Scoping Study to Inform a Survey of Knowledge, Attitudes and Behaviours on Sexual Health and Wellbeing and Crisis Pregnancy among the General Population in Ireland

sexualwellbeing.ie

hi Healthy Ireland

RCSI

Seirbhís Sláinte
Níos Fearr
á Forbairt

Building a
Better Health
Service

Scoping Study to Inform a Survey of Knowledge, Attitudes and Behaviours on Sexual Health and Wellbeing and Crisis Pregnancy among the General Population in Ireland

Kate Tierney
Dr Caroline Kelleher

April 2021

Published by the Sexual Health & Crisis Pregnancy Programme, HSE Health & Wellbeing,
Strategic Planning & Transformation

4th Floor
89–94 Capel Street
Dublin 1

The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the HSE.

Contents

Contents 4

List of Tables and Figures 7

Glossary 8

Foreword 9

Introduction 10

About the HSE Sexual Health & Crisis Pregnancy Programme 11

About the Authors 12

Acknowledgements 13

Executive Summary 14

- Introduction 14
- Methods 14
- Results 15
- Key Recommendations 15

Chapter 1: Introduction and Context 18

- 1.1 Introduction 18
- 1.2 Key Irish Health Policy Changes 19
  - 1.2.1 Healthy Ireland Framework 2013-2025 19
  - 1.2.2 National Sexual Health Strategy 2015-2020 20
  - 1.2.3 Sláintecare Action Plan 2019 20
  - 1.2.4 Programme for Government: Our Shared Future 20
- 1.3 Key Irish Health Legislation and Medication Licensing Changes 21
- 1.4 Population-Based Research Methods for Sexual Health 22

Chapter 2: Sexual Health in Ireland: Wellbeing, STIs and HIV, and Crisis Pregnancy 24

- 2.1 Introduction 24
- 2.2 Sexual Wellbeing 24
- 2.3 Sexually Transmitted Infections and HIV in Ireland 25
- 2.4 Crisis Pregnancy in Ireland 26

Chapter 3: Methodology 28

- 3.1 Introduction 28
- 3.2 Project Steering Committee and Ethics 28
- 3.3 Study Design 28
- 3.4 Development of Online Consultation Questionnaire 30
- 3.5 Data Analysis and Drafting Recommendations 30

Chapter 4: Overview of Literature Review Findings 31
4.1 Introduction 31
4.2 Surveys from Ireland 31
  4.2.1 Irish Contraception and Crisis Pregnancy (ICCP) Study 2003 31
  4.2.2 Irish Study of Sexual Health and Relationships (ISSHR) 2006 32
  4.2.3 Irish Contraception and Crisis Pregnancy (ICCP) Study 2010 32
4.3 Surveys from Britain and Northern Ireland 33
  4.3.1 National Surveys of Sexual Attitudes and Lifestyles 33
  4.3.2 Towards Better Sexual Health: A Survey of Sexual Attitudes and Lifestyles of Young People in Northern Ireland, 2002 35
4.4 Sexual Health Knowledge, Attitudes and Behaviours Surveys in the Rest of Europe and Elsewhere 35
4.5 Irish General Health Surveys with Sexual Health Components 38
  4.5.1 Survey of Lifestyles, Attitudes and Nutrition 38
  4.5.2 Healthy Ireland Surveys 38
4.6 International General Health Surveys with Sexual Health Components 39
4.7 Irish Sexual Knowledge, Attitudes and Behaviours Surveys with Specific Populations 42
  4.7.1 MSM Internet Survey Ireland 42
  4.7.2 European MSM Internet Survey Ireland 42
  4.7.3 Irish Contraception and Crisis Pregnancy Study: Supplemental Sample with Migrant Women 43
4.8 Chapter Summary 43

Chapter 5: Methodological Approaches for Sexual Health Surveys 45
5.1 Introduction 45
5.2 Face-to-Face Interview with Self-Completion Questionnaire Component 46
  5.2.1 Sampling 46
  5.2.2 Operational Procedures 46
  5.2.3 Strengths and Weaknesses 47
  5.2.4 Summary 48
5.3 Telephone Interviewing (Mobile and Landline) 48
  5.3.1 Sampling 48
  5.3.2 Operational Procedures 49
  5.3.3 Strengths and Weaknesses 49
  5.3.4 Summary 50
5.4 Online Self-Completion Survey 51
  5.4.1 Sampling 51
  5.4.2 Operational Procedures 52
  5.4.3 Strengths and Weaknesses 52
  5.4.4 Summary 52
5.5 Adding a Sexual Health Module to an Ongoing General Health Survey 53
  5.5.1 Sampling 53
  5.5.2 Operational Procedures 53
  5.5.3 Strengths and Weaknesses 54
  5.5.4 Summary 54

5.6 Paper-Based Self-completion Questionnaire 55
5.6.1 Sampling 55
5.6.2 Operational Procedures 56
5.6.3 Strengths and Weaknesses....56
5.6.4 Summary 56
5.7 Further Survey Design Considerations 56
5.7.1 Biological Sampling 56
5.7.2 Oversampling Key Populations....57
5.8 Limitations on Data Collection Presented by the COVID-19 Pandemic 58
5.9 General Population Survey Budget Range 60

Chapter 6: Results from the Online Stakeholder Consultation....62

6.1 Introduction 62
6.2 Respondent Information....62
6.3 Awareness and Use of Previous and Future Sexual Health Data in Ireland....64
6.4 Ranking of Topics for Inclusion on a Future Survey....66
6.5 Rationale for Selection of 10 Essential Survey Topics 70
6.6 The Importance of Collecting National Sexual Health Data....71
6.7 Respondent Recommendations for a Future Survey....72
6.8 Discussion of Findings 74

Chapter 7: Data Protection Requirements....75

7.1 Introduction 75
7.2 GDPR Principles in Health Research 75
7.3 Special Category Personal Data and Consent in Health Research 77
7.4 Examples of GDPR Compliance in Irish Research Organisations 77
7.5 Key Considerations for Data Protection in a Future Survey....78

Chapter 8: Recommendations 79

References....81

Appendices 93

Appendix 1: Joanna Briggs Scoping Review Protocol 93
Appendix 2: Search Strategy 96
Appendix 3: Inclusion Criteria for Chosen Studies 98
Appendix 4: Work Package 2 Stakeholder Consultation: Information Leaflet and Online Survey Questionnaire 100

List of Tables and Figures

Table 1.1. Key legislative changes relevant to sexual health and wellbeing and crisis pregnancy since 2010 21

Table 1.2. Relevant medication licensing changes since 2011 22

Table 4.1. International sexual health knowledge, attitudes and behaviours surveys 36

Table 4.2. International population-based general health surveys with sexual health components 40

Table 5.1. Face-to-face interview with self-completion questionnaire component methodology 46

Table 5.2. Telephone interviewing methodology 48

Table 5.3. Online self-completion survey methodology 51

Table 5.4. Adding a sexual health module to an ongoing general health survey methodology 53

Table 5.5. Paper-based self-completion questionnaire methodology 55

Table 6.1. Type of stakeholder organisations that took part in the consultation 63

Table 6.2. Focus of the work of the stakeholder organisations 63

Table 6.3. Type of individual stakeholders who took part in the consultation 63

Table 6.4. Particular usefulness of previous sexual health data 65

Table 6.5. Respondents' average rating of importance for topics to include in a future survey 67

Table 6.6. The topics respondents thought were essential to include in a future survey 69

Table 6.7. The rationale for respondents' top 10 topics to include on a future survey 71

Table 6.8. Respondents' thoughts on the importance/relevance of collecting national sexual health, wellbeing and crisis pregnancy data to their work 72

Table 6.9. Additional topics to include in a future survey 73

Table 6.10. Further suggestions to consider for a future survey 74

Figure 6.1. Data use of previous surveys and perceived data use of future survey 64

Glossary

CAPI	Computer-assisted personal interviewing
CASI	Computer-assisted self-interviewing
CATI	Computer-assisted telephone interviewing
CATVI	Computer-assisted telephone/video interviewing
CAVI	Computer-assisted video interviewing
CP	Crisis pregnancy
DSGBV	Domestic, sexual and gender-based violence
ECDC	European Centre for Disease Prevention and Control
ECP	Emergency contraception pill
EMIS	European MSM Internet Survey
gbMSM	Gay, bisexual and other men who have sex with men
GDPR	General Data Protection Regulation
HIV	Human immunodeficiency virus
HPSC	Health Protection Surveillance Centre
HPV	Human papillomavirus
HSE	Health Service Executive
ICCP	Irish Contraception and Crisis Pregnancy Study
ISSHR	Irish Study of Sexual Health and Relationships
KAB	Knowledge, attitudes and behaviours
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MISI	MSM Internet Survey Ireland
Natsal	National Surveys of Sexual Attitudes and Lifestyles
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PSC	Project steering committee
RCSI	Royal College of Surgeons in Ireland
RDD	Random-digit dialling
SAVI	Sexual Abuse and Violence in Ireland Survey
SLAN	Survey of Lifestyles Attitudes and Nutrition
STI	Sexually transmitted infection
UP	Unplanned pregnancy
WHO	World Health Organization
WP	Work package

Foreword

I am delighted to introduce this scoping study report, which was commissioned by the Sexual Health and Crisis Pregnancy Programme, HSE Health and Wellbeing, Strategic Planning and Transformation, to inform the next national survey on sexual health, wellbeing and crisis pregnancy among the general population in Ireland.

This report contributes to the evidence-based approach to strategy implementation set out in the National Sexual Health Strategy 2015–2020, which identifies a need for robust and high-quality sexual health information to underpin policy, practice, service planning and strategic monitoring.

Evidence-based practice to improve population health and wellbeing is a priority for the HSE and it is imperative that decisions about health care services and supports are based on current, valid and relevant research and evidence. Robust data is required to assess the impacts of strategy implementation to date and to provide guidance for policy, practice and future service provision. This scoping study and the national survey it will inform are very timely in this regard.

National surveys on sexual health and crisis pregnancy have been carried out in Ireland previously and we have a strong track record of evidence-based strategy and health interventions; however, it is almost a decade since the most recent study was published. Significant legislative, policy and social changes have taken place since then, and data is needed that reflects a new generation of adults living in Ireland.

I would like to thank the authors of this report, Dr Caroline Kelleher and Kate Tierney, from the Royal College of Surgeons in Ireland, Department of Psychology, for carrying out this study.

I would also like to thank the members of the Project Steering Committee for their time and expertise - Professor Catherine Mercer, University College London; Dr Fiona Mansergh, Department of Health; Dr Anne O'Farrell, HSE Research & Development; Dr Derval Igoe, Health Protection Surveillance Centre; and Owen Brennan, Sexual Health and Crisis Pregnancy Programme.

In addition I would like to thank Helen Deely, Assistant National Director for Health and Wellbeing with overall responsibility for the national policy priority programmes, including the work of the Sexual Health and Crisis Pregnancy Programme, and Maeve O'Brien, Interim Programme Lead for the Sexual Health and Crisis Pregnancy Programme, for commissioning and overseeing this study and for chairing the Project Steering Committee.

Finally I would also like to thank all of the stakeholders who took time from their busy schedules to participate in the consultation, which is such an important contribution to the forthcoming national survey.

Dr Stephanie O'Keeffe
National Director
Strategic Planning and Transformation, HSE

Introduction

We are very pleased to introduce this report. The Sexual Health and Crisis Pregnancy Programme, HSE Health and Wellbeing, Strategic Planning and Transformation, commissioned this study to enable the collation of necessary information to inform the design of the next knowledge, attitudes and behaviours survey on sexual health and crisis pregnancy among those living in Ireland; and to ensure that the data gathered is current, valid, relevant and representative.

This study has involved implementing a number of important steps; a synthesis of national and international literature to consider the methods used in comparative studies; a review of the relevant Irish legal and healthcare policy landscape, highlighting the significant changes that have taken place over the past decade; and a stakeholder consultation with almost eighty key stakeholders working in the fields of sexual health and crisis pregnancy, to understand the perceived value of this study in practice and to gather views on the range of topic areas for inclusion.

Among stakeholders, strong support was signalled for this study; and there was general agreement that national sexual health data is imperative to their work. Many outlined the value that new data would have across the policy-making, practice and service provision arenas.

This report concludes with recommendations from the Project's Steering Group, who in consideration of the document, provided advice on the future direction with regard to sampling and data collection within the current climate; stakeholder data priorities; and relevant data protection requirements.

We would like to acknowledge the hard work of the research team from the Department of Health Psychology, in the Division of Population Health Sciences, Royal College of Surgeons in Ireland in implementing this study; and the expertise provided by the Project Steering Group.

We look forward to acting on the recommendations emanating from this study and progressing work on the next survey on sexual health and wellbeing and crisis pregnancy among the population in Ireland.

Maeve O'Brien

Maeve O'Brien
Interim Programme Lead
HSE Sexual Health & Crisis Pregnancy Programme

Helen Deely

Helen Deely
Interim Assistant National Director
HSE Health and Wellbeing

About the Sexual Health & Crisis Pregnancy Programme

The Sexual Health and Crisis Pregnancy Programme is a Policy Priority Programme in HSE Health and Wellbeing, Strategic Planning and Transformation, and is responsible for implementing the National Sexual Health Strategy (2015-2020). The aims of the national Strategy are to improve sexual health and wellbeing and to reduce negative sexual health outcomes among the Irish population. The vision of the Strategy is that everyone in Ireland experiences positive sexual health and wellbeing and has access to high-quality sexual health information, education and services throughout life.

To read the Strategy, click here

About the Authors

Kate Tierney

Kate Tierney has a Masters of Public Health degree from University College Dublin and was employed as a Researcher in the Department of Health Psychology, in the Division of Population Health Sciences (PHS), Royal College of Surgeons in Ireland, Dublin. She is experienced in analysis of qualitative and quantitative data and in conducting literature reviews. She completed a Masters dissertation on the association between alcohol consumption and unprotected sexual behaviours among Irish females ages 18-29. Her interests are in improving sexual health outcomes through policy and practice informed by research.

Dr. Caroline Kelleher

Dr. Caroline Kelleher, is a fulltime academic in the Department of Health Psychology, in the Division of Population Health Sciences (PHS), Royal College of Surgeons in Ireland, Dublin. She has demonstrated a consistent commitment to a health-related research career with a strategic focus on sexual and reproductive health, sexual violence and research with sensitive topics and vulnerable populations. Her doctoral research was on sexual assault in Irish women and was funded by the Irish Research Council. She has also successfully competed for research funding for projects such as initiating the establishment of a second-generation surveillance for STIs and HIV in Ireland (2016) and assessing the preparedness of public STI clinics for the delivery and management of HIV-PrEP (2018).

Acknowledgements

This study was commissioned by the Sexual Health and Crisis Pregnancy Programme (SHCPP), HSE Health and Wellbeing, Strategic Planning and Transformation.

The research team would like to acknowledge, and appreciate, the expert guidance of the Project Steering Committee members who provided invaluable support throughout the duration of the project, namely:

- Professor Catherine Mercer, National Surveys of Sexual Attitudes and Lifestyles (Natsal) and Centre for Population Research in Sexual Health and HIV, University College London
- Dr Anne O'Farrell, Health Intelligence Unit, HSE Research & Development
- Dr Derval Igoe, HSE Health Protection Surveillance Centre (HPSC)
- Dr Fiona Mansergh, Health and Wellbeing Programme, Department of Health
- Maeve O'Brien (Chair), Sexual Health & Crisis Pregnancy Programme, HSE Health and Wellbeing
- Owen Brennan, Sexual Health & Crisis Pregnancy Programme, HSE Health and Wellbeing

Executive Summary

Introduction

Sexual health and wellbeing are fundamental to the experiences of individuals and to the societies and economies in which we live. Up-to-date and relevant information is vital for increasing our understanding of health behaviours and ultimately improving outcomes for the Irish population. General population surveys can provide both a broad and deep understanding of the sexual behaviours of the population, and can provide guidance for policy change, practice and service provision.

In 2015, Ireland launched its first National Sexual Health Strategy (2015–2020), with the Sexual Health and Crisis Pregnancy Programme (SHCPP), HSE Health and Wellbeing having the responsibility for implementation. The vision of the Strategy is that everyone in Ireland experiences positive sexual health and wellbeing and has access to high-quality sexual health information, education and services throughout life. The Strategy called for 'robust and high quality sexual health information' to be generated to underpin policy, practice, service planning and strategic monitoring.

While several national surveys on sexual health knowledge, attitudes and behaviours (KAB) have been carried out in Ireland, the most recent one was published approximately a decade ago, at the time of writing. In the intervening time, there have been significant legislative and health policy changes in Ireland such as the recognition of same-sex marriage, provision of termination of pregnancy services and increased access to a range of medications such as emergency contraception and pre-exposure prophylaxis (PrEP), among others. Therefore, an updated general population survey on sexual health and wellbeing and crisis pregnancy in Ireland is required to identify needs and provide guidance for further changes in policy and service provision.

The aims of this study are to provide an overview of the key considerations to inform the development of a general population survey, provide clarity on the topics that the survey should investigate, present best practice research methodologies and operational procedures that may be employed in a future survey, and provide budget range for the commissioning of a general population survey.

Methods

This study included three work packages (WPs). WP1 followed a scoping review methodology to conduct a desk-based assessment and synthesis of the literature. WP2 involved an online stakeholder consultation to gather stakeholder expertise on the topic areas to be considered in a future survey. This consultation collected both quantitative and qualitative findings from almost 80 stakeholders across Ireland. WP3 involved collating and synthesising the findings from WP1 and WP2 to draft a set of recommendations to inform decisions around commissioning a general population survey. The HSE SHCPP provided funding and oversight. A Project Steering Committee (PSC) shared their expertise and supported the research team for the duration of the project.

Results

The most prevalent modes of data collection in national population surveys asking about sexual health included face-to-face surveys with a self-completion questionnaire component; telephone interviews (mobile and landline); online self-completion surveys; the addition of a sexual health component to an ongoing general health survey; and paper-based self-completion questionnaires. Studies were assessed for their methods and relevant information was extracted in relation to sampling, operational procedures, and strengths and weaknesses of the methods used. Face-to-face interviews using computer-assisted personal interviewing (CAPI) were identified as the gold standard in sexual health research. Due to the ongoing COVID-19 pandemic, remote interviewing methods such as telephone surveys using computer-assisted telephone interviewing (CATI) or computer-assisted video interviewing (CAVI) are recommended.

Stakeholders (N=78) representing a wide range of services including community-based organisations and national government departments took part in the online consultation. Their plans to use data from any future sexual health survey included informing policy and practice, informing service provision and for advocacy purposes, or in teaching/training. Stakeholders were presented with 37 topic areas that had been identified from the three most recent general population surveys on sexual KAB in Ireland (ICCP 2010, ISSHR 2006 and ICCP 2003) and from the literature review component of the study. The consultation asked stakeholders to rate the importance of each topic using a sliding scale from zero to 100% with increments of 10%. Of the 37 topic areas, 13 topics received a stakeholder rating average of 80% or higher, suggesting that stakeholders agreed that the majority of the topics are important to include on a future survey. The stakeholders also prioritised their top 10 essential topics to include in a future survey, which included 'Sex education', 'Sexually transmitted infections/HIV testing', 'Access to contraception', 'Non-consensual sex/coercion', and 'Sexual health and reproductive knowledge', among others.

The overarching message from all types of stakeholders was that the collection of national sexual health data is imperative and invaluable to their work. Several stakeholders, from different organisation types, commented on the importance of data for meeting the needs of service users and delivering sexual health care. Stakeholders also mentioned that updated data would assist with funding applications for expanding services and could be used to improve sexual health promotion.

Of the 152 stakeholders invited to participate, there was a final sample of 78 participants, representing a response rate of 51.3%. This was a satisfactory response rate considering that some stakeholders were involved in the COVID-19 response during this period or impacted by the government's restrictions.

Key Recommendations

Based on the findings from the study, the following set of recommendations were developed and agreed upon by the research team and Project Steering Committee to inform the commissioning of a general population survey.

Key Policy Considerations

- The future survey should be cognisant of current health policy, medical licensing and health services changes that could impact sexual health and sexual behaviour.

- The survey should seek to align with national strategic planning and where possible regional operational health planning and policy.

Sampling:

- Probability sampling can be achieved either by random address sampling by GeoDirectory followed by recruitment by letter and computer-assisted personal interview (CAPI), or through random-digit dialling (RDD). If COVID-19-related public health restrictions are still in place at the time of fieldwork, RDD is likely to be the most viable method.
- Providing robust information on key at-risk populations would require a large and possibly cost-prohibitive sample size, therefore targeted convenience sample surveys could be considered for key groups (e.g. sexual, gender and ethnic minority groups), in parallel, which would complement information on these groups in the general population sample.
- While biological sampling can be immensely beneficial in a general population survey, many factors first need considering, including costs, follow-up protocols, logistical aspects and the precision that is required.

Data Collection Modes:

- Interviewer-administered data collection is currently considered the gold standard for obtaining robust and reliable data on such a sensitive topic as sexual health.
- In the context of the ongoing COVID-19 pandemic, the most viable data collection mode is computer-assisted telephone interview (CATI) or computer-assisted video interview (CAVI) or a combination of the two (CATVI).
- A web link to an online survey, during a remote interview to gather highly sensitive content, can be given to participants to allow for privacy while increasing the likelihood that participants complete this key component of the survey.
- If the budget allows, the collection of biological samples and thus biological data could be incorporated for some/all of the sample using an online ordering system for a home sexually transmitted infection (STI) testing service, as is currently being piloted by the HSE SHCPP.

Implications of COVID-19 Pandemic

- Despite the challenges presented by COVID-19, the general population survey should not be postponed and should be initiated by 2022.
- Due to COVID-19 implications, remote methods of interviewing, e.g. CATVI, are recommended.
- Public health guidance should be adhered to at all times in the piloting and fieldwork phases.

Budget Considerations

- Among the key drivers in estimating survey costs will be the type of sampling used, the mode of data collection, and the size of the target sample, which will be driven by the precision that the funders require for policy development and planning of services.

- Budget estimations should consider the above factors along with the size of the research team, sub-contractor costs to support aspects of the study such as data collection, cost of the pilot testing of the survey, length of the survey, and whether to oversample certain groups and/or include biological sampling.

Stakeholder Expertise and Data Needs

- Topic areas that were prioritised in the stakeholder consultation of the study should be included in the general population survey as far as length of interview and budget allow.
- The specific data needs of stakeholders gathered from the consultation should be considered when designing the general population survey to ensure the findings can inform policy and planning.
- Questionnaires should be piloted with stakeholders and a sample group prior to survey initiation.
- A project steering committee should include individuals with specific expertise and representatives from relevant stakeholder organisations, including the Department of Health, the HSE Research and Development Division, the HSE Health Protection Surveillance Centre, partner NGOs and public/patient representative groups.

Survey Topics for Inclusion

- The findings from the scoping review should be used to inform the list of potential survey topics.
- Prioritisation of survey topics should take place prior to finalisation of the questionnaire.
- Final survey topics/items should include the most up-to-date wording, be gender sensitive and inclusive, and reflect current population trends and patterns in sexual health knowledge, attitudes and behaviours.
- Where feasible, selected topics for inclusion should align with public health needs and national sexual health priorities.
- The survey should prioritise and address existing research and knowledge gaps.

Data Protection Requirements

- The survey must comply with the General Data Protection Regulation (GDPR), and ensure informed consent and pseudo-anonymisation.
- The survey must be in line with Health Research Regulations 2018 and the HSE Data Protection Policy.
- Handling or storing data in third countries without a comprehensive third-country data protection agreement should not be permitted.
- All data or reports made publicly available following the project should ensure that respondents cannot be identified and should follow all GDPR regulations.

Chapter 1: Introduction and Context

1.1 Introduction

Sexual health is an integral part of overall human health, and is fundamental to the social and economic development of societies (1). Ultimately, the sexual health of an individual contributes to the health of that individual, their partner(s) and consequently the wider community, thereby requiring a comprehensive and holistic approach (1). The concept of sexual health has evolved over time to have a more health-focused definition, both internationally and in Ireland (2). This is reflected in the current working definition of sexual health from the World Health Organization (WHO):

> *… a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (3).*

Evidence shows that a more holistic approach of viewing sexual health can positively impact sexual behaviours and ultimately improve outcomes for the population (2). Ireland has also adopted a holistic, inclusive and life-course approach to sexual health through the development of a national strategic framework (4).

In 2015, Ireland launched its first National Sexual Health Strategy (2015–2020), a nationally coordinated approach to reducing negative sexual health outcomes and improving the sexual health and wellbeing of the Irish population (4). The vision of the Strategy is that everyone in Ireland experiences positive sexual health and wellbeing and has access to high-quality sexual health information, education and services throughout their lives (4).

The most recent comprehensive survey on sexual health and crisis pregnancy among the general population in Ireland was conducted approximately a decade ago, at the time of writing. Given the significant changes in the law; health service delivery; population size; age profile; and social changes since then, there is limited knowledge relating to how these changes have effected those living in Ireland, in regards to sexual health and wellbeing and crisis pregnancy experience (5). In order to inform planning, policy and service provision, it is important that information among the population is collected; and that will provide a basis to measure impact.

In 2019, the Sexual Health and Crisis Pregnancy Programme (SHCPP), HSE Health and Wellbeing, Strategic Planning and Transformation, tendered for a qualified team to conduct a scoping study to inform planning for a general population survey of knowledge, attitudes and behaviours (KAB) on sexual health and wellbeing and crisis pregnancy. A research team from the Royal College of Surgeons in Ireland (RCSI) was successful in being awarded the contract and began conducting the study in November 2019.

The overall aims of the study were to (6):

- Provide an overview of the key considerations to inform the development of a general population study
- Provide clarity on the topics that the survey should include to fill existing gaps and to meet reporting requirements
- Consider best-practice research methodologies and operational procedures implemented for similar studies that may be employed to achieve a sample broadly representative of the general population in Ireland in line with identified requirements
- Provide budget for commissioning of general population surveys based on the methodologies and operational procedures from similar studies identified.

