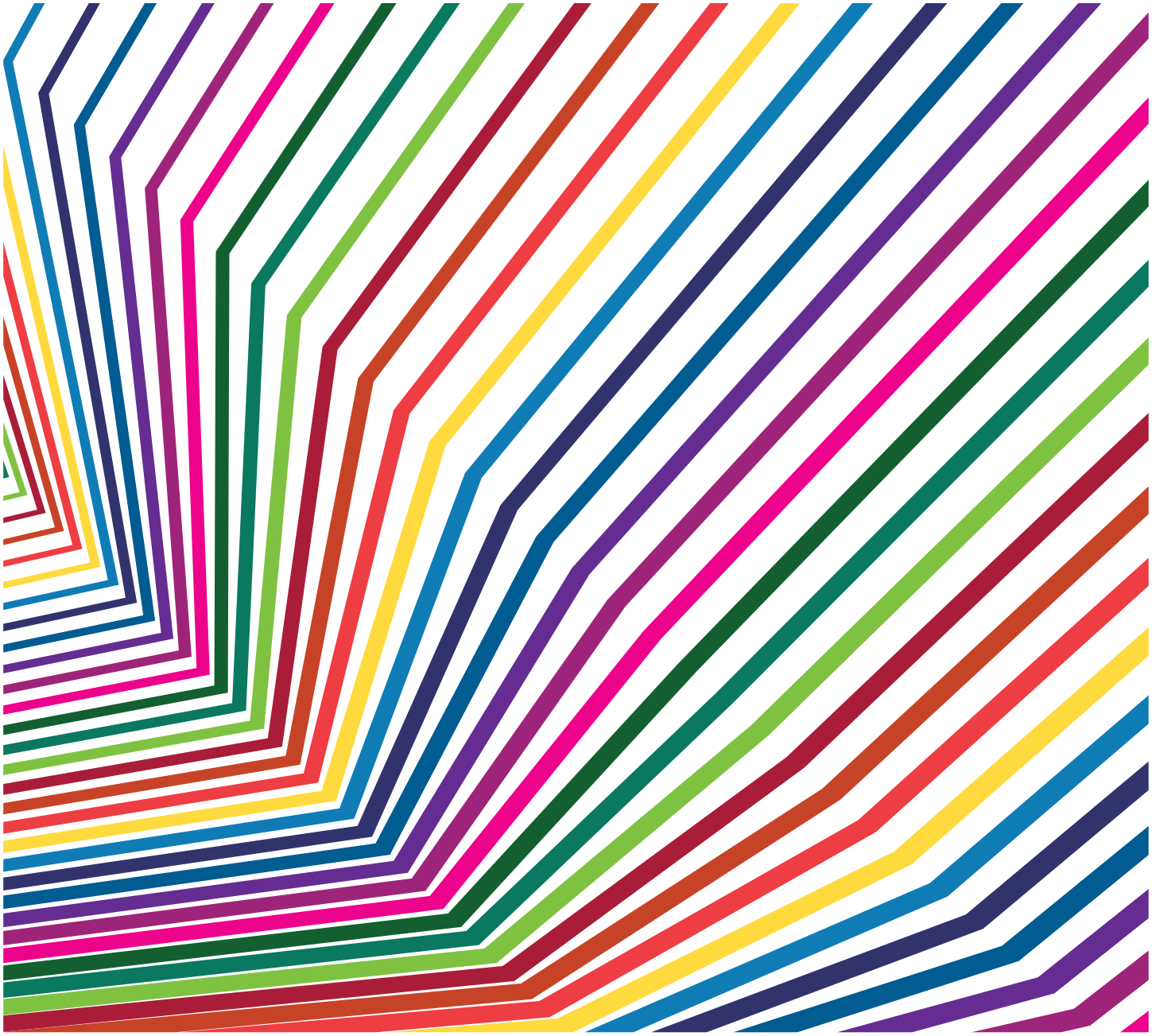
An Evaluation of the HSE's Foundation Programme in Sexual Health Promotion Training for Professionals 2016–2018



Sláinte Ghnéis &
Clár um Thoirchis Ghéarchéime
Sexual Health &
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An Evaluation of the HSE's Foundation Programme in Sexual Health Promotion Training for Professionals 2016–2018

prepared by
HSE Sexual Health & Crisis Pregnancy Programme and Core Research

About the HSE Sexual Health & Crisis Pregnancy Programme

The Health Service Executive (HSE) Sexual Health & Crisis Pregnancy Programme (SHCPP) is a national policy priority programme situated within the National Strategy and Planning function of the HSE. It is responsible for implementing the National Sexual Health Strategy 2015–2020 and related actions. The aims of this strategy are to improve sexual health and wellbeing and to reduce negative sexual health outcomes. A key focus of the strategy is the development and delivery of high-quality training for professionals to improve sexual health promotion across a range of different settings. Two guiding principles of the strategy are 'better use of evidence' and 'better measurement and evaluation'.

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Foreword by Helen Deely

I welcome this report evaluating the national roll-out of the Foundation Programme in Sexual Health Promotion (FPSHP). The FPSHP aims to upskill a diverse range of professionals to promote the development and expression of healthy sexuality throughout the life course, in line with the National Sexual Health Strategy 2015–2020 and the Healthy Ireland framework.

Personal discomfort plays a significant role in inhibiting professionals' ability to raise and discuss sexual health with service users. The FPSHP has been designed to prioritise the development of professionals' comfort and confidence in addressing sexual health matters. In addition, the programme aims to upskill participants in areas such as STIs, contraception and sexual dysfunction, and to allow participants to consider the social context around sexual health in Ireland.

The evaluation findings indicate that while the training course has had a positive impact on participants' levels of comfort and confidence in addressing sexual health issues, it is insufficient in itself to bring about the required impact on their practice. Additional supports at an organisational level may be required so that participants can translate their awareness, knowledge and skills into sexual health promotion activities within their work settings.

The SHCPP uses evidence-informed planning to support decision-making. The findings from this evaluation have informed the development of the SHCPP's Sexual Health Promotion Training Strategy 2019–2029. Through this training strategy, the SHCPP will work with organisations to support the establishment of measures to integrate sexual health promotion into their core business, thus enabling learning to be translated into practice more effectively.

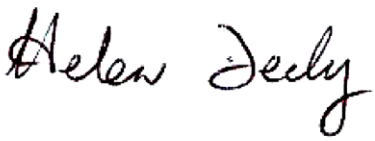
I would like to thank the FPSHP participants who took the time to complete the questionnaires that informed this evaluation.

I am also grateful to the HSE HP&I officers who efficaciously facilitated the FPSHP across the country and who supported and facilitated this evaluation. Particular thanks to Catherine

Byrne, National FPSHP Coordinator, and to Martin Grogan and Tracey Tobin from Health Promotion and Improvement for their invaluable support during the process.

Thanks to Hannah Keogh and Emma Kavanagh from Core Research for coordinating and managing the data collection and for carrying out the data analysis, and to the research team from Trinity College, Dublin, led by Professor Agnes Higgins, for designing the customised evaluation tool. I also thank Dr Carmel Downes, TCD and Moira Germaine, SHCPP for reviewing this report.

I would also like to thank Maeve O'Brien, Research Manager, and Owen Brennan, Research Assistant with the SHCPP for establishing, managing and coordinating the evaluation process, for drawing findings from the data and for drafting this report.



Helen Deely

Programme Lead, HSE Sexual Health & Crisis Pregnancy Programme

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List of abbreviations

CHO	community healthcare organisation
FPSHP	Foundation Programme in Sexual Health Promotion
GDPR	General Data Protection Regulation (European Union)
HP&I	Health Promotion and Improvement (HSE)
HSE	Health Service Executive
NGO	non-governmental organisation
PP	percentage point
SHCPP	Sexual Health & Crisis Pregnancy Programme (HSE)
SHP	sexual health promotion
STI	sexually transmitted infection
TCD	Trinity College, Dublin
UK	United Kingdom

Executive summary

About the Foundation Programme in Sexual Health Promotion (FPSHP)

Led by Health Promotion and Improvement, the FPSHP is a sexual health promotion training programme designed for professionals from a diverse range of disciplines. The aims of the FPSHP are to:

- develop participants' confidence, knowledge, skills and comfort levels in relation to sexual health promotion (SHP)
- explore participants' attitudes and values to sexual health
- create a broad understanding of the holistic nature of SHP
- enhance participants' skills for SHP roles.

The overarching objective of the programme is that – through the achievement of the above aims – SHP will be integrated into the core work of a range of professionals.

In 2014, following a positive evaluation of the programme in the HSE South area, and in advance of the publication of the National Sexual Health Strategy 2015–2020, the FPSHP was rolled out nationally to standardise HSE-led non-clinical SHP training for professionals. To monitor and evaluate the roll-out, the SHCPP commissioned a research team from Trinity College, Dublin to develop and pilot a customised evaluation tool to capture the programme's immediate and longer term outcomes.

About this evaluation

This evaluation has been informed by data collected between September 2016 and August 2018 from 194 respondents who each participated in one of fourteen FPSHP courses. The evaluation found that the participants were from a mix of employment backgrounds and represented a diverse range of professionals from social work, community development, health and education, which is in line with the programme's recruitment aims.

A customised evaluation tool was used in order to understand how the FPSHP performs as a national programme in relation to the core metrics that have been developed in line with the course objectives. The large number of participants enabled statistically robust analysis and

testing for significance, which has permitted inferences to be drawn with a level of statistical confidence about their accuracy.

Evaluation findings

The evaluation findings provide good evidence that the FPSHP has been successfully and efficaciously rolled out in new locations across the country and offer valuable insights into how it is impacting on participants. The evaluation identified significant improvements across a number of measures related to the aims of the programme following completion of the training course. These included increased numbers of participants who reported having:

- more confidence to deliver SHP activities
- increased skills with regard to SHP activities
- greater levels of knowledge about sexual health
- greater comfort discussing sexual health.

These increases tested as statistically significant, with a confidence interval of 95%, which implies that there is a high probability that the increases are related to the programme as opposed to occurring by chance. The results confirm, with a degree of certainty, that the programme has been successful in achieving its aims with the participants. These aims have been identified in the research literature as core aspects of SHP training for professionals.

However, in relation to achieving the overarching objective of enabling participants to integrate SHP into their core work, the findings are less definitive. The evaluation found marginal to moderate increases in the number of participants who reported engaging in specified SHP activities following completion of the training course. These increases were not statistically significant. It was also the case that six months after the programme, large proportions of participants reported 'never or rarely' engaging in many of the specified SHP activities that were measured. This finding contrasts to some degree with participants' perceptions of how the programme impacted on their practice. Six months after completing the programme, the vast majority of participants reported that the programme had had a very positive impact on their practice and high numbers anticipated that they would sustain those changes in their practice.

With regard to satisfaction with and helpfulness of the programme, the FPSHP is perceived very positively by participants, even six months after completion of the training course. The high levels of full attendance also reflect the popularity of the FPSHP, as adhering to a ten-day programme can be a considerable commitment for busy professionals.

