland) has highlighted that governments are now concerned with growing sexual health problems, similar to those in Ireland, such as increases in STI's and HIV, as well as teenage pregnancies and unwanted pregnancies (Department of Health, 2000; New Zealand Ministry of Health, 2001). A review of these developed regional and national policies can inform and contribute to the development of a strategy for the Western Area. The mechanism of policy development is important to consider, as are common themes and differences between policy initiatives.

### *Policy development*

In order to develop strategies and policies, various methods have been employed. Most national policies are developed through the medium of expert group consultations and meetings with the formation of multidisciplinary groups. The Scottish “Respect and Promoting Responsibility” National Strategy (Scottish Executive, 2005) developed their strategy through setting up an Expert Reference Group whose function was to carry out extensive consultations on draft proposals prepared by a multi-sectoral Expert Group. The New Zealand strategy was informed through the development of a broadly representative sector reference group that was used to provide advice, submissions and feedback. These included representatives of service providers in the country including the Family Planning Association, Education Sector, Sexual Education Sector, Medical Association and the New Zealand AIDS Foundation. An internal Ministry Project team was also established which included representatives from Public Health, the Personal and Family Health Directorate and the Disability Association Directorate (New Zealand Ministry of Health, 2001). The UK Strategy was developed through

consultation with both expert and service users across the country; taking a broader view by including the views of those using the sexual health services. The development involved a range of stakeholders including members of target groups and professionals in the field. A Strategy Steering group was set up including representatives of GUM Medicine, Family Planning, HIV and AIDS Associations. National public consultation was also carried out whereby service users were asked various questions in relation to sexual health services, as well as sexual health problems and issues (Department of Health, 2001).

In the Irish context both published regional strategies appear to have been developed using consultation processes with service providers and agencies, sectors and bodies related to or involved in sexual health. The Eastern Regional Strategy was developed through the medium of a consultation process with key experts in the sexual health field. The consultation process was held to obtain the knowledge and opinions of individuals and groups working in the field of sexual health, both locally and nationally in order to inform the strategy. A questionnaire was circulated to a wide variety of health professionals working in the area of sexual health to get detailed feedback concerning access and equity issues. The consultation process included a one day stakeholders forum, facilitated by an external consultant, where the themes of promoting sexual health, prevention of the transmission of STI's and prevention of unintended pregnancy were discussed by over 50 experts from the statutory, private, professional and voluntary sector (HSE Eastern Region, 2005).

The Southern Health Board Strategy was developed through a Strategy Working Group. Written submissions were invited from statutory and voluntary agencies including the youth sector. Using a similar method as the Eastern Region, agencies were also invited to attend a consultation meeting with members of the working group. The process described current service provision within the region, identified the main causes for concern among those who contributed and highlighted the gaps in current services (Southern Health Board, 2001). However, the Southern Health Board (2001) went further than the Eastern Region in their development of the strategy by canvassing the views of service users. Health

promotion officers facilitated five focus groups with young people from varying backgrounds in the region to provide insight into sexual health issues.

#### *Strategic aims and objectives*

It was highlighted in some national strategies and in the regional Irish strategies that the strategy development groups set out specific aims and objectives upon which to work. A review of various national policies has indicated a range of aims and objectives with most policies aiming to reduce STI's and HIV, unplanned pregnancies and other causes of sexual ill-health and sexual problems. Differences can be discerned in the level of specificity of the aims and objectives developed.

Both Irish regional strategies have set out clear aims, objectives and priorities that. The Eastern Region highlighted their main goals as *“to ensure the promotion of sexual health, the prevention and management of infection and the prevention of unintended pregnancy”* (HSE Eastern Region, 2005; p6). The Southern Health Board noted that the aim of their strategy drew on one of the strategic aims of the National Health Promotion Strategy 2000-2005 *“to promote sexual health and safer sexual practices”* (Department of Health and Children, 2000a)

#### *Strategic service provision*

There appears to be consistent themes and actions for achieving the goals and objectives across strategies. The provision of services and service action plans is central to many of these policies and strategies (eg. Department of Health, 2001). Accessibility and availability of services is also a key issue and action area in some strategies and the New Zealand strategy proposes to improve access to services, quality of services and quality of staff providing services, as a method for reducing and combating sexual health problems within the nation (New Zealand Ministry of Health, 2001). The Southern Health Board highlights that it will *“aim to provide sexual health services which are free, confidential, accessible, consumer focused and age and culture specific”* (Southern Health Board, 2001; p47). The Scottish Executive highlight that the challenge for Scottish health agencies today is providing a cohesive and seamless approach to

sexual health services where people have a choice when accessing services they can both afford and relate to (Scottish Executive, 2005).

Within the service development area there are also frequent references within strategies for improving the quality of services through integration and networking (eg. UK: Wales). This idea of integration and coordination of services was emphasised in the HSE Eastern Regional Strategy where it was recognised that coordination and integration between services in the region would improve their quality and accessibility. Within such a network of services the strategy makes reference to the setting up of “One-stop-shops and clinics” in order to increase accessibility and availability of services and provide their populations with more choice. This is also proposed within the Welsh and UK approaches.

The location of services was emphasised, with both the Scottish and Welsh strategies noting that rural areas require outreach services (Scottish Executive, 2005) and primary care services need to be delivered in a wider variety of sites, both rural and urban (National Assembly for Wales, 2000). The creation of telephone help lines for people seeking advice on sexual health problems was cited as a target area for the NHS in the UK strategy. That strategy describes how the NHS will review and update these phone services (e.g. National AIDS Helpline, Contraceptive Education Service Helpline) and proposed the development of more young people specific telephone services.

Other service issues that have been highlighted in strategies include the wider availability of condoms at locations frequented by young people (National Assembly for Wales, 2000) and the provision of condoms free of charge (New Zealand Ministry of Health, 2001).

#### *Strategic sexual health education*

Sexual health education features strongly in most strategies, with the Scottish Strategy strongly emphasising schools and school personnel as having a key role and responsibility in delivering comprehensive programmes. This corresponds with the overall aim of the strategy to “Promote Respect and Responsibility” and therefore school sexual education programmes are viewed as being integral to

building and promoting these skills with young people (Scottish Executive, 2005). The strategy highlights that programmes involving personal and social skill development such as assertiveness, self-identity, self-esteem and relationship building should begin at nursery and primary school level and it highlights the roles and responsibilities that both parents and teachers as primary educators have in the process (Scottish Executive, 2005). Both teachers and parents are acknowledged as requiring support in the delivery of such programmes and areas for action for key health agencies in the country to provide professional aid and assistance are set out. These include resources, funding and evidence based practice guidelines. The Welsh Strategy cites sex education as one of its key priorities for action as does the New Zealand Strategy. This strategy also indicates that educational initiatives should begin at a younger age and should target young people with disabilities, as they frequently get excluded from such educational programmes.

Similarly within the regional Irish strategies there is an emphasis on sexual health education as an action and priority through which to achieve their aims and goals. The Southern Health Board strategy identifies that emphasis will be placed on enabling the development of lifeskills in young people through the continued expansion of the Social Personal and Health Education (SPHE) programme in both primary and post-primary schools. This strategy highlights that the Southern Health Board will provide a main line of support within the schools for the development of such programmes (Southern Health Board, 2001). It was also agreed that frameworks for holistic sexual health programmes in non-school youth settings, with an emphasis on early school leavers and community settings as well as in third level institutions, would be developed (Southern Health Board, 2001). Similarly, the HSE Eastern Regional Strategy states that, “*the HSE supports the full implementation of the SPHE programmes in all schools in the region*” (HSE Eastern Region, 2005; p53). The strategy outlines that in order to achieve this, further training, support and development will be supported for youth workers, teachers and other appropriate personnel.