The study addressed the following objectives (6):

- Review Irish and international literature to identify topics for inclusion to allow for a level of comparison with previous surveys and measure new areas of inquiry
- Review the current legal and healthcare policy context in Ireland and draw out key considerations for the development of a general population survey
- Review operational and methodological procedures and assess costs of other similar surveys with specific attention to sampling concerns, data collection approaches and sensitivities and limitations
- Consider data protection requirements for collecting personal and sensitive information in compliance with the 2018 Data Protection Act and clearly set out the considerations
- Consult with key stakeholders on potential topics that may be included in a future survey, on data needs and usage and on methodological approaches
- Make recommendations on how a future Irish KAB study may best:
  - Achieve a nationally representative sample to support health service planning
  - Meet the data needs of national strategy and stakeholders
  - Meet the required data protection requirements.

This report presents the findings from a comprehensive review of the literature, policy and data protection regulations, and the results from a stakeholder consultation. It concludes with a set of recommendations on how a future survey in Ireland may best achieve a nationally representative sample to support health service planning.

1.2 Key Irish Health Policy Changes

There have been significant changes in health policy, legislation, access to medicines, and service provision in Ireland over the past decade, which have had direct impact on sexual knowledge, attitudes and behaviours of the Irish population.

1.2.1 Healthy Ireland Framework 2013-2025

The Healthy Ireland Framework 2013-2025 was published in 2013 and is a government initiative aimed at improving the health and wellbeing of all people living in Ireland. The vision of the national Framework is ‘a healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility' (7). The Framework includes four high-level goals and 64 actions to help achieve these goals. These goals are: to increase the proportion of people who are healthy at all stages of life; to reduce health inequalities; to protect the public from threats to health and wellbeing; and to create an environment where every individual and sector of society can play their part in achieving a healthy Ireland (7). Among the core goals of the Framework are research and evaluation, and ensuring that programmes and funding decisions are supported by high-quality, up-to-date and evidence-based data (7).

1.2.2 National Sexual Health Strategy 2015-2020

The National Sexual Health Strategy 2015-2020 was published in 2015 and developed in response to a recommendation from the National AIDS Strategy Committee to establish clear leadership within the health sector, particularly related to sexual health (4). The Strategy reflects the many changes that Ireland has experienced in regards to sexual behaviour, sexuality, legislation, education, and changing social attitudes towards sex (4). The aims are to improve sexual health and wellbeing and reduce negative sexual health outcomes, and the overarching goals are: everyone living in Ireland will receive comprehensive and age-appropriate sexual health information and/or education and will have access to appropriate promote and prevention services; equitable, accessible and quality driven sexual health services, which are targeted and tailored to need, will be available to everyone; and, robust and high quality sexual health intelligence will be generated to underpin policy, practice, service planning and strategic monitoring (4).This Strategy is one of the first national strategies to be published within the Healthy Ireland Framework, and it closely follows the guiding principles for implementation: better governance and leadership; better use of people and resources; better partnerships; better systems for healthcare; better use of evidence; better measurement and evaluation; and better programme management (4). The Strategy contains 71 recommendations that address a range of sexual health services, including prevention and surveillance, education and professional development, and treatment, counselling and supports (4).

1.2.3 Sláintecare Action Plan 2019

The Sláintecare Action Plan was launched in 2019 with a commitment to delivering a health and social care service that meets the needs of the Irish population (8). The 10-year plan aims to deliver a universal health service with a focus on developing primary and community services (8). The Action Plan recognises the significant improvements that are needed in health systems across Ireland, and aims to deliver the right services in the right way through efficient, effective and sustainable service delivery, referred to commonly as 'Right Care, Right Place, Right Time' (8). The plan proposes a greater focus on both prevention and population health initiatives to support the needs of all Irish people, and recommends a whole-society approach (8). A key work stream of Sláintecare is the Data, Research and Evaluation Programme, which consolidates existing data, collects new data, and ensures that data that is generated and produced is used to inform policy change to improve patient care, the health system and the economy as a whole (8).

1.2.4 Programme for Government: Our Shared Future

The Programme for Government: Our Shared Future, published in October 2020, included several commitments under the category of 'Promoting Women's Health' that plans for the provision of a wide range of changes that impact sexual health, wellbeing and crisis pregnancy outcomes (9). For example, the Programme aims to undertake a formal review of the Regulation of Termination of Pregnancy Act 2018 in 2021 (9). Additionally, there is a focus on the provision of free contraception, rolled out over a phased period, and starting with women aged 17–25 (9). The promotion of the human papillomavirus (HPV) vaccine will be prioritised, and safe zones to protect women accessing abortion services will be developed (9). Lastly, the Programme for Government committed to developing inclusive and age-appropriate Relationship and Sexuality Education (RSE) across both primary and post-primary schools (10).

1.3 Key Irish Health Legislation and Medication Licensing Changes

There have been key legislative changes in Ireland since the last general population survey on sexual health, which have relevance to the population regarding sexual health and wellbeing and crisis pregnancy. Table 1.1 highlights the key legislative changes since 2010.

Table 1.1. Key legislative changes relevant to sexual health and wellbeing and crisis pregnancy since 2010

Year	Name	Relevant Implications
2010	Civil Partnership and Certain Rights and Obligations of Cohabitants Act (11)	Provides a statutory civil partnership registration scheme for same-sex couples and affords civil partners, broadly all the same rights and obligations as a married couple
2013	Protection of Life During Pregnancy Act (12)	Regulates access to lawful termination of pregnancy in cases where there is a real and substantial risk to the life, as distinct from the health, of the pregnant woman which may only be averted by such a medical procedure
2015	Marriage Equality Act (13)	Provides for legal recognition of same-sex marriages
2015	Gender Recognition Act (14)	Provides for gender recognition certifications, enabling transgender citizens to legally identify as their preferred gender
2017	Criminal Law (Sexual Offences) Act (15)	Enhances and updates laws to combat the sexual exploitation and sexual abuse of children, maintains the age of consent at 17 years and criminalises the purchase of sexual services
2018	Health (Regulation of Termination of Pregnancy) Act (16)	Provides for termination of pregnancy to be carried out without restriction during up to 12 weeks gestation, or thereafter where there is a risk to the life, or serious harm to the health, of the pregnant woman, including in an emergency; or where there is a condition present which is likely to lead to the death of the foetus either before or within 28 days of birth
2020	Harassment, Harmful Communications and Related Offences Act (17)	Provides an offence for the recording, distribution or publication of intimate images, the distribution, publication or sending of threatening or grossly offensive communication and the anonymity of victims of such offenses

* Adapted from the HSE Invitation to Tender Document (6).

There have also been medication licensing changes in Ireland since the last general population survey was conducted, including: over-the-counter access in pharmacies to the emergency contraception pill (ECP) in 2011; and to the five-day ECP in 2015; and provision of the ECP to medical card holders without a prescription in 2017. Furthermore, in 2016, Truvada was licensed for use as pre-exposure prophylaxis

(PrEP) for HIV prevention in Europe, including Ireland. In 2017, generic PrEP came on the market, making PrEP more affordable to service users, and in 2019, PrEP was made available free of charge through the HSE, to those at substantial risk of acquiring HIV, through approved PrEP services. Table 1.2 highlights the relevant medication changes since 2011.

Table 1.2. Relevant medication licensing changes since 2011

Year	Medication/Licensing Change	Relevant Implications
2011	Irish Medicines Board grants over-the-counter status to three-day ECP	Three-day ECP can be purchased directly from pharmacies without a prescription
2015	Irish Medicines Board grants over-the-counter status to five-day ECP	Five-day ECP can be purchased directly from pharmacies without a prescription
2016	European Medicines Agency licenses Truvada	Truvada is licensed and available for use as PrEP in Europe and Ireland
2017	Medical card scheme expanded to include ECP	Medical card holders can access ECP without a prescription
2017	Generic PrEP became available in Ireland on a private prescription through community pharmacies	PrEP became more accessible and affordable to the service user
2019	Generic PrEP became available for free through the HSE to those at substantial risk of acquiring HIV through sex	PrEP is now available free of charge to those at substantial risk of acquiring HIV through sex

* Adapted from the HSE Invitation to Tender Document (6).

1.4 Population-Based Research Methods for Sexual Health

There have been major advances in sexual health research in the past 30 years, and an overall wider societal acceptance of openly discussing the subject of sex in general (18). The emergence of the HIV epidemic in the 1980s was the impetus for the first large-scale population-based surveys on sexual behaviour; however, the collection of such data was highly controversial at the time (18). Nevertheless, over the past three decades, sexual health and behaviours have been surveyed on a worldwide scale using a range of methodologies, and have informed policy and practice internationally.

National general population-based health surveys often include questions relating to sexual health, and can provide a broad and generalised overview of behaviours of a population (6). Other types of surveys using convenience sampling focus specifically on groups at increased risk, and while they may not be as comprehensive, they can provide deeper insights and can help target interventions (6). Such surveys are vital to more comprehensively understand and assess groups at increased risk, as general population surveys often do not have large enough sample sizes to gather comprehensive data on groups that comprise less than 5% of the population (19). Ultimately, to mitigate negative sexual health outcomes in a population, up-to-date and relevant population-based surveys are required to inform policy and service provision. Data on sexual health should be systematically collected, timely, accurate, detailed, standardised and representative to accurately monitor the health of the population and to implement current and future policies (4).

There have been major developments in how we understand and research sexual health over the past 20 years in Ireland. Research has been conducted on both the general population and groups at increased risk relating to sexual health and wellbeing and crisis pregnancy. In addition, ongoing surveillance under the guidance of the HSE Health Protection Surveillance Centre (HPSC) has allowed for the incidence and prevalence of notifiable STIs to be examined at a national level. The National Sexual Health Strategy 2015–2020 sets out the need for a second-generation sexual health surveillance system, to provide a better understanding of STI and HIV risk and protective behaviours among the general population (4). These efforts have improved and will continue to improve our understanding of the overall sexual health status of the general population.

Sampling strategies, standardisation of questions, and computer-assisted data collection methods have improved the quality of data collection over time both in Ireland and internationally (18). Most recently, the inclusion of biological sampling in sexual health surveys has provided quality data on the prevalence of STIs and other health conditions in several major general population surveys worldwide (18). A future survey on sexual health and wellbeing and crisis pregnancy in Ireland must consider the current context of the Irish population, policies and laws, and utilise the best methodology to capture relevant data on a national scale.

Chapter 2: Sexual Health in Ireland: Wellbeing, STIs and HIV, and Crisis Pregnancy

2.1 Introduction

Many factors contribute to an individual's sexual health and wellbeing, including their social and economic status; education; gender; sexual orientation; cultural background; mental and physical health; age; disability; family background; and alcohol and substance use (4). Understanding the factors that influence sexual behaviour is important because certain sexual behaviours are associated with negative outcomes such as sexually transmitted infections (STIs) and unplanned pregnancies (UPs) (20). The following sections detail sexual wellbeing and the issues of STIs and crisis pregnancies (CPs) in Ireland to provide context and highlight the need for updated research on the general population in these areas.

2.2 Sexual Wellbeing

The term 'sexual wellbeing' does not have a standardised definition or measure, and instead is a multidimensional term that encompasses the individual, interpersonal relationships and society (21). The World Health Organization and the United Nations Population Fund held a working group meeting in 2007 to identify sexual health indicators and to develop a definition of sexual wellbeing (22). While there was a lack of agreement on a specific definition, the discussions included aspects of sexual identity, sexual preference and sexual behaviour (22). In addition, the working group participants concluded that sexual wellbeing can be measured by self-perceived health (22). Both positive and negative elements impact sexual wellbeing, including the motivation to enhance one's own sexual health and the experience of sexual coercion or discrimination (22). Ultimately, the group determined that more research was needed to develop indicators for sexual wellbeing and that the topic itself was complex and multi-dimensional (22).

In 2019, a rapid review was published that examined sexual wellbeing definitions and measures in the literature. It concluded that the term should be looked at with a multidimensional perspective, and outlined the domains of 'individual cognitive-affect, interpersonal, socio-cultural' and sexual wellbeing freedom (21). Within the individual cognitive-affect, dimensions included sexual function, sexual satisfaction and sexual self-esteem (21). The most commonly identified dimensions within the interpersonal domain included relationship satisfaction and partner communication (21). Within the socio-cultural domain, issues of gender norms, stereotypes and other gender inequalities were presented (21). This review emphasised the importance of awareness of external influences in social and environmental contexts, and an understanding that changing an individual's living conditions could positively impact their sexual wellbeing (21). The review concluded that more research was needed in this field to determine measurements and to ultimately track and improve sexual wellbeing on an international scale (21).

In the development of the Irish Study of Sexual Health and Relationships questionnaire, one outcome from the scoping study was a recognition of sex as a positive behaviour that contributes to personal sexual wellbeing rather than solely a risky behaviour with negative outcomes (23). The accompanying report argued that sex is a 'fundamental part of the human experience', and that while most of the research at the time focused on CPs and STIs, the majority of Irish people had not experienced negative outcomes from sex (24). Looking at sexual health and wellbeing from a holistic viewpoint is important in moving forward in the area of sexual wellbeing.

More recently, the National Sexual Health Strategy 2015–2020 included sexual wellbeing as a key component and emphasised the need to reduce negative outcomes. (4). Negative health outcomes can develop from a number of causes, including domestic, sexual and gender-based violence, unhealthy relationships, experiences of STIs or CPs, sexual stigma, or negative attitudes towards sexuality (4). In order to promote sexual health and wellbeing in Ireland, individuals must have access to sexual health services, comprehensive sex education, and a culturally and legislatively supportive environment for sexual wellbeing (4).

The absence of sexual abuse and violence is a key component of overall sexual wellbeing. There is incomplete evidence on the prevalence of sexual violence in Ireland, which is required to inform policy, evaluate services, plan preventative interventions, and improve sexual wellbeing (25). However, the Sexual Abuse and Violence in Ireland Survey (SAVI) 2002 estimated the prevalence of various forms of sexual violence among Irish women and men across the lifespan from childhood through adulthood (25). The survey reported statistics on the prevalence and severity of sexual violence in Ireland. Twenty percent of women and almost 10% of men reported experiencing contact sexual assault in their adult life (25). Of the respondents who reported an experience of sexual violence, 47% reported that they had never previously disclosed their abuse to others prior to the interview (25). Furthermore, 25% of women reported having experienced post-traumatic stress disorder following their experience with sexual violence (25).

The Department of Justice and the Central Statistics Office are currently undertaking a comprehensive national survey on the prevalence of sexual violence in Ireland, building off the work and findings of SAVI 2002 (26). The survey will closely study the experiences of sexual violence of both men and women, and will be repeated every decade to monitor trends over time and direct policy efforts in this area (26). Additionally, supplementary data will be gathered in the periods between surveys to ensure that important information about sexual violence is not missed (26). The survey plans to have a sample size of 5,000 people and will enquire about explicit and intimate questions regarding behaviours associated with sexual violence (26).

2.3 Sexually Transmitted Infections and HIV in Ireland

The prevalence of STI notifications has been increasing since 1995 in Ireland, and although improved methods of data collection and increased STI testing are partially responsible for this increase, further research and surveillance are required (4). The Health Protection Surveillance Centre (HPSC) publishes annual trends of notifiable STIs in Ireland and, according to its most recent report, both chlamydia and gonorrhoea increased by 7% between 2017 and 2018 (27). According to the HPSC, and consistent with evidence from other countries, the groups at increased risk for acquiring and onward transmission of STIs include young people aged 15–24 years, and the gay, bisexual and other men who have sex with men (MSM) population (27, 28). Young people aged 15–24 years in Ireland accounted for 49% of chlamydia and 32% of gonorrhoea cases in 2018 (27). The MSM population in Ireland accounted for 86% of early infectious syphilis cases and 65% of gonorrhoea cases in 2018, despite comprising only approximately 6% of the population (27, 29).

While this study was under development, the global COVID-19 pandemic led to government restrictions on movement and interaction in Ireland and internationally. Since the restrictions have been in place, STI incidence has reduced, which may be a result of the pandemic restrictions reducing human interaction and sexual activity, STI clinic closures, and reduced access to testing (30). This drop in incidence is likely to be temporary and incidence may increase once the restrictions have ended. Further implications of the COVID-19 pandemic are discussed in Section 5.8.

The transmission of HIV continues to be a major public health concern in Ireland and worldwide (31). Rates of HIV have been steadily increasing in Ireland since 2015, and while some of the rise can be attributed to better detection procedures and improved and increased testing, the increase is concerning nonetheless (31, 32). In 2018 alone, there were 532 diagnoses of HIV in Ireland, a 7% increase from 2017. A large majority of diagnoses are found in the MSM population and 79% of people diagnosed with HIV were between the ages of 25 and 49 years (31). In addition, 71% of people diagnosed in 2018 were born outside of Ireland (31). Co-infection can be often identified in HIV diagnoses, with 13% of people diagnosed with HIV in 2018 also infected with chlamydia, gonorrhoea and/or syphilis (31). It is essential for health care services to meet the needs of recently diagnosed individuals to allow them to engage with services and start treatment to protect their own health and prevent further transmission (31).

Pre-exposure prophylaxis (PrEP) is the pre-emptive use of oral antiretroviral therapy by individuals who are HIV-negative to reduce the risk of HIV infection. The European Medicines Agency licensed Truvada for use as PrEP in Ireland and the rest of Europe in 2016. The WHO recommends PrEP for individuals who are at a substantial risk for HIV infection, as part of a holistic prevention approach (33).

In 2018, the Health Information and Quality Authority in Ireland undertook a health technology assessment of a PrEP programme for groups at increased risk of acquiring HIV through sex (34). This process included an assessment of the epidemiology of HIV in Ireland, a systematic review and meta-analysis of randomised controlled trials to identify the efficacy and safety of PrEP, and submission of a report to the Minister for Health (34). Following this assessment, it was determined that PrEP is both highly safe and effective at HIV prevention among individuals at a substantial risk of sexual HIV acquisition. The HSE implemented a PrEP programme in 2019 and now provides PrEP free of charge to those at substantial risk of acquiring HIV through sex who meet clinical eligibility criteria (35). PrEP is now available through approved PrEP services including some public STI clinics and approved private providers. National standards and clinical guidelines have been developed for health professionals to ensure best practice in the prescribing of PrEP in Ireland (35).

2.4 Crisis Pregnancy in Ireland

‘Crisis pregnancy’ (CP) is a unique term used only in Ireland and is defined in Irish legislation as ‘a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her’ (4). This term was first coined in 2001 to identify pregnancies that are unintended or unplanned, and result in a personal trauma, or crisis, for the woman or couple (36). Crisis pregnancies can either be entirely unplanned or occur when a planned pregnancy becomes a crisis due to changes in circumstances such as a medical difficulty, financial issue or change in employment status or circumstance (20). While unintended pregnancies are declining on a global scale, the WHO estimates that approximately half of all pregnancies are unplanned (37). In Ireland, one in eight pregnancies were reported as crisis pregnancies among adults surveyed in the Irish Contraception and Crisis Pregnancy 2010 (ICCP 2010) study (36).

According to that study, 35% of women who have experienced pregnancy in Ireland have had a CP (36). Younger women and women with lower education levels are at an increased risk of experiencing a CP (36). The findings showed that the most commonly reported reasons for a CP were that it was ‘not planned’ or that the woman was ‘too young’, in addition to financial constraints (36).

Findings from that study also show that ten years ago, the vast majority of women who experienced a CP chose to parent. Specifically, the data showed that 62% of CPs experienced by women ended in parenthood, 21% ended in an abortion, 14% ended in a miscarriage, 1% ended in an adoption, and 1% were ongoing at the time of the interview (36).

Prior to January 2019, women living in Ireland experienced restrictive abortion laws; women and their partners who had decided to terminate a pregnancy were required to travel abroad to jurisdictions where abortion was legally accessible, except for in limited circumstances due to the 2013 Act (38). Thousands of women living in Ireland have historically travelled to clinics in England, Wales and other countries to access abortion services each year. Women report experiencing shame and stigma, and many were unable to travel due to financial or personal constraints (38).

In more recent years, some women, when experiencing a CP, turned to online providers to source abortifacients (abortion pills), despite the fact that this was illegal in Ireland (36, 39). According to data from an online provider, between January 2010 and December 2015, 5,650 women in the Republic of Ireland accessed its online services to obtain abortion pills (39). While the exact number of women who used abortion pills prior to the legislative change is unknown, there were clear indicators that it was significant in relation to the numbers travelling abroad (39).

The high numbers of women travelling abroad for abortion services and ordering abortion pills online were among the key drivers behind the abortion referendum in Ireland in May 2018, which led to the removal of the 8th amendment to the Constitution and, commencing on 1 January 2019, the introduction of legal abortion in the following instances: during the first 12 weeks of pregnancy, when a woman's life or health is deemed to be at-risk, and in cases of fatal foetal abnormality (40).

The number of women with Irish addresses who travelled to England or Wales for an abortion declined by 87%; from 2,897 in 2018 to 375 in 2019 (40, 41). Reasons for travel following the introduction of abortion services following the 2018 Act include women who do not meet the legal criteria for abortion (41). Other reasons for travel have been documented as a nonfatal disability diagnosis, stigma or confidentiality reasons (41).

In June 2020, the Department of Health released the first Annual Report on the Health (Regulation of Termination of Pregnancy) Act 2018, providing notifications of the number of terminations of pregnancy in Ireland in 2019. The report stated that there were a total of 6,666 terminations in Ireland in 2019 (42). The findings show that the vast majority of terminations in Ireland in 2019 took place in within the first few weeks of pregnancy.

Chapter 3: Methodology

3.1 Introduction

A scoping study, or scoping review, is a research approach used to assess the nature and scope of the literature on a certain topic (25). Work Package 1 (WP1) followed a scoping review methodology to conduct a desk-based assessment and synthesis of the literature. Work Package 2 (WP2) involved an online stakeholder consultation to gather feedback from stakeholders (Step 6 of the scoping review methodology) on the importance of topic areas to be included in a future survey. Work Package 3 (WP3) collated and synthesised the findings from WP1 and WP2 to draft a set of recommendations to inform decisions around commissioning a general population survey.

3.2 Project Steering Committee and Ethics

A project steering committee (PSC) supported the research team by providing expertise and input on the research approach, stakeholder list, survey development and draft reports throughout the duration of the study. The PSC met in person for an initial meeting to discuss the objectives of the project and the proposed methodology. Due to restrictions of in-person gatherings because of COVID-19, the committee met online for the remainder of the project and was available by email for questions from the research team. The research team obtained ethical approval for the stakeholder consultation in September 2020 from the RCSI Research Ethics Committee.

3.3 Study Design

Within Work Package 1, the methodology used to undertake this scoping review was guided by a framework proposed by Arksey and O’Malley (43), and refined by Levac, Colquhoun, and O’Brien (44) and Khalil et al. (45). It requires six systematic stages: linking the purpose and research question; balancing feasibility with comprehensiveness required for a scoping process; using an iterative team approach when selecting studies; extracting data; reporting results; and considering implications of the findings for policy, practice and research (43). Importantly, a final step was incorporating the stakeholder consultation as a required knowledge translation component of the methodology (43).

The RCSI research team completed a Johanna Briggs Scoping Review Protocol prior to initiating the research, which can be found in Appendix 1 (46). A search strategy was developed to identify the scope of research on sexual KAB in the most efficient way possible. Searches were done in several electronic databases, including PubMed, Scopus, Web of Science and Google Scholar. Keywords included sexual behaviour, sexual knowledge, sexual attitudes, national survey, general survey, population survey, KAB, national, sexual health, sexual risks. Boolean operators were used to maximise accurate searches. A copy of the search strategy is included in Appendix 2.

The inclusion and exclusion criteria were developed by the research team and are discussed below. Since the scoping review must identify best practices for national general population surveys, only surveys of a national general population scale met the inclusion criteria. Secondly, surveys that studied sexual health were closely examined for features including sample size, age ranges, and survey instrument. Lastly, data were extracted from surveys that specifically measured sexual KAB to identify content areas and questions that can be adapted for the Irish survey. Only surveys from the year 2000 onwards were included due to the societal and cultural changes that have taken place in both Ireland and abroad in the past 20 years related to sexual health. Any research prior to year 2000 would limit the relevance to the current Irish context. Further information of the inclusion criteria can be found in Appendix 3.

This review considered studies involving respondents aged 17 and older. Respondents of any gender, ethnic background and geographical location were considered. No maximum age cut-off was used since there are varying maximum age restrictions in general population surveys of sexual health. The research team included all ages over 17 to determine the strengths and weaknesses of different age ranges for this kind of study.

The research team additionally searched national and international government and health policy organisations for general population surveys on sexual KAB. These included the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC), the Health Service Executive (HSE), the Health Protection Surveillance Centre (HPSC), The Centers for Disease Control and Prevention (CDC) and Global AIDS Monitoring (GAM). The reference lists of relevant reports were hand-searched to identify additional studies that met the inclusion criteria. All potential studies were reviewed and agreed by both the Principal Investigator and the researcher before being included.

A key component of this study was to seek the input of stakeholders on the content areas and topics for inclusion in a prospective general population survey. Within Work Package 2, the HSE SHCPP and the research team compiled a broad sampling frame of key stakeholders and organisations operating within the fields of sexual health and crisis pregnancy in Ireland. This list was further developed through recommendations from the PSC.

Two weeks prior to the planned online consultation, the RCSI research team sent an introductory letter from the HSE SHCPP, an information leaflet about the study and a ‘Save the Date’ to all potential stakeholder participants. The HSE SHCPP had drafted a letter to introduce stakeholders to the study and to highlight the importance of their contribution. Providing participants with full information on the study in advance provided them with the opportunity to ask questions and seek further clarification from the RCSI research team.

When the consultation survey opened, stakeholders were sent an individual link to the consultation on the survey platform, Smart Survey. Stakeholders could participate as individuals or on behalf of their organisation, or could nominate a colleague from their organisation to complete the consultation. The stakeholders were asked to complete the survey and to circulate the survey information to colleagues who work in the fields of sexual health and crisis pregnancy, or who could contribute to the study based on their area of work. This was done to ensure maximum inclusivity of stakeholders across Ireland.