Participants reported mixed results on the helpfulness of a range of factors linked to their employer organisations. Some areas of work practice/culture were found not to be helpful in the delivery of SHP by a significant minority of participants. Examples include issues relating to financial resources, the presence (or absence) of an organisational policy on SHP and limited availability of time and of physical space.

This evaluation has provided some valuable insights into the impact of the FPSHP:

- At the individual level, the findings suggest a significant and positive impact. The programme is successful at upskilling participants and increasing their levels of comfort and confidence to deliver SHP activities as part of their roles. It is also very popular with participants: the course is very well attended and participants report high levels of satisfaction with the programme and perceive it as helpful.

- At the organisational level, the data reveals far more moderate improvements in terms of the delivery of SHP activities with many participants reporting that they still had not undertaken these activities six months after completion of the programme.

It can be concluded that although the FPSHP training course has a significant impact on participants' levels of comfort and confidence in addressing sexual health issues, it may be insufficient in itself to bring about the required impact on their SHP practice. This conclusion suggests that additional supports at organisational level may be required to enable participants to translate their awareness, knowledge and skills into SHP activities within their work settings.

Implications for practice

The findings from this evaluation have been taken into account in the development of the SHCPP's Sexual Health Promotion Training Strategy 2019–2029. This training strategy sets out a ten-year plan for building the SHP capacity of individuals and organisations working in the areas of health, education, community and youth work, so that they can better support their clients to achieve optimum sexual health. Key actions of this strategy are to support relevant employers to develop their in-house SHP training, and to engage with HSE disciplines and other organisations to encourage the integration of SHP into their work. On a strategic level, the implementation of these actions will create more supportive organisational cultures, which in turn will overcome some of the factors that may be currently inhibiting FPSHP participants from implementing their learning more extensively.

In the shorter term, the FPSHP national coordinator and facilitators may wish to take the following actions:

- Examine the findings of this evaluation and consider how to maintain the identified benefits of the FPSHP while simultaneously developing additional measures to improve the organisational environments in which FPSHP participants operate. The solution may involve decisions about the deployment of available resources for optimum effect.

- Consider engaging with FPSHP past participants to reflect on the findings of this evaluation and to explore the seeming discrepancy between some of the responses in relation to practice, the identified barriers to SHP implementation in the workplace, and possible interventions/activities to overcome the difficulties encountered.

Chapter 1: Introduction

1.1 About this report

This report presents the results of an evaluation of the Health Service Executive's (HSE) Foundation Programme in Sexual Health Promotion (FPSHP). The evaluation was designed to understand the impact that the training programme has had on course participants in relation to building or improving their capacity to incorporate sexual health promotion (SHP) into their daily professional practice. This report presents findings relating to the programme's design that have been measured over time with the programme's participants.

The report is based on data collected from 194 participants who attended one of fourteen training courses held at eleven different locations across Ireland. The large number of participants enabled statistically robust analysis and testing for significance, which has permitted inferences to be drawn with a level of statistical confidence about their accuracy.

This report is set out in ten chapters. This introductory chapter provides the background to the FPSHP and sets out the rationale for this evaluation. Chapter 2 gives an overview of the evaluation design. Chapter 3 provides information on the sample of participants whose data is used in this report. Chapters 4 to 9 present the findings: Chapter 4 covers participants' self-reported frequency of delivering a range of SHP activities in the workplace; Chapter 5 examines participants' self-reported confidence levels in relation to facilitating SHP at work; Chapter 6 looks at participants' self-reported knowledge levels on a range of different sexual health topics; Chapter 7 deals with participants' self-reported skills in SHP; Chapter 8 covers participants' self-reported levels of personal comfort with SHP; and Chapter 9 examines participants' satisfaction levels with the FPSHP. Chapter 10 presents the conclusion to this evaluation and considers the implications of the findings.

1.2 About the Foundation Programme in Sexual Health Promotion

Developed by HSE Health Promotion and Improvement (HP&I) in 2009, the FPSHP is a ten-day training course for professionals. It is currently delivered as part of the National Sexual Health Strategy 2015–2020 in eight community healthcare organisations (CHOs) across Ireland. It is managed by a national coordinator drawn from HP&I and is located within the overall 'education and training' function of the HSE Sexual Health & Crisis Pregnancy Programme (SHCPP).

HP&I is responsible for the delivery and funding of the programme at CHO level, and HP&I staff with a remit in sexual health manage all aspects of the programme, cofacilitating with

colleagues or NGO partners. These facilitators belong to a national FPSHP working group, which offers peer support and contributes to the ongoing development of the programme.

1.2.1 Aims

The FPSHP aims to enhance the capacity of participants to incorporate SHP into their work through the development of their levels of confidence, knowledge, skills and comfort in relation to sexual health. The learning outcomes are described as providing participants with the opportunity to:

- increase self-awareness of sexual health issues and how they might affect their work
- appreciate how their own sexual socialisation affects their values and attitudes to sex
- recognise that people are sexual beings throughout their life course and have needs with regard to sexual health, whatever their age or their level of sexual activity
- add to their knowledge of sexual health issues
- expand their understanding of sexual health in an Irish context
- develop or enhance their facilitation skills with regard to sexual health topics
- understand the need for organisational sexual health policy development.

The programme seeks to integrate SHP into the core work of a diverse range of disciplines across the health, education and community sectors both within and outside the HSE. The ten-day course is run over a period of three to five months and sessions are purposefully spaced to enable participants to develop relationships with each other and to enable them to return to their work environments, make changes to practice and then come back to the training programme for feedback, support and suggestions.

1.2.2 Content

The FPSHP covers a range of topics related to the positive promotion of sexual health in Ireland (see Table 1). The programme aims to upskill participants in areas such as sexually transmitted infections (STIs), contraception and sexual dysfunction. It has also been designed to encourage participants to consider the social context around sexual health in Ireland. It provides participants with the time to explore organisational policy development in SHP and utilises adult and experiential learning methodologies to enable participants to reflect on and think critically about sexual issues and their own attitudes and beliefs.

Following completion of the programme, the participants are offered ongoing support by facilitators and have access to a range of resources.

Table 1: Overview of FPSHP content

Day	Programme content
1	Introduction to the programme
2	Sexual health promotion in the Irish context
3	Sexual health: A life course approach
4	Physical sexual health
5	Self-esteem and sexual health
6	Sex, society and culture
7	Irish law and sexual health; power and sex
8	Policy development and facilitation skills
9	Facilitation skills practice workshop
10	Facilitation skills practice workshop; action planning; course closure

1.2.3 Participants

Recruitment to the programme is managed by the lead facilitator for each course. The recruitment policy favours professionals working with vulnerable groups, as identified in the National Sexual Health Strategy 2015–2020. There is a two-step application process whereby applicants are shortlisted on the basis of their application form and are subsequently invited to have a telephone conversation with the relevant course facilitator to ensure that the programme is suitable for their preferred learning style and that the learning can be applied in their place of work for the benefit of their client group.

A training group for each course is formed based on the relevance of the training to the participants' core work and the suitability of the content to their work. The training groups normally comprise between sixteen and twenty participants.

Participants are drawn from a broad range of professional backgrounds, including social work, nursing, psychology, midwifery, youth work, community work and medical practice, and from both statutory and NGO organisations. The programme has been accredited for continuing professional development purposes by several professional bodies in Ireland including the Nursing and Midwifery Board of Ireland, Irish Association of Social Workers and Irish Association for Counselling and Psychotherapy.

The HSE funds the course delivery, with participants and their organisations being responsible for travel and locum costs as necessary.

1.2.4 Course locations

Table 2 lists the dates and locations of the FPSHP courses involved in this programme evaluation. Three locations held two training courses during the evaluation period and these courses are labelled (a) and (b) in the table.

Table 2: Overview of FPSHP courses delivered during the evaluation period

	Course location	Dates of delivery	CHO Area
1	Kilkenny city, Co. Kilkenny	September to November 2016	CHO Area 5
2	Ardee, Co. Louth	September 2016 to January 2017	CHO Area 8
3	Cork city, Co. Cork (a)	October 2016 to February 2017	CHO Area 4
4	Castlebar, Co. Mayo (a)	October 2016 to March 2017	CHO Area 2
5	Tallaght, Dublin 24 (a)	January to March 2017	CHO Area 7
6	Tullamore, Co. Offaly	January to May 2017	CHO Area 8
7	Killarney, Co. Kerry	January to May 2017	CHO Area 4
8	Letterkenny, Co. Donegal	January to May 2017	CHO Area 1
9	Wexford town, Co. Wexford	April to June 2017	CHO Area 5
10	Tallaght, Dublin 24 (b)	September to December 2017	CHO Area 7
11	Cork city, Co. Cork (b)	September 2017 to January 2018	CHO Area 4
12	Limerick city, Co. Limerick	September 2017 to February 2018	CHO Area 3
13	Longford town, Co. Longford	September 2017 to February 2018	CHO Area 8
14	Castlebar, Co. Mayo (b)	September 2017 to February 2018	CHO Area 2

1.3 Background to the FPSHP and to this evaluation

The FPSHP was developed in 2009 by HSE health promotion officers in the former HSE South area. Between 2009 and 2012, the programme was rolled out in four locations (one per year): Waterford city; Clonmel, Co. Tipperary; Cork city; and Killarney, Co. Kerry. The development of the programme was informed by:

- a feasibility study carried out in 2008 with managers and staff of relevant organisations
- a review of the research literature in relation to SHP and the need for same, training as an element of health promotion capacity-building and appropriate training methodologies to explore attitudes and values with adult learners.

The programme content took account of recommended quality standards for sexual health training (Department of Health UK, 2005) and the choice of topics was influenced by practitioner experience and documentation from the International Planned Parenthood Federation (Braeken et al., 2006).

A research team from the School of Nursing and Midwifery in Trinity College, Dublin (TCD) was commissioned in 2013 to evaluate the programme in HSE South. This evaluation employed a retrospective mixed-method approach, using qualitative and quantitative methods (Higgins et al., 2013; Keogh et al., 2016). Data was collected using surveys, focus group interviews, telephone interviews and documentary analysis. To gain an in-depth perspective, data was collected from all the key stakeholders, including past participants, their managers and the facilitators of the programme. Findings from this HSE South evaluation indicated that the programme had had a positive impact on:

- capacity-building at both individual and organisational levels
- past participants' self-reported confidence and competence in communicating about sexual matters
- past participants' knowledge of the field.

In addition, participants, managers and facilitators were very satisfied with all aspects of the FPSHP, including content, facilitation and follow-up supports, as well as its impact on the SHP work of the participants. However, as the study was limited to a post-participation evaluation, it was recommended that consideration be given to undertaking a more robust study, incorporating a pre/post/follow-up design to identify the impact of the programme, including a comparison between outcomes and baseline measures taken before participation.