### *Strategic information provision*

Information for sexual health issues has been recognised within strategies as a key priority and action area when attempting to promote and protect the sexual health of populations and nations. The UK strategy recognises that preventing and promoting sexual health and problems, “*depends on everyone having the information that they need*” (Department of Health, 2001; p18) and cites this as a key priority area for action.

Information actions feature strongly in the Southern Health Board Strategy with all six priorities listed in the strategy being backed up with relevant information actions. For example, for the priority ‘*to ensure awareness of and easy access to family planning and pregnancy counselling services*’ the Southern Health Board identify that they will develop materials which are attractive, informative and comprehensive, as well as being target specific. They also identify that they will improve public awareness of present service provision with regards to pregnancy counselling, post-abortion counselling and after care (Southern Health Board, 2001). Similarly for the priorities ‘*to reduce the incidence of teenage pregnancy*’ and ‘*to reduce the incidences of sexually transmitted infection*’, they again place emphasis on developing accurate, accessible, appropriate, gender specific, and culture specific materials and information (Southern Health Board, 2001). A similar list of actions is suggested in the Eastern Regional Strategy, but includes the development of a Sexual Health Services Directory providing up-to-date information on family planning and HIV/STI services at local level for specific groups and the general population (HSE Eastern Region, 2000).

### *Strategic research in sexual health*

‘Supporting Change’ is one of the four strategic directions highlighted in the UK strategy as an area for achieving their goals and objectives. One of the main areas for action within this is described as identifying the sexual health needs of the UK population (Department of Health, 2000). The New Zealand strategy emphasises the importance of research, evaluation of services and data collection for working towards improving the sexual health of the New Zealand population (New Zealand Ministry of Health, 2001).

### *Strategic resourcing for sexual health*

The UK strategy highlights that financing and resources are key priority areas and in order for all the actions, goals and aims to be realised adequate funding is needed. Reference is made to the department setting new priorities for funding to better reflect the aims for HIV prevention and the broader objectives of the strategy. The HSE Eastern Regional Strategy, identifies one of its main recommendations as developing a Regional Sexual Health Forum whose main remit will be, “*determination of funding and resources for implementation of the action plan of the strategy*” and also “*to ensure the inclusion of the action plan and resource needs in the HSE Service Plan*” (HSE Eastern Region, 2005; p52).

### *Strategic sexual health training*

Another recurring theme and area for action that is emphasised in some sexual health strategies, both at regional and national level is that of training for professionals and those involved in promoting sexual health. The Scottish strategy identifies that in order to achieve its aims and objectives, one of the main principles is to provide appropriate care “*provided by appropriately trained staff*” (Scottish Executive, 2005; p18). It goes on to outline that staff will need to be trained and work across a variety of disciplines and that each health area within Scotland has the responsibility to invest in an appropriate mix of consultants, in the training and employment of GP’s with sexual health interests and in the training of practice nurses (Scottish Executive, 2005). The Southern Health Board focuses on similar issues highlighting the area of training as integral to each of their six main priorities listed (Southern Health Board, 2001). The Eastern Regional Strategy lists training as one of its main recommendations and emphasises the pre-service training of medical professionals. It also recommends that, in keeping with the 2001 National Primary Care Strategy, (Department of Health and Children, 2001) training and continuing education in sexual health should be provided for GP’s and other health professionals (HSE Eastern Region, 2005)

In summary, a number of consistent themes can be discerned from the review of strategies developed to promote sexual health. A number of discrepancies can also be noted particularly in relation to the specificity of stated strategy aims and

objectives. While review of developed policies can inform the development of a sexual health strategy for the Western Area, regional issues need to be identified and taken into account.

### **2.3 Consensus Development**

Health professionals are often required to make choices about key policy issues that arise and there is often uncertainty about the value and range of different options that are available in dealing with these issues. In an ideal world issues to be included in policies would be based on guidelines and evidence derived from rigorously conducted empirical studies (Murphy *et al.*, 1998). However, according to Bowling (2000) in health care there are few areas where sufficient research based evidence exists or may ever exist to guide policy decision-making and appropriateness of healthcare interventions. In such situations the development of decision-making will inevitably be based partly or largely on the opinions and experiences of those professionals and others with knowledge of the subjects at issue (Bowling, 2000).

Consensus development methods have been identified as a useful tool for decision making in health care especially where policy issues are concerned (e.g. O'Loughlin & Kelly, 2004, Okoli & Pawlowski, 2004). Consensus development methods have been described as “*a process for making policy decisions, not a scientific method for creating new knowledge*” (Murphy *et al.*, 1998). These methods are used to make the best of available information and the expertise and knowledge of the participants involved in the process. These formal methods were introduced in an attempt to combat difficulties arising from informal meetings such as powerful member domination, only one person being able to speak at a time limiting the information and ideas being discussed and also the premature reaching of agreement due to a desire to produce results (Murphy *et al.*, 1998). By providing a structured and controlled process, formal methods are therefore envisioned to eliminate some of the negative characteristics associated with group decision making.

## **2.4 Aims & Objectives**

The aim of this research is to establish what goals, objectives and actions are important to include in a sexual health strategy for the HSE Western Area. This research will investigate the opinions of representatives of sexual health service providers.

### Research Aim

- ❖ To achieve consensus from representatives of sexual health service providers of what is relevant to include in a sexual health strategy for the HSE Western Area.

### Research Objectives

- ❖ To identify from service providers possible goals, objectives and actions to include in a sexual health strategy for the HSE Western Area
- ❖ To achieve consensus from service providers and representatives about what goals and objectives are relevant to inform a sexual health strategy for the HSE Western Area
- ❖ To achieve consensus from service providers on what actions relating to services, accessibility of services, responses to changing needs, information, sexual health education, educators and training are important to include in a sexual health strategy for the HSE Western Area
- ❖ To achieve consensus from service providers about what are the most effective actions to achieve the proposed goals and objectives of a sexual health strategy for the HSE Western Area.

## **Section 3 - Methods**

### **3.1 Introduction**

This section outlines the research design used, which divides the study process into three stages. These three separate but linked stages are described in relation to their sample, method of data collection and analysis of collected data. As aspects of the findings from one stage informs the development of the next, some of the results, such as actual sample size and characteristics are reported in this section for clarity.

#### Overall Study Design

The need for a structured formal process via which to develop consensus on goals, objectives and actions to include in a sexual health strategy is provided through the application of the Delphi Technique. The Delphi process has been variously described in the literature as a multi-stage process whereby each stage builds on the results of the previous stage and a series of repeated anonymised questionnaires or rounds completed by ‘experts’ in the field is used to both gather and provide information about a particular subject (McKenna, 1994; Whitmann, 1990). In this instance the application of the Delphi technique comprised three stages:

#### **❖ Stage 1**

Semi-structured interviews to investigate what issues were seen as relevant to sexual health for inclusion in Stages 2 and 3.

#### **❖ Stage 2**

Postal, self-completed questionnaire constructed from the issues that emerged from the interviews conducted at Stage 1. Respondents invited to rank strategic options presented and invited to contribute additional information.

#### **❖ Stage 3**

Responses obtained from Stage 2 were summarised and re-sent to respondents. Again, respondents were invited to rank the strategic options

presented and invited to contribute any additional information they felt was relevant.