Any additional stakeholders who were identified through snowball sampling were then sent a unique link to complete the consultation. Before commencing the questionnaire, participants were asked to provide an electronic record of their informed consent. Progression through the survey was not be possible without participants providing their explicit consent to each of the consent questions (see Appendix 4 for the consent questions). The consultation was anonymous and participation was voluntary. Data were collected over a two-week period in September–October 2020. To maximise response rates a reminder email was sent after one week and again 24 hours before the survey closed.

3.4 Development of Online Consultation Questionnaire

To develop the questionnaire, the research team first adapted the Natsal-4 Stakeholder Consultation Questionnaire to fit the Irish context (47). The objective of the questionnaire was to seek stakeholders' opinions on the importance of topics that should be included in a future general population survey on sexual health and crisis pregnancy in Ireland.

Topic areas were identified from the three most recent general population surveys on sexual KAB in Ireland (ICCP 2010, ISSHR 2006 and ICCP 2003) and from the literature review component of the study. The terminology of the topic areas from the previous Irish surveys were amended where necessary to include more up-to-date terminology. Many of the topics found in the literature review had been included in international general population sexual KAB surveys but had not previously been included in an Irish general population survey.

The consultation asked stakeholders to rate the importance of each topic using a sliding scale from 0 to 100% with increments of 10%. This allowed stakeholders to rate the relative importance of topics. They also had an opportunity to suggest topics that were important to include from their perspective, and recommend changes to the proposed topic areas.

The consultation also contained brief introductory questions regarding the stakeholders and their areas of expertise; if and how they used the data from previous population surveys; and how they proposed to use the data from a future general population survey.

Members of the PSC piloted the online consultation survey to identify any issues and the research team made several adjustments based on the feedback from the committee prior to sending the survey to the stakeholders.

3.5 Data Analysis and Drafting Recommendations

Work Package 3 involved analysing, collating and synthesising the findings from both WP1 and WP2 to draft a set of recommendations. Chapter 8 presents the recommendations in more detail.

The results from WP2 were analysed on Smart Survey, exported and presented in Chapter 6. The data from WP2 included a mixture of qualitative and quantitative findings. All responses were anonymised, and each respondent was categorised by stakeholder type and given a unique identifier number. Qualitative data were analysed for common themes in the responses and categorised by theme. For the quantitative findings, average percentages were calculated to determine data uses of previous and future surveys and the overall importance rating of topics by stakeholders.

Chapter 4: Overview of Literature Review Findings

4.1 Introduction

This chapter presents findings from a comprehensive literature search, assessing the range, methods and approaches taken nationally and internationally to administer surveys on sexual health among the general population. This is a key component of WP1 of this study.

4.2 Surveys from Ireland

In the past 20 years, several surveys in Ireland have gathered information on sexual health, wellbeing and crisis pregnancy. However, as these surveys have not been carried out consistently, with similar aims and objectives, there remains a gap in comprehensively understanding the current context in terms of population-level sexual health and behaviour patterns in Ireland.

The surveys that have specifically gathered sexual health information in the past two decades include the 2003 Irish Contraception and Crisis Pregnancy Study (ICCP) (5), the 2006 Irish Study of Sexual Health and Relationships (ISSHR) (48), and the 2010 ICCP Study (36). An overview of these surveys is presented below, highlighting their aims, objectives, and some of the key findings.

4.2.1 Irish Contraception and Crisis Pregnancy (ICCP) Study 2003

The ICCP 2003 survey was a cross-sectional national telephone-based survey with the aim of identifying attitudes, knowledge and experiences of crisis pregnancy, contraception and service options in Ireland (5). There was a sample size of 3,000 participants. The survey also aimed to identify experiences of sex, lifestyle choices, and levels of recognition of a public information campaign (5). It was primarily designed to establish baseline measures for both crisis pregnancy and sexual health, as these did not exist in Ireland at the time (36).

The survey gathered in-depth details from many individuals who had experienced a pregnancy. Of the participants who had experienced a pregnancy, 28% of women had experienced a crisis pregnancy (5). When asked why the pregnancy was a crisis, 41% of women explained that it was not planned; other reasons were that they were too young, unmarried, having relationship or financial difficulties, or in a new or unsteady relationship at the time of the pregnancy (5).

Key findings from the survey include 80% of participants responding that they had always used a method of contraception or precaution when having sex in the past year (5). For those who did not use contraception during their most recent sexual intercourse, the reasons stated were that the sex was not planned, they were not prepared, or they had been drinking alcohol or taking drugs (5).

4.2.2 Irish Study of Sexual Health and Relationships (ISSHR) 2006

The ISSHR 2006 study was a broader sexual health, behaviour and lifestyle telephone-based survey that assessed 7,441 Irish people aged 18–64 years about their knowledge, attitudes and behaviours regarding sexual health and relationships (48). The purpose of the study was to provide a standard to evaluate the impact of policies and practices in Ireland concerning the sexual health of the population, and a benchmark for future research and policy change in the area of sexual health (48).

ISSHR 2006 was the first study of sexual KAB ever to take place in Ireland, and provided an unprecedented amount of relevant data to inform sexual health policy at the time (23). This ground-breaking study generated the first nationally representative picture of the sexual KAB of the Irish population and contributed evidence-based recommendations for the education sector, public education campaigns, health promotion strategies, further research and national service provision planning (23, 49).

The questionnaire was broken into several content areas, which included learning about sex; knowledge, attitudes and beliefs; first sexual experience; attraction; heterosexual and same-sex partnerships and practices; most recent sexual experience; sexual problems; sex outside Ireland and the United Kingdom; STIs and use of healthcare services; demographics and personal characteristics (48).

The key findings included the discovery of societal level change in attitudes toward discussing sex in recent years, at the time of the survey. The survey also gave a broad view of the sexual identities and behaviours of the population, including that almost 6% of men and women reported some level of same-sex attraction at some point in their life (48). In addition, a decreasing age of first sexual intercourse was noted, which showed that an increasing number of young people were having sex prior to the age of consent: 17 years of age (48). While the ISSHR 2006 report presented some positive findings on aspects of sexual health, there were many statistics related to sex education, contraception use, and poorer outcomes for individuals with lower social and economic status. For example, 44% of respondents reported that they had received no sex education from any source (48). In addition, 73% of men and 36% of women under age 25 years did not know the correct time limits for emergency contraception use (48).

4.2.3 Irish Contraception and Crisis Pregnancy (ICCP) Study 2010

The ICCP 2010 survey was a cross-sectional telephone-based general population survey with the aim of gathering nationally representative and reliable data on knowledge and attitudes towards contraception, crisis pregnancy and services in Ireland (36). The survey had a sample size of 3,002 participants and was designed to provide data on KAB of sex, contraception and pregnancy in Ireland, and explore the trends and changes that had occurred since the previous ICCP survey in 2003.

The interview was broken down into topic areas, which included: personal details; sex education received and speaking to own children about sex; knowledge and attitudes about contraception; contraception use in the last year; sourcing contraception and contraceptive services; knowledge of HIV; STIs and testing; most recent partner; experience of pregnancy and crisis pregnancy; knowledge of crisis pregnancy services and abortion; and demographics (36).

The results from ICCP 2010 were extremely valuable in identifying important trends in sexual behaviour, contraceptive use and pregnancy outcomes among the Irish population. While the questionnaire varied slightly from ICCP 2003, core questions were worded exactly the same to ensure comparability. Identifying trends in attitudes and behaviours among the general population over time is important to understand changes and patterns in contraceptive use and pregnancy experiences. The survey found that use of both condoms and the contraceptive pill had increased since 2003, and the reported difficulties in accessing contraception were lack of access, embarrassment and high costs (36). ICCP 2010 found that more women had experienced a crisis pregnancy than in 2003, with rates of 35% and 28% respectively (36). Of women who experienced a crisis pregnancy, the outcomes were 62% parenthood, 14% miscarriage, 21% abortion, 1% adoption, and 1% still pregnant (36).

4.3 Surveys from Britain and Northern Ireland

This section summarises the national sexual health KAB studies that were conducted in Britain and Northern Ireland since 1999.

4.3.1 National Surveys of Sexual Attitudes and Lifestyles

The National Surveys of Sexual Attitudes and Lifestyles (Natsal) are among the most widely known and respected probability surveys on sexual behaviours in the world. They have been ongoing since 1990 and include a large sample size and detailed view into the sexual lives of the resident population of Britain. Natsal-1 was conducted in 1990–1991, Natsal-2 in 1999–2001 and Natsal-3 in 2010–2012. Natsal-4 is due to begin collecting data in 2022 (50).

Over 45,000 individuals have taken part in Natsal since its inception (50). The surveys are administered through computer-assisted face-to-face interviews in participants' homes and utilise self-completion questionnaires for more sensitive topics.

Since consistent methodologies were used throughout, Britain can comprehensively understand the trends and changes in the sexual health of the population over time. Due to the societal, individual and technological changes of the past three decades, the consistency and repetition of the Natsal surveys are critical in improving service delivery and shifting public health priorities over time (50). The impact of the Natsal studies on health policy and sexual health interventions is significant. The data have been used to help understand transmission of STIs among populations; service use; how young people learn about sex; risk factors for unplanned pregnancy; and many other crucial public health topics (51). The data have provided an evidence-base for programmes including the National Chlamydia Screening Programme, National Sexual Health and HIV strategies, enhanced HIV testing programmes, the HPV vaccination programme, the Teenage Pregnancy Strategy, and sex education in schools across Britain (50).

The Natsal surveys have been conducted approximately every 10 years since 1990, and Natsal-1 was a direct response to the HIV epidemic in the 1980s. The data are representative of the general population due to the probability sampling method that randomly selects individuals from across Britain. Natsal-1 used paper-based interviewing with a self-completion questionnaire for sensitive topics and interviewed individuals aged 16–59 years (51). The sample size was 18,876 individuals and fieldwork was completed between 1990 and 1991.

While each Natsal survey is broadly consistent with the previous one, improvements and changes have been made to reflect the context of sexual health at the time. For example, Natsal-2 and 3 used computer-assisted personal interviewing (CAPI) and computer-assisted self-interviewing (CASI) for sensitive questions, rather than the paper-based questionnaire used in Natsal-1 (52).

Natsal-2 interviewed 12,110 respondents between 1999 and 2001, and additionally gathered urine samples to test for chlamydia for the first time, which provided a unique view of the epidemiology of chlamydia in the British population (51). The outcomes from the biological sampling combined with the survey's sociodemographic and behavioural data informed England's National Chlamydia Screening Programme and sexual health service provision more broadly in Britain (51). The findings from Natsal-2 were published in over 50 journals and the data were used in secondary analyses. In addition, the survey findings were compared with Natsal-1 to examine changes that had occurred over the decade (53). A study on the changes over time found that the increased reporting of risky sexual behaviours was consistent with changing patterns of cohabitation and an increase in STIs across Britain (53). A different study found that there was an increase in condom use and a decline in reporting no contraceptive use at first sexual experience (54). Meanwhile, the median age at first sexual intercourse remained at age 16 (54).

The age range for Natsal-3 was extended to capture data on sex across the life course, and included individuals aged 16–74 years. This round of the survey also included questions on sexual function and non-consensual sex, which were not previously included on Natsal surveys. The sample size for Natsal-3 was 15,162 and the survey was completed between 2010 and 2012. In addition, the biological sampling extended to include testing for five STIs. These adaptations show that the aims of the Natsal studies have evolved over time to mirror the changing definition and societal acceptance of sexual health (18). Natsal-3 used the WHO definition of sexual health to design and frame the analysis and interpretation of the study, to ensure that the study encompassed topics of pleasure and safe sexual experiences rather than just the absence of disease (18).

The Natsal-3 findings have been used in many publications, including one paper that examined the attendance at various types of sexual health clinics in Britain. The data found that the population used a variety of sources to access contraceptives, and that community clinics were more often used by younger people and those with a greater sexual health risk (55). The findings include that 87% of women and 73% of men had accessed at least one method of contraceptives in the past year (55).

Natsal-4 is due to begin collecting data in 2022; however, a scoping review has already been published. The scoping review was conducted to identify the most appropriate methodology to use for the Natsal-4 general population survey and make recommendations based on the review (51). A stakeholder consultation invited suggestions for new topics that had not previously been asked about by the Natsal surveys, including the role of digital media in how people learn about sex, meet partners, and access information, advice and healthcare through digital platforms (51).

The recommendations from the scoping review are that Natsal-4 should be a new dedicated survey that uses the same methodology as the past three Natsal surveys, which is an address-based probability sampling frame and face-to-face interviews with CAPI and CASI instruments, with a random selection of one individual per household (51). This recommendation is based on the idea that a face-to-face interview would enable a longer interview time that would lead to the collection of robust data on sexual health (51). At the time of publication (March 2021), the proposed study design for Natsal-4 has been revised in light of COVID-19 and social distancing. While in-person recruitment by field interviewers is still planned at least for the pilot, there is the offer of a remote interview using videoconferencing or a phone interview if participants do not wish to have an in-person interview or if in-person interviews are not feasible for when the pilot fieldwork is scheduled (June 2021).

In addition to the benefits to individual selection and response rates (and potentially response bias) of in-person recruitment by field interviewers, face-to-face interviews enable a longer interview, with explanation of biological sampling enabling the collection of rich and detailed data that can benefit the scientific and policy community, rather than answering a limited number of focused research questions (51).

4.3.2 Towards Better Sexual Health: A Survey of Sexual Attitudes and Lifestyles of Young People in Northern Ireland, 2002

This was a three-year study of sexual attitudes and lifestyles of young people aged 14–25 years in Northern Ireland, and a large scale self-administered survey with focus groups and one-to-one interviews (56). The survey was developed in response to Northern Ireland being excluded from the first Natsal survey in Britain (56). Natsal had originally intended to include Northern Ireland in its target population; however, universities and market research companies in Northern Ireland were not able to conduct the in-person survey due to the perceived sensitivity of the questions on sexual behaviour in the context of Northern Ireland at the time (57).

The content areas included social background and upbringing, general health, alcohol and drug use, attitudes towards sexual relationships and sexual health, and knowledge about sexual health and STIs (56). Key findings included that over one quarter of respondents had sex before age 16 years of age (57). Those who had sex when they were under 16 were more likely to report that being drunk was the reason sexual intercourse occurred (57). In terms of sexual education, young people reported that their friends were their most important source of sex education and listed school-based sex education as the second most important source (57). The respondents also documented that they wanted more sex education in schools that was needs-based and included sensitive information (57).

4.4 Sexual Health Knowledge, Attitudes and Behaviours Surveys in the Rest of Europe and Elsewhere

Over the past three decades there has been an increased focus internationally on sexual health (58). With this, there has been an increase in the number of research studies aimed at better understanding sexual behaviours and investigating interventions to improve sexual health (58). The scope of international research provides a comprehensive understanding of sexual behaviours, and provides policymakers with essential information to design and assess interventions to improve sexual health globally (58).

Table 4.1 presents studies identified as part of the literature review component of the study, including the methodologies; sample sizes; areas of investigation; and key findings. The methodologies included online questionnaires; telephone and face-to-face interviews; and biological sampling. The sample sizes ranged from under 2,000 to 10,000 participants, and the age ranges were diverse, with the youngest participant age being 14 years and the oldest being 102 years.

Table 4.1. International sexual health knowledge, attitudes and behaviours surveys

Title	Country	Year	Methodology	Sample Size	Age Range	Content Areas	Key Findings
National Survey of Sexual Health and Behaviours (59, 60, 61)	United States of America	7 waves (2009–2018)	Probability sampling; online questionnaire	3,000–6,000	14–102	Sexual behaviours; condom and contraceptive use; overall sexual health	Many older adults have active sex lives with different sexual behaviours and types of partners; adults over age 40 years have the lowest rates of condom use
Australian Longitudinal Study of Health and Relationships (1, 62, 63)	Australia	2002, 2013, repeated every decade	Random digit dialling; interviews conducted through CATI	9,000–10,000	16–69	Sexual history; sexual activity in last month year; contraceptive practices; experience of pregnancy; physical and emotional satisfaction with sexual relationships; emotional and mental wellbeing; alcohol and other drug use	Less than half of sexually active reported using a condom; 17% of women and 13% of men had completed an STI test in the past year;
Italian National Survey of Knowledge, Attitudes and Sexual Behaviours (64)	Italy	2006	Cross-sectional survey; self-administered questionnaire; 53 multiple choice questions	1,985	18–49	General information; health education campaigns; HIV/ AIDS knowledge; sexual behaviour; current sexual partners	34% of sexually active respondents did not report regular condom use; 40% of respondents reported risky sexual behaviour
Sexual Health in the Netherlands: A Population Survey Among Dutch Adults (65)	Netherlands	2006	Random selection through internet panels taking 30 minutes to complete	4,147	19–69	Sexual health issues; sexual and relational satisfaction; sexual identity; excessive desire; sexual dysfunction; contraception; abortion; infertility; STI and HIV testing; condom use; sexual violence	Young people and people with an ethnic minority background have an increased need for sexual health services; 24% of women and 19% of men had a need for professional sexual health care in the past year; only half of those who needed care received it

Table 4.1. International sexual health knowledge, attitudes and behaviours surveys

Title	Country	Year	Methodology	Sample Size	Age Range	Content Areas	Key Findings
National Survey of Sexual Lifestyles, Attitudes and Health in Slovenia (66)	Slovenia	2001	Probability sampling; face-to-face interviews with an anonymous self-completion questionnaire component; integrated testing for chlamydia	1,752	18–49	Health; family; religious affiliation; first heterosexual experience; different attitudes to sexual lifestyles; social characteristics Self-administered questionnaire asked more sensitive questions; urine samples were collected for chlamydia testing	Positive chlamydia diagnosis was highest among 18–24 year olds, with a prevalence of 4.7% of individuals in that age group who have had sexual intercourse
South African National HIV Prevalence, Incidence Behaviour and Communication Survey (67, 68, 69)	South Africa	2002, 2005, 2008, 2012, 2017	Cross-sectional survey; multi-stage stratified cluster sampling design; household interviews; blood samples for HIV testing	11,776	All ages	Sexual health and behaviour; tuberculosis; exposure to HIV communication campaigns; intimate partner violence	68% of males aged 15–24 years with multiple partners used condoms in their last sexual experience; 47.3% of females aged 15–25 years reported condom use in their last sexual experience
National Sexual Behaviour Survey of Thailand (70, 71)	Thailand	2006	Probability sampling; face-to-face interviews with sex-matched interviewers	6,048	18-24	Age at first sex, sex with non-regular partners or commercial partners, condom use and history of sexually transmitted diseases, history of HIV testing	Age of first intercourse decreasing nationally; 52.9% of men and 14.3% of women reported using condoms with their last partner

It is clear from Table 4.1 that international surveys have included topic areas that have not been previously included in any Irish sexual KAB surveys, such as infertility and physical and emotional satisfaction with sexual relationships. Several surveys presented above have provided for trends to be monitored over time by using almost identical questionnaires at the point of data collection.

An important finding from the United States National Survey of Sexual Health and Behaviours 2018, was that older adults who were surveyed were found to have active sex lives yet low rates of condom use (60). Consideration should be given for the inclusion of older adults in a future survey in Ireland.

4.5 Irish General Health Surveys with Sexual Health Components

Several general population health-related surveys in Ireland in recent years have incorporated questions about sexual health. These surveys are useful in gathering population-level data on general health issues, ranging from nutrition and exercise to smoking habits and other health behaviours. However, due to the breadth of topics covered by these surveys, the number of questions on sexual health and crisis pregnancy has been limited.

4.5.1 Survey of Lifestyles, Attitudes and Nutrition Surveys

SLÁN 2007 was the third national Survey of Lifestyles, Attitudes and Nutrition, following on from studies from 1998 and 2002, and aimed to gather information on general health, health behaviours and use of health services in Ireland (72). This was a paper-based survey with a sample size of 4,000 respondents (72). Topics included health service use, breastfeeding, mental health, physical activity, alcohol and use of illicit drugs. The 2007 survey was able to compare sexual health data with the previous studies, allowing for the recognition of trends in Ireland. A secondary analysis of SLÁN 1998 and 2002 data was done to further explore contraceptive use and sexual behaviours among adults (73). The findings showed that women were more likely than men to always use contraception, at a rate of 56.5%, and men were more likely to never use contraception (73). However, 10% of sexually active single adults reported that they never use contraception in both the 1998 and 2002 surveys (73).

4.5.2 Healthy Ireland Surveys

Healthy Ireland is an annual face-to-face survey commissioned by the Department of Health and is a key component of the Healthy Ireland Framework, to improve the health and wellbeing of people living in Ireland (74). The survey comprises a range of topic areas including physical activity, weight, smoking and GP usage (74). It included separate modules on sexual health in 2015 and 2016, with topics including HIV and STI testing, and condom and contraception use. The Healthy Ireland surveys provided a comprehensive overview of the health status of the Irish population; however, due to its wide remit, the scope to include comprehensive questions on sexual health was limited. This, in turn, has limited a deeper understanding of sexual behaviours among the general population. Key findings from 2017 related to sexual health included that 21% of respondents reported ever having an HIV test, and 22% reported ever having a STI test in their lifetimes (74). More specifically, of those who had multiple sexual partners in the past 12 months, 16% had an STI test and 13% had an HIV test in that time (74).

4.6 International General Health Surveys with Sexual Health Components

During the literature search, the research team came across international general population-based surveys that incorporated sexual health questions. It is important to highlight this to demonstrate that data on sexual health behaviours can be gathered through national health surveys, however there are some limitations. These surveys can include questions on a particular sexual health topic area to meet a particular information need. However, they cannot provide a comprehensive picture.

Table 4.2 presents six international general health surveys with sexual health components that were identified in the literature review and met the inclusion criteria of the scoping review.

Table 4.2. International population-based general health surveys with sexual health components

Title	Country	Year	Methodology	Sample Size	Age Range	Content Areas	Key Findings
National Survey of Family Growth (24)	United States of America	Five-year cycles: 2006, 2010, 2015, 2019	Face-to-face interviewing, different questionnaires for women and men	10,416	15–44	Contraceptive and pregnancy history; family planning; medical services; infertility	64.9% of women aged 15–49 years were currently using contraception; percentage of white women using contraception (67%) was higher than non-Hispanic black women (59.9%)
Sexual Health Among Young Adults in Finland (75, 76)	Finland	Ten-year cycles: 2000, 2011	Home-based interviewing using CAPI; self-administered questionnaire for sensitive topics returned by mail	1,894	18–29	Infertility; STIs; contraception; sexual activity; casual partners; risk behaviour; STI screening	Approximately half of sexually active men and women reported that they had used condoms recently, with younger age groups reporting a higher use of condoms
Northern Ireland Health Survey (77, 78, 79)	Northern Ireland	Annual survey; 2010/2011 first year with sexual health questions	Systematic random sample of about 6,000 private household addresses selected from an Address Registrar; face to face interviewing	3,593	16+	Sexual activity; sexual preference; attitudes to STIs; methods of prevention; risk of infection; access to treatment services; where respondents received STI advice	Knowledge regarding STIs has declined since 2015–2016, with 26% of respondents reporting that they thought the pill would provide protection against STIs; General Practitioner was the preferred location for STI treatment among 58% of respondents; 38% reported the greatest barrier to getting treatment for STIs was ‘embarrassment in talking about these issues’

Table 4.2. International population-based general health surveys with sexual health components

Title	Country	Year	Methodology	Sample Size	Age Range	Content Areas	Key Findings
Japanese National Fertility Survey (80)	Japan	Every 5 years since 1952	Survey staff provide respondents with a self-completion questionnaire, and collect the questionnaires in an envelope after completion	8,752	18–49	Contraception preference and use	89.1% of unmarried men and 87.4% of unmarried women aged 18–34 reported using contraception in the past year; condoms were the most popular contraceptive method used by married respondents, and only 2.3% reported using oral contraceptive pills
New Zealand Health Survey (81, 82, 83, 84, 85, 86, 87)	New Zealand	Every 5 years; 2014/2015 included first self-completion sexual and reproductive health component	Multi-stage, stratified, probability-proportional-to-size sampling design; home-based interviewing using CAPI; electronic show cards introduced in 2017	14,000 adults and 5,000 children	16–74	First heterosexual sex; heterosexual sexual behaviour; contraception; pregnancy planning; STIs; non-volitional sex	83% of men and 80% of women reported using at least one form of contraception if they were sexually active; sexually active adults living in socioeconomically deprived areas were less likely to use contraception; one in five women and one in nine men who had ever had sex reported having been diagnosed with an STI at some point in their lives
Health Survey England (88, 89, 90)	England	Annually since 1990	Stratified random probability sample of private households; face-to-face interview with self-completion	8,178	16+	General health and behaviours; smoking; drinking alcohol; sexual health; biological sampling	Men reported an average of 9.3 female sexual partners in their life so far, while women reported an average of 4.7 male sexual partners

Table 4.2 presents an overview of what has been done internationally on general health surveys to gather sexual health data. The surveys vary in their regularity, and range from collecting data annually to every 10 years. They have large sample sizes, generally of over 5,000 participants, and are nationally representative. Most of the surveys presented above use face-to-face interviewing, often with a self-completion component for sensitive sexual health-related topics. The age range is generally 16 years and older, with up to 74-year-old participants in New Zealand, and up to 44-year-old participants in the United States.

Content areas among the studies were quite similar, with most asking participants about contraception use, sexual activity and STI testing. More specific and detailed questions were asked about sexual health on several surveys, which provide a closer look at the sexual behaviours and lifestyles of the population. For example, the Northern Ireland Health Survey asked about sexual preference and access to advice on STIs. The New Zealand Health Survey asked questions related to non-volitional sex and pregnancy planning. These surveys provide examples of the wealth of sexual health information that can be gathered from general health surveys.

4.7 Irish Sexual Knowledge, Attitudes and Behaviours Surveys with Specific Populations

Several surveys in the past two decades have looked at specific populations in Ireland to gather more information about their sexual KAB. Different population groups experience different sexual health outcomes and needs throughout their life span, and general population surveys are not large enough to assess the sexual health of specific populations (91).