In 2014, just prior to the publication of the National Sexual Health Strategy 2015–2020, and based on the evaluation of the programme in HSE South, the SHCPP Programme Lead decided to begin the national roll-out of the programme so as to standardise the HSE's non-clinical SHP training for professionals across the country.

In order to monitor and inform the national roll-out, the SHCPP commissioned a research team from TCD to develop and pilot an evaluation tool to capture the immediate and longer term impact of the FPSHP with participants. Due to the unique structure of the programme and its

specificity for the Irish context, a customised evaluation tool was required. The development of the evaluation tool was informed by the integrative literature review, findings from the previous evaluation and input from the programme facilitators.

Three questionnaires were developed (Higgins et al., 2016):

- Survey 1 (conducted before participants started the programme) measured SHP activities, knowledge, confidence, skills and comfort in addressing aspects of sexual health using a combination of scales and open questions.

- Survey 2 (on completion of the programme) had the same questions as the first survey but added items on satisfaction with the FPSHP and on the impact of programme participation on participants' SHP activities in the workplace.

- Survey 3 (six months after completion of the programme) repeated the core of the items and requested information on factors enabling and sustaining change in SHP practice.

The surveys were piloted at three sites in 2015 and validated across the three time points: pre-programme, post programme and follow-up at six months after completion of the programme. In total, 61 participants completed Survey 1, 57 completed Survey 2 and 39 completed Survey 3, representing a 36% rate of attrition from the first to the third survey (Higgins et al., 2016; Higgins et al., 2019).

To assist refinement of the evaluation tool, information was gathered from various sources, including: feedback from the participants on the relevance and clarity of questions in each survey, a review of the statistical findings and limitations, consideration of comments received from the HSE team and a research team member review. A number of refinements were made in response.

In addition, as is customary in evaluation tool development, a condensed version of the tool based on the original version was developed. Its aim was to reduce the time commitment of the evaluation administration and completion, and to reduce data analysis time and cost.

1.4 Literature and policy context

Historically, SHP has been a policy priority for specific issues such as unplanned pregnancies, STIs and, more recently, sexual abuse and violence. However, an emphasis on sexual health in its more holistic and expansive sense and on the value of training a wide range of diverse professionals to integrate SHP into their work is increasingly evident in the literature and in the policy context (World Health Organization, 2010; Department of Health Ireland, 2015; HSE Sexual Health & Crisis Pregnancy Programme, 2019).

1.4.1 Literature on SHP training for professionals

SHP training for various professionals is recognised as an important aspect of sexual wellbeing. Quality standards issued by the UK's Department of Health in 2005 set out that the purpose of sexual health education and training for those involved in delivering health promotion is to facilitate the acquisition of the requisite knowledge, skills, values and competencies to 'deliver sensitive and appropriate sexual health advice, education, information, services and support' (p. 2). The standards recommend that best-practice sexual health education and training should:

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

The literature also suggests that SHP education and training should: reduce anxiety and difficulties related to sexual care, advance knowledge, develop self-awareness, challenge discrimination and prejudice, develop understanding of sexual rights and responsibilities, encourage tolerance and promote cognisance of sexual diversity and its expression (Surgeon General, 2001; Department of Health UK, 2003, 2005; Braeken et al., 2006; Higgins et al., 2013; Bauer et al., 2013).

The literature identifies some core content to be addressed within SHP training programmes, namely: self-awareness, exploration of values and attitudes, provision of information, communication skills, sexual orientation, relationships, cultural differences and the needs of people with a disability (Department of Health, Social Services and Public Safety Northern Ireland, 2008).

Elsewhere the literature outlines the importance of education and training that emphasises the development of teaching, facilitation and personal development skills to support participants

and build their confidence and ability to implement SHP (Ahmed et al., 2006; Murphy-Lawless et al., 2008). The socially constructed nature of sexuality as 'private', 'sensitive' and 'taboo' requires people who engage in SHP to be comfortable with their own sexual identity and to have the confidence to discuss sexuality issues in an open and relaxed manner (Allen, 2009; Higgins et al., 2009).

In terms of facilitation and learning methodologies, there is general agreement within the literature that it is best practice to incorporate an active approach to learning underpinned by adult learning theory and experiential, participatory methodologies (Department of Health UK, 2005; Ahmed et al., 2006; Mayock et al., 2007).

The literature finds that participatory learning methodology is the most useful means of developing the characteristics of effective facilitators. These attributes include: facilitators' acceptance of sexual thoughts and desires as natural, an awareness of their own sexuality, a comfort with sexual issues, a sense of humour, a non-judgmental and non-moralistic attitude, a tolerance of ambiguity and an awareness of limitations as educators and facilitators (Public Health Agency of Canada, 2003).

1.4.2 National policy context

The National Sexual Health Strategy 2015–2020 promotes a positive and holistic approach to improving sexual health across the life course (Department of Health Ireland, 2015). This strategy acknowledges that training for professionals is a crucial element of promoting sexual health and wellbeing and reducing negative sexual health outcomes. It identifies how training for professionals should not only seek to improve participants' knowledge and skills but also provide the space for participants to explore their own attitudes and values and to normalise communication about sexual health so as to increase comfort levels with the topic. The strategy states that such training will prepare professionals to deal with clients whose life stage or belief may be different from their own and to acknowledge diversity of views and experiences.

The strategy provides a necessary policy framework and direction to support the expansion of SHP delivery and training in Ireland. This policy commitment, in particular its recommended actions on the upskilling of professionals, will be further strengthened by the implementation of the Sexual Health Promotion Training Strategy 2019–2029 (HSE Sexual Health & Crisis Pregnancy Programme, 2019).

1.5 About this evaluation

To have a clear understanding of how the FPSHP was performing as it was rolled out in new locations, the SHCPP undertook to evaluate the programme between September 2016 and August 2018 using the pre/post/follow-up evaluation tool developed by TCD (see 1.3 above).

To facilitate this, the SHCPP commissioned a research company, Core Research, to control and coordinate data collection and data management across the fourteen training courses. See Chapter 2 for further information on the evaluation design.

Chapter 2: Evaluation design

2.1 Introduction

The aim of this study is to evaluate the impact of the FPSHP on participants in terms of building or improving their capacity to incorporate SHP into their daily professional practice, as it is rolled out nationally. The objectives are to:

- measure self-reported changes in participants' confidence, knowledge, attitudes and behaviours regarding a number of key areas relating to the programme
- measure self-reported changes regarding integrating SHP into professional practices.

The evaluation design involved using a customised and validated pre/post/follow-up data collection instrument. Data collection was carried out with programme participants from fourteen training courses delivered in eleven different locations. This chapter outlines the design of this evaluation, including the approach to data collection and data analysis. It also sets out the study's limitations and ethical considerations.

2.2 Evaluation tool

In 2015 the SHCPP commissioned the development of an evaluation tool to measure self-reported changes in FPSHP participants' confidence, knowledge, attitudes and behaviours regarding a number of key areas relating to the programme. The customised evaluation tool was designed and tested by a team of researchers from TCD (Higgins et al., 2016).

The evaluation tool was designed for data collection to take place at three different points in time: prior to participating in the programme, directly on completion of the programme and six months after programme completion. This three-wave approach was selected to provide an understanding of the immediate impact of the programme and also its impact in the longer term when participants have had time to reflect on their learning and apply it to their practice.

Knowledge, skills, confidence, comfort, satisfaction with and perceived helpfulness of the programme were measured on eleven-point ratio scales ranging from 0 to 10, with higher scores indicating higher self-reported knowledge, skills, confidence, comfort, satisfaction and perceived helpfulness. Frequency of delivering SHP activities were measured on five-point ordinal scales.

All three questionnaires asked participants to indicate how frequently they engage in certain SHP activities, and to self-rate their confidence, knowledge, skills and comfort in relation to a range of SHP topics. This continuity allowed for changes to be tracked across the three waves of data collection, and for the subsequent measurement of the impact of the programme. The second and third questionnaires included additional questions about participants' satisfaction with the programme and their perceptions of its impact on their SHP activities.

2.3 Data collection

Core Research was contracted to design and manage a web-based data collection process and to analyse the data across the three time points. This work involved transposing the three questionnaires onto an online platform to allow for an online method of data collection; developing a system for anonymising and tracking respondents using individual identifiers so that data could be matched across the time points; generating individualised links for participants; and dispatching the questionnaires to participants. This process was managed in a phased way as the fourteen training courses involved in the evaluation ran at different dates over the evaluation period.

The research company was required to liaise closely with the FPSHP national coordinator and each course facilitator to ensure that participants were contacted at the appropriate stage and in a timely way over the three time points. Once a training group had been formed for each course, the facilitator shared the list of participants' names and email addresses with the research company. All participants who were accepted onto a course were made aware that their data would be shared in this way. The research company sent the survey via email to all participants before their programme began, immediately after it ended and six months later.

2.4 Data analysis

In order to work from a complete dataset for the three surveys, SHCPP and Core Research decided to analyse only the data from participants who completed all three waves of data collection. The research company cleaned the dataset, removing all partial respondents.

Data from the evaluation tool's eleven-point ratio scales were re-categorised into ordinal variable scales and the results were grouped accordingly. For example, for the eleven-point scale, scores 0 to 3 were categorised as 'low' confidence, knowledge, skills or comfort; scores 4 to 6 were categorised as 'moderate' confidence, knowledge, skills or comfort; and scores 7 to 10 represented 'high' confidence, knowledge, skills or comfort.

Descriptive statistics, including frequencies and percentages, were generated to describe the data. The proportion of participants grouped into the ordinal categories according to their response were presented across each measure at each time point, and t-tests were

used to compare the changes over time to determine whether the differences between the measurements were real or attributable to a sampling error. Significance testing was carried out at a 95% confidence level and was conducted to determine any statistically significant changes in the key measures over time. When results report a statistically significant difference, it means the difference between two percentage points has less than a 5% probability of occurring by chance or sampling error alone.

While the tables in this report present the changes across the three waves of data collection, the key focus of the report is on the differences between the first and third waves, as this information provides an assessment of the longer term impact of the programme. This is presented as percentage point changes, which is the arithmetic difference of two percentages. Where increases and decreases are noted, it is the percentage point change that is being measured as opposed to a percentage change across the sample.

2.5 Sample

A total of 249 participants completed the FPSHP in the fourteen training courses held over the two-year evaluation period (September 2016 to August 2018) and completed the first questionnaire. A total of 194 participants completed all three questionnaires, providing a complete response rate of 78%. See Chapter 3 for further information on the sample.

2.6 Ethical considerations and data protection

No ethical approval was required for this evaluation; however, due consideration was given to each participant's right to consent to participate, the confidentiality of the process, the right to anonymity and the treatment of the data.

During the period in question, applicants for the FPSHP were made aware that engagement in the evaluation was a requirement of acceptance onto the programme. Prospective participants were informed that the evaluation would involve completing online questionnaires before participating in the programme, directly upon completion of the programme and six months after completing the programme. They were informed that this approach had been designed to measure the impact of the FPSHP directly after completion and later when participants had had the opportunity to reflect on their learning and to apply it in their practice. Acceptance of a place on the course and the completion of each questionnaire was considered as consent to participate in this evaluation and all participants over the evaluation period consented to participation.