### **3.2 Stage 1: Interviews**

#### Sample

The Sexual Health Strategy Research Team and members of the Sexual Health Steering Committee drew up an agreed list of key sexual health service providers with expertise and key knowledge of the issues. There were 17 ( $n= 17$ ) interviewees identified for the first part of the study. The sample included representatives from the following services and sectors:

- ❖ AIDS West
- ❖ Crisis Pregnancy Services
- ❖ Department of Health and Children
- ❖ General Practitioners
- ❖ GUM Medicine
- ❖ Health Promotion
- ❖ Obstetrics and Gynaecology Services
- ❖ Psychosexual Counselling
- ❖ Public Health
- ❖ Teenage Pregnancy Support Services
- ❖ Women's Health Committee

#### Data Collection

Data was collected through semi-structured interviews. As part of the interview participants were asked to identify other service providers for inclusion in further stages of the research. All of the interviews were audio-taped and subsequently transcribed with the permission of participants.

#### Data Analysis

The interview data was analysed using basic content analysis as described by Holsti (1969). The headings, goals, objectives and areas for action were predetermined from a review of policies described previously, while the sub-

headings under areas for action emerged from the interview data collected. These are presented below.

- ❖ Goals
- ❖ Objectives
- ❖ Areas for actions:
  - Services
  - To ensure accessibility of services
  - Responsiveness to changing needs
  - Information
  - Sexual Health education
  - Educators
  - Training

### **3.3 Stage 2: Questionnaire Round 1**

#### Sample

A snowball technique employed in Stage 1 generated the sample for Stage 2. The sample size for Stage 2 totalled 58 ( $n=58$ ) people, which included the original 17 interviewees. Representatives from various sectors and services in both the HSE Western Area and on a national basis contributed. See the Appendix for a listing.

#### Data Collection

Analysed data from the interviews conducted in Stage 1 were configured into a postal questionnaire format and sent to respondents. Participants were asked to rank, in order of importance, the goals, objectives and actions identified at Stage 1 for inclusion in a sexual health strategy. Participants were asked to add any goals, objectives or actions that they felt had been omitted. Following a reminder, a total of 38 questionnaires were returned, rendering a response rate of 65.5%.

#### Data Analysis

The returned questionnaires ( $n=38$ ) for Stage 2 were entered into and analysed using SPSS “*Statistical Package for the Social Sciences 12.0*”. For the purpose of Stage 2, data were analysed to determine both importance of the proposed goals, objectives and actions and the degree of consensus regarding the importance of

these proposals. The importance of each individual goal, objective and action was calculated using the median rank. Consensus was determined by using the following formula for the semi-interquartile range:

$(Q3-Q1)/2$ , where:

0-1	=	High level of consensus/agreement
1.1-2.0	=	Medium level of consensus/ agreement
2.1 +	=	Low level of consensus/ agreement

For goals, objectives and actions that had the same median after ranking the consensus level was used to determine which was placed in higher ranking order. Those with a higher degree of consensus were placed more highly. For those that had the same median and the same consensus value the ranking order was arbitrary. As participants were asked to provide any suggestions or proposals for goals, objectives and actions they felt had been omitted, these suggestions were qualitatively analysed using content analysis according to the topic areas previously developed following the interviews at Stage 1.

### **3.4 Stage 3: Questionnaire Round 2**

#### Sample

The sample for Stage 3 consisted of the same 58 participants ( $n = 58$ ) as those in Stage 2. Following a reminder, as in Stage 2, a total of 37 questionnaires were returned rendering a response rate for Stage 3 of 63.8%.

#### Data Collection

A second round questionnaire was formed for goals, objectives and actions using the analysed output from Stage 2 and sent to respondents. In relation to goals and objectives, the top two goals and objectives identified from Stage 2 were presented and participants asked to agree or disagree with them.

For the actions, each was placed in a table format in order of ranked importance and level of consensus achieved previously. The tables indicated the median rank given to the action as well as how much consensus was associated with it (high, medium, low agreement). Participants were asked to indicate whether they agreed

with the aggregate rankings and were invited to re-rank the components within the tables. Analysed qualitative data from the proposed actions was also placed in a table form and participants were requested to indicate, on a five point likert-type scale, how important they perceived these additional components to be.

### Data Analysis

The returned questionnaires ( $n=37$ ) for Stage 3 were entered into and analysed using SPSS "*Statistical Package for the Social Sciences 12.0*". The perceived importance of each action was calculated and analysed using the median with the lower median values indicating actions of higher importance than those with higher median values. Consensus was calculated by using the same formula as in Stage 2.

For actions that had the same median rank the consensus level was used to determine which one was placed higher in the ranking order. The likert-type scale with the proposed actions respondent's felt had been omitted from the questionnaire in Stage 2 was analysed using mean values. The mean value indicated how important (scale 1-5) respondents felt these actions and issues were to include in a sexual health strategy for the HSE Western Area.

## **Section 4 – Results**

### **4.1 Introduction**

This section presents the results of the three stages of the study and includes details of the respondents in terms of the services they provide, and their responses to the two Delphi questionnaire rounds. The questionnaire responses are presented by section. Thus, the findings from both rounds in relation to possible goals are presented first, followed by those in relation to objectives and finally those in relation to the sets of possible actions.

### **4.2 Sample Profile**

The sample included those working in 7 medical services, 5 support services, 3 educational services, 3 counselling services and 5 other services. In terms of geographical coverage, 13% had a national remit, 41% covered the HSE Western Area, 21% Galway city and county, a further 13% Galway city, and the remaining 12% covered geographical areas outside the Western Region; the North-Western area and the Midlands. A wide range of population groups were served by these service providers; 37% general population, 15% young people, 12% women, 6% third level students, 6% medical workers, and one participant each covering female sex workers, people with disabilities, homeless people, victims of domestic violence, members of the travelling community, asylum seekers and adults with progressive neurological illnesses. Details of the service breakdown, geographical spread and population groups served can be found in the appendix.

### 4.3 Goals

Table 4.3 below presents the aggregate responses to the set of possible goals for the sexual health strategy from the first questionnaire round at Stage 2. The 10 goals are presented in order of their perceived importance, with rank 1 indicating the most important and 9 the least important. Also presented are the median ranks achieved by each possible goal along with their consensus values and levels.

**Table 4.3 Ranked importance and consensus for possible strategic goals**

Goals	Rank	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Develop health and social infrastructure to support people in making informed & healthy choices in terms of sexual health	1	2.00	1.50	Medium
Mainstream sexual health as part of overall health	2	3.00	1.62	Medium
Promoting positive sexual health	3	3.00	2.50	Low
Promote ability to develop healthy relationships	4	4.00	2.00	Low
Create an integrated sexual health service	5	4.00	2.12	Low
Reduce sexually transmitted infections	6	6.00	1.27	Medium
Co-ordinate all sexual health policy initiatives	7	6.00	2.12	Low
Reduce unplanned pregnancies	8	7.00	1.75	Medium
Increase awareness of nation's sexual health	9	7.00	2.00	Low

Table 4.3 illustrates that low or medium agreement or consensus was achieved in the ranking.

In Stage 3 respondents were presented with the two goals:

1. “Develop health and social infrastructure to support people in making informed and healthy choices in terms of sexual health”
2. “Mainstream sexual health as an equally important part of overall health”.

Respondents were asked to indicate if they agreed or disagreed with their adoption. In the second round, 97.2% of respondents agreed with these two goals.

#### 4.4 Objectives

Table 4.4 below presents the aggregate responses to the set of possible objectives for the sexual health strategy from the first questionnaire round. The 7 objectives are presented in order of their perceived importance, with rank 1 indicating the most important and 7 the least important. Also presented are the median ranks achieved by each possible objective along with their consensus values and levels.