4.7.1 MSM Internet Survey Ireland

The MSM Internet Survey Ireland (MISI) 2015 gathered information on the sexual health knowledge, attitudes, needs and behaviours of 3,090 MSM in Ireland (92). MISI 2015 was a behavioural surveillance online self-completion survey for men aged 18–80 years (92). The content areas of the questionnaire included HIV and STI testing, sexual behaviour, substance use, access to and use of HIV prevention interventions, knowledge about HIV and STIs, and awareness and impact of Irish health promotion materials (92). The survey found that 37% of respondents had never tested for HIV, and 61% had not been tested for HIV in the past year (92). In addition, it found a significant gap in knowledge about HIV transmission, with 32% of respondents unaware that effective treatment of HIV reduces the risk of transmission (92).

4.7.2 European MSM Internet Survey Ireland

Similarly to MISI 2015, the European MSM Internet Survey Ireland (EMIS) 2017 was an online behavioural surveillance survey aimed at gathering data to be used in the strategic planning of prevention and care programmes for STIs and HIV among the MSM population. The survey gathered important data on coinfections among this population, including the finding that MSM with a reported HIV diagnosis also reported a higher frequency of gonorrhoea, chlamydia and syphilis diagnoses in the past 12 months compared to respondents who had never been tested for HIV or who had a negative test result in their last HIV test (19).

4.7.3 Irish Contraception and Crisis Pregnancy Study: Supplemental Sample with Migrant Women

The ICCP 2010 survey included a supplementary sample of Polish and Nigerian women living in Ireland to help address the lack of knowledge about the pregnancy experiences and sexual behaviour of these migrant populations (5). This involved an opportunistic sample of 261 women, aged 18 to 34 years old, and included questions regarding their views, practices and service needs in relation to sexual health and pregnancy (5). The findings included that 23% of women reported that they had been pregnant when they did not want to be in the past (5). Additionally, the study found that knowledge of contraceptive methods was high, with 84% of Nigerian women and 90% of Polish women being aware of contraception options that they could use to avoid pregnancy (5).

4.8 Chapter Summary

This chapter has provided an overview of Irish and international research on sexual health KAB at a national general population level. The study findings highlight the different approaches that can be taken to survey a national population on sexual health behaviours. Most studies identified in the literature review used either computer-assisted face-to-face interviewing or telephone interviewing methodologies. Quite often, self-completion questionnaires were used for especially sensitive questions, or for sexual health components of general health surveys to encourage honesty and openness from respondents about their behaviours.

The age ranges differed quite significantly on the surveys identified in the literature. Some studies interviewed respondents as young as 14 years old; however, most had a sample age range of between approximately 16 and 70 years old. A survey with 18 as the minimum age decided to leave out younger respondents to avoid the potential issues with obtaining consent from both the respondent and parent as required (93). Age ranges that included older adults were often determined by the lack of information on older groups' sexual behaviours; however, Natsal-3 found that response tends to decrease with age (94). Sample sizes also differed quite drastically, most likely due to differences in resources, funding and allocated time to undertake the research.

It is clear that many surveys have been repeated over time to allow for the monitoring of trends in sexual behaviours and changes in attitudes within the population. This repetition of surveying is crucial for improving service delivery and shifting public health priorities over time due to ever-changing social, individual, technological and cultural factors. While surveys that are repeated are often almost identically replicated to allow for trend monitoring, there are always slight alterations to reflect the current context. This is essential for Ireland to consider both when developing an initial questionnaire and when planning for follow-up surveys in the future.

Biological sampling was identified as a contemporary research technique to provide a more accurate understanding of STI prevalence in the population, and to support the quantitative and qualitative results of a survey. This has been highly successful both in the Natsal surveys and in Slovenia, by providing a unique view of the epidemiology of STIs and informing service provision. The benefits gained from including biological sampling should be considered in Ireland for any future survey.

While many surveys had similar topic areas, and included a comprehensive list of questions on all aspects of sexual KAB, some novel topic areas were identified. Since several international surveys included topic areas that have not been previously included in Irish surveys, it is important to consider new topics in the development of a future survey in Ireland.

Chapter 5: Methodological Approaches for Sexual Health Surveys

5.1 Introduction

This chapter presents five data collection methods identified in the literature that were most commonly used in sexual health knowledge, attitudes and behaviours (KAB) surveys both nationally and internationally. This study examined the designs of these surveys to assess the appropriateness of these methods for replication in a future Irish survey. While most of the sample designs are probabilistic, convenience-sampling methods in online self-completion surveys were included due to the increase in online surveys and the lower costs associated with this method.

The data collection mode chosen for a future survey has major implications for both the costings and the quality of the data that can be collected (51). Ultimately, a future sexual health survey in Ireland must collect data using a method that will allow for an understanding of the varying factors that influence the knowledge, attitudes and behaviours within the context of the general population.

Five Most Common Data Collection Modes:

1. Face-to-face survey with self-completion questionnaire component
2. Telephone Interview (mobile and landline)
3. Online self-completion survey
4. Adding a sexual health component to an ongoing general health survey
5. Paper-based self-completion questionnaire

The tables below highlight the key features and commonalities of methods used in national and international sexual health KAB surveys. Details on sample design, sampling frame, sample size, survey instrument, strengths, weaknesses and cost implications are presented, with examples from the surveys found in the scoping review.

5.2 Face-to-Face Interview with Self-Completion Questionnaire Component

Table 5.1. Face-to-face interview with self-completion questionnaire component methodology

Method:	Face-to-face interview with self-completion questionnaire component
Sample Design	• Multistage probability sampling design (74)
Sampling Frame	• A random sample from an address registrar or the Postcode Address File was used in Britain (95)
Survey Instrument	• Computer-assisted personal interview (CAPI) • Computer-assisted self-interview (CASI)
Sample Size	• The sample sizes can range from 3,593 (95) to 15,162 (94).
Strengths	• Physical measurements and respondent-administered biological sampling possible with interviewer (74) • Self-completion questionnaire can help the respondent feel anonymous and provide more accurate data (48) • CAPI/CASI can include sophisticated computerised routing to minimise data cleaning required post-fieldwork and human error • Higher quality of data as interviewer can clarify issues and monitor data quality (48) • Detailed questionnaire can gather comprehensive overview of sexual health topics (51) • High response rates (88)
Weaknesses	• Time-consuming • Safety concerns of interviewer and respondent (25)
Cost Implications	• High fieldwork costs (51)

5.2.1 Sampling

This method allows for a broad representation of the general population in Ireland. In the Natsal surveys, in-person address-based recruitment is performed by interviews with a random selection of one participant per household (51). Doorstep screening for both young people and people from specific ethnic groups is done to boost sample addresses, but this is time-consuming and therefore costly (51).

5.2.2 Operational Procedures

In order to ensure respondents understand the purpose of the survey and provide informed consent, respondents are sent an introductory letter explaining the survey, including its specific goals and what is required of respondents, e.g. the selection process and time commitment (66). The letter should mention that the most sensitive and intimate questions would be answered anonymously and that respondents have the right to refuse to answer any question (66). To minimise the impact on respondents, the New Zealand Health Survey took several measures, including selecting only one eligible adult and one eligible child per household, using well-tested and proven questionnaires, using professional, trained interviewers to conduct the interviews, and making an appointment to conduct each interview at a time that suited the respondent (87). The New Zealand surveys took on average 40 minutes to complete, with the core questions using CAPI taking 31 minutes and the self-completion questionnaire taking nine minutes to complete on average (87).

To maximise response rates, the Natsal Surveys and the Slovenian National Survey used show cards with pre-coded answers to help respondents answer more sensitive questions without having to mention potentially embarrassing sex-related words, which created a more comfortable environment for both the interviewer and the respondent (66).

The Natsal-3 survey used the face-to-face CAPI method for general questions including first sexual experience, learning about sex, contraception, periods and attitudes towards different types of relationships, but for these more sensitive topics show-cards were used so that respondents just needed to report letter codes (94). The CAPI included a CASI for the most sensitive questions including sexual practices, condom use, number of partners, same-sex experiences, paying for sex, unplanned pregnancies, STI diagnoses, recreational drug use, HIV testing, and other topics on which the respondent may find it difficult to answer questions when face to face with an interviewer even if show-cards are used (94).

5.2.3 Strengths and Weaknesses

The face-to-face interview with a self-completion component methodology was used in the first five waves of Healthy Ireland surveys and the previous Natsal surveys, among others. However, due to current COVID-19 restrictions, different methodologies are being trialled in these two surveys to comply with infection control measures.

Face-to-face interviews with a self-completion questionnaire component for sensitive topic areas are internationally regarded as the gold-standard method (96). This method often leads to higher participant cooperation and lower refusal rates, and allows interviews to be longer and more detailed. This is because interviewers have the opportunity to explain the rationale, format and clear definitions to the respondent, while also identifying and questioning any inconsistent or unclear responses (97).

An additional strength of this methodology is the ability to conduct biological sampling during the face-to-face interview. The Finland Health Surveys in 2000 and 2011 were broken down into three components: an at-home face-to-face health interview, a clinical examination and a self-completion component (98).

This method has shown high response rates and relatively low item non-response, with only 2% of eligible participants in Natsal-3 refusing the CASI component, and 9% of eligible participants in Health Survey England 2010 not completing the self-completion booklet (88).

However, this method is not without disadvantages, which can include higher administration costs and a longer period needed to collect data (96). Travel time and associated costs, cancelled or missed interviews requiring additional scheduling, and concern for the safety of both the interviewer and the respondent when discussing sensitive issues in a household setting are additional issues that need to be weighed when determining if this method is appropriate (25). Face-to-face interviews can also lead to reporting bias, which creates a lower reporting rate of socially deviant attitudes or behaviours because respondents are in the presence of an interviewer (97).

5.2.4 Summary

This methodology is the gold standard for sexual health research seeking a representative sample. However, in the context of the ongoing COVID-19 pandemic, it may not be an option for fieldwork in the short to medium term. Public health guidelines must be followed for all research during a pandemic. Implications of COVID-19 for research methodologies are discussed at the end of this chapter.

5.3 Telephone Interviewing (Mobile and Landline)

Table 5.2. Telephone interviewing methodology

Method:	Telephone interviewing
Sample Design	• Probability sampling
Sampling Frame	• Three sampling frames were used: separate landline sampling frames for men and women, and another sampling frame for those contacted by mobile phone (63) • Dual-frame modified random-digit dialling (RDD) to recruit a sample (63) • RDD with both landline and mobile phones (63) • Non-institutionalised population in private residential housing (48) • Systematically selected from a national sampling frame (electoral register or GeoDirectory) (48)
Survey Instrument	• Computer-assisted telephone interview (CATI)
Sample Size	Examples of sample size: • 3,120 (response rate was 71.44%) (25) • 3,002 (1,416 landline and 1,586 mobile with response rate of 79% for the landline and 61% for the mobile) (36)
Strengths	• Anonymity and privacy • Quality control of data collection • Low cost • Safety • Shorter than face-to-face interviews
Weaknesses	• Doesn't allow for exploration of more complex topics due to time constraints • Lacks visual aids
Cost Implications	• Cheaper than face-to-face interviews and allows for more interviews for the same cost

5.3.1 Sampling

Random-digit dialling (RDD), where a sample is recruited by generating telephone numbers at random, is used by most polling companies in Ireland. This is a cheaper and more eco-friendly recruitment method than the post. However, it is not without disadvantages, in that more weighting is required since it can be harder to access disadvantaged cohorts.

Any future telephone survey should include samples accessed through both landline and mobile phones. ICCP 2010 was the first national survey in Ireland to recruit respondents through both mobile and landline phones, due to the nationwide increase in mobile phone use and the decrease in households with landline telephones (36). Landlines are becoming less common in homes of younger people; therefore, it is important to ensure that mobile phones are included in the sampling process. The Australian Survey of Health and Relationships 2 (ASHR 2) used a dual-frame modified RDD approach to recruit a sample, and combined traditional landline-based RDD with RDD of mobile telephones motivated by the increase in mobile telephone use among the population (63).

5.3.2 Operational Procedures

In relation to providing assurances and protecting respondents participating in telephone surveys, the ASHR 2, which used telephone methods, obtained consent verbally over the phone once a prospective respondent was selected (63). Once having agreed to participate in the study, respondents were clearly informed of their right to decline to answer any question, and most questions required a 'yes' or 'no' answer so that anyone who could overhear the conversation would not know the context, allowing for respondents to answer with more privacy and honesty (63). The SAVI survey took similar measures to ensure that respondents understood the confidentiality and safety measures put in place by the research team to protect them. The interviewers were comprehensively trained and monitored, they explained the purpose of the study in great detail to respondents, and they provided a phone number for respondents to call to authenticate the study prior to initiation (25).

Telephone interviews can reduce the burden on participants through use of CATI. CATI allows for skip patterns, whereby irrelevant questions can be skipped for certain respondents and certain features can be tailored to the respondent (63). CATI also improves data quality since the data do not have to be coded from a paper questionnaire, minimising human error (48).

At the time of the SAVI Report, telephone interviewing had become the international method of choice for surveys of sexual violence because they can facilitate respondents to report abuse while maintaining anonymity (25). For telephone interviews to be effective, is it essential for respondents to have full trust in and understanding of the survey (25). These benefits of a telephone survey are also applicable for sexual health and behaviour surveys due to the sensitivity and desire to remain anonymous.

5.3.3 Strengths and Weaknesses

This methodology offers a number of advantages, especially when the questionnaire asks respondents questions of a sensitive nature (96). These advantages include feelings of anonymity and privacy for respondents (which can lead to higher reporting of accurate information); monitoring and supporting of interviewers due to a centralised workplace; and efficiency in interview time (96). In addition, telephone interviews do not require high levels of literacy, allow for quality control of data collection, reduce interviewer biases and cost less than face-to-face interviews (63). While telephone interviewing saves time and is more efficient in general, it also allows for the interview to be more like a real conversation, ultimately improving the quality of the interview and data collection (63).

Telephone interviewing can often provide many of the same benefits as face-to-face interviews, including the ability to develop rapport with respondents. Telephone surveys can also ensure physical safety of both the respondent and interviewer by not putting them in an unfamiliar environment (25). The most recent national general population sexual KAB survey in Ireland, ICCP 2010, chose the telephone method because of the success of this method in the ICCP 2003, ISSHR 2006 and SAVI 2002 surveys (36). This demonstrates that this method is highly acceptable and familiar to the Irish population, and can be used successfully in collecting sensitive data from participants.

Response rates are quite high for the telephone interview method, and respondent satisfaction and honesty appear high as well. For example, 90% of respondents in the ASHR 2 survey were 'not at all' or 'slightly' embarrassed by the questionnaire, and 89% reported that their answers to the questions were 'entirely honest' (63). The SAVI report documented a 71% participation rate, which is very successful for a public survey in Ireland, especially with such sensitive topic areas (25). In addition, ICCP 2010 had a response rate of 69%, with 79% for the landline telephone sample and 61% for the mobile telephone sample (36). Since telephone surveys can be completed from a centralised office, they are ultimately cheaper than face-to-face surveys and allow for a larger number of interviews to take place than face-to-face surveys with the same budget.

As with all survey methods, telephone interviewing has its drawbacks, including that interviews are often shorter than face-to-face interviews, they lack the ability to use visual aids, and respondents can only remember a limited number of options, therefore making the data less complex than in a face-to-face interview (48). Since telephone surveys are recommended to be less than 30 minutes, this may impact the depth of data collected (99). Other sources recommend that telephone interviews should last only 15 minutes, and the mean interview length for ASHR 2 was 18.8 minutes (63).

5.3.4 Summary

Telephone interviewing, supported by CATI, is often used in national probability surveys and is now considered the preferred method in the context of ongoing COVID-19 restrictions. This methodology has been adopted by the Central Statistics Office and other major research organisations for the near future to reduce the spread of infection.

5.4 Online Self-Completion Survey

Table 5.3. Online self-completion survey methodology

Method:	Online self-completion survey methodology
Sample Design	• Convenience sampling strategy • Online panels or targeted advertising
Sampling Frame	• Internet sampling frames
Survey Instrument	• Internet
Sample Size	• 2,083 (19) • 3,090 (92) • MISI reached approximately 7% of MSM population aged 18–64 in Ireland (92)
Strengths	• Quick to complete • Offers greater sense of confidentiality than face-to-face interview (92) • Large sample size is accessible (19) • Various recruitment methods can be used (offline promotion in bars, and health services for MSM) (19) • Survey available in 33 languages (19) • Broad geographical coverage across Ireland (19)
Weaknesses	• Convenience sample • Self-reported survey • Long completion time among Irish respondents – 29 minutes (19) • Not nationally representative (92) • Low response rate (65) • Exclusive to individuals with internet access
Cost Implications	• Low cost (51)

5.4.1 Sampling

A convenience sampling strategy can lead to both a selection and a participation bias. These biases can cause skewed results if the surveyed population have more access to health services or are more sexually active than the population who were not reached through the survey promotion (92). Other limitations include that only individuals with higher literacy skills can complete this type of survey, and the MISI 2015 results show that over half of respondents reported having a degree or other higher education, causing a potential for bias in the results (92).

A unique feature of the sampling process of the Sexual Health in the Netherlands Survey was that after 2,000 questionnaires had been completed, the research team examined the representativeness of the sample to identify underrepresented groups. Following the review of the sample, a second recruitment wave targeted populations with specific demographics that were lacking in the first sample, including the MSM population, ethnic minorities, and older individuals with a lower education level (65).

Online surveys are often promoted on a widespread scale across the internet through targeting social media and dating sites frequented by desired respondents. The 2017 EMIS survey reached the MSM community through advertising on MSM dating sites including Grindr and Planet Romeo, along with advertisements in a monthly free gay community newspaper and through a recruitment session in a gay bar in Dublin (19). The 2015 MISI survey used Facebook and Twitter, along with a press release and advertisements on health promotion websites for MSM, to gather the sample (92). The 2006 Sexual Health in the Netherlands Survey used online panels to identify potential respondents, and the members of the panels were approached through email campaigns, online banners and editorials (65).

5.4.2 Operational Procedures

Survey experts recommend that online surveys should take a maximum of 20 minutes to complete to avoid the risk of respondents refusing to participate or dropping out halfway through (100). Online surveys have taken 14 minutes with MISI, 29 minutes with EMIS and 30 minutes with the Netherlands survey, and the authors of each report have noted that the length of the questionnaire could have led to some participants not completing it (92). The surveys are often available for completion for several months, and participants must confirm that they are eligible to participate and understand that they can withdraw from the survey at any point prior to initiating the survey (92).

5.4.3 Strengths and Weaknesses

Online surveys have become a commonly used methodology in sexual KAB surveys worldwide, and can be far-reaching in terms of sample size due to the ease of online access.

The EMIS survey is known as the largest international study ever conducted on the MSM population, with over 180,000 MSM across Europe completing the survey online (92). This form of surveying has many strengths, including the ability to offer the questionnaire in different languages. EMIS 2017 offered respondents a choice of 33 languages and therefore reduced the barrier of not speaking the English language (19). Another strength is that research has shown that internet questionnaires provide a sense of anonymity to participants, allowing them to disclose sensitive information more openly (65).

There are many limitations with this methodology, including that individuals without access to the internet are unable to participate. It is also possible that respondents who participate in an online survey may have different demographic and behavioural characteristics than respondents who do not participate, which causes the sample to not represent the national population (92).

5.4.4 Summary

This method is not recommended for a national general population survey, as using it would not provide a probabilistic sample, which is one of the key requirements of the tender. However, this method could be used to provide supplementary data on key topics in addition to or in between dedicated national probability surveys (51). Another consideration is to follow the current Healthy Ireland survey in trialling this method by providing a link to an online survey for the more sensitive topics, requesting an email address on completion of the telephone interview and sending participants the link afterwards to complete in their own time. This method could be a beneficial way to gather sensitive information, shorten telephone interview times, and potentially have higher response rates.

5.5 Adding a Sexual Health Module to an Ongoing General Health Survey

Table 5.4. Adding a sexual health module to an ongoing general health survey methodology

Method:	Adding a sexual health module to an ongoing general health survey
Sample Design	• Stratified random probability sample of households (90) • Multi-stage, stratified, probability-proportional-to-size sampling design (81) • Aim to interview a randomly selected individual at each selected address (101)
Sampling Frame	• Dual frame approach (participants are selected from an area-based sample and a list-based electoral roll sample to increase the sample sizes for ethnic groups) (81) • The resident population of all ages is the target (total of 3.6 million adults and 0.9 million children according to the New Zealand Census figures) (81) • Represent the population living in private households (no boost sample) (90) • An Post/Ordnance Survey Ireland GeoDirectory (a complete database of every building in the Republic of Ireland with 2.2 million addresses) (102) • The sampling frame was the Postcode Address File (90)
Survey Instrument	• CAPI • Self-completion component • Biological sampling (81)
Sample Size	• Large sample sizes are possible • 7,539 participants (101)
Strengths	• Broad baseline understanding of health issues can be identified • Can gather sexual health data that may not otherwise be collected as frequently • Biological sampling can be done • Large sample sizes
Weaknesses	• Module content changes every year therefore you can't compare data consistently over the years (81) • Limited number of sexual health questions (only 4 related questions in Healthy Ireland 2017) (74) • May lead to lower reporting of risky sexual behaviours (88)
Cost Implications	• Very cost effective because of integration of questions into an existing survey (51)

5.5.1 Sampling

Sampling depends on the strategy of the national population survey to which the sexual health components are being added. This can vary widely, but most national health surveys use probabilistic sampling.

5.5.2 Operational Procedures

The New Zealand Health Survey added a comprehensive Sexual and Reproductive Health Module to gather data on individuals aged 16–74 years for the first time in 2014–2015. This was in response to high rates of teen pregnancy, abortion and STI prevalence, and the lack of national data to inform policy (82). The module was self-completed by respondents on a laptop and was skipped if respondents were unable to complete the module due to technological illiteracy or language barriers (81). Potential respondents were given an information pamphlet prior to the interview with details on the general survey, and a separate information sheet with details on the sexual health module (81). Following their participation, respondents were given a thank-you note with a list of health and community-based organisations with contact details for respondents to get health advice on issues raised during the survey (81).

The overall response rate was quite high in the New Zealand Health Survey, with a rate of 79% for adults (81). In addition, 87% of eligible respondents completed at least some parts of the sexual health questionnaire in the 2015 Healthy Ireland survey (101). The average interview length for the Health Survey England 2010 was 50 minutes, and the nurse visit for biological testing took an additional 50 minutes on average (90).

In a comparison study of Natsal-3, a dedicated sexual health survey, and Health Survey England 2010, a general health survey with a sexual health module, researchers found that there was lower reporting of risky sexual behaviours and STI indicators in the general health survey than in the specific sexual health survey (88). This may show that the capturing of accurate and sensitive data will be higher and more acceptable in a dedicated sexual health survey than in a general survey.

5.5.3 Strengths and Weaknesses

The strengths of this methodology include access to a large sample, with over 13,000 respondents contributing to Health Survey England 2010 (90). Biological sampling could be included with this methodology, as many of the international general health surveys include some form of biological testing as an addition to the survey. The New Zealand Health Survey uses biological testing to support varying policy priorities, and in 2014–2015 it gathered blood and urine to identify risk factors for diabetes and cardiovascular disease, tobacco exposure and nutrition levels among the population (81). In Health Survey England, blood, saliva and urine samples were gathered by a trained nurse (90). Healthy Ireland also captures height, weight and waist circumference, and 81% of respondents participated in this module in 2015, demonstrating that these tests do not cause a burden to most participants (101). It is important to note that gathering biometric measurements will be difficult in the context of COVID-19, as several surveys including Healthy Ireland are trialling telephone surveys instead of the usual face-to-face methodology.

A limitation of this methodology is that the modules on sexual health are not always included in the general surveys each year. For example, the New Zealand Health Survey changes its module topics every 12 months, making it difficult to monitor population-level trends in sexual health over time (81). Healthy Ireland included questions on sexual health in 2015 and 2016, but did not include this module in 2018 or 2019 (102). In addition, the questions differed slightly between the years, limiting the ability to track trends and changes over time (102). Another limitation to this methodology is that the sexual health module would contain significantly fewer questions than in a dedicated sexual health survey. For example, Healthy Ireland 2017 included only four questions on sexual health (74).

5.5.4 Summary

If national surveys on sexual health are not done on a regular basis, the data may become out of date and irrelevant to informing health policy. However, adding a sexual health module to an ongoing general health survey may be helpful in establishing a baseline of sexual health KAB of the population (88). Adding sexual health questions to general population surveys can supplement sexual behaviour surveys as well, by providing some data in the years the sexual health surveys are not run (97). This allows for a continuation and increase of the understanding of national sexual health issues and contributes to policy by providing current data (97). Research has shown that it is feasible to include sexual health modules within general health surveys while maintaining high levels of participant response and willingness (88). Overall, this is a viable option to reduce costs, retain a high-quality sample and still gather small amounts of sexual health data (51).

5.6 Paper-Based Self-completion Questionnaire

Table 5.5. Paper-based self-completion questionnaire methodology

Method:	Paper-based self-completion questionnaire
Sample Design	• Quota sampling where everyone had a chance to be recruited to the sample (64)
Sampling Frame	• A number of quotas were applied to the government's population estimate (56) • Efforts were made to include people from ethnic minorities, disabled people, and other groups (56)
Survey Instrument	• Paper questionnaire sent by mail or CASI
Sample Size	• 2,000 (64) • 2,450 (56)
Strengths	• Anonymous • Low cost • CASI can minimise errors and reduce burden on participants
Weaknesses	• Poor response rates • Requires literacy • Requires participant self-motivation to complete and return the questionnaire
Cost Implications	• Lower costs than CAPI or CATI

5.6.1 Sampling

The third Italian national survey on knowledge, attitudes and sexual behaviour used the self-completion questionnaire method for its sample of about 2,000 individuals aged 18–49 years (88). The questionnaire was designed as 53 multiple-choice questions divided into four sections: general information, health education campaigns and HIV/AIDS knowledge, sexual behaviour, and current sexual partners (64). In addition, a survey of sexual attitudes and lifestyles of young people in Northern Ireland had a large-scale self-administered survey along with focus groups and one-to-one in-depth interviews with selected respondents (56). A total of 2,450 questionnaires with pre-stamped return envelopes were distributed to young people aged 14–25 years over a two year period in schools, youth centres, sports clubs and workplaces (56). Respondents were given an information sheet explaining the purpose of the study and the importance of accurate responding, and ensuring confidentiality (56). To minimise bias, support was given to individuals with low literacy or special needs in completing the questionnaire (56). A downside to this method was that some surveys were returned only partially completed, due to respondents not having time or not understanding the questionnaire and lacking the support of an interviewer (56). The response rate was only 42.8% (56).