The evaluation was designed so that each participant's data was anonymised. Each participant was assigned an identification code that allowed matched responses across the three time points. Participants were made aware that their full name, email address and

place of work would be shared with the research company. These details were held on the research company's secure computer drive and each file was password protected. Following the publication of the GDPR legislation, the research company developed a protocol for the deletion of data, which was agreed with the SHCPP. On completion of this report, the data identifying the FPSHP participants was deleted.

2.7 Limitations

As with all studies, there are a number of limitations that should be considered:

- The data includes only the information provided by participants who completed all three waves of data collection. No data is presented on the 55 participants who failed to complete all three questionnaires. This report is therefore unable to give a complete picture of the impact of the course on all participants over the evaluation period. Also, the results may be influenced by response bias, as the more motivated participants are more likely to have completed all three questionnaires.

- As there was no control group, it is not possible to assert that changes between each wave of data collection were caused directly or solely by participating in the programme.

- The self-reported nature of the data means the findings are based on participants' perceptions.

- The fact that the data comes from a single source – programme participants – does not allow for triangulation with other data sources.

Chapter 3: Participants' backgrounds and attendance

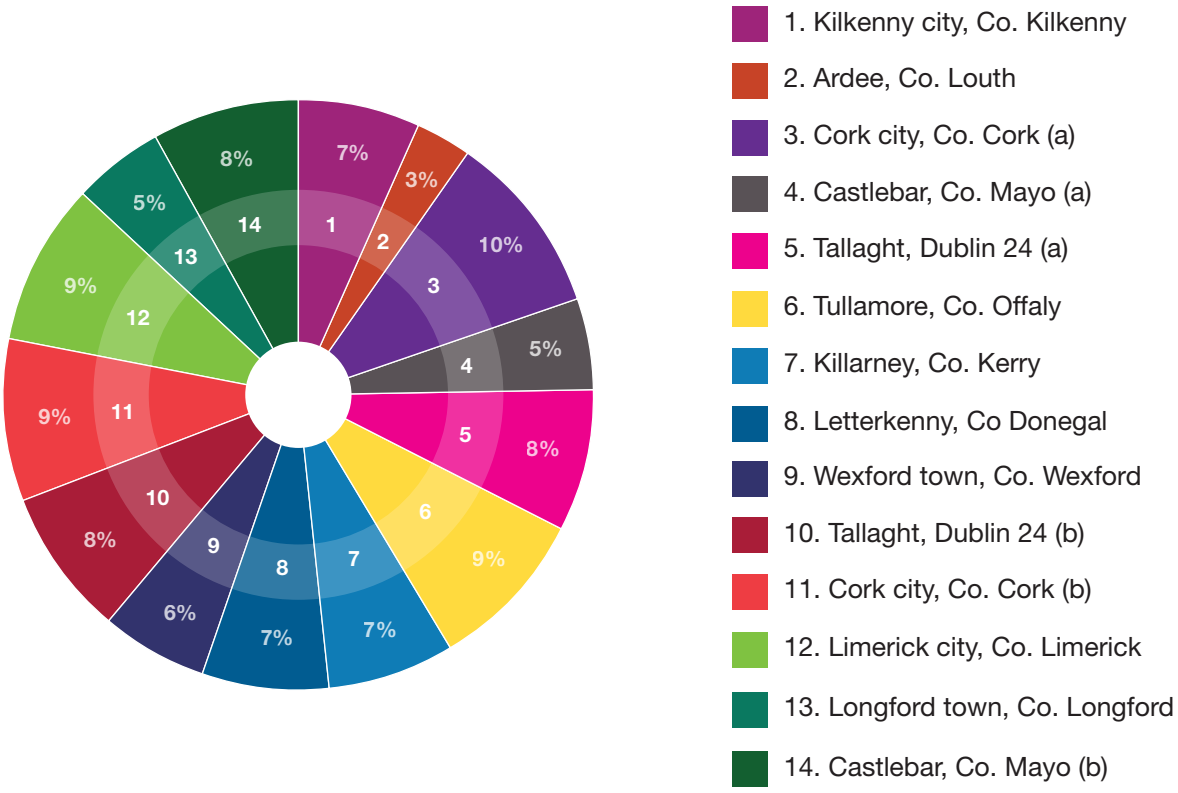
3.1 Introduction

The total number of participants who completed all three questionnaires was 194. This chapter provides more information about the participants.

3.2 Demographic profile

Figure 1 shows the proportion of participants from each of the fourteen different FPSHP courses held over the two-year evaluation period. The number of respondents per course ranged from six in Ardee, Co. Louth to nineteen in Cork city (a).

Figure 1: Proportion of participants from each course location (n=194)



Participants mostly identified themselves as female (89%), with 11% identifying themselves as male.

Participants were from a mix of employment backgrounds (see Table 3) and represented a diverse range of professionals. Many came from large public employment organisations: HSE and Tusla staff accounted for half of the participants. Smaller proportions of participants came from the education sector (6.7%), general practice (6.7%), general NGOs (6.2%), the youth sector (5.2%) and from NGOs working with individuals who have a disability (4.6%). Just over 20% of participants defined their professional background/sector as 'other'.

Table 3: Employment backgrounds of participants

Employer/sector	Number	Proportion of total sample
HSE	77	39.7%
Tusla	21	10.8%
Education	13	6.7%
General practice	13	6.7%
NGO	12	6.2%
Youth sector	10	5.2%
NGO disability	9	4.6%
Other	39	20.1%
Total	194	100%

Participants were asked about their specific roles in their current employment organisations:

- For HSE employees, the vast majority were working in nursing and midwifery and in social work. Many were employed in the areas of public health and health promotion. Others included psychotherapists and psychologists.
- From Tusla, the vast majority were social care workers and after care workers. Others were team leaders, social work practitioners and family support workers.
- Education sector participants included education facilitators and primary and post-primary teachers.
- General practice participants were mainly practice nurses.
- NGO participants were project workers and community support workers. From the NGO

disability sector, there were a range of different roles, including support workers, instructors, and vocational support and social care staff.

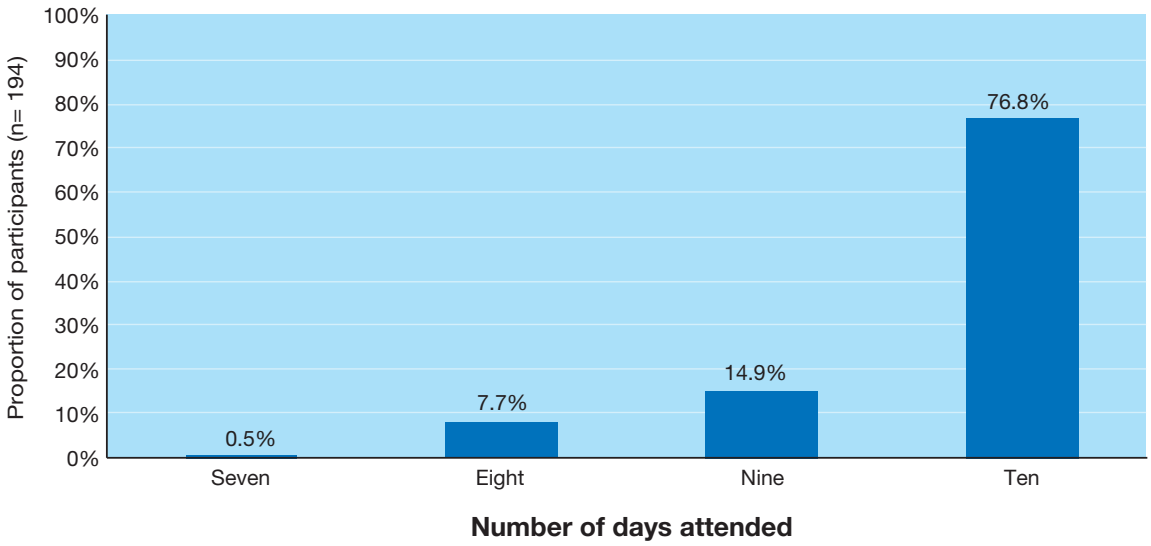
- Most youth sector participants were youth workers.
- Participants in the 'other' category included counsellors, medics, community social workers, parents and volunteers.

The majority (78%) of participants reported being involved in SHP in their roles before joining the programme, suggesting that many had a basic knowledge of the area before they commenced the training course. The remaining 22% had not had any previous involvement in SHP.

3.3 Attendance at FPSHP

Self-reported attendance at the courses was good. Just over three-quarters of participants attended all ten days of the programme; just under 15% attended nine days; and almost 8% attended eight days. One participant attended seven days of the programme.

Figure 2: Overview of participants' attendance during the programme



3.4 Chapter summary

A total of 194 FPSHP participants from fourteen courses completed all three waves of the evaluation. These participants came from a mix of employment backgrounds and represented a diverse range of professionals from social work, community development, health and education. HSE and Tusla staff accounted for half of the participants, with the remainder mainly coming from the education sector, general practice, NGOs and the youth sector. Most participants were female. Attendance levels across the programme were high, with the majority of the sample attending all ten days.

Chapter 4: Measuring the frequency of delivering SHP activities

4.1 Introduction

FPSHP participants were asked a series of questions about how frequently they engaged in SHP activities in their current roles. These questions sought to learn more about their activities with service users, staff and colleagues and their contribution to the development of SHP workplace practices and policies. The data gathered from the five-point ordinal scales in the evaluation tool was re-categorised into three-point ordinal variable scales: response categories 'never' and 'rarely' were categorised as 'never or rarely', response category 'sometimes' remained unchanged; and response categories 'frequently' and 'always' became a single category 'frequently or always'. This chapter sets out the findings related to differences measured between the first and third waves of the evaluation.

4.2 Engaging service users

Participants were asked four questions around their frequency of engaging service users in SHP activities. These questions related to assessing service users' SHP needs, providing SHP information, making referrals to sexual health services and providing sexual health education.

4.2.1 Assessing the SHP needs of service users

There was a 6 percentage point (PP) decrease in the number of participants who reported 'never or rarely' assessing the SHP needs of service users six months after the programme ended; the proportion of participants who reported 'frequently or always' engaging in this activity increased by 13 percentage points. These figures suggest a small improvement over time. However, six months after the programme ended, over one-fifth (22%) of participants still reported 'never or rarely' assessing the SHP needs of service users.

Table 4: Frequency assessing the SHP needs of service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	28% (n=55)	19% (n=37)	22% (n=43)	–6
Sometimes	43% (n=83)	42% (n=81)	36% (n=69)	–7
Frequently or always	29% (n=56)	39% (n=76)	42% (n=82)	13
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.2.2 Providing written/verbal SHP information to service users

There was an 8 percentage point decrease in the number of participants who reported 'never or rarely' providing written or verbal SHP information to service users six months after the programme ended; the proportion who reported 'frequently or always' engaging in this activity increased by 12 percentage points. These figures suggest a small improvement over time. Six months after the programme ended, however, 27% of participants reported 'never or rarely' providing written or verbal SHP information to service users.