**Table 4.4 Ranked importance and consensus for possible strategic objectives**

Objectives	Rank	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Ensure availability of sexual health services	1	2.00	1.06	High
Ensure accessibility of sexual health services	2	2.00	1.63	Medium
Ensure responsiveness of sexual health services to changing needs	3	4.00	1.50	Medium
Ensure that sexual health education is meeting the needs of young people	4	4.00	1.50	Medium
Build capacity amongst educators, both formal and informal, to deliver sexual health education	5	4.00	1.63	Medium
Provide sexual health training for service providers	6	5.00	1.75	Medium
Meet sexual health information needs	7	5.00	1.75	Medium

Table 4.4 illustrates that a high level of consensus was achieved for the first ranked objective with medium levels of agreement found in the remaining ranking.

In Stage 3 respondents were presented with the two objectives

1. “Ensure availability of sexual health services in the HSE Western Area”
2. “Ensure easy accessibility of services in the HSE Western Area”.

Respondents were asked if they agreed or disagreed with their adoption. In the second round, Stage 3, 94.4% indicated that they agreed with these objectives.

#### **4.5 Actions**

Tables 4.5.1 – 4.5.7 below present the aggregate responses to the set of possible actions from the first and second questionnaire rounds. The actions are presented by topic and in order of their perceived importance. The percentage of respondents indicating that they thought that this particular action would be most effective are presented in the second column. Also presented are the median ranks achieved by each possible action along with their consensus values and levels, for both survey rounds, Stages 2 and 3.

**Table 4.5.1 Ranked importance, perceived effectiveness and consensus for possible service development action**

Service Development	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Increase state investment in existing sexual health services	1	50	2.00	1.5	Medium	1.00	1.00	High
Create one stop shops for all sexual health needs	2	25	2.50	2.00	Medium	2.00	0.75	High
Develop under resourced sexual health services	3	25	4.00	1.13	Medium	3.00	0.58	High
Integrate all government services around sexual health provisions	4	12.5	4.00	2.13	Low	4.00	0.75	High
Provide specific sexual health services for young people	5	0	5.00	1.63	Medium	4.50	0.5	High
Create public private partnership to provide sexual health services	6	0	5.00	1.75	Medium	6.00	0.17	High
Provide free/subsidised condoms	7	6.3	7.00	1.62	Medium	7.00	0.14	High

Table 4.5.1. illustrates the seven actions relating to Service Development in terms of their ranking order and the values and levels of consensus about their ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that the consensus level increases between Stages 2 to 3.

**Table 4.5.2 Ranked importance, perceived effectiveness and consensus for possible accessibility of services actions**

Accessibility of Services	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Central sexual health service locations	1	36.8	2.00	1.5	Medium	1.00	2.00	Medium
Extend opening hours	2	45	2.00	1.5	Medium	2.00	0.00	High
Provide outreach sites where needed	3	26.3	3.00	1.0	High	3.00	0.71	High
Develop good links with all services in each local area	4	21.1	3.00	1.0	High	4.00	0.31	High
Create low call numbers to ensure telephone support	5	10	3.00	1.5	Medium	5.00	0.20	High

Table 4.5.2. depicts the five actions relating to Accessibility of Services in relation to their ranking order and the values and levels of consensus about that ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that the consensus level for the first ranked action remains the same between Stages 2 and 3, while the consensus around the actions ranked 2-5 increases.

**Table 4.5.3 Ranked importance, perceived effectiveness and consensus for possible information actions**

Information	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Ensure formats for information are culturally appropriate and encompass different literacy levels	1	40	3.00	1.50	Medium	1.00	2.75	Low
Run campaigns to inform population about what and where sexual health services are	2	30	3.00	2.00	Medium	2.00	0.88	High
Ensure messages from service users view points	3	25	3.00	2.00	Medium	3.00	0.33	High
Coordinate and integrate all information campaigns	4	15	4.00	1.00	High	4.00	0.25	High
Ensure messages gender and group specific targeted	5	10	4.00	1.50	Medium	5.00	0.20	High
Exploit every setting in relation to delivering sexual health messages	6	5	4.00	1.75	Medium	6.00	0.16	High
Build campaign around famous face	7	10	7.00	0.50	High	7.00	0.00	High

Table 4.5.3. shows the seven actions relating to Information in terms of their ranking order and the values and levels of consensus about that ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that the consensus level for the action ranked most important falls between Stages 2 and 3 from medium to low but the remaining actions achieve high levels of consensus around their ranking in the final stage.

**Table 4.5.4 Ranked importance, perceived effectiveness and consensus for possible actions related to ensuring responsiveness**

	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Carrying out needs assessments on regular basis	1	63.2	2.00	0.5	High	1.00	1.00	High
Continuously evaluate sexual health services	2	36.8	3.00	1.25	Medium	2.00	0.50	High
Enshrine flexibility in creation of sexual health services	3	21.1	3.00	1.5	Medium	3.00	0.34	High
Include research as part of all sexual health service funding	4	21.1	4.00	1.25	Medium	4.00	0.00	High
Include evaluation as part of all sexual health service funding	5	21.1	4.00	1.75	Medium	5.00	0.20	High
Regularly map service provisions	6	21.1	5.00	1.5	Medium	6.00	0.13	High

Table 4.5.4. shows the six actions relating to Ensuring Services Remain Responsive to Changing Needs in terms of their ranking order and the values and levels of consensus about their ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that a high level of consensus is achieved by Stage 3.

**Table 4.5.5**

***Ranked importance, perceived effectiveness and consensus for possible actions related to sexual health education in schools***

Sexual Health Education in Schools	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Deliver programmes that emphasise relationship building rather than sex	1	81.8	3.00	1.50	Medium	1.00	1.00	High
Deliver programmes for young people to create intimacy and respect within relationships	2	18.2	3.00	1.75	Medium	2.00	0.50	High
Deliver programmes that build self confidence	3	9.1	3.00	2.25	Low	3.00	0.33	High
Deliver programmes to enhance negotiation skills	4	0	4.00	2.00	Medium	4.00	0.25	High
Deliver programmes to increase assertiveness	5	0	5.00	2.00	Medium	5.00	0.20	High
Deliver programmes based on behaviour change	6	9.1	6.00	2.25	Low	6.00	0.33	High
Deliver programmes beginning in primary school	7	0	6.00	2.50	Low	7.00	0.14	High
Create specific programmes for young people with disabilities	8	0	7.00	1.50	Medium	7.00	0.21	High
Deliver programmes in third level settings	9	0	7.00	2.00	Medium	9.00	0.22	High
Revise the Social Personal and Health Education Programme	10	0	8.00	3.13	Low	10.0	0.00	High

Table 4.5.5. depicts the ten actions relating to Sexual Health Education in Schools in terms of their ranking order and the values and levels of consensus about their ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that, as in the previous table, high levels of consensus are achieved about the ranking order by Stage 3.

**Table 4.5.6 Ranked importance, perceived effectiveness and consensus for possible actions related to educators**

Educators	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Develop teachers capacity to deliver sexual health education programmes	1	13.3	3.00	2.00	Medium	1.00	1.00	High
Ensure parents are included in school sexual health education	2	46.7	4.00	2.00	Medium	3.00	0.42	High
Ensure more parental support exists to build their capacity as primary educators	3	40	4.00	2.13	Low	3.00	0.67	High
Develop and deliver parenting programmes free to every parent	4	13.3	4.00	2.13	Low	4.00	0.50	High
Teachers trained in order to increase ability to be explicit	5	13.3	5.00	1.50	Medium	5.00	0.20	High
Ensure professional sexual health providers invited schools as supports for delivering SPHE	6	0	5.00	2.00	Medium	6.00	0.38	High
Ensure teachers given time to develop SPHE programme	7	20	6.00	1.50	Medium	7.00	0.11	High
Professionals invited in schools to deliver sexual health programmes	8	0	7.00	2.50	Low	8.00	0.13	High
Review the Social Personal and Health Education Programme	9	6.1	8.00	2.13	Low	9.00	0.06	High

Table 4.5.6. illustrates the nine actions relating to Educators in terms of their ranking order and the values and levels of consensus about their ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table illustrates that the consensus level increases between Stages 2 to 3 achieving a consistently high level of consensus with the ranking by Stage 3.