5.6.2 Operational Procedures

Self-completion questionnaires should be short and simple, with limited open-ended questions to allow for ease for respondents (97). Studies have shown that computer-assisted self-interviews (CASI) and audio computer-assisted self-interviews (ACASI) lead to higher levels of reporting of sexual behaviours than CAPI (103). CASI can also help overcome illiteracy in respondents, provide the questionnaire in different languages, and allow respondents to maintain their sense of anonymity (97). Respondents can enter their responses directly into a device, and more complex questionnaires are possible (97).

5.6.3 Strengths and Weaknesses

Self-completion questionnaires can be a cost-efficient way to gather sexual health data and allow for respondents to have the advantage of anonymity and answer the questions at their own pace (64). This may lead to respondents reporting sensitive behaviours more accurately than in a face-to-face interview (97), as they may be more comfortable reporting accurately on a confidential form (103).

However, this methodology has several disadvantages, including the possibility of respondents skipping questions or giving inconsistent answers, contributing to poor response rates (64, 97). Self-completion surveys also require respondents to be literate, to be motivated to complete the survey on their own, and to have the time to do so (88). Research has shown that people with poorer literacy skills are less likely to complete a self-completion questionnaire, leading to a biased sample and the inability to generalise the results to the general population (48).

5.6.4 Summary

This methodology is not recommended for a future survey of sexual health in Ireland, as it would not serve the gathering of robust national data to inform policy.

5.7 Further Survey Design Considerations

5.7.1 Biological Sampling

Biological sampling can significantly enhance the data of a national probability sample survey by providing an accurate understanding of the epidemiology of STIs among the population (51). This supporting data can help shape health policy by providing a clearer view of STI testing needs and undiagnosed and untreated cases, and help identify if there is a need for programmes such as a national STI screening programme (104). Currently in Ireland, data on notifiable STIs are collated by the HPSC. Biological sampling in a general population survey could identify infections that would otherwise be missed. STI surveillance cannot accurately measure the prevalence of STIs in the population due to the high rate of asymptomatic and undiagnosed infections (105). The benefit of including biological sampling in a population survey is that risk factors and prevalence can be linked, to then identify interventions and services that are accessed by both infected and at-risk individuals (106).

Findings from large population surveys with biological sampling have shown that STIs are distributed widely across the population and support the need for integrated biological testing on sexual health general population surveys (106). Nationally representative biological sampling findings can inform health policy and improve screening strategies and testing uptake (105).

The Natsal-2 and 3 surveys collected biological samples of urine to measure prevalence and identify sociodemographic and behavioural risk factors associated with biologically ascertained (vs self-reported) STIs in the British population, to enhance the data gathered in face-to-face interviews (51). The samples were tested for chlamydia and type-specific HPV in Natsal-2, and chlamydia, type-specific HPV, gonorrhoea, HIV antibody and Mycoplasma genitalium in Natsal-3 (51). The biological sampling component incorporated a sample of individuals aged 18–44 who had reported having at least one sexual partner (107). Eligible respondents signed a consent form and provided a urine sample to the interviewer (107). The interviewer sent the sample to a laboratory for testing, and any respondents who tested positive were informed of treatment options and partner notification by a nurse (107). Respondents also gave consent before the study team passed the results to a clinic for treatment (107). The findings presented a significant burden of chlamydia infection among respondents, which demonstrated that biological sampling is very important to consider if seeking to identify undiagnosed infection among a population (107). The findings from biological sampling have been used in many secondary analyses in Britain on STIs.

Slovenia adapted biological sampling from the Natsal surveys and integrated testing for chlamydia into its sexual health survey to determine the distribution of chlamydia in the population and identify risk factors of transmission (66). A small-scale study was run to assess the feasibility of integrating urine testing into a general population sexual behaviour survey, and due to the acceptability for participants, testing for chlamydia was integrated into the main survey in 2001 (66). The general population survey found a high prevalence of chlamydia among 18–24 year olds, despite low-risk sexual behaviours and low self-reporting. This suggested that there was a gap in diagnosis and treatment of infections in the population, leading to a large proportion of infected individuals remaining untreated (108). This finding supported the need for widespread chlamydia screening at a national level and demonstrated the importance of biological sampling in a population survey in that context (108).

5.7.2 Oversampling Key Populations

Health surveys often ‘oversample’ or ‘boost’ specific groups of people in order to gather a more accurate estimate of certain attributes of those groups (109). This sampling technique is often used to access hard-to-reach populations or low-prevalence groups (109). For example, oversampling young adults in sexual health surveys can provide a deeper understanding of the population most at-risk of negative sexual health outcomes (104). General population surveys such as Natsal-3 oversampled young adults aged 16–34 years so that this age range would make up almost half of the entire sample. This allowed for an in-depth exploration of the behaviours of this age group (104). The sampling process was designed as a core sample of individuals aged 16–74 and two boost samples with ages 16-34 and 16–29 years (104).

Migrants have been oversampled previously in Ireland, when an opportunistic sample of Polish and Nigerian women aged 18–34 was recruited as a supplemental sample to the ICCP 2010 general population study (36). This supplemental sample allowed for information on the contraceptive needs and pregnancy experiences of women living in Ireland with specific cultural and ethnic backgrounds to be gathered to help improve pregnancy-related services for all women in Irish society (36). Additionally, the study sought to obtain an overview of the practices and views of migrant women in relation to sexual health and sexual behaviour (36). The rationale for recruiting a migrant sample was that women who spent their childhood in a different social, educational and cultural environment than Ireland may have different KAB towards sexual health, contraception and pregnancy (36). Polish and Nigerian women were specifically recruited because the Census data at the time showed that a majority of immigrants living in Ireland originated from these two countries (36). According to the most recent Census in 2016, Polish, United Kingdom, Lithuanian, Romanian, Latvian and Brazilian were the top nationalities living in Ireland. Additionally, the Census identified that the number of Travellers had increased by 5.1% since 2011 (110). This data may be of interest if a supplemental sample is considered in the design of a future general population survey on sexual health in Ireland.

The National Sexual Health Strategy 2015–2020 identifies migrants as a key population group requiring support (4). Barriers to accessing sexual health and crisis pregnancy services were linked to cultural and religious backgrounds, legal status issues, costs of services, and language and communication issues (4).

While oversampling specific populations within a general population is possible, it can be very costly to get sufficient numbers of respondents. The benefits of oversampling any group in a general population survey must be balanced against the budget. While oversampling key populations should be considered for a future survey, it is important to remember that general population surveys often have difficulty in recruiting sufficient sample sizes within smaller key risk groups. Therefore, other data collection methods may be required to gather robust data on these groups. A future general population survey could provide the contextual data required for smaller studies to be conducted on specific key populations (48).

5.8 Limitations on Data Collection Presented by the COVID-19 Pandemic

The COVID-19 global pandemic has presented a variety of challenges for researchers worldwide (111). Governments have imposed lockdowns and limits on in-person interactions and home visits to reduce the spread of the virus since March 2020. Researchers must adapt their data collection methods to be in line with both the goals of their research and the current context of COVID-19 (111). Ultimately, the health, safety and privacy of the interviewers and the respondents must be the most important consideration when deciding on a methodology for any future survey.

While CAPI is recognised as the gold standard in sexual health survey research internationally, current government infection control measures would make this methodology unviable in the current climate. A feasible alternative that is being considered by other population health research (e.g. Healthy Ireland) is CATI. CATI is known as the predominant choice for remote data collection and has been used successfully in several previous Irish sexual behaviour surveys (ICCP 2010; ISSHR 2004). CATI can still provide high-quality data, honest responses from participants and a representative sample (99).

However, while CATI can act as a substitute for CAPI during a pandemic, some operational procedures should be considered. Firstly, the duration of the survey should be shorter than a face-to-face interview using CAPI (99). Telephone surveys should ideally be less than 30 minutes, as loss of concentration can occur after 20 minutes, which could cause partial responses to increase and quality of data to decline (99). If a CATI survey must be longer than 30 minutes, the interviewer could suggest conducting the interview over two sessions, and always inform the participant of the typical duration of the survey at the outset (99). Secondly, privacy issues will arise if respondents do not live alone, therefore it is important to verify that the respondent is in a private location where they can complete a survey and disclose sensitive information (99). This can increase the quality of data (99). Another option, as mentioned above, would be to provide a web link to an online survey during a remote interview to allow for privacy while increasing the likelihood that participants complete this key component of the survey. This method is currently being trialled in the Healthy Ireland survey.

Research during the COVID-19 pandemic can utilise technology in ensuring safe data collection. The option of CAVI could also be considered, and this remote interviewing technique will be trialled in the upcoming Natsal-4 pilot. This option utilises video-conferencing platforms to have interviewer-led interviews while following public health guidelines. Fortunately, there has been increased use of the internet during the pandemic, which presents researchers with opportunities to engage with participants in novel ways, due to a familiarity with videoconferencing platforms and other sites (112).

While remotely conducted research using the telephone, online surveys or videoconferencing platforms can prevent viral transmission, there are challenges in using these strategies (113). Many respondents would be working from home with additional caretaking demands; they would require more flexibility and might have less time to partake in a survey (114). Therefore, both online and telephone surveys should allow for more flexibility and patience for participants. If participants have limited literacy, interviewers can read the questions to them or use survey platforms with audio-recording capabilities for the questions (113).

Remote surveying raises the concern of the sample not being representative (99). The use of letters sent by post or random-digit dialling (RDD) could allow for safe recruitment on a national scale, and these have been successfully used in other Irish general population surveys, such as ICCP 2010, and Healthy Ireland, which is currently piloting these methods. Finally, the restrictions on face-to-face data collection for the near future also have implications for the collection of biological data from participants. The trialling of home STI testing using an online platform for asymptomatic patients, which is currently being trialled by the HSE, may provide useful lessons and a possible solution to the collection of biological samples. A home STI testing service using an online ordering system, adapted from the HSE pilot could be incorporated for a subset of the population if the budget allows. This could provide invaluable biological data on a specific age range of the respondents and cost much less than implementing a biological sampling component to the general survey. While strong evidence supports the effectiveness of self-testing for STIs in increasing STI services uptake, its reliability in a telephone-based general population survey of sexual health, wellbeing and crisis pregnancy needs to be explored further (115). Ultimately, sexual health research must continue despite the current COVID-19 pandemic, and researchers must adapt their methodology with the key priority of keeping both participants and staff safe.

5.9 General Population Survey Budget Range

An objective of this study was to provide a budget range for the commissioning of a general population survey based on the methodologies and operational procedures from similar studies. In spite of extensive research, it has been very challenging to obtain clear costing data for similar general population surveys due to the commercial sensitivity of releasing such information. Among the key drivers in estimating survey costs will be the mode of data collection and the type of sampling used.

The research team consulted polling companies in Ireland with extensive research experience in data collection for nationally representative surveys. Based on their expertise, budget ranges could not be estimated without concrete information such as the sample size, the length of survey and the number of questions. However, one source provided a very broad range, suggesting that a national telephone survey with 4,000 participants lasting 30 minutes would cost €200,000 to €500,000 for the services of a market research company to undertake the project. There would be additional costs for a research team from an academic institution, depending on the size and composition of the team and the duration of their role. According to the Irish Universities Association's Research Salary Scales, the costs for research assistants and postdoctoral researchers vary based on the qualifications and experience of the individual (116). For example, a research assistant with a primary degree and little to no experience would cost €29,459 per year, and the highest level of a research assistant salary would cost €46,118 (116). The range for a postdoctoral researcher, based on their experience, is €49,596– €64,229 per year (116). Often, a principal investigator is on a salary through their university, therefore a survey budget would not have to consider this additional cost. It is important to note that the inclusion of biological sampling for STIs would incur significant additional costs and polling companies are not typically equipped for this, so it would require support from an academic group, a healthcare company, the HSE or funding organisation.

A number of the polling companies consulted also insisted on the consideration of online surveys for a future national sexual health survey. While this method is not suggested for a population survey with probability sampling, the polling companies felt strongly that it would be well suited for a future national survey. Due to the increasing costs of research and declining response rates, online surveys offer new possibilities for cost reductions (117). A reduction in costs and increased time efficiency are the most commonly cited advantages of online surveys, with no costs for interviewer salaries, staff travel or training (118).

Finally, the addition of biological sampling in population health surveys can provide many benefits, including informing interventions to improve health, monitoring of changes in health, and advocating for changes in policies to address health needs of the population (119). The inclusion of biological data in national surveys may lead to new perspectives in public health and can have a major impact on national health programmes and services (119). However, there must be a public health rationale behind the inclusion of biological sampling, in terms of costs, feasibility, and whether there is a programme or intervention that relates to the infection. Adding biological sampling not only increases logical complexity and cost for the testing, but also increases the costs for recruitment, training and transport of additional staff (119). According to the World Health Organization, costs per test vary greatly, and depend on sample size and where the processing is being done (119). One of the great challenges presented by the inclusion of biological sampling is what to do about informing participants of their test results, and potentially treating them. This can add significant costs, and has been discussed widely by the Natsal team in Britain. Due to the costs of returning results to participants, Natsal-3 performed voluntary anonymous testing for five STIs without returning results (120).

Further investigation of costs, including discussions with polling companies, should be undertaken prior to deciding on a data collection mode, sample size and the inclusion or exclusion of biological sampling for any future sexual health survey.

Chapter 6: Results from the Online Stakeholder Consultation

6.1 Introduction

The aim of the stakeholder consultation was to seek the expertise and feedback of stakeholders working in the fields of sexual health and crisis pregnancy in Ireland in relation to potential topics for inclusion in the next general population sexual health and crisis pregnancy survey and their data needs and usage.

This chapter presents the qualitative and quantitative findings from this online stakeholder consultation, which was part of Work Package 2 (WP2). Data were collected from stakeholders online, over a two-week period in late September–early October 2020. Explicit consent was obtained electronically and participation was voluntary, confidential and anonymous. The original sampling frame contained 97 stakeholders, all of whom were invited to participate in the online consultation. In order to maximise response rates and enhance inclusivity, stakeholders were encouraged to share the information about the consultation within their own networks. This led to a total sample size of 152 stakeholders.

In total, 66 stakeholders completed the online questionnaire in full while a further 42 completed it partially. On further examination of the partially completed consultations, 30 were removed from any further analyses (13 of these were duplicate questionnaires and 17 had been left blank). This resulted in a final sample of 78 participants, representing an overall response rate of 51.3%. This was a satisfactory response rate considering that some stakeholders were involved in the COVID-19 response during this period or impacted by the government's restrictions.

Findings are presented with the response rates for each survey item and, where appropriate, illustrative quotes from stakeholders. Any identifying data has been amended or removed to protect the anonymity of stakeholders and their organisations. A copy of the stakeholder consultation online survey is available in Appendix 4.

6.2 Respondent Information

Respondents were able to take part as individuals or on behalf of their organisation, or to nominate a colleague to complete the consultation. The proportion of respondents who took part on behalf of their organisation was (67.9%; n=53); these represented a wide range of services such as the charity/voluntary sector, the clinical/health service, and national government departments. Tables 6.1 and 6.2 present the type and focus of the stakeholder organisations involved in this consultation.

Table 6.1. Type of stakeholder organisations that took part in the consultation

Type of Organisation	% (N)
Charity/Voluntary Sector	34 (18)
Clinical/Health Service	32.1 (17)
Other	11.3 (6)
National Government Department	9.4 (5)
Community/Grassroots	9.4 (5)
Academic/Research	1.9 (1)
Local/Regional Government	1.9 (1)

Table 6.2. Focus of the work of the stakeholder organisations

Focus of Organisation	% (N)
Sexual Health	45.3 (24)
Public Health	41.5 (22)
Other	37.8 (20)
Human Rights/Advocacy	35.8 (19)
Education	30.1 (16)
Crisis Pregnancy	26.4 (14)
Reproductive Health	20.8 (11)

Respondents (n=6) who selected ‘Other’ as their type of organisation included an independent statutory body that advises government, a community counselling service and the youth work sector, among others. Respondents (n=20) who chose ‘Other’ in terms of the focus of their organisation included homelessness, addiction and mental health, family support, general counselling, HIV and health promotion, among others.

Almost one third (32.1%; n=25) of respondents indicated that they were taking part in the consultation as an individual rather than an organisation. The data are presented in Table 6.3. Respondents who selected ‘Other’ in response to this question included additional comments such as being involved in communications or ‘a scientist’.

Table 6.3. Type of individual stakeholders who took part in the consultation

Individual Stakeholders	% (N)
Clinician/Public Health Practitioner/Therapist	36.0 (9)
Academic/Researcher	28.0 (7)
Service Commissioner/Policy Maker	16.0 (4)
Other	12.0 (3)
Representative of a Charity, Community Group, or Collective	4.0 (1)
Teacher/ Lecturer/Educator	4.0 (1)

6.3 Awareness and Use of Previous and Future Sexual Health Data in Ireland

Respondents were asked if they had heard of the three most recent sexual knowledge, attitudes and behaviours surveys that had been conducted in Ireland (i.e. ICCP 2003; ISSHR 2006; ICCP 2010). Approximately four in five (79.2%; n=61) had heard of these surveys prior to taking part in this consultation. This highlights the broad reach of the previous surveys in Ireland, and shows that respondents from various backgrounds were aware of the research, despite it taking place a decade or more ago. Of those that had heard of these surveys (79.2%; n=61), further information was gathered in relation to how they used the previous surveys in their work, and how they plan to use the data from a prospective survey on sexual health and wellbeing and crisis pregnancy in their future work. Respondents could select more than one reason for using both previous and future data.

For comparison purposes, the data from these two questions, prior and future use of sexual health data by stakeholders, are presented in Figure 6.1. In summary, the three most common ways of using data from previous sexual health surveys (e.g. ISSHR 2006) were: to inform policy or practice (45.0%; n=27); for teaching/training purposes (33.3%, n=20); and for their own personal interest (28.3%; n=17). Similarly, when asked about their plans to use data from any future sexual health survey, informing policy and practice was the top ranked response (68.4%; n=52), followed by informing service provision (48.7%; n=37), and for advocacy purposes, for teaching/training, for planning services (39.4%; n=30) (all of these responses were endorsed equally by respondents).

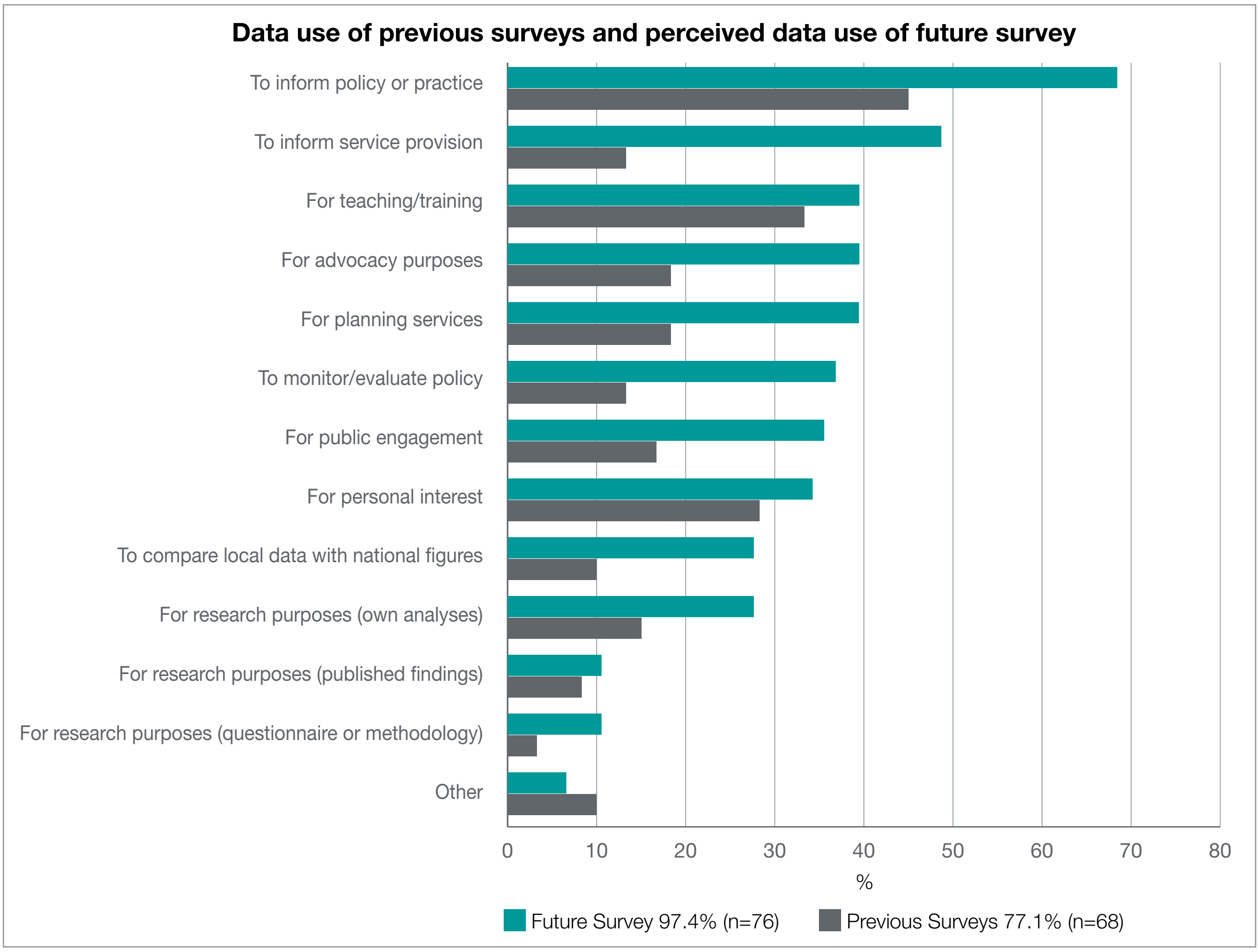

Figure 6.1. Data use of previous surveys and perceived data use of future survey

Figure 6.1 clearly illustrates that informing policy or practice will be a key way that the data from a future survey will be used by respondents. While over 20% of respondents who were aware of the previous surveys have not used the data from them, less than 5% will not use the data in the future. Therefore, Figure 6.1 demonstrates the importance of updated national data for the broad range of stakeholders and their work in the fields of sexual health and crisis pregnancy.

Respondents were invited to provide additional comments on their prior use of sexual health data in an open text-box, and 18 did. These included comments such as using the data from prior sexual health surveys to inform bidding applications, or in campaigning for the provision of free contraception.

Many of the respondents identified specific data from the previous surveys that they found most useful in progressing their work. For example, several respondents, from different organisation types, highlighted the use of the data for better understanding contraceptive use rates in young adults, access to contraception in Ireland, and cohort-level differences in sex education. They remarked that the data were particularly useful in training programmes, policy discussions, and informing practice among health workers. In addition, several respondents highlighted the use of previous data in working towards universal access to contraception in Ireland. Table 6.4 presents some illustrative comments from respondents to support these findings.

Table 6.4. Particular usefulness of previous sexual health data for stakeholders

Respondent Type	Comment
Charity/Voluntary Sector 1	*Information about accessibility to and use of contraceptives is useful to advocate for greater access and link to preventative work. Information about sexual health … is useful to show trends and argue for greater services and education.*
National Government 1	*Findings … were used to inform policy discussions … around providing universal access to contraception. Findings of all three were also referred to in developing policy around termination of pregnancy.*
Clinician/Public Health Practitioner/ Therapist 6	*Helpful for lobbying for free contraception, helped highlight that up to date research is needed.*
Representative of a Charity, Community Group or Collective 1	*They are also used to support our training and education services and workshops, and provide a strong rationale for our work.*
Communications 1	*When briefing and planning for sexual health and unplanned pregnancy campaigns.*

Respondents (n=12) also provided comments on their plans to use any data from a future general population survey on sexual health, wellbeing and crisis pregnancy in their work. These included, but were not limited to, informing funding applications, planning programmes, stakeholder engagement and consultation planning. Overall, it is clear that respondents will use the data from a future survey in a comprehensive and meaningful way to influence their work.

6.4 Ranking of Topics for Inclusion on a Future Survey

An objective of this study is to provide clarity on the topics that a future survey should inquire about, to fill existing gaps and to meet data needs. To achieve this, respondents were provided with 37 relevant topic areas and answered two separate questions regarding these topics.

Firstly, respondents were asked to rate the importance of each topic from a list using a sliding scale of zero to 100% in 10% increments. Zero represented ‘not very important to include’ and 100 represented ‘very important to include’. Seventy-five respondents completed each question regarding topic importance and three skipped the entirety of these questions. Table 6.5 shows the average ratings of importance by respondents of the topic areas.

Table 6.5. Respondents' average rating of importance for topics to include in a future survey

Topics to Include in a Future Survey	Average Rating of Importance (0–100%) n=75
Sexual health and reproductive knowledge	86.0
Sex education	84.9
Non-consensual sex/coercion	84.7
Gender-based violence	83.6
Sexual pleasure and wellbeing	81.9
Experience of crisis pregnancy	81.2
Access to contraception	81.1
Condom use and access to condoms	80.8
Sexually transmitted infections/HIV testing	80.8
Contraception use and methods	80.7
Knowledge, attitudes and beliefs about abortion	80.7
Knowledge, attitudes and beliefs about HIV	80.5
Drug and alcohol use	80.1
Emergency contraception	79.9
Human papillomavirus (HPV) vaccine	79.7
Sexual guilt	79.2
Knowledge, attitudes and beliefs about different kinds of relationships and sexual lifestyles	78.9
Media, communication and norms	78.9
Mental health	78.1
Gender identity	77.2
Pornography	77.2
Use of technology (internet, apps) in sexual lifestyles	76.9
Sexual practices for both same and opposite sex partners	76.3
Sexual problems	74.0
First sexual experience	73.9
Sexual function	73.2
General health	72.9
Sexual attraction	72.4
Sex work	72.3
Sexual Intercourse	71.6
Periods	70.8
Menopause	70.0
Experience with pregnancy/pregnancy history	69.7
Fertility intentions and infertility	68.3
Most recent sexual event	67.9
Sex outside Ireland and the UK/sex with people from other countries	58.8
Masturbation	58.5

As shown in Table 6.5, ‘Sexual health and reproductive knowledge’ received the highest average rating of importance, and ‘Masturbation’ received the lowest rating. ‘Sex education’, ‘Non-consensual sex/coercion’, ‘Gender-based violence’ and ‘Sexual pleasure and wellbeing’ received the next highest averages. Out of the 37 topic areas, 13 received a rating average of 80% or higher, 19 received a rating of 70% or higher, and three received a rating of 60% or higher. This suggests that respondents agreed that most of the topics are important to include on a future survey.