Table 5: Frequency providing written/verbal SHP information to service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	35% (n=68)	22% (n=43)	27% (n=52)	–8
Sometimes	41% (n=79)	44% (n=85)	37% (n=72)	–4
Frequently or always	24% (n=47)	34% (n=66)	36% (n=70)	12
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.2.3 Referring service users to sexual health services

There was a 12 percentage point decrease in the number of participants who reported 'never or rarely' referring service users to sexual health services six months after the programme ended; the proportion who reported 'frequently or always' making such referrals increased by 4 percentage points. These figures suggest a very marginal improvement over time. Six months after the programme ended, however, 32% of participants reported 'never or rarely' referring service users to sexual health services.

Table 6: Frequency referring service users to sexual health services

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	44% (n=84)	35% (n=69)	32% (n=62)	–12
Sometimes	42% (n=82)	40% (n=77)	50% (n=97)	8
Frequently or always	14% (n=28)	25% (n=48)	18% (n=35)	4
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.2.4 Providing sexual health education to service users

There was a 23 percentage point decrease in the number of participants who reported 'never or rarely' providing sexual health education to service users six months after the programme ended; the proportion who reported 'frequently or always' providing education increased by 12 percentage points. These figures suggest a small to moderate improvement over time. Six months after the programme ended, however, 26% of participants reported 'never or rarely' providing sexual health education to service users.

Table 7: Frequency providing sexual health education to service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	49% (n=95)	36% (n=69)	26% (n=51)	–23
Sometimes	30% (n=58)	35% (n=69)	41% (n=79)	11
Frequently or always	21% (n=41)	29% (n=56)	33% (n=64)	12
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.3 Addressing organisational needs

Participants were asked four questions about responding to the SHP needs of colleagues and staff both within and outside their organisations.

4.3.1 Assessing the SHP education needs of staff within own organisation

There was a 6 percentage point decrease in the number of participants who reported 'never or rarely' assessing the SHP education needs of staff within their organisation six months after the programme ended; there was a 2 percentage points increase in the proportion who reported 'frequently or always' doing this. These figures suggest a very marginal improvement over time. Six months after the programme ended, however, 65% of participants reported 'never or rarely' assessing the SHP education needs of staff within their organisation.

Table 8: Frequency assessing the SHP education needs of staff within own organisation

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	71% (n=137)	68% (n=131)	65% (n=127)	–6
Sometimes	21% (n=41)	23% (n=46)	25% (n=48)	4
Frequently or always	8% (n=16)	9% (n=17)	10% (n=19)	2
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.3.2 Providing SHP education to staff within own organisation

There was a 23 percentage point decrease in the number of participants who reported 'never or rarely' providing SHP education to staff within their organisation six months after the programme ended; there was a 7 percentage point increase in the proportion who reported 'frequently or always' doing this. These figures suggest a small improvement over time. However, six months after the programme ended, 62% of participants reported 'never or rarely' providing SHP education to staff within their organisation.

Table 9: Frequency providing SHP education to staff within own organisation

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	85% (n=165)	66% (n=129)	62% (n=121)	–23
Sometimes	12% (n=24)	25% (n=47)	28% (n=54)	16
Frequently or always	3% (n=5)	9% (n=18)	10% (n=19)	7
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.3.3 Developing or contributing to the development of sexual health education programmes

There was a 27 percentage point decrease in the number of participants who reported 'never or rarely' developing or contributing to the development of sexual health programmes six months after the programme ended; the number who reported 'frequently or always' engaging in this practice increased by 8 percentage points . These figures suggest a moderate improvement in the number of participants developing sexual health education programmes. However, six months after the programme ended, 51% of participants reported 'never or rarely' engaging in this activity.

Table 10: Frequency developing or contributing to the development of sexual health education programmes

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	78% (n=151)	50% (n=97)	51% (n=100)	–27
Sometimes	15% (n=30)	34% (n=65)	34% (n=65)	19
Frequently or always	7% (n=13)	16% (n=32)	15% (n=29)	8
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.3.4 Providing SHP education to staff from other organisations

There was a 14 percentage point decrease in the number of participants who reported 'never or rarely' providing SHP education to staff from other organisations six months after the programme ended; the number who reported 'frequently or always' engaging in this activity increased by 3 percentage points . These figures suggest a small improvement over time. However, six months after the programme ended, 77% of participants reported 'never or rarely' providing SHP education to staff from other organisations.

Table 11: Frequency providing SHP education to staff from other organisations

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	91% (n=178)	77% (n=150)	77% (n=150)	–14
Sometimes	6% (n=11)	17% (n=32)	17% (n=32)	11
Frequently or always	3% (n=5)	6% (n=12)	6% (n=12)	3
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.4 Contributing to service practice and development

Participants were asked five questions about contributing to service practice and development in the area of SHP within their organisations. These questions related to the development of sexual health support services, written information for service users, administrative practices and sexual health policies.

4.4.1 Developing or contributing to the development of sexual health support services for service users

There was a 20 percentage point decrease in the number of participants who reported 'never or rarely' developing or contributing to the development of sexual health support services for service users six months after the programme ended; the number who reported 'frequently or always' engaging in this activity increased by 12 percentage points . These figures suggest a moderate improvement over time. However, six months after the programme ended, 48% of participants reported that they had 'never or rarely' developed or contributed to the development of sexual health support services for service users.

Table 12: Frequency developing or contributing to the development of sexual heath support services for service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	68% (n=131)	48% (n=93)	48% (n=94)	–20
Sometimes	23% (n=44)	34% (n=66)	31% (n=61)	8
Frequently or always	9% (n=19)	18% (n=35)	21% (n=39)	12
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.4.2 Advocating for the development of sexual health support services for service users

There was a 15 percentage point decrease in the number of participants who reported 'never of rarely' advocating for the development of sexual health support services for service users six months after the programme ended; there was a 12 percentage point increase in the number who reported 'frequently or always' engaging in this activity. These figures suggest a small improvement over time. However, six months after the programme ended, 30% of participants had 'never or rarely' advocated for the development of sexual health support services for service users.

Table 13: Frequency advocating for the development of sexual health support services for service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	45% (n=87)	28% (n=55)	30% (n=58)	–15
Sometimes	36% (n=69)	31% (n=60)	39% (n=76)	3
Frequently or always	19% (n=38)	41% (n=79)	31% (n=60)	12
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.4.3 Developing or contributing to written SHP information for service users

There was a 20 percentage point decrease in the number of participants who reported 'never or rarely' developing or contributing to the development of written information on sexual health for service users six months after the programme ended; the number who reported 'frequently or always' engaging in this activity increased by 8 percentage points. These figures suggest a moderate improvement over time. However, six months after the programme ended, 53%

of participants reported that they 'never or rarely' developed or contributed to written SHP information for service users.

Table 14: Frequency developing or contributing to written SHP information for service users

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	73% (n=141)	48% (n=93)	53% (n=103)	–20
Sometimes	22% (n=43)	32% (n=62)	34% (n=66)	12
Frequently or always	5% (n=10)	20% (n=39)	13% (n=25)	8
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.4.4 Adapting administrative practices to include aspects of SHP

There was a 26 percentage point decrease in the number of participants who reported 'never or rarely' adapting administrative practices to include aspects of SHP six months after the programme ended; the number who reported 'frequently or always' engaging in this activity increased by 11 percentage points. These figures suggest a moderate improvement over time. However, six months after the programme ended, 54% of participants reported 'never or rarely' adapting their administrative practices to include aspects of SHP.

Table 15: Frequency adapting administrative practices to include aspects of SHP

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	80% (n=155)	51% (n=98)	54% (n=105)	–26
Sometimes	13% (n=25)	30% (n=59)	28% (n=55)	15
Frequently or always	7% (n=14)	19% (n=37)	18% (n=34)	11
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.4.5 Developing or contributing to sexual health policies/guidelines

There was a 26 percentage point decrease in the number of participants who reported 'never or rarely' developing or contributing to the development of sexual health policies/guidelines six months after the programme ended; the number who reported 'frequently or always' engaging in this activity increased by 9 percentage points. These figures suggest a moderate

improvement over time. However, six months after the programme ended, 56% of participants had 'never or rarely' developed or contributed to sexual health policies or guidelines.

Table 16: Frequency developing or contributing to sexual health policies/guidelines

Frequency	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Never or rarely	82% (n=159)	53% (n=103)	56% (n=109)	–26
Sometimes	11% (n=21)	31% (n=60)	28% (n=54)	17
Frequently or always	7% (n=14)	16% (n=31)	16% (n=31)	9
Total	100% (n=194)	100% (n=194)	100% (n=194)	

4.5 Chapter summary

The data in this chapter infers marginal to moderate increases in the numbers of FPSHP participants who reported engaging in a range of SHP activities with service users and colleagues within their organisations six months after the programme ended. It also shows low to moderate increases in the numbers of participants who reported contributing to service practice and development around SHP. Although there were marginal increases in the numbers who reported 'frequently or always' carrying out these activities across all the measures, there were often greater increases in the numbers who reported that they 'sometimes' carried out these activities. The numbers reporting frequently or always engaging in SHP activities six months after completion ranged from 6% to 42% of the sample, representing increases of 3 to 13 percentage points between the first and third waves of the evaluation. This finding suggests small levels of change, however, none of the changes in this section were statistically significant. Across all the measures in this section, it remained the case that six months after the programme, sizeable proportions (ranging from 22% to 77%) of participants still responded 'never or rarely' to engagement in the activities.

Chapter 5: Measuring confidence to engage in SHP activities at work

5.1 Introduction

Building confidence has been linked with improved ability to implement SHP (Ahmed et al., 2006; Murphy-Lawless et al., 2008). The evaluation tool included scales to measure FPSHP participants' confidence in engaging with service users and staff in the area of SHP and in contributing to the development of practices and policies in this area. The data gathered from the eleven-point ratio scales in the evaluation tool was re-categorised into three-point ordinal variable scales as follows: scores 0 to 3 were categorised as 'low', scores 4 to 6 as 'moderate' and scores 7 to 10 as 'high'. This chapter sets out the findings related to differences measured between the first and third waves of the evaluation.

5.2 Confidence to engage in SHP activities with service users

Participants were asked to rate their levels of confidence when engaging in the following SHP activities with service users: assessing SHP needs, providing information, making referrals to sexual health services and providing sexual health education.

5.2.1 Assessing the SHP needs of service users

Between the first and third waves of the evaluation, the data shows a 36 percentage point decrease in the number of participants who reported having a 'low' level of confidence about assessing the SHP needs of service users. There was a significant increase of 61 percentage point in the number who reported a 'high' level of confidence*.