**Table 4.5.7 Ranked importance, perceived effectiveness and consensus for possible training actions**

Training	Rank	Most Effective (%)	Questionnaire Round 1: Stage 2			Questionnaire Round 2: Stage 3		
			Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level	Median Rank	Consensus Value (Q3-Q1)/ 2	Consensus Level
Update GP skills to ensure opportunistic sexual health interventions	1	60	3.00	1.13	Medium	1.00	1	High
Establish standards regarding maintenance of competency in relation to sexual health in primary care	2	20	3.00	2.13	Low	2.00	0.5	High
Mainstream health professionals in sexual health	3	13.3	3.00	2.50	Low	3.00	0.67	High
Train nurses to be able to deliver sexual health services	4	6.7	4.00	2.00	Medium	4.00	0.22	High
Deliver specialised sexual health training to all care workers	5	6.7	4.00	2.50	Low	5.00	0.2	High
Train Gardai in relation to sexual violence and sexual assault	6	7.7	5.00	1.50	Medium	6.00	0.17	High
Provide cultural competency training to all sexual health service providers	7	0	5.00	1.50	Medium	7.00	0.14	High
Train General Practitioners to deal with young people	8	20.7	5.00	2.00	Medium	8.00	0.33	High

Table 4.5.7. depicts the eight actions relating to Training in relation to their ranking order and the values and levels of consensus about their ranking order and importance for inclusion in a sexual health strategy for the Western Area. The table shows that the consensus level increases between Stages 2 to 3 so that, as with the previous table, a high level of consensus is achieved by Stage 3.

## 4.6 Additional Suggestions

As part of Stage 2, participants were invited to provide any extra comments or include issues that they felt had been omitted. Not all respondents took this opportunity, with just 7 respondents providing extra information.

### Goals

Participants that provided extra comment identified that the goals suggested were all equally as important and were difficult to rank, but felt the goals of “*reducing sexually transmitted infections*” and “*reducing unplanned pregnancies*” would not be achieved by the strategy alone and that “*it would depend on the implementation of issues and actions suggested in the strategy that would achieve these goals*”. It was suggested that addressing inequalities in sexual health should be a clear goal for the strategy and that this was essential.

### Service Development

The majority of those who gave opinions on service provision and accessibility of services felt that this was a key area for inclusion in a sexual health strategy. It was highlighted that “*a range of services is required across a range of settings*” and that “*a mixture of mainstreaming of services and targeting of services was essential to ensure top service provision*”. It was proposed that accessibility of services needs to be improved “*to include all excluded and minority communities*”. Other respondents were concerned with evaluation measures for services and it was suggested that “*the strategy should include long-term measures to ensure services are improved in the future*”. It was recognised that more immediate measures were essential “*to address shortcomings and deficiencies in current service provision*”. Another respondent identified that the importance of funding for sexual health services was a key issue and “*HSE management need to recognise the importance of this*”. Other issues arising concerned needs assessments and mapping of services with it being indicated strongly that “*there is a lack of knowledge with the board about exactly what services are being provided for the people of the region*” and also “*services need to be tracked and mapped to ensure they stay up-to date*”. It was identified that in order to ensure services were accessible they should be, based on their own

experience, “the four P’s”: “Public Profile, Policy and Procedure, Professional Development and Programme Development”.

### Sexual Health Education

Respondents commented that the actions “*revising and reviewing the SPHE curriculum*” were not important to include as “*the SPHE curriculum has yet to be evaluated*”. Some respondents felt that the SPHE curriculum was not being adhered to was “*ad-hoc*” and “*not consistent*” in many schools and an appropriate action could therefore be, “*to enforce that SPHE be provided in all schools across the board*”.

### Information

Information campaigns were another action emphasised as an important consideration for a sexual healthy strategy. Two participants suggested that sexual health information needed to be included with other health information “*to reduce the stigma associated with sexual health problems*” and also “*to make it culturally acceptable to seek help for sexual health*”.

### Training

The training of professionals was presented as a key issue and as “*essential to implement issues targeted by a sexual health strategy*”. Respondents were of the opinion that training was needed across the board from “*practice nurses*” to “*updating GP skills*”, “*training for all staff in HSE who are in contact with young people*” “*training of professionals in the community who work with people with disabilities*” and “*training of educators*”.

### Ranking of the additional suggestions

From these suggestions a list of 11 further actions were presented in tabular form to respondents in Stage 3. Respondents were invited to rank these actions individually on a five point, likert-type scale as to their relative importance for inclusion in a sexual health policy. The rating scale ranged from 1 (not at all important) to 5 (very important). Table 4.6.1 below presents the mean rank (and standard deviation) given to these actions by respondents to the second questionnaire at Stage 3.

**Table 4.6.1 Mean (sd) rankings given to the proposed additional actions**

<b>Additional Actions</b>	<b>Mean Rating</b>	<b>Standard Deviation</b>
Ensure a mix of mainstream and targeting of sexual health services	3.97	1.09
Ensure all sexual health services are accessible to excluded communities	4.57	0.80
Run campaigns that focus on changing attitudes and behaviours rather than just information	4.19	0.95
Include sexual health information with all other types ( <i>of information</i> ) to reduce stigma	4.27	0.96
Ensure the social, personal and health education and sexual health education is provided in all schools	4.43	0.96
Deliver programmes based on developing value systems for young people	4.36	0.90
Deliver programmes focusing on sexual orientation	3.19	1.24
Deliver programmes for gay / bisexual people specific to their sexual health needs	3.49	1.22
Deliver programmes focusing on alcohol consumption and its link with sexual behaviour and health	4.41	0.96
Ensure professionals dealing with out of school education also receive adequate training	4.11	1.07
Ensure all sexual health services have a) a public profile, b) policies and procedures to support them, and c) include programme development	4.62	0.59

## **Section 5 - Discussion**

### **5.1 Introduction**

The three stages of data collection and corresponding analysis aimed to distil and identify key areas for inclusion and subsequent development for a sexual health strategy for the Western Area. A brief overview of the three stages of the study will be presented, followed by more detailed consideration of the areas for discussion.

#### Sample Profile

The sample profile indicates that the study respondents and sample involved a wide range of service representatives across a wide range of disciplines such as Medical Services, Support Services, Counselling, Education and Health Promotion. Respondents are responsible for the provision of services right across the area for which the strategy is being developed, as well as, in some instances in neighbouring counties and on a national basis. The profile revealed a wide variety of population groups being targeted and catered for by these services, from the general population, to various sub-population groups such as women, school children, third level students and asylum seekers.

#### Interviews (Stage 1)

The Stage 1 interviews functioned to investigate and seek opinions on which areas for development were important to include in a sexual health strategy. A broad number of areas were identified with a wide number of proposed actions emerging. The issues and ideas generated were used to form and develop the tables for the questionnaire rounds (Stages 2 and 3). This was consistent with the Delphi literature, which indicates that a first round of data collection is advisable in order to generate ideas and themes (Hasson *et al.*, 2000) and this stage proved successful in this regard.

#### Questionnaire Round 1 (Stage 2)

The results of Stage 2 indicate that there were varying levels of consensus and agreement between respondents for various sets of actions, goals and objectives.

For the nine goals there were medium to low levels of consensus amongst respondents about the ranks, with respondents not achieving a high level of agreement about any of the goals presented. The set of objectives listed was generally met with medium agreement between respondents. The top ranked objective “to ensure availability of sexual health services” achieved a high level of agreement amongst respondents indicating that respondents were in high agreement about this being the most important objective for a sexual health strategy.