Following this question, respondents were also asked to say which top 10 topics are essential to include in a future survey. They did not specifically rank the topics from 1 to 10 but rather chose only 10 topics that they thought were essential to include. Seventy-two respondents answered this question and six skipped it, which was a response rate of 92.3%. Table 6.6 presents the topics that respondents thought were essential to include in a future survey, in descending order.

Table 6.6. The topics stakeholders thought were essential to include in a future survey

Topics to Include in a Future Survey	Top Ten Topics % (N)
Sex education	61.1 (44)
Sexually transmitted infections/HIV testing	61.1 (44)
Access to contraception	54.2 (39)
Non-consensual sex/coercion	52.3 (38)
Sexual health and reproductive knowledge	50.0 (36)
Experience of crisis pregnancy	45.8 (33)
Contraception use and methods	44.4 (32)
Sexual pleasure and wellbeing	41.7 (30)
Knowledge, attitudes and beliefs about abortion	38.9 (28)
Knowledge, attitudes and beliefs about different kinds of relationships and sexual lifestyles	38.9 (28)
Pornography	38.9 (28)
Mental health	36.1 (26)
Gender identity	36.1 (26)
Condom use and access to condoms	34.7 (25)
Drug and alcohol use	34.2 (25)
Gender-based violence	33.3 (24)
Knowledge, attitudes and beliefs about HIV	30.6 (22)
First sexual experience	27.8 (20)
Use of technology (internet, apps) in sexual lifestyles	26.4 (19)
Sexual practices for both same and opposite sex partners	22.2 (16)
Sex work	22.2 (16)
Emergency contraception	19.4 (14)
Human papillomavirus (HPV) vaccine	18.1 (13)
Media, communication and norms	16.7 (12)
Sexual function	15.3 (11)
Menopause	13.9 (10)
Most recent sexual event	13.9 (10)
Sexual guilt	13.9 (10)
Experience with pregnancy/ pregnancy history	13.9 (10)
General health	12.5 (9)
Fertility intentions and infertility	11.1 (8)
Masturbation	8.3 (6)
Sexual Intercourse	8.3 (6)
Periods	8.3 (6)
Sexual problems	6.9 (5)
Sexual attraction	6.9 (5)
Sex outside Ireland and the UK/sex with people from other countries	2.8 (2)

As shown in Table 6.6, ‘Sex education’ and ‘Sexually transmitted infections/HIV testing’ had the highest number of respondents – (61.1%; n=44) – select them as absolutely essential to include. ‘Sex outside Ireland and the UK/ sex with people from other countries’ received the lowest percentage, with only (2.8%; n=2) choosing this in their top ten topics to include. Five topics received percentages of 50% of more, which included ‘Sex Education’, ‘Sexually transmitted infections/HIV testing’, ‘Access to contraception’, ‘Non-consensual sex/coercion’, and ‘Sexual health and reproductive knowledge’.

Comparing the results from the two questions regarding topics to include on a future survey shows many similarities and several differences. Table 6.6 mirrored the findings in Table 6.5, in that of the 10 highest rated topics in Table 6.5, eight match the findings from Table 6.6. This highlights the significance of including these highly ranked topics in a future survey. However, while ‘Gender-based violence’ and ‘Condom use and access’ were over 80% in their importance rating, these two topics did not score in the top 10 most essential topics to include in a future survey overall. In fact, less than 35% of respondents chose these on their list of essential topics.

Respondents were asked to provide other essential topics that were not suggested by the research team. These included post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) knowledge, use and access, education on cultural barriers for ethnic minority women’s sexual lives, and the diverse barriers to accessing sexual health services, such as communication or legal barriers.

6.5 Rationale for Selection of 10 Essential Survey Topics

Respondents (n=51) provided a rationale for their choices of essential topics. There was general agreement that it was difficult to choose only 10 topics, and that many of the listed topics are essential to include in a future survey. Another commonality among respondents was the need to address sexual pleasure and wellbeing rather than just the negative aspects of sexual health.

Several organisations highlighted that stigma was an issue, although they discussed it in different ways. For example, a respondent noted that sex workers are some of the most marginalised people in Ireland and face barriers to accessing stigma-free health care. In support of stigma reduction, a respondent commented on the need to prioritise areas related to general awareness of and access to services, especially for vulnerable groups. Stigma reduction was a consistent theme highlighted by respondents throughout the entire survey. Table 6.7 presents illustrative commentary from respondents on a variety of other issues.

Table 6.7. The rationale for respondents' top 10 topics to include on a future survey

Respondent Type	Comment
Charity/Voluntary Sector 1	*It is vital that we build normalised attitudes to abortion, HIV and diversity to ensure support for the variety of human experiences and to be as inclusive as possible. By gathering this information, we know where we need to target services and campaigns.*
Charity/Voluntary Sector 3	*The list, although comprehensive, did not include items on healthy relationships, communication skills for accessing health sexual experiences or models for supporting problematic sexual behaviour such as sex addiction.*
Charity/ Voluntary Sector 7	*Important to also get evidence and information on the link between mental and sexual health which would include relationship, self-esteem, not just the physical sex act.*
National Government 5	*It would be interesting to explore how technology and access to pornography is influencing attitudes and experiences of people in relation to sexual health and wellbeing.*
Academic/ Researcher 2	*This study is a great opportunity to understand technology and modern influences on sexuality, as well as understanding under-studied but vastly important topics like sexual pleasure, masturbation and the persistence of sexual guilt in Ireland.*

6.6 The Importance of Collecting National Sexual Health Data

Respondents were asked to outline the relevance and/or importance of the systematic collection of national data on sexual health and wellbeing and crisis pregnancy in Ireland to their work and/or the work of their organisation. Sixty-four responded to this question, a response rate of 82.0%.

The overarching message from respondents was that the collection of national sexual health data is imperative and invaluable for their work. They expressed that they require updated national data for a variety of purposes, including informing policy and practice, service provision, developing health promotion programmes, and training purposes. Several respondents, from different organisation types, commented on the importance of data for meeting the needs of service users and delivering sexual health care. Respondents also mentioned that updated data would assist with funding for expanding services and promoting the worth of sexual health promotion.

Respondents consistently recognised the changes in Irish society and the need for relevant and continuous data to assess patterns and trends over time. For example, some highlighted the need for current evidence to fit the new Irish context, and that updated data can help to continually monitor and inform sexual health practices and show the current lived experiences of the Irish population.

Respondents discussed the importance of national data for improving the overall health and wellbeing of the nation, and progressing sexual health strategies and interventions. Table 6.8 presents some illustrative commentary to support this point.

Table 6.8. Respondents' thoughts on the importance/relevance of collecting national sexual health, wellbeing and crisis pregnancy data to their work

Respondent Type	Comment
Academic/Research Organisation 1	*These data are absolutely essential to making progress on the sexual health strategies nationally and cross-nationally…the lack of recent data has been a very real barrier in making progress on sexual health.*
Clinician/Health Service 6	*This data collection is so important to keep sexual health on the agenda and find out what are the current sexual health issues which are ever-changing … sexual health is an integral part of our over health and wellbeing and is often missed out. Also, to build on previous research and compare results especially around services and supports.*
Academic/Researcher 1	*The systematic collecting of national data on sexual health and wellbeing and crisis pregnancy in Ireland would inform the development of behavioural interventions to promote safer sex and pregnancy.*
Academic/Researcher 4	*Without this data it is impossible to know where Irish people fare regarding their sexual health outcomes in comparison to those of other countries … we often end up having to use international data in the development of Irish interventions for youth because we have such limited data on sexuality at a population level.*
Clinician/Public Health Practitioner/ Therapist 8	*It is essential to have comprehensive systematically collected information on knowledge attitudes and behaviours which influence likelihood of contracting STIs and HIV. They help explain trends, and provide valuable information to aid targeting prevention interventions.*
Scientist 1	*This data is important in understanding knowledge, beliefs and attitudes surrounding STIs and HIV, so that national HIV/STI surveillance data can be better understood.*

6.7 Respondent Recommendations for a Future Survey

Respondents were also asked if they thought any additional questions or topics should be included in a future survey, and (37.1%; n=26) replied 'yes'. This question had a response rate of 89.7%; 70 respondents answered. They provided a diverse range of topics, including questions on access to PEP/PrEP, knowledge of condom size differences, experiences of sexual healthcare, barriers to pregnancy termination services and body image.

Additionally, some felt that it was pertinent to include a question on ethnicity and culture, and for questions on sexual orientation and gender changes to become the norm in all health research moving forward. Several respondents highlighted that ethnicity data are poorly gathered in health research in Ireland, and questions on how ethnicity intersects with knowledge, attitudes and behaviours towards sexual health should be included.

Many agreed that consent was a crucial topic to be considered for inclusion, and offered several ideas for including this broad topic in a future survey. Table 6.9 supports this point with illustrative comments.

Table 6.9. Additional topics to include in a future survey

Respondent Type	Comment
Independent Statutory Body that Advises Government 1	*Consent/capacity to consent (understanding around consent-giving and receiving it, supports received to understand and make decisions around sexual relations, sexual education delivered in range of accessible ways, confidence that an individual understands what they are consenting to.) Many people struggle with understanding consent and some people … will struggle more than others.*
Charity/Voluntary Sector 16	*A survey that includes sexual health, wellbeing and risks, should consider the issue of consent and sexual violence in the context of what a healthy relationship looks like.*
Academic/Researcher 2	*Worth considering … sexual competency at first sex … (if) both partners (are) equally willing, and absence of regret.*
Charity/Voluntary Sector 2	*Problematic sexual behaviour is a growing public health issue which needs to be considered … due to its link to relationships, consent and sexual misconduct. Healthy relationships and individuals communication skills should also be considered.*
Charity/Voluntary Sector 3	*More information about sexting and the amount of young people in particular who have had images shared non-consensually and the supports that were available for them.*

Another consultation question asked if they believed that existing questions from ICCP 2003, ISSHR 2006 and ICCP 2010 should be changed or updated. There was a response rate of (87.1%; n=68) on this question. Respondents were also asked to comment if they thought any topics should be removed from a future survey.

There was wide agreement that questions on sexual identity and gender identity must be inclusive and include genders other than just ‘male’ and ‘female’. In addition, the need to include socially excluded groups in a national survey was raised by several respondents. For example, there was a recommendation to extend the supplemental section of data collection from the ICCP 2010 survey to include more subpopulations beyond the Polish and Nigerian female populations. In addition, a respondent highlighted the need to develop the survey tool in consultation with socially excluded groups to ensure it is culturally competent.

Many respondents raised the important point of the changes in legislation in Ireland since the last survey in 2010 and the need for a future survey to reflect these. For example, several respondents agreed that due to the changes in abortion law and service provision, it might be useful to cover abortion-related issues in less detail as it is now legal in Ireland. However, others felt that because of the new legislation on abortion, more questions should be asked such as where respondents had their termination of pregnancy, how they found information on where to go, whether they had difficulty accessing services, if they felt safe doing so, and whether they were satisfied with the service they received.

There was a general agreement that questions regarding ‘most recent partner’ and ‘a partner in another country’ should be removed.

For the final question of the consultation, twenty respondents commented with further suggestions for a future survey on sexual health and wellbeing and crisis pregnancy in Ireland, which was a response rate of 25.6%. Several comments are displayed in Table 6.10.

Table 6.10. Further suggestions to consider for a future survey

Respondent Type	Comment
Clinical/Health Service 11	*It would be useful if the new study took cognisance of the Indigenous cultural groups, (traveller community) as well as 'new Irish', and sexual health in older age.*
Charity/Voluntary Sector 6	*It would be very beneficial to test the draft questionnaire with different groups, such as young women, women from ethnic minority groups, to ensure that it is clear and covers issues which are significant for them.*
Academic/Researcher 1	*With the amount of different important topics to cover, it may be useful to use a Planned Missingness design so that different shorter versions of the full survey are randomly administered. You'll get a full picture without having to subject all participants to an overly long survey.*

6.8 Discussion of Findings

The respondents provided a wealth of information and guidance on the topics that should be considered for inclusion in a future sexual health survey in Ireland. The welcoming of new and relevant topics reflected the sexual behaviour surveys that have taken place internationally in recent years. The results reinforced the findings from the literature review regarding the relevance and scope of topics that should be included on a general population survey of knowledge, attitudes and behaviours on sexual health and wellbeing and crisis pregnancy. It is clear that respondents propose to use these future data in a variety of ways, and they have a particular interest in using the findings to inform policy and planning in Ireland. The respondents additionally provided Irish-specific recommendations and expertise that are invaluable for the development of a future survey. Recommendations on survey content and development are presented in Chapter 8.

Chapter 7: Data Protection Requirements

7.1 Introduction

The EU General Data Protection Regulation (GDPR) took effect in in May 2018 and is a comprehensive and multifaceted regulation in Ireland and the other European Union member states. The Health Research Regulations 2018 are formally called the Data Protection Act 2018 (Section 36(2)) (Health Research) Regulations 2018; they were enacted by the Minister for Health under section 36 of the Data Protection Act 2018 and came into effect on 8 August 2018. The Health Research Regulations 2018, within the Data Protection Act 2018, are the guidelines behind the governing of personal data for the purpose of health research (121). These regulations outline specific measures to ensure that health research in Ireland follows best practices and aligns with the GDPR requirements (121).

There are seven key principles related to the processing of an individual's data, which data controllers/organisations need to comply with when collecting and processing personal data in health research, all of which will need to be considered in the design and roll out of the survey. The principles are:

- **Lawfulness, fairness, and transparency –** there is a valid lawful basis in order to process personal data, a person's data is only used in the way they expect it to be used and they experience no unjustified adverse effects, and a person clearly knows and understands how you intend to use their personal data
- **Purpose limitation** – a person's data is only used for a specific processing purpose, they are aware of this purpose and it cannot be used for any other purpose within their further consent
- **Data minimisation –** the minimum amount of a person's data should be kept by an organisation in order to achieve its processing purpose
- **Accuracy** – date should be accurate and where necessary kept up-to-date
- **Storage limitation** – personal data should be kept in a form which permits identification of a data subject for no longer than is necessary
- **Integrity and confidentiality** – data should be handled and processed in a manner that ensures the appropriate security of the personal data
- **Accountability** – the data controller is responsible for, and must be able to demonstrate, their compliance with all of the above-named Principles of Data Protection (122).

7.2 GDPR Principles in Health Research

Population health research is clearly identified within the Health Research Regulations, 2018 as a valid form of health research. Under GDPR Principles, personal data is any information that can be used to identify a living person, and includes their name, date of birth, email address, phone number, address, characteristics or location (122). Data is not considered personal data if it is completely anonymised and cannot be used to identify a person; however, partially anonymised or pseudo-anonymised information is still considered personal data. Once data is anonymised or pseudo-anonymised, it is no longer possible to erase data if requested by participants, as the personal identifiers are deleted. Therefore, information leaflets should always include a date after which identifiers will be removed and participants can no longer have their personal data removed.

Data controllers are the key decision makers who have the overall control over the reason and purposes behind data collection and the method of data processing in health research (123). Data controllers must provide certain information to the participants when they collect their data. This includes the identity and contact details of the data controller, the purpose and legal basis for the data processing, who the data will be shared with, how long the data will be stored, and acknowledgement of the participant's rights (124). This information must be provided in writing in an accessible and understandable manner (124). Data controllers must take measures to ensure that personal data are protected through technical and organisational measures, and require privacy and data protection measures to be built into the systems they use (124).

Participants have specific rights under the data protection law to allow them to have control over how their data are processed and to keep them informed (124). These include the right:

1. To be informed if, how, and why your data are being processed;
2. To access and get a copy of your data;
3. To have your data corrected or supplemented if it is inaccurate or incomplete;
4. To have your data deleted or erased;
5. To limit or restrict how your data is used;
6. To limit data portability;
7. To object to processing of your data;
8. Not to be subject to automated decisions without human involvement, where it would significantly affect you (124).

Certain types of sensitive personal data are subject to additional protection under the GDPR. These include (but are not limited to): personal data revealing racial or ethnic origin; religious or philosophical beliefs; data concerning health; and data concerning a natural person's sex life or sexual orientation (125). Processing of these special categories is prohibited, except in limited circumstances set out in Article 9 of the GDPR. While the GDPR does not specifically apply to bio-banking per se, it does apply to the personal data associated with the biomaterial (126). Special considerations are needed in relation to the consent of participants for the collection of biological data, and any plans for future use or bio-banking of participant data should be described as well as possible before consent is obtained (126).

7.3 Special Category Personal Data and Consent in Health Research

The proposed general population survey on sexual health and crisis pregnancy will collect sensitive and personal data from participants and therefore will need to comply with all of the stated GDPR principles. Special category personal data includes personal data that reveals the following: race; ethnic origin; political opinion; religious or philosophical beliefs; trade union membership; genetic data; biometric data for the purpose of uniquely identifying a natural person; data concerning health; data concerning a natural person's sex life or sexual orientation.

Under GDPR Article 9, this type of data can only be collected and processed if the data controller meets one or more conditions in addition to having the appropriate legal basis for data processing. Some of these conditions with particular relevance to this survey are explicit consent; substantial public interest; and public interest in the area of public health.

Therefore, collecting sensitive data and ensuring informed consent must be carefully planned from the design stage and must closely follow the current data protection laws (124). Participant consent must be both informed and appropriately recorded in order for it to be considered valid and lawful under these regulations (123). In addition, consent must be freely given, unambiguous and explicit, with data subjects allowed to withdraw their consent and their data at any point (124). Informed consent means that the participant has enough information provided by the data controller to allow them to make an informed decision and is allowed sufficient time to assess the information before making the decision (123). In addition, only the minimum amount of personal data necessary for the research study must be sought (123).

7.4 Examples of GDPR Compliance in Irish Research Organisations

In order to understand the operationalisation of GDPR compliance in practice, this section will present two short outlines of GDPR procedures that have been used in general population research-focused organisations in Ireland. The Central Statistics Office (CSO) is Ireland's national statistical office and its remit is to impartially collect, analyse and make available statistics about Ireland's people, society and economy. These statistics are used to inform decision-making across a range of areas including construction, health, welfare, the environment and the economy, and they provide an accurate picture of Ireland's economic and social performance and enable comparisons between Ireland and other countries at the European level. The CSO is currently developing a Sexual Violence Survey (SVS), which will involve the collection of highly sensitive data; its experience and compliance with GDPR is a good example for the future planning of a general population survey on sexual health and wellbeing and crisis pregnancy.

The CSO has put a number of safeguards in place to ensure the protection of the fundamental rights and freedoms of data subjects – i.e. rights of individual persons. This extensive system ensures the confidentiality of any data collected and includes: legal protection and appropriate training of staff under the Statistics Act; a clear governance structure and a Data Management Policy that clearly outlines the roles, responsibilities and corporate rules in relation to statistical confidentiality, data security and data protection; restriction of staff access to statistical data and to the CSO buildings and password-controlled staff access to IT systems; secure destroying of survey forms and other data records that are no longer required for statistical purposes; and the management of any linkages between projects and administrative data sources via a Privacy Impact Assessment and other risk assessments.

The Economic and Social Research Institute (ESRI) undertakes research with the aim of advancing evidence-based policy to support a healthy economy and promote social progress (127). The ESRI often collects data for research purposes to provide insight into economic and social issues in Ireland, and therefore has issued a notice of its privacy and data collection policy (127). They conduct both qualitative and quantitative research, and process data from other agencies. Personal data, such as name, email address or contact details, is stored separately and linked to the dataset only through an assigned identification. If the main dataset allows for possible identification of a participant, it will also be considered and treated as personal data (127). Following completion of the research, the ESRI removes any identifier of participants, and the anonymised dataset is retained for further research and analysis. It is not possible to identify any individual from the dataset once it has been anonymised. If the research is a longitudinal study, data is retained as long as the study is ongoing to allow for analysis of trends over time.

The ESRI ensures compliance with data protection by having protocols to ensure that personal data is fully protected, including a data protection policy, data breach procedures and a data protection officer, among others.

7.5 Key Considerations for Data Protection in a Future Survey

It is essential for the successful tenderer to be aware of the obligations as a data holder under the Data Protection Bill 2018 and the EU GDPR. Depending on which methodology is chosen, the research team must adhere to specific GDPR guidelines throughout the process of data collection. As this study will fall under the Department of Health, there will be clear adherence to its Health Privacy Policy (https://www.gov.ie/en/organisation-information/2f7457-department-of-healths-privacy-policy/) as well as that of the organisation that conducts the research.

Chapter 8: Recommendations

To conclude this report, the research team and Project Steering Committee, based on the findings of this study, agreed the following recommendations to inform the decision-making around the commissioning of a general population survey of knowledge attitudes and behaviours on sexual health and wellbeing and crisis pregnancy.

Key Policy Considerations

- The future survey should be cognisant of current health policy, medical licensing and health services changes that could impact sexual health and sexual behaviour.
- The survey should seek to align with national strategic planning and where possible regional operational health planning and policy.

Sampling:

- Probability sampling can be achieved either by random address sampling by GeoDirectory followed by recruitment by letter and computer-assisted personal interview (CAPI), or through random-digit dialling (RDD). If COVID-19-related public health restrictions are still in place at the time of fieldwork, RDD is likely to be the most viable method.
- Providing robust information on key at-risk populations would require a large and possibly cost-prohibitive sample size, therefore targeted convenience sample surveys could be considered for key groups (e.g. sexual, gender and ethnic minority groups), in parallel, which would complement information on these groups in the general population sample.
- While biological sampling can be immensely beneficial in a general population survey, many factors first need considering, including costs, follow-up protocols, logistical aspects and the precision that is required.

Data Collection Modes:

- Interviewer-administered data collection is currently considered the gold standard for obtaining robust and reliable data on such a sensitive topic as sexual health.
- In the context of the ongoing COVID-19 pandemic, the most viable data collection mode is computer-assisted telephone interview (CATI) or computer-assisted video interview (CAVI) or a combination of the two (CATVI).
- A web link to an online survey, during a remote interview to gather highly sensitive content, can be given to participants to allow for privacy while increasing the likelihood that participants complete this key component of the survey.
- If the budget allows, the collection of biological samples and thus biological data could be incorporated for some/all of the sample using an online ordering system for a home sexually transmitted infection (STI) testing service, as is currently being piloted by the HSE SHCPP.

Implications of COVID-19 pandemic

- Despite the challenges presented by COVID-19, the general population survey should not be postponed and should be initiated by 2022.

- Due to COVID-19 implications, remote methods of interviewing, e.g. CATVI, are recommended.
- Public health guidance should be adhered to at all times in the piloting and fieldwork phases.

Budget Considerations

- Among the key drivers in estimating survey costs will be the type of sampling used, the mode of data collection, and the size of the target sample, which will be driven by the precision that the funders require for policy development and planning of services.
- Budget estimations should consider the above factors along with the size of the research team, sub-contractor costs to support aspects of the study such as data collection, cost of the pilot testing of the survey, length of the survey, and whether to oversample certain groups and/or include biological sampling.

Stakeholder Expertise and Data Needs

- Topic areas that were prioritised in the stakeholder consultation of the Scoping Study should be included in the general population survey as far as length of interview and budget allow.
- The specific data needs of stakeholders gathered from the consultation should be considered when designing the general population survey to ensure the findings can influence policy and planning.
- Questionnaires should be piloted with stakeholders and a sample group prior to survey initiation.
- A project steering committee should include individuals with specific expertise and representatives from relevant stakeholder organisations, including the Department of Health, the HSE Research and Development Division, the HSE Health Protection Surveillance Centre, partner NGOs and public/patient representative groups.

Survey Topics for Inclusion

- The findings from the scoping review should be used to inform the list of potential survey topics.
- Prioritisation of survey topics should take place prior to finalisation of the questionnaire.
- Final survey topics/items should include the most up-to-date wording, be gender sensitive and inclusive, and reflect current population trends and patterns in sexual health knowledge, attitudes and behaviours.
- Where feasible, selected topics for inclusion should align with public health needs and national sexual health priorities.

Data Protection Requirements

- The survey must comply with the General Data Protection Regulation (GDPR), and ensure informed consent and pseudo-anonymisation.
- The survey must be in line with Health Research Regulations 2018 and the HSE Data Protection Policy.
- Handling or storing data in third countries without a comprehensive third-country data protection agreement should not be permitted.
- All data or reports made publicly available following the project should ensure that respondents cannot be identified and should follow all GDPR regulations.