Table 17: Confidence assessing the SHP needs of service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	37% (n=72)	2% (n=4)	1% (n=1)	–36
Moderate	43% (n=83)	14% (n=27)	18% (n=34)	–25
High	20% (n=39)	84% (n=163)	81% (n=159)	61 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

* ↑ represents statistical significance.

5.2.2 Providing written/verbal SHP information to service users

Between the first and third waves of the evaluation, the data shows a 29 percentage point decrease in the number of participants who reported having a 'low' level of confidence about providing written or verbal SHP information to service users. A significant increase of 57 percentage points was measured in the number who reported a 'high' level of confidence.

Table 18: Confidence providing written/verbal SHP information to service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	31% (n=60)	1% (n=2)	2% (n=3)	–29
Moderate	45% (n=87)	10% (n=19)	17% (n=33)	–28
High	24% (n=47)	89% (n=173)	81% (n=158)	57 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.2.3 Referring service users to sexual health services

Between the first and third waves of the evaluation, the data shows a 20 percentage point decrease in the number of participants who reported having a 'low' level of confidence about referring service users to sexual health services. There was a significant increase of 42 percentage points in the number who reported a 'high' level of confidence. It should be noted that a large minority of the sample (46%) reported a 'high' level of confidence about referring service users to sexual health services before participating in the programme.

Table 19: Confidence referring service users to sexual health services

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	22% (n=42)	1% (n=1)	2% (n=2)	–20
Moderate	32% (n=63)	8% (n=16)	10% (n=19)	–22
High	46% (n=89)	91% (n=177)	88% (n=173)	42 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.2.4 Providing sexual health education to service users

Between the first and third waves of the evaluation, the data shows a decrease of 32 percentage points in the number of participants who reported having a 'low' level of confidence about providing sexual health education to service users in a one-to-one or group setting. There was a significant increase of 58 percentage points in the number who reported a 'high' level of confidence.

Table 20: Confidence providing sexual health education to service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	35% (n=68)	0% (n=0)	3% (n=5)	–32
Moderate	38% (n=73)	11% (n=22)	12% (n=23)	–26
High	27% (n=53)	89% (n=172)	85% (n=166)	58 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.3 Confidence to engage in SHP education with staff

Participants were asked four questions about their confidence to assess the SHP education needs of their colleagues and the staff they liaise with within and outside their organisation in relation to their health promotion needs.

5.3.1 Assessing the SHP education needs of staff within own organisation

Between the first and third waves of the evaluation, the data shows a decrease of 50 percentage points in the number of participants who reported having a 'low' level of confidence about assessing the SHP education needs of staff within their organisation. There was a significant increase of 38 percentage points in the number who reported a 'high' level of confidence.

Table 21: Confidence assessing the SHP education needs of staff within own organisation

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	65% (n=126)	11% (n=21)	15% (n=30)	–50
Moderate	24% (n=46)	30% (n=59)	36% (n=69)	12
High	11% (n=22)	59% (n=114)	49% (n=95)	38 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.3.2 Providing SHP education to staff within own organisation

Between the first and third waves of the evaluation, the data shows a decrease of 50 percentage points in the number of participants who reported having a 'low' level of confidence about providing SHP education to staff within their organisation. There was a significant increase of 46 percentage points in the number who reported a 'high' level of confidence.

Table 22: Confidence providing SHP education to staff within own organisation

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	64% (n=125)	8% (n=16)	14% (n=27)	–50
Moderate	25% (n=49)	26% (n=50)	29% (n=57)	4
High	11% (n=20)	66% (n=128)	57% (n=110)	46 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.3.3 Developing or contributing to the development of sexual health education programmes

Between the first and third waves of the evaluation, the data shows a decrease of 47 percentage points in the number of participants who reported having a 'low' level of confidence about developing or contributing to the development of sexual health education programmes. There was a significant increase of 51 percentage points in the number who reported a 'high' level of confidence.

Table 23: Confidence developing or contributing to the development of sexual health education programmes

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	56% (n=108)	3% (n=6)	9% (n=18)	–47
Moderate	29% (n=57)	21% (n=40)	25% (n=48)	–4
High	15% (n=29)	76% (n=148)	66% (n=128)	51 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.3.4 Providing SHP education to staff from other organisations

Between the first and third waves of the evaluation, the data shows a decrease of 53 percentage points in the number of participants who reported a 'low' level of confidence about providing SHP education to staff outside their organisation. There was a significant increase of 42 percentage points in the number who reported a 'high' level of confidence.

Table 24: Confidence providing SHP education to staff from other organisations

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	68% (n=131)	7% (n=14)	15% (n=29)	–53
Moderate	22% (n=43)	31% (n=61)	33% (n=64)	11
High	10% (n=20)	62% (n=119)	52% (n=101)	42 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.4 Confidence regarding service practice and development

Participants were asked to rate their confidence about engaging in five activities relating to service practice and development in the area of SHP including: advocating for or contributing to the development of sexual health support services, developing written sexual health information, adapting administrative practices to incorporate sexual health and developing sexual health policies.

5.4.1 Developing or contributing to the development of sexual health support services for service users

Between the first and third waves of the evaluation, the data shows a 48 percentage point decrease in the number of participants who reported a 'low' level of confidence about developing or contributing to the development of sexual health support services for service users. There was a significant increase of 53 percentage points in the number who reported a 'high' level of confidence.

Table 25: Confidence developing or contributing to the development of sexual health support services for service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	52% (n=101)	3% (n=5)	4% (n=8)	–48
Moderate	33% (n=64)	21% (n=40)	28% (n=54)	–5
High	15% (n=29)	76% (n=149)	68% (n=132)	53 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.4.2 Advocating for the development of sexual health support services for service users

Between the first and third waves of the evaluation, the data shows a decrease of 40 percentage points in the number of participants who reported a 'low' level of confidence about advocating for the development of sexual health support services for service users. The number who reported a 'high' level of confidence increased significantly by 56 percentage points.

Table 26: Confidence advocating for the development of sexual health support services for service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	42% (n=81)	1% (n=1)	2% (n=4)	–40
Moderate	36% (n=69)	12% (n=23)	20% (n=38)	–16
High	22% (n=44)	87% (n=170)	78% (n=152)	56 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.4.3 Developing or contributing to written SHP information for service users

Between the first and third waves of the evaluation, the data shows a decrease of 47 percentage points in the number of participants who reported a 'low' level of confidence about developing or contributing to written information on sexual health for service users. There was a significant increase of 55 percentage points in the number who reported a 'high' level of confidence.

Table 27: Confidence developing or contributing to written SHP information for service users

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	51% (n=99)	3% (n=5)	4% (n=8)	–47
Moderate	34% (n=65)	15% (n=30)	26% (n=50)	–8
High	15% (n=30)	82% (n=159)	70% (n=136)	55 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.4.4 Adapting assessment forms to include sexual health

Between the first and third waves of the evaluation, the data shows a decrease of 50 percentage points in the number of participants who reported a 'low' level of confidence about adapting their administrative practices by developing or changing assessment forms to include sexual health. There was a significant increase of 53 percentage points in the number who reported a 'high' level of confidence.

Table 28: Confidence adapting assessment forms to include sexual health

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	56% (n=108)	4% (n=7)	6% (n=12)	–50
Moderate	29% (n=56)	21% (n=40)	26% (n=50)	–3
High	15% (n=30)	75% (n=147)	68% (n=132)	53 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.4.5 Developing or contributing to sexual health policies/guidelines

Between the first and third waves of the evaluation, the data shows a decrease of 52 percentage points in the number of participants who reported a 'low' level of confidence about developing or contributing to the development of sexual health policies/guidelines. There was a significant increase of 53 percentage points in the number who reported a 'high' level of confidence.

Table 29: Confidence developing or contributing to sexual health policies/guidelines

Confidence	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	58% (n=113)	3% (n=6)	6% (n=12)	–52
Moderate	27% (n=52)	24% (n=47)	26% (n=50)	–1
High	15% (n=29)	73% (n=141)	68% (n=132)	53 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

5.5 Chapter summary

Confidence has been reported to be a key component in the effective delivery of SHP activities. The data in this chapter shows large increases in the numbers of FPSHP participants who, six months after the programme ended, reported feeling more confident about engaging in SHP activities with service users and with colleagues. The data also shows large increases in participants' levels of confidence in influencing practice development. The numbers reporting high levels of confidence six months after completion ranged from 49% to 88% of the sample, representing increases of 38 to 42 percentage points between the first and third waves of the evaluation. The increases tested as statistically significant, with a confidence interval of 95%, which implies that there is a high probability that they are related directly to the programme as opposed to occurring by chance.

Chapter 6: Measuring knowledge of sexual health topics

6.1 Introduction

FPSHP participants were asked to rate their perceived levels of knowledge of certain sexual health topics. The data gathered from the eleven-point ratio scales in the evaluation tool was re-categorised into three-point ordinal variable scales as follows: scores 0 to 3 were categorised as 'low', scores 4 to 6 as 'moderate' and scores 7 to 10 as 'high'. This chapter sets out the findings related to differences measured between the first and third waves of the evaluation.

6.2 Sexual health topics

Participants were asked to rate their perceived levels of knowledge about: SHP needs throughout the life course, contraception, STIs, fertility issues, sexual function, sexual dysfunction, sexual orientation, gender identity, health inequalities in relation to sexual health, sexuality as a holistic concept, pleasure and sexual behaviour, self-esteem and sexual behaviour, legal issues associated with sexual offences, SHP policy development, sexual health in the Irish context, and access to sexual health information.

6.2.1 SHP needs throughout the life course

Between the first and third waves of the evaluation, the data shows a decrease of 26 percentage points in the number of participants who reported having a 'low' level of knowledge about sexual health needs throughout the life course. There was a significant increase of 73 percentage points in the number who reported a 'high' level of this knowledge.

Table 30: Knowledge about SHP needs throughout the life course

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	26% (n=50)	1% (n=1)	0% (n=0)	–26
Moderate	56% (n=109)	8% (n=16)	9% (n=18)	–47
High	18% (n=35)	91% (n=177)	91% (n=176)	73 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.2 Contraception

Between the first and third waves of the evaluation, the data shows a decrease of 10 percentage points in the number of participants who reported having a 'low' level of knowledge about contraception. There was a significant increase of 49 percentage points in the number who reported a 'high' level of this knowledge. It should be noted that a large minority of the sample (47%) reported having a 'high' level of knowledge about contraception before participating in the programme.

Table 31: Knowledge about contraception

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	10% (n=19)	0% (n=0)	0% (n=0)	–10
Moderate	43% (n=84)	4% (n=7)	4% (n=7)	–39
High	47% (n=91)	96% (n=187)	96% (n=187)	49 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.3 Sexually transmitted infections

Between the first and third waves of the evaluation, the data shows a decrease of 17 percentage points in the number of participants who reported having a 'low' level of knowledge about STIs. There was a significant increase of 60 percentage points in the number who reported a 'high' level of this knowledge. Over one-third of participants reported having a 'high' level of knowledge about STIs before participating in the programme.