For the ‘Service Development’ actions there was primarily medium levels of agreement amongst respondents about the ranks. Within ‘Accessibility of Services’, respondents displayed a high level of agreement about the actions “provide outreach services where needed” and “develop good links with all services in local area” indicating that respondents were in strong agreement as to these being placed as 3<sup>rd</sup> and 4<sup>th</sup> most important actions in this set. There was also a strong level of agreement amongst respondents about “carrying out needs assessments on a regular basis” as being the most important within ‘Ensuring that Services Remain Responsive to Changing Needs’.

For the set of actions relating to ‘Information’, there was generally a medium level of consensus amongst respondents as to the ranks. However, there was a high level of consensus for the action “build a campaign around a famous face” indicating that respondents were in strong agreement as to this being the least important action in this set. For actions relating to ‘Sexual Health Education in Schools’ respondents ranked the programmes concerned with building and developing skills such as “assertiveness”, “self confidence” and “negotiation” as the most important actions with issues such as “beginning in primary school”, “delivering in third level settings” ranked as less important. For actions relating to ‘Educators’ and ‘Training’ there was generally medium to low levels of consensus about the importance and ranking of these actions. In the ‘Educators’ set of actions the data indicated that respondents ranked parental involvement and support as being very important issues, with three actions about parents being ranked as 2<sup>nd</sup> 3<sup>rd</sup> and 4<sup>th</sup> most important in this set of actions.

### Questionnaire Round 2 (Stage 3)

For the goals and objectives that were presented in the second round questionnaire almost all respondents were seen to agree with the goals and objectives that had been proposed for a sexual health strategy for the Western Area. The data indicated that once all the actions for each set had been re-ranked in the second questionnaire (Stage3) there was no change in rankings between rounds with every single action maintaining its rank. Corresponding to this maintenance of ranking order for all actions, the data also revealed that almost all actions saw an increase in consensus with most actions falling within the high consensus range. Thus, after the second questionnaire round at Stage 3 there was generally a high level of agreement amongst respondents about the ranks. There were two exceptions to this, with the action “central sexual health service locations” in the ‘Accessibility of Services’ set of actions, maintaining a medium level of consensus. The top ranked action in the ‘Information’ set of actions had a drop in consensus level in Stage 3, revealing a low level of agreement about this being the top ranked action as opposed to a medium level of consensus in Stage 2.

The data from Stage 3 also revealed that respondents rated the extra actions presented as important actions to include in a sexual health strategy. These actions were those contributed by respondents in Stage 2 as actions they felt were important to include but had been omitted in the first questionnaire. When asked to choose which actions in each set that respondents felt were the most effective for achieving the goals and objectives of a sexual health strategy, it was found generally that respondents chose the top ranked action as the most effective action. Actions within the tables ‘Accessibility of Services’ and ‘Educators’ were the exceptions to this, with the highest proportion of respondents choosing the 2<sup>nd</sup> ranked actions as the most effective for both sets. Note that in some cases respondents chose more than one action per table, and thus the percentages do not sum to 100%.

## **5.2 Consensus**

### Goals

Reviewing the strategy and policy literature has indicated that most strategies are developed with clear goals set out and on which actions are generally based. In this study from the interview Stage 1 to the second questionnaire (Stage 3) there was a clear set of nine goals, which were identified as being the most relevant for a sexual health strategy for the Western Area. The interview stage of the Delphi saw a wide range of goals being proposed with broad goals such as “to promote positive sexual health” and “to develop social and health infrastructures to support people in making informed and healthy choices in terms of sexual health” proposed as the most important goals for a sexual health strategy for the Western Area.

The interviews also revealed specific goals relating to sexual health problems such as “to reduce incidences of unplanned pregnancy” and “to reduce STI’s” being proposed as important to include in a strategy. The literature and research evidence to date supports the inclusion of these issues. The rates of STI’s in Ireland have been steadily increasing (HPSC, 2003), and high levels of teenage pregnancy have also been reported and both of these issues have been considered as causes for concern (Fullerton, 2004). It is evident that service providers and representatives feel that these issues are priorities and should be included as goals of a sexual health strategy.

The goals that emerged from the interview stage of this Delphi study concur with the goals set out in various national policies outside of Ireland and in regional Irish strategies. The UK (Department of Health, 2001) and Scottish (Scottish Executive, 2005) national policies both list reducing the transmission of HIV and STI’s and reducing the rates of unintended pregnancies as main goals of their strategies with the UK strategy focusing on HIV as it’s main theme. The regional Irish strategies (HSE Eastern Region, 2005; Southern Health Board, 2001) emphasise similar goals with the HSE Eastern Region setting its goals as “the prevention and management of infection and the prevention of unintended pregnancy”. The goals referring to healthy relationships and promoting positive sexual health that emerged in this study for the HSE Western Area are mirrored to

some degree in strategies from both Wales (National Assembly for Wales, 2000) and Scotland as well as in the strategy developed by the Southern Health Board (2001). The Welsh strategy highlights “enhancing general health and well-being of the population by enabling and supporting fulfilling relationships” as one of its goals (National Assembly for Wales, 2000) and the Southern Health Board state “the promotion of sexual health and safer sexual practices” as one of its main goals (Southern Health Board, 2001). The Scottish strategy states one of the main goals as “to promote a broad understanding of sexual health and sexual relationships that encompasses emotions attitudes and understanding” (Scottish Executive, 2005).

After the first questionnaire round (Stage 2) when the goals were put to the wider sample it was revealed that the broader and more holistic goals were viewed as being the most important for a strategy rather than the more specific goals. The goals of “mainstreaming sexual health”, “promoting positive sexual health” and “promoting the ability to develop healthy relationships” all fell in the top ranked actions. The specific goals “reducing unintended pregnancies” and “reducing STI’s” were ranked in the bottom half of the actions in 6<sup>th</sup> and 8<sup>th</sup> place respectively. This finding did not reflect the fact that most policies and strategies, whether regional or national, clearly identify both of these as major goals for sexual health strategies. It must be noted that a relatively low ranking does not mean that these goals are unimportant, or that their more specific nature would not be included within the broader goals that had received higher rankings.

However, these ranks may be partially explained by the development of the definition of sexual health. The WHO defines sexual health not merely as the absence of infections and problems but encompassing a wide range of issues including positive sexuality, sexual well-being and sexual relationships (WHO, 2002), a broad concept mirrored by others (e.g. Robinson *et al.*, 2002; US Department of Health and Human Services, 2001). Perhaps, with these perspectives on sexual health now dominant in the literature, this was reflected in the rankings of these actions as being the most important goals of a sexual health strategy for the HSE Western Area.

## Objectives

The study indicated that there was a wide range of objectives identified by respondents as being important and relevant to include in a sexual health strategy for the HSE Western Area. Objectives identified were related to services (provision, accessibility, availability, and responsiveness to changing needs), sexual health education (programmes and educators) and also related to the training of sexual health professionals. All of these objectives identified by this study appear to have been targeted and focused on in other sexual health strategies and policies. The Southern Health Board Strategy identified the areas of information, education and training as key actions for targeting priority areas and achieving the (Southern Health Board, 2001) Similarly, the UK Department of Health strategy emphasised 'Better services' as a key target area of their strategy (Department of Health, 2001).