References

1. Smith AM, Pitts MK, Shelley JM, Richters J, Ferris J. The Australian longitudinal study of health and relationships. BMC Public Health. 2007 Dec 1; 7(1):139. Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-7-139

2. Douglas Jr JM, Fenton KA. Understanding sexual health and its role in more effective prevention programs. 2013. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3562741/

3. World Health Organization. Sexual and reproductive health: gender and human rights. 2020. Available from: http://wwwwhoint/reproductivehealth/topics/gender_rights/sexual_health/en/

4. Department of Health. National Sexual Health Strategy 2015-2020. 2015. Available from: https://www.gov.ie/en/policy-information/8feae9-national-sexual-health-strategy/

5. Rundle K, Leigh C, McGee H, Layte R. Irish Contraception and Crisis Pregnancy [ICCP] Study. A survey of the general population. 2004. Available from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/irish-contraception-and-crisis-pregnancy-iccp-study.pdf

6. Health Service Executive. Open Tender for Scoping Study to inform General Population Survey of Knowledge, Attitudes and Behaviours on Sexual Health & Wellbeing and Crisis Pregnancy in Ireland. 2019. Available from: https://irl.eu supply.com/ctm/Supplier/PublicPurchase/148221/0/0?returnUrl=ctm/Supplier/publictenders&b=ETENDERS_SIMPLE

7. Department of Health. Healthy Ireland Framework 2019-2025. 2019. Available from: https://www.gov.ie/en/policy-information/706608-healthy-ireland-policies/#the-healthy-ireland-survey

8. Department of Health. Slaintecare Action Plan 2019. 2019. Available from: https://www.gov.ie/en/publication/109e2b-slaintecare-action-plan-2019/

9. Irish Government. Programme For Government- Our Shared Future. 2020 Available from: https://staticrassetie/documents/news/2020/06/draft-programme-for-govtpdf

10. Irish Family Planning Association. IFPA Annual Report 2019. 2020. Available from: https://wwwifpaie/app/uploads/2020/11/IFPA_AR_2019_LRpdf?fbclid=IwAR2aC84P2WTQSeGK0TMKa0IRr8rUt8fmi4EEWkMbpcZOheCzKP79fBdr7Vc

11. Civil Partnership and Certain Rights and Obligations of Cohabitants Act, 2010. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2010/act/24/enacted/en/print.html

12. Protection of Life During Pregnancy Act 2013 Ireland, 2013. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/print

13. Marriage Act, 2015.(Ireland). Available from: http://www.irishstatutebook.ie/eli/2015/act/35/enacted/en/html

14. Gender Recognition Act, 2015. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2015/act/25/enacted/en/html

15. Criminal Law (Sexual Offences) Act, 2017. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2017/act/2/enacted/en/html

16. Health (Regulation of Termination of Pregnancy) Act, 2018. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html

17. Harassment, Harmful Communications and Related Offences Act, 2020. (Ireland). Available from: http://www.irishstatutebook.ie/eli/2020/act/32/enacted/en/print.html

18. Wellings K, Johnson AM. Framing sexual health research: adopting a broader perspective. The Lancet. 2013;382(9907):1759-62. Available from: https://researchonline.lshtm.ac.uk/id/eprint/1380058/1/1-s2.0-S0140673613623788-main.pdf

19. Health Protection Surveillance Centre. EMIS-2017 Ireland: Findings from the European Men who have sex with men Internet Survey (Ireland). 2019. Available from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/emis-final.pdf

20. Health Service Executive. Sexual Health in Ireland- what do we know. 2018. Available from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/sexual-health-in-ireland_june2018.pdf

21. Lorimer K, DeAmicis L, Dalrymple J, Frankis J, Jackson L, Lorgelly P, McMillan L, Ross J. A rapid review of sexual wellbeing definitions and measures: should we now include sexual wellbeing freedom? The Journal of Sex Research. 2019 Sep 2;56(7):843-53. Available from: https://pubmed.ncbi.nlm.nih.gov/31335208/

22. World Health Organization. Measuring sexual health: conceptual and practical considerations and related indicators. Geneva: World Health Organization; 2010. Available from: https://apps.who.int/iris/handle/10665/70434

23. Layte R, McGee H, Quail A, Rundle K, Cousins G, Donnelly C, et al. The Irish study of sexual health and relationships summary report. Psychology Reports 2006. Available from: https://core.ac.uk/download/pdf/60774086.pdf

24. Copen CE. Condom use during sexual intercourse among women and men aged 15-44 in the United States: 2011-2015 National Survey of Family Growth. National health statistics reports. 2017. (105):1-8. Available from: https://europepmc.org/article/med/29155683

25. McGee H, Garavan R, de Barra M, Byrne J, Conroy R. The SAVI report: sexual abuse and violence in Ireland. Psychology Reports. 2002:10. Available from: https://www.researchgate.net/publication/254645044_The_SAVI_Report_Sexual_Abuse_and_Violence_in_Ireland_Executive_Summary

26. Department of Justice. Press Release: Minister Flanagan announces major changes to the collection of data on the prevalence of sexual violence. 2018. Available from: http://wwwjusticeie/en/JELR/Pages/PR18000361

27. Health Protection Surveillance Centre. STI Slide Deck 2018. 2019. Available from: https://www.hpsc.ie/a-z/sexuallytransmittedinfections/publications/stireports/

28. World Health Organization. Sexually transmitted infections (STIs). 2019. Available from: https://wwwhoint/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)#:~:text=STIs%20have%20a%20profound%20impact,and%20trichomoniasis%20(156%20million)2019

29. Health Protection Surveillance Centre. Annual trends update: HIV, Hepatitis and STIs among MSM in Ireland (to the end of 2018). 2019. Available from: https://wwwhpscie/a-z/sexuallytransmittedinfections/dataonhivandstisamongmenwhohavesexwithmenmsm/

30. Health Protection Surveillance Centre. HIV & STI Weekly Reports. 2020. Available from: https://wwwhpscie/az/sexuallytransmittedinfections/publications/stireports/stiweeklyreports/

31. Health Protection Surveillance Centre. Annual Epidemiological Report: HIV in Ireland: 2018. 2019. Available from: https://www.hpsc.ie/abouthpsc/annualreports/

32. HIV Ireland. Record numbers of people diagnosed with HIV. 2017. Available from: https://wwwhivirelandie/record-numbers-of-people-diagnosed-with-hiv/#

33. Health Service Executive. Clinical management guidance for individuals taking HIV PrEP within the context of a combination HIV (and STI) prevention approach in Ireland. 2019. Available from: https://wwwsexualwellbeingie/for-professionals/prep-information-for-service-providers/guidelines-for-the-management-of-prep-in-irelandpdf

34. Health Information and Quality Authority. Health technology assessment of a PrEP programme for populations at substantial risk of sexual acquisition of HIV. 2019. Available from: https://wwwhiqaie/sites/default/files/2019-06/PrEP-HTApdf

35. Department of Health. Taoiseach and Ministers for Health announce HIV PrEP programme. 2019. Available from: https://wwwgovie/en/press-release/taoiseach-and-ministers-for-health-announce-hiv-prep-programme/

36. McBride O, Morgan K, McGee H. Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010). A Survey of the general population. 2012. Available from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/iccp-2010_report.pdf

37. Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. The Lancet Global Health. 2020;8(9):e1152-e61. Available from: https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(20)30315-6.pdf

38. Aiken AR, Johnson DM, Broussard K, Padron E. Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study. BMJ sexual & reproductive health. 2018;44(3):181-6. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6237647/

39. Sheldon S. Empowerment and privacy? Home use of abortion pills in the Republic of Ireland. Signs: Journal of Women in Culture and Society. 2018;43(4):823-49. Available from: https://www.journals.uchicago.edu/doi/full/10.1086/696625

40. United Kingdom Department of Health and Social Care. Abortion statistics for England and Wales: 2019. 2020. Available from: https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales

41. Irish Family Planning Association. UK abortion statistics show women and girls still travelling to UK abortion services From every county in Ireland. 2020. Available from: https://wwwifpaie/uk-abortion-statistics-show-women-and-girls-still-travelling-to-uk-abortion-services-from-every-county-in-ireland/

42. Department of Health. Health (Regulation of Termination of Pregnancy) Act 2018 - Annual report on notifications 2019. 2020. Available from: https://wwwgovie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/

43. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International journal of social research methodology. 2005;8(1):19-32. Availale from: https://www.tandfonline.com/doi/abs/10.1080/1364557032000119616

44. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implementation science. 2010;5(1):69. Available from: https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-5-69

45. Khalil H, Peters M, Godfrey CM, McInerney P, Soares CB, Parker D. An evidence-based approach to scoping reviews. Worldviews on Evidence-Based Nursing. 2016;13(2):118-23. Available from: https://pubmed.ncbi.nlm.nih.gov/26821833/

46. Joanna Briggs Institute. JBI Manual for evidence synthesis. Available from: https://jbiglobal/scoping-review-network/resources. 2020

47. Ridge MC, Lapham C, et al. The Fourth National Survey of Sexual Attitudes and Lifestyles (Natsal-4)-responses to the consultation on questionnaire content. Available from: https://natsalacuk/media/6359/Responses-to-the-Natsal-4-consultation-on-questionnaire-content-report-201020-v1pdf

48. Layte R, McGee H, Quail A, Rundle K, Cousins G, Donnelly C, et al. Irish Study of Sexual Health and Relationships. Dublin: Crisis Pregnancy Agency & Department of Health and Children. 2006. Available from:

https://www.sexualwellbeing.ie/for-professionals/research/research-reports/irish-study-of-sexual-health-and-relationships-main-report.pdf

49. McGee H, Rundle K, Donnelly C, Layte R. The Irish Study of Sexual Health and Relationships sub-report 2: Sexual health challenges and related service provision. 2008. Available from: https://repository.rcsi.com/articles/The_Irish_Study_of_Sexual_Health_and_relationships_SubReport_2_Sexual_Health_Challenges_and_Related_Service_Provision/10770311/1

50. Natsal. About. 2019. Available from: http://wwwnatsalacuk/aboutaspx

51. Clifton S, Swales K, et al. Design of a survey of sexual behaviour and attitudes in the British population-Scoping review. 2019.

52. Johnson A, Copas A, Erens B, et al. Effect of Computer-assisted self-interviews on reporting of sexual HIV risk behaviours in a general population sample: a methodological experiment. AIDS. 2001;15 (1):111-5. Available from: https://pubmed.ncbi.nlm.nih.gov/11192852/

53. Johnson A, Mercer CH, Erens B, Copas A, McManus S, Wellings K, et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. The Lancet. 2001;358(9296):1835-42. Available from: https://pubmed.ncbi.nlm.nih.gov/11741621/

54. Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer CH, et al. Sexual behaviour in Britain: early heterosexual experience. The Lancet. 2001;358(9296):1843-50. Available from: https://pubmed.ncbi.nlm.nih.gov/11741623/

55. French RS, Geary R, Jones K, Glasier A, Mercer CH, Datta J, et al. Where do women and men in Britain obtain contraception? Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). BMJ sexual & reproductive health. 2018;44 (1):16-26. Available from: https://srh.bmj.com/content/44/1/16

56. Northern Ireland Family Planning Association. Towards Better Sexual Health: A Survey of Sexual Attitudes and Lifestyles of Young People in Northern Ireland. Family Planning Association, London. 2002. Available from: https://pure.qub.ac.uk/en/publications/towards-better-sexual-health-a-survey-of-sexual-attitudes-and-lif

57. Schubotz D, Rolston B, Simpson A. Sexual behaviour of young people in Northern Ireland: first sexual experience. Critical Public Health. 2004:14 (2):177-90. Available from: https://pure.qub.ac.uk/en/publications/sexual-behaviour-of-young-people-in-northern-ireland-first-sexual

58. Wellings K, Collumbien M, Slaymaker E, Singh S, Hodges Z, Patel D, et al. Sexual behaviour in context: a global perspective. The Lancet. 2006;368(9548):1706-28. Available from: https://pubmed.ncbi.nlm.nih.gov/17098090/

59. Dodge B, Herbenick D, Fu T, Schick V, Reece M, Sanders S, et al. Sexual behaviours of US men by self-identified sexual orientation: Results from the 2012 National Survey of Sexual Health and Behavior. The Journal of Sexual Medicine. 2016;13(4):637-49. Available from: https://pubmed.ncbi.nlm.nih.gov/26936073/

60. Indiana School of Public Health Center for Sexual Health Promotion. National Survey of Sexual Health and Behavior 2009. 2009. Available from: https://nationalsexstudy.indiana.edu/

61. Reece M, Herbenick D, Schick V, Sanders SA, Dodge B, Fortenberry JD. Background and considerations on the National Survey of Sexual Health and Behaviour (NSSHB) from the investigators. The Journal of Sexual Medicine. 2010;7:243-5. Available from: https://pubmed.ncbi.nlm.nih.gov/21029382/

62. de Visser RO, Badcock PB, Rissel C, Richters J, Smith AM, Grulich AE, Simpson JM. Safer sex and condom use: findings from the Second Australian Study of Health and Relationships. Sexual health. 2014 Nov 7;11(5):495-504. Available from: https://pubmed.ncbi.nlm.nih.gov/25377002/

63. Richters J, Badcock PB, Simpson JM, Shellard D, Rissel C, de Visser RO, et al. Design and methods of the Second Australian Study of Health and Relationships. Sexual health. 2014;11(5):383-96. Available from: https://www.researchgate.net/publication/267932171_Design_and_methods_of_the_Second_Australian_Study_of_Health_and_Relationships

64. Signorelli C, Pasquarella C, Limina RM, Colzani E, Fanti M, Cielo A, et al. Third Italian national survey on knowledge, attitudes, and sexual behaviour in relation to HIV/AIDS risk and the role of health education campaigns. The European Journal of Public Health. 2006;16(5):498-504. Available from: https://www.researchgate.net/publication/222108138_Third_Italian_national_survey_on_knowledge_attitudes_and_sexual_behaviour_in_relation_to_HIVAIDS_risk_and_the_role_of_health_education_campaigns

65. Vanwesenbeeck I, Bakker F, Gesell S. Sexual health in the Netherlands: Main results of a population survey among Dutch adults. International Journal of Sexual Health. 2010;22(2):55-71. Available from: https://www.researchgate.net/publication/233254701_Sexual_Health_in_the_Netherlands_Main_Results_of_a_Population_Survey_Among_Dutch_Adults

66. Klavs I, Svab I. Slovenian National Survey of Sexual Lifestyles, Attitudes and Health: preparatory work and feasibility study. 2006. Available from: https://www.dlib.si/details/URN:NBN:SI:DOC-WETABYJJ?&language=eng

67. Human Sciences Research Council. The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. 2018. Available from: http://wwwhsrcacza/uploads/pageContent/9234/SABSSMV_Impact_Assessment_Summary_ZA_ADS_cleared_PDFA4pdf

68. Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, et al. South African national HIV Prevalence, Incidence and Behaviour Survey, 2012. 2015. Available from: https://www.researchgate.net/publication/279953589_South_African_National_HIV_Prevalence_Incidence_and_Behaviour_Survey

69. Simbayi L, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, et al. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017: towards achieving the UNAIDS 90-90-90 targets. 2019 Available from: https://tbsouthafrica.org.za/sites/default/files/201910%20South%20African%20National%20HIV%20Prevalence%2C%20Incidence%2C%20Behaviour%20and%20Communication%20Survey%202017.pdf

70. Chamratrithirong A, Kaiser P. The dynamics of condom use with regular and casual partners: analysis of the 2006 National Sexual Behavior Survey of Thailand. PloS one. 2012;7(7):e42009. Avaialble from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0042009

71. National AIDS Prevention and Alleviation Committee. UNGASS Country Progress Report, Thailand Reporting period: January 2006-December 2007. 2008. Available from: https://data.unaids.org/pub/report/2008/thailand_2008_country_progress_report_en.pdf

72. Morgan K, McGee H, Watson D, Perry I, Barry MM, Shelley E, et al. SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Main Report. 2008. Available from: https://www.publichealth.ie/sites/default/files/documents/files/slan.pdf

73. Shiely F, Kelleher C, Galvin M. Sexual health of the Irish adult population: Findings from SLÁN: Crisis Pregnancy Agency; 2004. Available from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/sexual-health-of-the-irish-adult-population-finding-form-slan.pdf

74. Department of Health. Healthy Ireland 2017: Summary of findings. Government Publications: Dublin; 2017. Available from: https://www.gov.ie/en/policy-information/706608-healthy-ireland-policies/#the-healthy-ireland-survey

75. Nikula M, Koponen P, Haavio-Mannila E, Hemminki E. Sexual health among young adults in Finland: Assessing risk and protective behaviour through a general health survey. Scandinavian Journal of Public Health. 2007;35(3):298-305. Available from: https://journals.sagepub.com/doi/abs/10.1080/14034940701269654

76. Aromaa A, Koskinen S. Health and functional capacity in Finland: Baseline results of the Health 2000 health examination survey. 2004. Available from: https://www.julkari.fi/handle/10024/78534

77. Northern Ireland Department of Health. Health Survey Northern Ireland 2011/2012 Bulletin 4:Sexual Health 2012. Available from: https://www.health-ni.gov.uk/publications/health-survey-northern-ireland-sexual-health

78. Northern Ireland Statistics and Research Agency. Health Survey Northern Ireland. Available from: https://wwwnisragovuk/statistics/find-your-survey/health-survey-northern-ireland#toc-0. 2020.

79. Northern Ireland Department of Health. Health Survey (NI): First results 2018/19. 2020. Available from: https://www.health-ni.gov.uk/news/health-survey-northern-ireland-first-results-201819

80. National Institute of Population and Social Security Research. The Fifteenth Japanese National Fertility Survey in 2015 - Summary of the Survey Results on Married Couples/ Singles 2017. Available from: http://www.ipss.go.jp/ps-doukou/e/doukou15/Nfs15_gaiyoEng.html

81. Ministry of Health. Methodology Report 2014/15: New Zealand Health Survey. Wellington: Ministry of Health. 2015. Available from: https://www.health.govt.nz/system/files/documents/publications/nzhs-methodology-report-2014-15-dec-15.pdf

82. Ministry of Health. Questionnaires and Content guide 2014/2015 New Zealand Health Survey. 2015. Available from: https://www.health.govt.nz/publication/questionnaires-and-content-guide-2014-15-new-zealand-health-survey

83. Ministry of Health. Sample design from 2015/16: New Zealand Health Survey. 2016. Available from: https://www.health.govt.nz/publication/sample-design-2015-16-new-zealand-health-survey

84. Ministry of Health. Content guide 2018/19 : New Zealand Health Survey 2019. Available from: https://www.health.govt.nz/publication/content-guide-2018-19-new-zealand-health-survey

85. Ministry of Health. Contraception: findings from the 2014/15 New Zealand Health Survey. 2019. Available from: https://www.health.govt.nz/publication/contraception-findings-2014-15-new-zealand-health-survey

86. Ministry of Health. Sexually transmitted infections: Findings from the 2014/15 New Zealand Health Survey. 2019. Available from: https://www.health.govt.nz/publication/sexually-transmitted-infections-findings-2014-15-new-zealand-health-survey

87. Ministry of Health. Methodology report 2017-2018 New Zealand Health Survey. 2019. Available from: https://www.health.govt.nz/publication/methodology-report-2017-18-new-zealand-health-survey

88. Prah P, Johnson AM, Nardone A, Clifton S, Mindell JS, Copas AJ, et al. Asking about sex in general health surveys: comparing the methods and findings of the 2010 Health Survey for England with those of the third National Survey of Sexual Attitudes and Lifestyles. PLoS One. 2015;10(8). Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0135203

89. Lifestyles Team, NHS Digital. Health Survey for England: A quick guide 2019. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019

90. Lifestyles Team, NHS Digital. Health Survey for England 2010- Volume 2- methods and documentation. 2011. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2010-respiratory-health

91. Ivankovich MB, Leichliter JS, Douglas Jr JM. Measurement of sexual health in the US: an inventory of nationally representative surveys and surveillance systems. Public Health Reports. 2013;128(2_suppl1):62-72. Available from: https://pubmed.ncbi.nlm.nih.gov/23450886/

92. O'Donnell K, Fitzgerald M, Barrett P, Quinlan M, Igoe D. MISI 2015: Findings from the men who have sex with men internet survey. 2016. Available from: https://www.hpsc.ie/a-z/specificpopulations/menwhohavesexwithmenmsm/msminternetsurveys/misi2015/misi2015reportandexecutivesummary/

93. Klavs I, Rodrigues LC, Weiss HA, Hayes R. Factors associated with early sexual debut in Slovenia: results of a general population survey. Sexually transmitted infections. 2006 Dec 1;82(6):478-83. Available from: https://sti.bmj.com/content/sextrans/82/6/478.full.pdf?casa_token=XwThg-wAsqcAAAAA:kvRVAparq2IblqBrnPRsuS3FnnReHkNAcmCHOmOFaFhvi6khzxPiLeTh_7aAwaiHvvdiy6blhw

94. Erens B, Phelps, A. et al. National Survey of Sexual Attitudes and Lifestyles 3 - technical report: Volume 1: Methodology. 2013. Available from: https://sti.bmj.com/content/90/2/84

95. Northern Ireland Department of Health. Health Survey (NI): technical report 2018/19. 2020. Available from: https://www.health-ni.gov.uk/publications/health-survey-northern-ireland-first-results-201819

96. Department of Justice. Report of the scoping group on sexual violence data. 2018. Available from: http://justice.ie/en/JELR/Report-of-the-Sexual-Violence-Survey-Scoping-Group.pdf/Files/Report-of-the-Sexual-Violence-Survey-Scoping-Group.pdf

97. Fenton KA, Johnson AM, McManus S, Erens B. Measuring sexual behaviour: methodological challenges in survey research. Sexually transmitted infections. 2001;77(2):84-92. Available from: https://pubmed.ncbi.nlm.nih.gov/11287683/

98. Finnish Institute of Health and Welfare. Methodology report, Health 2000 Survey. 2008. Available from: https://thl.fi/en/web/thl-biobank/for-researchers/sample-collections/health-2000-and-2011-surveys

99. Innovations for Poverty Action. Remote surveying in a pandemic: handbook 2020. 2020. Available from: https://wwwpoverty-actionorg/sites/default/files/publications/IPA-Phone-Surveying-in-a-Pandemic-Handbookpdf. 2020.

100. Revilla M, Ochoa C. Ideal and maximum length for a web survey. International Journal of Market Research. 2017;59(5):557-65. Available from: http://www.websm.org/db/12/19155/Web%20Survey%20Bibliography/Ideal_and_maximum_length_for_a_web_survey/

101. Department of Health. Healthy Ireland Survey 2015 Summary of Findings. 2015. Available from: https://www.gov.ie/en/publication/fedbc9-healthy-ireland-survey-2015-summary-of-findings/

102. Department of Health. Healthy Ireland Survey 2018 technical report. 2018. Available from: https://www.gov.ie/en/collection/231c02-healthy-ireland-survey-wave/

103. Hamilton DT, Morris M. Consistency of self-reported sexual behavior in surveys. Archives of sexual behavior. 2010;39(4):842-60. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4097026/

104. Erens B, Phelps A, Clifton S, Mercer CH, Tanton C, Hussey D, et al. Methodology of the third British national survey of sexual attitudes and lifestyles (Natsal-3). Sexually transmitted infections. 2014;9(2):84-9. Available from: https://www.researchgate.net/publication/258924331_Methodology_of_the_third_British_National_Survey_of_Sexual_Attitudes_and_Lifestyles_Natsal-3

105. Johnson AM, Mercer CH, Beddows S, de Silva N, Desai S, Howell-Jones R, et al. Epidemiology of, and behavioural risk factors for, sexually transmitted human papillomavirus infection in men and women in Britain. Sex Transm Infect. 2012;88(3):212-7. Available from: https://pubmed.ncbi.nlm.nih.gov/22261135/

106. Sonnenberg P, Clifton S, Beddows S, Field N, Soldan K, Tanton C, et al. Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). The Lancet. 2013;382(9907):1795-806. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61947-9/fulltext

107. Fenton KA, Korovessis C, Johnson AM, McCadden A, McManus S, Wellings K, et al. Sexual behaviour in Britain: reported sexually transmitted infections and prevalent genital Chlamydia trachomatis infection. The Lancet. 2001;358(9296):1851-4. Available from: https://pubmed.ncbi.nlm.nih.gov/11741624/

108. Klavs I, Rodrigues L, Wellings K, Keše D, Hayes R. Prevalence of genital Chlamydia trachomatis infection in the general population of Slovenia: serious gaps in control. Sexually Transmitted Infections. 2004;80(2):121-3. Available from: https://sti.bmj.com/content/80/2/121

109. Vaughan R. Oversampling in health surveys: why, when, and how? American Journal of Public Health-LGBT Surveillance. 2017;107:8. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508166/

110. Central Statistics Office. Census 2016 Profile 7 - migration and diversity.2016. Available from: https://wwwcsoie/en/csolatestnews/presspages/2017/census2016profile7-migrationanddiversity/

111. Superfine A. Conducting research in the time of pandemic: A pause or an opportunity? Journal of Mathematics Teacher Education. 2020:1-3. Available from: https://link.springer.com/article/10.1007/s10857-020-09478-w

112. Hausmann JS, Sufka P, Bhana S, Liew JW, Machado PM, Wallace ZS, et al. Conducting research in a pandemic: The power of social media. European Journal of Rheumatology. 2020;7(Suppl 2):S85. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7431333/

113. Saberi P. Research in the time of coronavirus: continuing ongoing studies in the midst of the COVID-19 pandemic. AIDS and Behavior. 2020:1-4. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7165077/

114. Lupton D. Doing Fieldwork in a Pandemic. 2020 Available from: https://nwssdtpacukfileswordpresscom/2020/04/doing-fieldwork-in-a-pandemic2-google-docspdf

115. Ogale Y, Yeh PT, Kennedy CE, Toskin I, Narasimhan M. Self-collection of samples as an additional approach to deliver testing services for sexually transmitted infections: a systematic review and meta-analysis. BMJ global health. 2019;4(2):e001349. Available from: https://gh.bmj.com/content/4/2/e001349

116. Irish Universities Association. Guidelines for contract researchers salary scales 2019. Available from: https://wwwiuaie/for-researchers/researcher-salary-scales-career-framework/. 2019

117. Vehovar V, Berzelak J, Lozar Manfreda K, Belak E. Optimising survey costs in a mixed mode environment: Univerza v Ljubljani, Fakulteta za družbene vede; 2009. Available from: https://ec.europa.eu/eurostat/documents/1001617/4398401/S8P2-OPTIMISING-SURVEY-COSTS-VEHOVAR-ET-AL.pdf

118. Skarupova K. Technical Report: Computer-assisted and online data collection in general population surveys. Eropean Monitoring Center for Drugs and Drugs Addiction. 2014. Available from: https://www.emcdda.europa.eu/publications/technical-reports/online-data-collection-gps_en

119. World Health Organization. Biological and clinical data collection in population surveys in less developed countries. 2000. Available from: https://wwwwhoint/hiv/pub/surveillance/en/biomarkerspdf?ua=1

120. Field N, Tanton C, Mercer CH, Nicholson S, Soldan K, Beddows S, et al. Testing for sexually transmitted infections in a population-based sexual health survey: development of an acceptable ethical approach. Journal of medical ethics. 2012;38(6):380-2. Available from: https://pubmed.ncbi.nlm.nih.gov/22252417/

121. Health Research Board, Data Protection Act 2018 (Section 36(2)) (Health Research) Regulations 2018. 2018. Available from: https://wwwhrbie/funding/gdpr-guidance-for-researchers/health-research-regulations-2018/

122. Data Protection Commission. Quick guide to the principles of data protection. 2019. Available from: https://wwwdataprotectionie/sites/default/files/uploads/2019-11/Guidance%20on%20the%20Principles%20of%20Data%20Protection_Oct19pdf

123. Department of Health. Guidance on Information Principles for informed consent for the processing of personal data for health research. 2018. Available from: https://wwwhrbie/fileadmin/1_Nonplugin_related_files/RSF_files/GDPR_guidance_for_researchers/Health_Research_Information_Principlespdf

124. Data Protection Commission. Data Protection Basics. 2019. Available from: https://wwwdataprotectionie/sites/default/files/uploads/201907/190710%20Data%20Protection%20Basicspdf

125. Data Protection Commission. Guidance on Anonymisation and Pseudonymisation. 2019. Available from: https://wwwdataprotectionie/sites/default/files/uploads/2019-06/190614%20Anonymisation%20and%20Pseudonymisationpdf

126. Health Research Board. Health Research Regulations 2018- Data Protection Act 2018 (Section 36(2)) (Health Research) Regulations 2018. Available from: https://wwwhrbie/funding/gdpr-guidance-for-researchers/health-research-regulations-2018/

127. Economic and Social Research Institute. ESRI privacy notice for research 2019. Available from: https://wwwesriie/esri-privacy-notice-for-research

Appendices

Appendix 1: Joanna Briggs Scoping Review Protocol

Title:

General Population Survey on Sexual Health Knowledge Attitudes and Behaviours: A Scoping Review Protocol

Scoping Review Question:

What sexual health KAB surveys have been done in Ireland and abroad in the past 20 years? What are the best practices, relevant content, and methodology that can be adapted for use in the 2021 Irish general population sexual KAB survey?