Table 32: Knowledge about STIs

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	17% (n=33)	0% (n=0)	0% (n=0)	–17
Moderate	48% (n=94)	5% (n=10)	5% (n=9)	–43
High	35% (n=67)	95% (n=184)	95% (n=185)	60 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.4 Fertility issues

Between the first and third waves of the evaluation, the data shows a decrease of 33 percentage points in the number of participants who reported having a 'low' level of knowledge about fertility issues. There was a significant increase of 53 percentage points in the number who reported a 'high' level of this knowledge.

Table 33: Knowledge about fertility issues

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	35% (n=68)	2% (n=4)	2% (n=4)	–33
Moderate	44% (n=86)	20% (n=39)	24% (n=46)	–20
High	21% (n=40)	78% (n=151)	74% (n=144)	53 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.5 Sexual function

Between the first and third waves of the evaluation, the data shows a decrease of 26 percentage points in the number of participants who reported having a 'low' level of knowledge about sexual function. There was a significant increase of 64 percentage points in the number who reported a 'high' level of this knowledge.

Table 34: Knowledge about sexual function

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	27% (n=53)	1% (n=1)	1% (n=1)	–26
Moderate	49% (n=95)	11% (n=22)	11% (n=23)	–38
High	24% (n=46)	88% (n=171)	88% (n=170)	64 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.6 Sexual dysfunction

Between the first and third waves of the evaluation, the data shows a decrease of 34 percentage points in the number of participants who reported having a 'low' level of knowledge about sexual dysfunction. There was a significant increase of 66 percentage points in the number who reported a 'high' level of this knowledge.

Table 35: Knowledge about sexual dysfunction

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	36% (n=69)	2% (n=3)	2% (n=3)	–34
Moderate	49% (n=95)	16% (n=32)	17% (n=34)	–31
High	15% (n=30)	82% (n=159)	81% (n=157)	66 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.7 Sexual orientation

Between the first and third waves of the evaluation, the data shows a decrease of 20 percentage points in the number of participants who reported having a 'low' level of knowledge about sexual orientation. There was a significant increase of 53 percentage points in the number who reported a 'high' level of this knowledge. Over one-third of participants reported a 'high' level of knowledge about sexual orientation before participating in the programme.

Table 36: Knowledge about sexual orientation

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	21% (n=41)	1% (n=2)	1% (n=1)	–20
Moderate	44% (n=85)	8% (n=16)	11% (n=21)	–33
High	35% (n=68)	91% (n=176)	88% (n=172)	53 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.8 Gender identity

Between the first and third waves of the evaluation, the data shows a decrease of 26 percentage points in the number of participants who reported having a 'low' level of knowledge about gender identity. There was a significant increase of 55 percentage points in the number who reported a 'high' level of this knowledge.

Table 37: Knowledge about gender identity

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	27% (n=52)	2% (n=3)	1% (n=2)	–26
Moderate	44% (n=86)	9% (n=18)	15% (n=29)	–29
High	29% (n=56)	89% (n=173)	84% (n=163)	55 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.9 Health inequalities in relation to sexual health

Between the first and third waves of the evaluation, the data shows a decrease of 41 percentage points in the number of participants who reported having a 'low' level of knowledge about health inequalities in relation to sexual health. There was a significant increase of 70 percentage points in the number who reported a 'high' level of this knowledge.

Table 38: Knowledge about health inequalities in relation to sexual health

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	42% (n=82)	1% (n=2)	1% (n=1)	–4
Moderate	48% (n=92)	12% (n=24)	19% (n=37)	–29
High	10% (n=20)	87% (n=168)	80% (n=156)	70 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.10 Sexuality as a holistic concept

Between the first and third waves of the evaluation, the data shows a decrease of 35 percentage points in the number of participants who reported having a 'low' level of knowledge about sexuality as a holistic concept. There was a significant increase of 70 percentage points in the number who reported a 'high' level of this knowledge.

Table 39: Knowledge about sexuality as a holistic concept

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	35% (n=68)	0% (n=0)	0% (n=0)	–35
Moderate	47% (n=91)	6% (n=12)	12% (n=24)	–35
High	18% (n=35)	94% (n=182)	88% (n=170)	70 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.11 Pleasure and sexual behaviour

Between the first and third waves of the evaluation, the data shows a decrease of 25 percentage points in the number of participants who reported having a 'low' level of knowledge about pleasure and sexual behaviour. There was a significant increase of 64 percentage points in the number who reported a 'high' level of this knowledge.

Table 40: Knowledge about pleasure and sexual behaviour

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	25% (n=48)	0% (n=0)	0% (n=0)	–25
Moderate	49% (n=95)	8% (n=15)	10% (n=20)	–39
High	26% (n=51)	92% (n=179)	90% (n=174)	64 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.12 Self-esteem and sexual behaviour

Between the first and third waves of the evaluation, the data shows a decrease of 23 percentage points in the number of participants who reported having a 'low' level of knowledge about self-esteem and sexual behaviour. There was a significant increase of 67 percentage points in the number who reported a 'high' level of this knowledge.

Table 41: Knowledge about self-esteem and sexual behaviour

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	23% (n=44)	0% (n=0)	0% (n=0)	–23
Moderate	49% (n=95)	6% (n=12)	5% (n=9)	–44
High	28% (n=55)	94% (n=182)	95% (n=185)	67 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.13 Legal issues associated with sexual offences

Between the first and third waves of the evaluation, the data shows a decrease of 39 percentage points in the number of participants who reported having a 'low' level of knowledge about the legal issues associated with sexual offences. There was a significant increase of 60 percentage points in the number who reported a 'high' level of this knowledge.

Table 42: Knowledge about legal issues associated with sexual offences

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	40% (n=78)	1% (n=2)	1% (n=1)	–39
Moderate	45% (n=88)	14% (n=28)	24% (n=47)	–21
High	15% (n=28)	85% (n=164)	75% (n=146)	60 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.14 SHP policy development

Between the first and third waves of the evaluation, the data shows a decrease of 62 percentage points in the number of participants who reported having a 'low' level of knowledge about policy development in the area of SHP. There was a significant increase of 66 percentage points in the number who reported a 'high' level of this knowledge.

Table 43: Knowledge about SHP policy development

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	63% (n=123)	4% (n=7)	1% (n=2)	–62
Moderate	31% (n=59)	21% (n=40)	27% (n=52)	–4
High	6% (n=12)	75% (n=147)	72% (n=140)	66 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.15 Understanding of sexual health in the Irish context

Between the first and third waves of the evaluation, the data shows a decrease of 53 percentage points in the number of participants who reported having a 'low' level of understanding of sexual health in the Irish context. There was a 76 percentage point increase in the number who reported a 'high' level of this understanding.

Table 44: Understanding of sexual health in the Irish context

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	53% (n=103)	2% (n=3)	0% (n=0)	–53
Moderate	38% (n=73)	9% (n=18)	15% (n=30)	–23
High	9% (n=18)	89% (n=173)	85% (n=164)	76 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.2.16 Access to SHP information

Between the first and third waves of the evaluation, the data shows a decrease of 30 percentage points in the number of participants who reported having a 'low' level of knowledge about accessing SHP information. There was a significant 67 percentage point increase in the number who reported having a 'high' level of this knowledge.

Table 45: Knowledge about access to SHP information

Knowledge	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	30% (n=59)	1% (n=1)	0% (n=0)	–30
Moderate	41% (n=80)	4% (n=8)	4% (n=8)	–37
High	29% (n=55)	95% (n=185)	96% (n=186)	67 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

6.3 Chapter summary

The data in this chapter shows large increases in the number of participants who reported having increased knowledge about a range of SHP-related topics six months after the programme ended. While the evaluation sometimes found high levels of knowledge being self-reported prior to beginning the programme, the numbers reporting high levels of knowledge six months after completion ranged from 72% to 96%, representing increases of 49 to 76 percentage points between the first and third waves of the evaluation. The percentage point increases across the measures tested as statistically significant, with a confidence interval of 95%, which implies that there is a high probability that the increases are related directly to the programme as opposed to occurring by chance.

Chapter 7: Measuring SHP skills

7.1 Introduction

FPSHP participants were asked to rate their skills level with regard to engaging in a range of SHP activities. The data gathered from the eleven-point ratio scales in the evaluation tool was re-categorised into three-point ordinal variable scales as follows: scores 0 to 3 were categorised as 'low', scores 4 to 6 as 'moderate' and scores 7 to 10 as 'high'. This chapter sets out the findings related to differences measured between the first and third waves of the evaluation.

7.2 SHP skills

Participants were asked to rate their skill levels on sixteen SHP activities including: opening discussions, providing one-to-one support or group facilitation, designing programmes, making presentations, accessing up-to-date information, developing information leaflets, developing policies, reflecting on own practice, and networking.

7.2.1 Opening a discussion on sexual health with service users

Between the first and third waves of the evaluation, the data shows a 26 percentage points decrease in the number of participants who reported having a 'low' level of skill at opening a discussion on sexual health with service users. There was a significant increase of 63 percentage points in the number who reported a 'high' level of this skill.

Table 46: Skill at opening a discussion on sexual health with service users

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	26% (n=51)	0% (n=0)	0% (n=0)	–26
Moderate	45% (n=87)	5% (n=9)	8% (n=15)	–37
High	29% (n=56)	95% (n=185)	92% (n=179)	63 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.2 Providing one-to-one support related to SHP

Between the first and third waves of the evaluation, the data shows a 28 percentage points decrease in the number of participants who reported having a 'low' level of skill at providing one-to-one support related to SHP. There was a significant increase of 67 percentage points in the number who reported a 'high' level of this skill.

Table 47: Skill at providing one-to-one support related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	28% (n=55)	0% (n=0)	0% (n=0)	–28
Moderate	47% (n=91)	3% (n=5)	8% (n=15)	–39
High	25% (n=48)	97% (n=189)	92% (n=179)	67 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.3 Providing group facilitation related to SHP

Between the first and third waves of the evaluation, the data shows a 47 percentage points decrease in the number of participants who reported having a 'low' level of skill at group facilitation related to SHP. There was a significant increase of 62 percentage points in the number who reported a 'high' level of this skill.

Table 48: Skill at providing group facilitation related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	48% (n=94)	1% (n=1)	1% (n=2)	–47
Moderate	35% (n=67)	13% (n=26)	20% (n=39)	–15
High	17% (n=33)	86% (n=167)	79% (n=153)	62 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.4 Designing programmes related to SHP

Between the first and third waves of the evaluation, the data shows a 53 percentage points decrease in the number of participants who reported having a 'low' level of skill at programme design related to SHP. There was a significant increase of 61 percentage points in the number who reported a 'high' level of this skill.

Table 49: Skill at designing programmes related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	55% (n=107)	2% (n=4)	2% (n=4)	–53
Moderate	35% (n=67)	13% (n=26)	27% (n=53)	–8
High	10% (n=20)	85% (n=164)	71% (n=137)	61 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.5 Making presentations related to SHP

Between the first and third waves of the evaluation, the data shows a 49 percentage points decrease in the number of participants who reported having a 'low' level of skill at presenting in relation to SHP. There was a significant increase of 64 percentage points in the number who reported a 'high' level of this skill.