Following Stage 2 it was found that the top two ranked objectives were "to ensure the accessibility of sexual health services" and "to ensure availability of sexual health services" and there was high to medium levels of consensus and agreement that these were the most important objectives for a strategy. This finding is significant, as the provision of services, particularly contraceptive services, have been identified in the literature as an area for concern with regards sexual health. The Crisis Pregnancy Agency audit of contraceptive services in 2003 indicated that service provision varied from region to region with urban areas tending to have more services (Mason, 2004). The literature also highlighted that the provision of services such as Family Planning Centres and Well Woman Clinics was sporadic in rural areas and that these services were viewed as extremely accessible services when available and preferred by many women, especially younger women (Smith & McElnay, 1994). The concern surrounding accessibility and availability of services was also noted in Stage 2 when respondents provided written rationales and comments with it being identified that "*measures were essential to address shortcomings and deficiencies in current service provision in the west*".

The ranking of “accessibility and availability of services” as being the most important objectives for a sexual health strategy is consistent with the policy literature. Both the New Zealand (New Zealand Ministry of Health, 2001) and Scottish (Scottish Executive, 2005) national sexual health policies include these issues as key areas for action. The New Zealand strategy proposed to improve access and quality of services and the Scottish strategy indicates giving people a choice when accessing services as a key priority when attempting to tackle growing sexual health problems.

### Service Development & Accessibility of Services

The interview stage of the study saw a wide range of actions being suggested as important relating to accessibility and service development. ‘Service Development’ actions were mainly concerned with the development of existing services such as “increasing state investment into existing services”, “creating public private partnerships to provide sexual health services”, and “creating one stop shops for all sexual health needs”. Also emerging as a ‘Service Development’ action was “providing free and subsidised condoms”. After Stage 2 the actions that emerged as most important were seen to be “increasing state investment” and “creating one stop shops” with “providing free and subsidised condoms” being seen as the least important service development action. This remained consistent after the second round of rankings with all actions maintaining order of importance. These findings and themes that emerged remain somewhat consistent with the policy and strategy literature that exists. The notion of “creating one stop shops” was highlighted in the HSE Eastern Region Strategy as being a key area for action under the Priority D “Organisation of services” where it was recommended to pilot one stop sexual health clinics in the region (HSE, Eastern Region, 2005). The UK strategy also made reference to this, piloting three of these clinics in the UK to evaluate their impact on sexual health services (Department of Health, 2001).

What was interesting to note was that the least important action after both studies was seen to be “providing free and subsidised condoms” with a high level of agreement amongst respondents about this being the least important action for service development. This action has received numerous references within

national policies with the UK, Welsh and New Zealand strategies all emphasising the provision of free and subsidised condoms as a priority to reduce increasing levels of STI's and teenage pregnancies. Interestingly there was no reference to this service or action within either of the regional Irish strategies reviewed.

For 'Accessibility of Services' actions the themes that emerged from the interviews and from the ranking exercise in Stage 2 all appear to be in line with both national and regional policies. The action that was ranked as most important was "central sexual health service locations" and remained the most important action after Stage 3. The UK strategy includes the provision of services in urban centres that are accessible to all as an essential element of providing "Better services" and working towards their aims and goals. This choice by respondents as the most important action reflects the fact that the issue of service location is one that often prevents young people from accessing and making use of sexual health services (Fullerton, 2004).

#### To Ensure Services Remain Responsive to Changing Needs

This study indicated that in order for the goals and objectives of a sexual health strategy for the Western area to be achieved there must be some emphasis placed on ensuring that services remain responsive to changing needs. The interview stage saw actions such as "carrying out regular needs assessments", "continuous evaluation" "research as part of sexual health funding" as important issues to include in a sexual health strategy. From the ranking stages there was very strong agreement amongst respondents that "carrying out regular needs assessments" was the most important action in relation to this issue and this remained the same after the second ranking. "Supporting Change" is one of the main strategic tenets of the UK strategy and within this regular needs assessments of local populations is a key area for action in order to keep services updated and also to ensure services were based on user needs. Within the UK strategy it was noted that service mapping was necessary, a requirement that also emerged in this study but which, it should be noted, was ranked as the least important action. The action of "continuous evaluation of services" was seen as one of the most important actions and the inclusion of this action is consistent with the New Zealand Strategy.

### Information

This study revealed that service providers and representatives felt that information for sexual health was a key area for action to be included in a sexual health strategy for the Western area. From the interview stage of the study it emerged that sexual health information campaigns were seen as important. Issues relating to coordinating and integrating campaigns, building campaigns with celebrities and famous people and running campaigns to inform potential service users where sexual services were located were some of the main actions suggested for inclusion. In both questionnaire rounds the issues that came to the fore as being most important were practical issues such as “ensuring formats for information are culturally appropriate and have different literacy levels” and “run campaigns to inform the population about where and what services are”. It was also revealed that targeted messages and gender specific messages were not seen to be as important. This perhaps indicates that service users felt that practical and simple issues like language and targeting the general population were more important than disseminating information targeted at specific groups. This finding was consistent with other sexual health policies and strategies. Both the regional strategies in Ireland highlighted this with the HSE Eastern Region (2005) indicating that sexual health information needs to be accessible, clear, appropriate and positive.

### Sexual Health Education and Educators

The findings of this study indicated that sexual health education was viewed as an important area to include in a sexual health strategy for the Western area. The interview data indicated that sexual health education programmes in schools are considered a vital and integral part of sexual health. Clearly from this study it is indicated that service providers and representatives feel that emphasis needs to be placed on providing sexual health education in schools in order to promote safe sexual practices and positive sexual health amongst young people.

Stages 2 and 3 indicated that service providers viewed sexual health programmes being delivered in schools that focus on “building relationships”, “creating intimacy and respect”, “build self confidence” and “build negotiation skills” as

the most important actions for sexual health education. This remained consistent throughout the study, with high levels of agreement amongst respondents about these being the most important actions after the second questionnaire round. These findings regarding skills delivery and personal development based programmes have been mirrored in other policies and strategies. The Scottish Strategy places particular emphasis on sexual health education as a method for “Promoting Respect and Responsibility”. The strategy highlights that programmes involving personal and social skills development, such as assertiveness, self-identity, self-esteem and relationship building, should begin at preschool and primary school level and illustrate the roles and responsibilities that both parents and teachers as primary educators have in the process (Scottish Executive, 2005). The Southern Health Board similarly identified sexual health education programmes with skills and personal development emphasised as being key. The strategy also recognises frameworks for holistic sexual health programmes in non-school youth settings, with an emphasis on early school leavers and community settings as well as third level institutions. These issues were addressed in the current study where it was identified at the interview stage that “to deliver programmes in third level settings and out of schools settings” was an important action (Southern Health Board, 2001).

The important role of educators has also been emphasised in this study. From the interviews at Stage 1, teachers, parents and professionals were all identified as potential educators of sexual health. After the two rounds of questionnaires it was indicated that parental involvement, support for parents and parents receiving an education programme were some of the most important issues. This finding is consistent with other sexual health strategies with the Scottish strategy identifying parents as “primary educators” of sexual health education.

### Training

This Delphi study revealed that a wide range of professionals across a number of disciplines were viewed as being central to promoting sexual health and also central to the development of a sexual health strategy. The interview stage indicated that General Practitioners should receive further training to deal with sexual health issues, as should practice nurses, members of the Gardai and all care

workers. After the rankings during the two questionnaires it was found that “updating GP skills to ensure opportunistic interventions” was seen as the most important action with relation to training with “training nurses to be able to deliver sexual health services” being ranked in the top four most important actions.