Introduction:

A scoping review will be completed to help inform the commissioning of a future Irish general population survey of knowledge, attitudes and behaviours (KAB) on sexual health and wellbeing and crisis pregnancy. This scoping review will encompass several components including a literature review of recent sexual health KAB surveys in Ireland and abroad, a review of health policy documents related to sexual health and crisis pregnancy, a review and assessment of methodological procedures used in sexual health KAB surveys, and a consideration of GDPR requirements. An integral component of a scoping review is a consultation with stakeholders to consider their expertise in the areas of sexual health and crisis pregnancy. The Arksey and O'Malley framework for conducting a scoping review will be used as guidance throughout this review.

This scoping review will take a multi-faceted and multi-step structured approach to searching the literature using variations of search terms in both peer-reviewed and grey literature. The researchers will review national general population surveys, with specific interest in surveys that look at sexual health knowledge attitudes and behaviours. The aim of this scoping review is to identify best practice in the field of general population sexual health research in order to draft recommendations for the Irish general population survey on sexual KAB.

A preliminary search for existing scoping and systematic reviews on sexual KAB general population surveys was conducted on 23 January 2020 using the Cochrane Library and PubMed. Terms used were (Sex AND knowledge OR behaviour OR attitudes AND scoping study OR systematic review).

Inclusion Criteria:

Participants:

This review will consider all members of the public who are 17 and older. Participants of any gender, ethnic background and geographical location will be considered. The exclusion criteria will be anyone under 17 years of age. No maximum age cut-off will be used since there are varying maximum age restrictions in general population surveys of sexual health. The research team wish to include all ages over 17 to determine the strengths and weaknesses of different age ranges for this kind of study.

Concept:

The field of sexual health research is very broad; however, there is a gap in studies focused on behavioural surveillance of sexual health. Ireland has not specifically studied this topic for more than a decade, which demonstrates the need for both a scoping review and a general population survey.

Context:

The HSE SHCPP is responsible for implementing the National Sexual Health Strategy 2015–2020, in which one key component called for robust and high-quality sexual health information to support policy, practice and service provision. In order to ensure that the general population survey is conducted in the most cost-effective and comprehensive way, this scoping review will undertake an examination on a national and international scale to determine the best methods used to gather population data on sexual KAB in recent years.

Types of studies:

Since the scoping review must identify best practices for general population surveys, only surveys of a national general population scale will be considered. Secondly, surveys that studied sexual health will be closely examined for methods including sample size, age ranges, survey instrument, etc. Lastly, extensive data will be extracted from surveys that specifically measure sexual KAB to identify content areas and questions that can be adapted for the Irish survey.

It is important for this scoping review to be comprehensive and broad while maintaining relevancy to the purpose and aim of the review. Therefore, the research team will examine both peer-reviewed journals and grey literature to identify general population surveys on sexual KAB with an iterative approach.

Studies written in the English language or translated to English will be included. Only studies from the year 2000 onwards will be included due to the societal and cultural changes that have taken place in both Ireland and abroad in the past 20 years related to sexual health. Any research prior to year 2000 would limit the relevance to the current Irish context.

Search Strategy:

Several online databases will be used for the scoping review. These include MEDLINE (PubMed), Google Scholar, Web of Science, Scopus and PsycINFO, accessed through the Royal College of Surgeons Ireland library. In addition, national and international government and health policy organisations will be searched for general population surveys on sexual KAB. These include the European Centre for Disease Control and Prevention (ECDC), the Health Service Executive (HSE), the Health Protection Surveillance Centre (HPSC), The Centers of Disease Control and Prevention (CDC), the World Health Organization (WHO) and Global AIDS Monitoring (GAM). The reference lists of relevant reports will be hand-searched to identify additional studies that meet the inclusion criteria.

Within these databases and organisation's sites, keywords will be identified in the titles and abstracts and then included as 'Search Terms' for the scoping review.

An information scientist will be utilised to give their expertise on search strategies and scoping review techniques. This will allow for a second opinion and the potential to incorporate other search terms into the search strategy. If the research team cannot locate the full-text article, they will attempt to contact the authors or the RCSI library for access or support.

The full text of the selected studies will be assessed to ensure they meet the inclusion criteria. Any studies that are excluded will be documented and an explanation will be included in the appendix.

Following the search, citations will be uploaded onto EndNote.

Study Selection

Tiles and abstracts will be reviewed following the initial search on each database. From there, relevant articles that discuss general population sexual KAB surveys will be saved for full-text examination. Once full-text examination is complete, studies will be selected based on inclusion/exclusion criteria and relevance to the aim of the scoping review.

Data Extraction:

Data will be extracted from all relevant studies, and specific details will include the author, year of publication, country, study population, sample size, age range, methodology, and any other comments that could contribute to drafting recommendations for the Irish survey.

Presentation of Results:

The results will be presented in summary for the Irish and UK studies and in table format for international and general health surveys to display the information for each chosen study.

Appendix 2: Search Strategy

Overview of Search Strategy

Research Questions:

What sexual health KAB surveys have been done in Ireland and abroad in the past 20 years?

What are the best practices, relevant content, and methodology that we can adopt for a future Irish general population sexual KAB survey?

Inclusion:

After year 2000, English language, 17+ age group, national general survey, sexual health knowledge, attitudes and behaviours as main focus

Direct searches for known surveys:

Google/Google Scholar

Key word search in databases:

PubMed, Web of Science, Scopus, Google Scholar

Searching Known/Relevant Agencies:

European Centre for Disease Control and Prevention (ECDC), the Health Service Executive (HSE), the Health Protection Surveillance Centre (HPSC), The Centers of Disease Control and Prevention (CDC), the World Health Organization (WHO) and Global AIDS Monitoring (GAM).

References/Citations Searches:

Major survey reference lists

Summary of Searches:

Direct Searches on Google Scholar:

January 2020

ISSHR, ICCP, NATSAL 1,2,3, MISI, EMIS, Healthy Ireland, SLAN, NSSHB, YRBS, SAVI, HBSC, Canada Sexual Health Survey, New Zealand Sexual Health Survey, Australia Sexual Health Survey

Database searches:

January 2020

Web of Science:

‘sexual behaviour’ AND (national OR general) survey AND (attitude OR knowledge OR behaviour)

130 results→abstracts screened→19 chosen for full text analysis→5 excluded (3 population, 2 secondary data)→14 full text analysed→10 excluded (7 population, 1 secondary data, 1 can’t access, 1 regional data)→4 remaining articles

PubMed:

‘sexual health’ AND sexual knowledge AND attitude AND behaviour AND general survey

220 results→abstracts screened→9 chosen for full text analysis→8 excluded (5 regional data, 2 age, 1 secondary data)→1 remaining article

Scopus:

sexual AND behaviour AND general AND survey AND attitude

211 results→abstracts skimmed and all articles are secondary data or regional surveys→all excluded

Google Scholar:

‘sexual health’ and ‘general population survey’ and (knowledge or attitude or behaviour)

246 results→abstracts skimmed→duplicates removed→all remaining articles are secondary data or not national surveys

Appendix 3: Inclusion Criteria for Chosen Studies

STUDY TITLE	METHODS	RATIONALE FOR INCLUSION IN LITERATURE REVIEW
ICCP 2003	telephone survey (landline only)	Irish-based study, essential to present what has been done nationally, sexual KAB survey, national probabilistic sample
ISSHR 2004	telephone survey (CATI)	Irish-based study, essential to present what has been done nationally, sexual KAB survey, national probabilistic sample
ICCP 2010	telephone survey (CATI)	Irish-based study, essential to present what has been done nationally, sexual KAB survey, national probabilistic sample
MISI	internet	Irish-based study, essential to present what has been done nationally, sexual KAB survey
EMIS	internet	Irish-based study, essential to present what has been done nationally, sexual KAB survey
SAVI	telephone survey (CATI)	Irish-based study, essential to present what has been done nationally
Healthy Ireland	face to face with self-completion	Irish-based study, essential to present what has been done nationally, general survey with sexual topics, national probabilistic sample
SLAN	telephone	Irish-based study, essential to present what has been done nationally, general survey with sexual topics
Natsal 1	paper-based	Sexual KAB survey – General Population, national probabilistic sample
Natsal 2	face to face CAPI and CASI	Sexual KAB survey – General Population, national probabilistic sample
Natsal 3	CAPI and CASI	Sexual KAB survey – General Population, national probabilistic sample
Towards Better Sexual Health (Northern Ireland)	self-administered questionnaire	Sexual KAB survey – General Population, national probabilistic sample
NSSHB, USA	telephone	Sexual KAB survey – General Population, national probabilistic sample
Australia ASHR 1 and 2	CATI	Sexual KAB survey – General Population, national probabilistic sample
Italian Survey	self-administered questionnaire	Sexual KAB survey – General Population, national probabilistic sample
Population Survey – Netherlands	online questionnaire	Sexual KAB survey – General Population, national probabilistic sample
Slovenia	face to face with self-completion	Sexual KAB survey – General Population, national probabilistic sample
South Africa HIV	questionnaire- HIV testing	Sexual KAB survey – General Population, national probabilistic sample
Family Growth Survey, USA	face to face with CASI	Large population health survey with sexual health component

Young Adults in Finland	face to face with self-completion	Large population health survey with sexual health component
Health Survey Northern Ireland	face to face with self-completion	Large population health survey with sexual health component
National Fertility Survey Japan	self-completed	Large population health survey with sexual health component
New Zealand Health Survey	CAPI and CASI for sexual health component	Large population health survey with sexual health component
Health Survey England	face to face with biological sampling	Large population health survey with sexual health component
Thailand	face to face	Large population health survey with sexual health component

Appendix 4: Work Package 2 Stakeholder Consultation: Information Leaflet and Online Survey Questionnaire

1. Introduction

What is this stakeholder consultation for?

To inform the planning and topics of a national sexual health and wellbeing and crisis pregnancy survey among the general adult population in Ireland. The survey is planned to inform policy and practice and measure changes in these areas over time. Completing this consultation will provide key stakeholders with the opportunity to contribute to the development of the questionnaire for the general population survey.

Who is conducting the research?

The Royal College of Surgeons Ireland (RCSI) has been commissioned by the Health Service Executive Sexual Health and Crisis Pregnancy Programme (HSE SHCPP) to carry out a Scoping Study to inform the planning of this survey. The Scoping Study will provide clarity on priority areas for the survey and will make recommendations on research methods and operational procedures. Consultation with stakeholders is a key component of the scoping study.

Why am I being asked to complete this stakeholder consultation?

You or your organisation has been identified as a key stakeholder, working in the area of sexual health and wellbeing and crisis pregnancy support in Ireland. Your contribution to this Scoping Study would be greatly valued.

What will completing this stakeholder consultation involve?

This stakeholder consultation will ask you to rate a range of topic areas with regard to their importance for potential inclusion in a general population study on sexual health and wellbeing and crisis pregnancy. Some of these areas have been asked about in previous Irish surveys and may be familiar to you, while others will be new. You will also have the opportunity to suggest topics that we have not included or asked you about, but that you feel are important to be included in a general population survey. The questionnaire will take approximately 15–20 minutes to complete and all of your responses will be anonymised. It will not be possible to identify you in any publications related to this study. Your answers will be saved in case you cannot complete the consultation in one sitting.

How else is my data protected if I decide to take part?

This stakeholder consultation has ethical approval from the RCSI Research Ethics Committee (REC), as part of broader ethical approval received for the scoping study. Your data and survey responses will be used and stored in line with the Irish Data Protection Act (DPA 2018) and the EU General Data Protection Regulation (GDPR 2016) and your individual responses will not be shared beyond the RCSI research team. Further detailed information has been forwarded to you in an Information Leaflet, attached to the email with the link to this survey. If you do not have a copy of this, the RCSI research team would be happy to forward one to you.

1. In order to participate in this stakeholder consultation, we require a record of your informed consent. Please record your agreement by selecting your response next to each statement.

   Yes No

   I have read and understood the Information Leaflet about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction. I have been given a copy of this consent form and the Information Leaflet for my records.

   I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out.

   I am fully aware of the potential risks, and benefits of this research study and I consent to taking part in this study.

   I give informed explicit consent to have my data processed as part of this research study.

   I am aware and have read Smart Survey's privacy policy and am happy to participate in this survey. Please find a copy of Smart Survey's privacy policy here: https://www.smartsurvey.co.uk/privacy-policy

   Further information

   You cannot complete the stakeholder consultation without giving your informed consent. If you require any further information before you decide to complete the consultation, please contact the research team. We would be happy to assist you with any questions.

2. Please tell us a bit about yourself. Are you taking part in this consultation as an individual, or on behalf of an organisation?

   Individual

   Organisation

3. Name of organisation you are completing this consultation on behalf of (this is optional):

4. Type of organisation (Please select the option that best describes your organisation)

   Academic/Research

   Clinical/Health service

   Charity/voluntary sector

   Community/grassroots

   Local or regional government

   National government department

   Private sector

   Other (please specify):

5. Focus of organisation (select all that apply)

   Sexual health

   Reproductive health

   Crisis pregnancy

   Education

   Human rights / advocacy for particular population groups

   General public health

   Other (please specify):

6. Are you happy for us to list this organisation as having taken part in the consultation when we report the findings?

   Yes

   No

7. Are you taking part as a (choose the option most relevant to you)

   Academic/Researcher

   Clinician/public health practitioner/therapist

   Representative of a charity, community group, or collective

   Service commissioner / Policy maker

   Teacher/Lecturer/Educator

   Other (please specify):

8. Three general population surveys on sexual health and crisis pregnancy have been carried out in Ireland in the past. 1. Irish Crisis Pregnancy and Contraception Study (ICCP, 2003) 2. Irish Study of Sexual Health and Relationships (ISSHR, 2006), 3. Irish Crisis Pregnancy and Contraception Study – 2010 (ICCP, 2010). (The reports on all of these studies can be accessed by clicking here) Had you heard of these studies prior to taking part in this consultation?

   Yes

   No

   Not Sure

9. Have you ever used the data from ICCP 2003, ISSHR 2006, or ICCP 2010? (select all that apply)

   Yes – for my own personal interest]

   Yes – to inform policy or practice]

   Yes – to monitor/evaluate policy and service provision]

   Yes – to compare local data with national figures]

   Yes – for planning services]

Yes – data used for research purposes (own analyses)]

Yes – published findings used for research purposes]

Yes – questionnaire or methodology used for research purposes]

Yes – for public engagement]

Yes – for advocacy purposes]

Yes – for teaching / training]

Yes – other (please say what in the comment box below)]

No

Comments:

If any of the questionnaire data or findings from ICCP 2003, ISSHR 2006, or ICCP 2010 have been particularly useful to you it would be helpful to know more about what these were and how you used them. Otherwise, please leave the box blank.

10. Do you expect to use the results of a future general population survey on sexual health and crisis pregnancy in Ireland? (select all that apply)

Yes – for my own personal interest

Yes – to inform policy or practice

Yes – to monitor / evaluate policy

Yes – to compare local data with national figures

Yes – for planning services

Yes – for research purposes (own analyses)

Yes – for research purposes (published findings)

Yes – for research purposes (questionnaire or methodology)

Yes – for public engagement

Yes – for teaching / training

Yes – for advocacy purposes

Yes – to inform service provision

Yes – other (please say what in the comment box below)

No

Not sure

Comments:

11. What topics should a future general population survey on sexual health and crisis pregnancy in Ireland include?

We would like to know your opinion on what topics should be included in the next general population survey of knowledge, attitudes and behaviours on sexual health and wellbeing and crisis pregnancy in Ireland.

The following questions include topics that have been either asked about previously in an Irish survey (ICCP, ISSHR) or have been identified in the literature and included on international surveys. The questions contain both a broad topic area and examples of questions and content. These specific examples do not necessarily represent what will be asked on a future Irish survey, but rather highlight what has been asked in previous Irish and international surveys within each broader topic area.

For each topic, please choose how important you, or your organisation think it is to include this topic in the next survey.

Please answer on a sliding scale of 0–100% with increments of 10.

0: Not important to include

100: Very important to include

11. Sex Education (e.g., how you learned about sex, things you wished you'd known more about, how you would have liked to learn about them, speaking to children about sex)
12. Emergency Contraception (ECP) (e.g., knowledge, attitudes and beliefs of ECP, previous use of ECP, access to ECP)
13. Sexual Intercourse (e.g., sexual history)
14. Contraception use and methods (e.g., contraception use, precautions taken to avoid pregnancy, contraceptives used currently and in the past)
15. Access to contraception (e.g., difficulty accessing contraception, preference of location to access contraception, obtaining most recent contraceptive)
16. Condom use and access to condoms (e.g., used condom at last sexual intercourse, used condom during most recent intercourse with casual partners, used condom during last oral sex, consistent condom use, number of partners without using condoms)
17. Knowledge, attitudes and beliefs about abortion (access to current service provision, experience of current service provision)
18. Knowledge, attitudes and beliefs about different kinds of relationships and sexual lifestyles
19. Knowledge, attitudes and beliefs about Human Immunodeficiency Virus (HIV) (e.g., perceived risk of HIV acquisition)
20. Sexual health and reproductive knowledge (e.g., being able to reject major misconceptions about transmission of sexually transmitted infections (STIs) and reproductive health issues, being able to correctly identify ways of preventing STIs and HIV)

21. First sexual experience (e.g., age at first sexual experience, contraceptive use during first sexual experience, willingness to have first sexual experience, relationship to partner, how long you had known each other, reasons for having sex)

22. Sexual attraction (e.g., feelings of attraction towards same or opposite sex, asexuality)

23. Gender identity

24. Experience with pregnancy/pregnancy history (e.g., outcome of previous pregnancies)

25. Experience of crisis pregnancy (e.g., knowledge of crisis pregnancy counselling, experience of abortion, support during a crisis pregnancy, attitudes toward crisis pregnancy)

26. Sexual practices for both same and opposite sex partners (e.g., last occasion of vaginal, oral or anal sex, condom use, number of partners in the last 12 months, multiple partnerships overlapping in time, men who have unprotected sex with men and women)

27. Most recent sexual event (e.g., relationship status and age of most recent partner, use of contraceptives, satisfaction and pleasure with most recent partner)

28. Sexual problems (e.g., issues preventing enjoyable sex, erection problems, pain during intercourse, experiences seeking professional help for sexual problems)

29. Sex outside Ireland and the UK/sex with people from other countries (e.g., number of sexual partners while abroad, contraceptive use with new partners from other countries)

30. Sexually transmitted infections/HIV testing (e.g., recent STI, ever diagnosed with an STI, currently receiving treatment for HIV, seeking advice on STIs, preference of sexual health services)

31. Non-consensual sex/coercion (e.g., unwanted sexual experience due to intoxication, forced or frightened into sex, seeking help after non-consensual sex)

32. Gender-based violence (e.g., experience of intimate partner violence (physical, sexual, emotional, domestic) with partner)

33. Pornography (e.g., age at first experience of viewing pornographic material, use of sex sites on the internet in the last 12 months)

34. Masturbation

35. Sex work (e.g., frequency of sex work, having ever received payment or other form of exchange for sex)

36. Use of technology (internet, apps) in sexual lifestyles (e.g., use of internet site or smart-phone application to look for potential partners, experience meeting someone in person that you met first on an internet site)

37. Sexual guilt (e.g., feelings of anxiety towards sex, stigma about sexual behaviour, feelings of guilt towards your sexual behaviour)

38. Media, communication and norms (e.g., media use, sources of STI/HIV information)

39. Drug and alcohol use (e.g., sexual activity while under the influence of alcohol and/or psychoactive substances, how alcohol and drug use changes sexual behaviour)

40. Mental health (e.g., emotional wellbeing, treatment for depression, feelings of hopelessness in recent weeks)

41. General health (e.g., a measure of how good health is in general, disability and limiting illnesses)

42. Periods (e.g., age of first menstruation, difficulty of cost of period products)

43. Menopause (e.g., experience taking hormone replacement therapy (HRT), access to menopause services)

44. Fertility intentions and infertility (e.g., experience seeking medical or professional help about infertility)

45. Human Papillomavirus (HPV) vaccine (e.g., vaccination against cervical cancer, where was the vaccine administered)

46. Sexual function (e.g., experience of sexual difficulties, the relationship context, satisfaction with sex life, experience taking medication or pills to assist sexual performance such as Viagra)

47. Sexual pleasure and wellbeing (e.g., psychological wellbeing in relation to sex life, level of emotional satisfaction in current relationship)

13. Top 10 Essential Topics to Include

48. If a future survey on sexual health and wellbeing and crisis pregnancy in Ireland could only include 10 topics, please select which topics are absolutely essential to include. If there is topic you think is essential but is not on the list, please include it in the comment box as one of your 10 topics. Please only choose 10 topics in total. *

    Access to contraception

    Condom use and access to condoms

    Contraception use and methods

    Drug and alcohol use

    Emergency contraception

    Experience of crisis pregnancy

    Experience with pregnancy/pregnancy history

    Fertility intentions and infertility

    First sexual experience

    Gender identity

    Gender-based violence

General health

Human Papillomavirus (HPV) vaccine

Knowledge attitudes and beliefs about abortion

Knowledge attitudes and beliefs about different kinds of relationships and sexual lifestyles

Knowledge attitudes and beliefs about HIV

Masturbation

Media, communication and norms

Menopause

Mental health

Most recent sexual event

Non-consensual sex/coercion

Periods

Pornography

Sex education

Sex outside Ireland and the UK/sex with people from other countries

Sex work

Sexual attraction

Sexual function

Sexual guilt

Sexual health and reproductive knowledge

Sexual intercourse

Sexual pleasure and wellbeing

Sexual practices for both same and opposite sex partners

Sexual problems

Sexually transmitted infections/HIV testing

Use of technology (internet, apps) in sexual lifestyles

Other (please specify):

Please provide a rationale for your top 10 choices

14. Your thoughts on the usefulness of sexual health data in your role

49. Briefly outline the relevance and/or importance of the systematic collecting of national data on sexual health and wellbeing and crisis pregnancy in Ireland for your work and/or the work of your organisation. Please use the text box below to briefly comment.

50. Are there any additional questions or topics that you think should be included a future general population survey? This could be a new topic that we have not listed already, or new questions that you think should be added to an existing topic. Please bear in mind that a future general population survey cannot explore in detail rare behaviours or experiences (those that affect less than around 2% of the population). *

    Yes

    No

    Don't Know

51. Please briefly outline, in the comment box below, which other questions or topics you think should be included in a future general population survey on sexual health and wellbeing and crisis pregnancy and why the topic(s) should be included. Please give as much information as you can about why these new questions are important. For your information we have provided links to view the questionnaires for ICCP 2004, ISSHR 2006 and ICCP 2010 which might help you answer this question. Also, it is worth bearing in mind that there may be limited space to include new questions in a survey, as the interview will need to be kept at a reasonable length for people who take part.

52. Are there any existing questions that you think need changing or updating (e.g. changes to the question wording or answer options)? Please click on the following links to view the questionnaires for ICCP 2004, ISSHR 2006 and ICCP 2010.

    Yes

    No

    Don't Know

53. Please tell us what changes need to be made and why.

54. To make room for new questions in a future survey and allow for the survey to be relevant and up-to-date, some existing questions must be removed. Which questions would you choose to remove from the survey to make room for new questions? Please explain why if you can. Please click on the following links to view the questionnaires from ICCP 2004, ISSHR 2006 and ICCP-2010. Please leave blank and move on to the next question if you don't know or aren't able to comment.

55. If there are any other suggestions you'd like to make to the research team, please use this box:

21. Thank you!

Many thanks for taking part in this consultation process. We really appreciate your time and expertise.

We hope that you and your families have all been safe and well over the last few months and continue to do so in the months ahead.

If you have any questions about your participation, the survey questions or the Scoping Study please feel free to contact the RCSI research team.

sexualwellbeing.ie