It was indicated that all health professionals should receive sexual health training “mainstreaming all health professionals in sexual health with the expansion of third level training” which was ranked as the third most important action. This finding was consistent with the policy literature from the Eastern Regional strategy which also lists training as one of its main recommendations and emphasises the training of all medical professionals during third level (HSE Eastern Region, 2005). This study indicated that all care workers and those involved in their training should receive specialised sexual health training and this finding mirrors actions in the Scottish strategy. The Scottish strategy highlights that professionals across a wide range of disciplines should receive education and training, making explicit reference to physicians, practice nurses, teachers, midwives, school nurses, health advisers, community and youth workers and psychologists. However, as regards training there was no clarity about what type of training all these professionals should receive. This has been considered within the UK strategy and Scottish strategies; both highlight that training needs to cover core skills, awareness issues, attitudes, information, communication skills, sexuality, sexual health and relationships (Scottish Executive, 2005, Department of Health, 2001).

### Conclusion

In Ireland there is currently no national sexual health policy and very little literature and evidence appeared to exist about what is relevant and important to include in a sexual health strategy. Bowling (2000) noted that in health care there are few areas where sufficient research based evidence exists or may ever exist to guide policy decision-making and appropriateness of healthcare interventions. In such situations the development of decision making will inevitably be based partly or largely on the opinions and experiences of those professionals and others with knowledge of the subjects at issue (Bowling 2000). This process has

successfully identified areas that are relevant to include in a sexual health strategy for the HSE Western Area

## **Appendix**

Representation drawn from the following services and organisations

- ❖ AIDS West
- ❖ Accord
- ❖ Army
- ❖ Cope Foundation
- ❖ Crisis Pregnancy Services
- ❖ Department of Health and Children
- ❖ Galway Family Planning Association
- ❖ Garda Siochana
- ❖ General Practitioner Services
- ❖ GUM Medicine
- ❖ Health Promotion Departments
- ❖ MS Ireland
- ❖ National Council for the Blind
- ❖ Obstetrics and Gynaecology Services
- ❖ Primary Care Services
- ❖ Public Health Services
- ❖ Pharmacy Services
- ❖ Probation and Welfare Services
- ❖ Psychosexual counselling
- ❖ Rape Crisis Centre
- ❖ Refugee and Asylum Seeker Support Services
- ❖ SPHE Coordinator
- ❖ Social Work Services
- ❖ Third Level Medical/Nursing Staff
- ❖ Traveller Support Services
- ❖ Teenage Parents Support Services
- ❖ Women's Refuge
- ❖ Women's Health Committee

❖ Youthreach

## Appendix

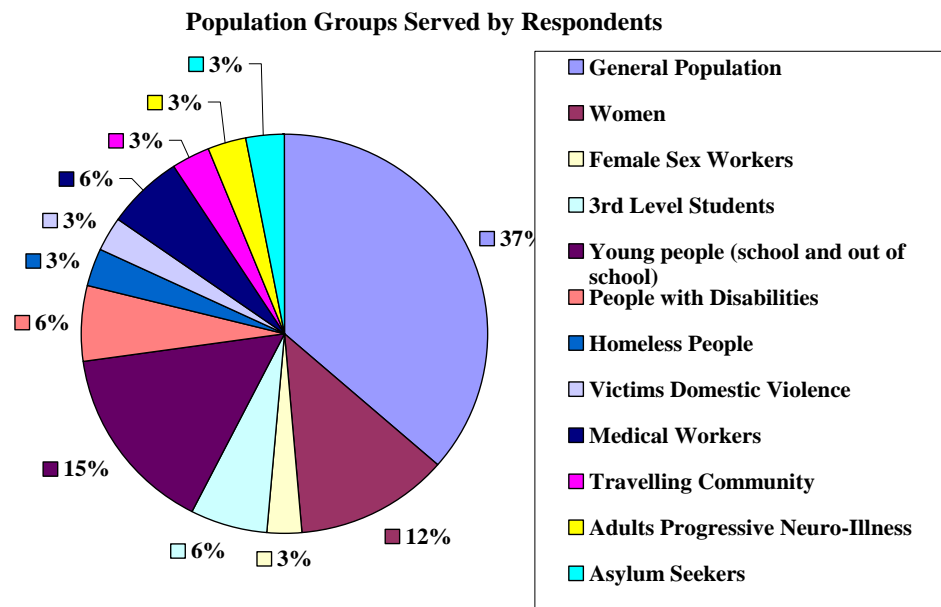
This table lists the services that respondents to the Delphi Stage 2 provide. Services are categorised into Medical, Support, Education, Health Promotion, Counselling and Other services.

**Table 5: Services offered by respondents**

<b>Category</b>	<b>Specific Service</b>
<b>Medical Services</b>	Screening
	Women's Health Services
	GUM Clinic
	STI clinics and services
	Travellers Health
	Pharmacy
	GP service
	Student Health Unit
	Pregnancy & Maternity Unit
<b>Support Services</b>	Crisis Pregnancy Support
	Support for Court Offenders in the Community
	Social Support for people living with HIV
	Teenage Parent Support
	Support for Homeless people and victims of Domestic Violence
<b>Education Services</b>	GP's and Nurses
	Education and training of nurses in hospital setting
	Department of General Practice, NUI Galway
<b>Counselling Services</b>	Crisis Pregnancy Counselling
	Psychotherapy
	Victims of sex crimes (violence, assault, rape)
<b>Health Promotion</b>	General Health Promotion

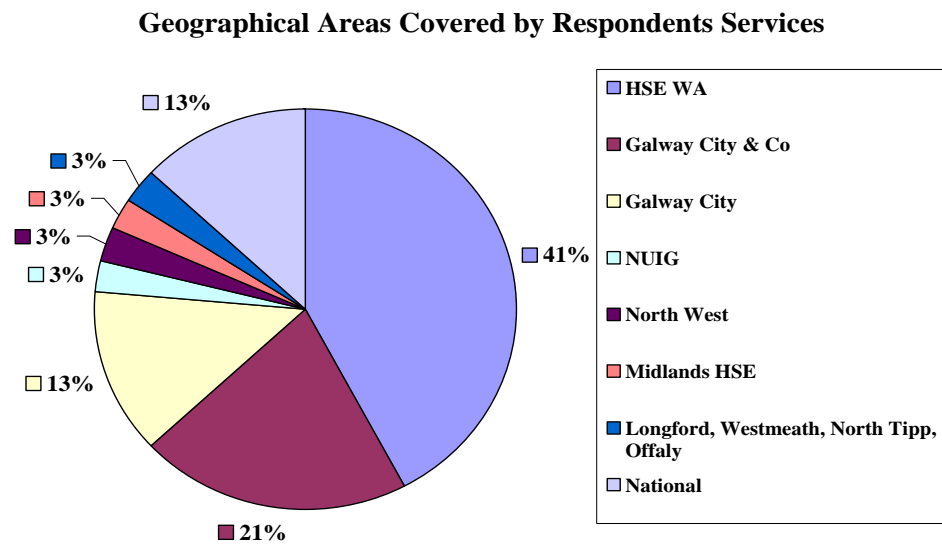
	Health Promotion: SPHE & teacher training
<b>Other Services</b>	Criminal Law
	Policy Development
	Teenage Health Initiative
	Support Rehab & Counselling for people living with a sensory disability
	Support, Advice, training for people who are deaf

Graph 1: Population groups served by respondents



Graph 1 depicts the population groups covered by the services that respondents provide. The largest numbers of respondents are providing services to the general population (37%). Women are also well catered for by the respondent's services with 12% providing women specific services. There were 15% of services provided specifically to young people both in and out of school settings.

Graph 2: Geographical coverage of services offered by respondents



Graph 2 illustrates the geographical areas covered by the services that respondents provide. The largest number of respondents provides services to the HSE Western Region consisting of Galway, Mayo and Roscommon (41%). Galway County and City is covered by 21% of respondents and 13% provide services in Galway City alone. A small percentage of respondents provide services outside the Western region covering the North West, Midlands and counties surrounding Galway (Longford, Westmeath and Tipperary). Some respondents (3%) also reported providing services on a national basis.