Table 50: Skill at making presentations related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	51% (n=99)	1% (n=2)	2% (n=3)	–49
Moderate	35% (n=67)	9% (n=17)	20% (n=39)	–15
High	14% (n=28)	90% (n=175)	78% (n=152)	64 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.6 Accessing up-to-date information on SHP

Between the first and third waves of the evaluation, the data shows a 35 percentage points decrease in the number of participants who reported having a 'low' level of skill at accessing up-to-date information on SHP. There was a significant increase of 62 percentage points in the number who reported a 'high' level of this skill.

Table 51: Skill at accessing up-to-date information on SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	35% (n=67)	0% (n=0)	0% (n=0)	–35
Moderate	38% (n=75)	4% (n=8)	11% (n=22)	–27
High	27% (n=52)	96% (n=186)	89% (n=172)	62 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.7 Developing information leaflets related to SHP

Between the first and third waves of the evaluation, the data shows a 49 percentage point decrease in the number of participants who reported having a 'low' level of skill at developing information leaflets related to SHP. There was a significant increase of 64 percentage points in the number who reported a 'high' level of this skill.

Table 52: Skill at developing information leaflets related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	53% (n=102)	2% (n=3)	4% (n=8)	–49
Moderate	38% (n=74)	14% (n=28)	23% (n=45)	–15
High	9% (n=18)	84% (n=163)	73% (n=141)	64 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.8 Developing policies related to SHP

Between the first and third waves of the evaluation, the data shows a 56 percentage point decrease in the number of participants who reported a 'low' level of skill at developing policies related to SHP. There was a significant increase of 63 percentage points in the number who reported a 'high' level of this skill.

Table 53: Skill at developing policies related to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	61% (n=119)	3% (n=5)	5% (n=9)	–56
Moderate	34% (n=65)	19% (n=37)	27% (n=52)	–7
High	5% (n=10)	78% (n=152)	68% (n=133)	63 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.9 Reflecting on own SHP practice

Between the first and third waves of the evaluation, the data shows a 35 percentage point decrease in the number of participants who reported having a 'low' level of skill at reflecting on their own practice in relation to SHP. There was a significant increase of 68 percentage points in the number who reported a 'high' level of this skill.

Table 54: Skill at reflecting on own SHP practice

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	35% (n=67)	0% (n=0)	0% (n=0)	–35
Moderate	44% (n=86)	5% (n=9)	11% (n=21)	–33
High	21% (n=41)	95% (n=185)	89% (n=173)	68 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.2.10 Networking in relation to SHP

Between the first and third waves of the evaluation, the data shows a 41 percentage point decrease in the number of participants who reported having a 'low' level of skill at networking about SHP with other individuals and organisations. There was a significant increase of 65 percentage points in the number who reported a 'high' level of this skill.

Table 55: Skill at networking in relation to SHP

Skill	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	44% (n=86)	0% (n=0)	3% (n=5)	–41
Moderate	38% (n=74)	5% (n=10)	14% (n=28)	–24
High	18% (n=34)	95% (n=184)	83% (n=161)	65 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

7.3 Chapter summary

The data in this chapter shows large increases in the number of participants who reported having improved skills with regard to SHP activities six months after the programme ended. The numbers of participants reporting high levels of such skills six months after completion ranged from 68% to 92%, representing increases of between 61 and 68 percentage points. These increases tested as statistically significant, with a confidence interval of 95%, which implies that there is a high probability that the increases are related directly to the programme as opposed to occurring by chance.

Chapter 8: Measuring comfort levels with SHP issues

8.1 Introduction

Studies on good practice outline that professionals engaging in SHP are required to be comfortable with their own sexual identity and to have the confidence to discuss sexuality issues in an open and relaxed manner (Allen, 2009; Higgins et al., 2009). FPSHP participants were asked to rate their comfort levels with a range of SHP topics. The data gathered from the eleven-point ratio scales in the evaluation tool was re-categorised into three-point ordinal variable scales as follows: scores 0 to 3 were categorised as 'low', scores 4 to 6 as 'moderate' and scores 7 to 10 as 'high'. This chapter sets out the findings related to differences measured between the first and third waves of the evaluation.

8.2 Personal comfort levels

Participants were asked about their comfort levels regarding topics such as using professional language or slang to speak about sexual health, asking questions about sexual health, and discussing sexual dysfunction, sexual abuse or trauma, contraception, fertility issues, STIs, body image, self-esteem, sexual orientation, gender identity, and pleasure and sexual behaviour.

8.2.1 Using professional language to speak about sexual health

Between the first and third waves of the evaluation, the data shows a decrease of 19 percentage points in the number of participants who reported having a 'low' level of comfort using professional language to speak about sexual health. There was a significant increase of 55 percentage points in the number who reported a 'high' level of comfort. Before participating in the programme, 38% of participants reported having a 'high' level of comfort using professional language.

Table 56: Comfort using professional language to speak about sexual health

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	19% (n=36)	1% (n=1)	0% (n=0)	–19
Moderate	43% (n=83)	5% (n=9)	7% (n=13)	–36
High	38% (n=75)	94% (n=184)	93% (n=181)	55 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.2 Using slang to speak about sexual health

Between the first and third waves of the evaluation, the data shows a decrease of 28 percentage points in the number of participants who reported having a 'low' level of comfort using slang to speak about sexual health. There was a significant increase of 49 percentage points in the number who reported a 'high' level of comfort.

Table 57: Comfort using slang to speak about sexual health

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	33% (n=64)	4% (n=7)	5% (n=9)	–28
Moderate	37% (n=71)	14% (n=27)	16% (n=32)	–21
High	30% (n=59)	82% (n=160)	79% (n=153)	49 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.3 Asking questions about sexual health

Between the first and third waves of the evaluation, the data shows a decrease of 16 percentage points in the number of participants who reported having a 'low' level of comfort asking questions about sexual health. There was a significant increase of 46 percentage points in the number who reported a 'high' level of comfort. It should be noted that 47% of participants reported having a 'high' level of comfort asking questions about sexual health before participating in the programme.

Table 58: Comfort asking questions about sexual health

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	16% (n=32)	0% (n=0)	0% (n=0)	–16
Moderate	37% (n=72)	7% (n=14)	7% (n=14)	–30
High	47% (n=90)	93% (n=180)	93% (n=180)	46 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.4 Discussing sexual dysfunction

Between the first and third waves of the evaluation, the data shows a decrease of 30 percentage points in the number of participants who reported having a 'low' level of comfort discussing sexual dysfunction. There was a significant increase of 52 percentage points in the number who reported a 'high' level of comfort. One in three participants (33%) reported having a 'high' level of comfort discussing sexual dysfunction before participating in the programme.

Table 59: Comfort discussing sexual dysfunction

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	31% (n=60)	0% (n=0)	1% (n=2)	–30
Moderate	36% (n=70)	15% (n=30)	14% (n=27)	–22
High	33% (n=64)	85% (n=164)	85% (n=165)	52 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.5 Discussing sexual abuse or trauma

Between the first and third waves of the evaluation, the data shows a decrease of 23 percentage points in the number of participants who reported having a 'low' level of comfort discussing sexual abuse or trauma. There was a significant increase of 41 percentage points in the number who reported a 'high' level of comfort. Before participating in the programme, 40% of participants stated they had a 'high' level of comfort discussing sexual abuse or trauma.

Table 60: Comfort discussing sexual abuse or trauma

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	24% (n=46)	1% (n=1)	1% (n=1)	–23
Moderate	36% (n=70)	15% (n=30)	18% (n=35)	–18
High	40% (n=78)	84% (n=163)	81% (n=158)	41 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.6 Discussing contraception

Between the first and third waves of the evaluation, the data shows a decrease of 10 percentage points in the number of participants who reported having a 'low' level of comfort discussing contraception. There was a significant increase of 40 percentage points in the number who reported a 'high' level of comfort. It should be noted that 55% of participants reported having a 'high' level of comfort discussing contraception before participating in the programme.

Table 61: Comfort discussing contraception

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	10% (n=19)	0% (n=0)	0% (n=0)	–10
Moderate	35% (n=68)	4% (n=7)	5% (n=10)	–30
High	55% (n=107)	96% (n=187)	95% (n=184)	40 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.7 Discussing fertility issues

Between the first and third waves of the evaluation, the data shows a decrease of 19 percentage points in the number of participants who reported having a 'low' level of comfort discussing fertility issues. There was a significant increase of 40 percentage points in the number who reported a 'high' level of comfort. It should be noted that 45% of participants reported having a 'high' level of comfort discussing fertility issues before participating in the programme.

Table 62: Comfort discussing fertility issues

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	19% (n=37)	0% (n=0)	0% (n=0)	–19
Moderate	36% (n=69)	12% (n=23)	15% (n=30)	–21
High	45% (n=88)	88% (n=171)	85% (n=164)	40 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.8 Discussing STIs

Between the first and third waves of the evaluation, the data shows a decrease of 14 percentage points in the number of participants who reported having a 'low' level of comfort discussing STIs. There was a significant increase of 42 percentage points in the number who reported a 'high' level of comfort. It should be noted that 51% of participants reported having a 'high' level of comfort discussing STIs before participating in the programme.

Table 63: Comfort discussing STIs

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	14% (n=27)	0% (n=0)	0% (n=0)	–14
Moderate	35% (n=68)	4% (n=7)	7% (n=13)	–28
High	51% (n=99)	96% (n=187)	93% (n=181)	42 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.9 Discussing body image

Between the first and third waves of the evaluation, the data shows a decrease of 13 percentage points in the number of participants who reported a 'low' level of comfort discussing body image. There was a significant increase of 41 percentage points in the number who reported a 'high' level of comfort. It should be noted that 52% of participants reported having a 'high' level of comfort discussing body image before participating in the programme.

Table 64: Comfort discussing body image

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	13% (n=25)	0% (n=0)	0% (n=0)	–13
Moderate	35% (n=68)	4% (n=8)	7% (n=13)	–28
High	52% (n=101)	96% (n=186)	93% (n=181)	41 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.10 Discussing self-esteem

Between the first and third waves of the evaluation, the data shows a decrease of 9 percentage points in the number of participants who reported a 'low' level of comfort discussing self-esteem. There was a significant increase of 35 percentage points in the number who reported a 'high' level of comfort. It should be noted that 61% of participants reported having a 'high' level of comfort discussing self-esteem before participating in the programme.

Table 65: Comfort discussing self-esteem

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	9% (n=18)	0% (n=0)	0% (n=0)	–9
Moderate	30% (n=57)	3% (n=6)	4% (n=8)	–26
High	61% (n=119)	97% (n=188)	96% (n=186)	35 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.11 Discussing sexual orientation

Between the first and third waves of the evaluation, the data shows a decrease of 18 percentage points in the number of participants who reported a 'low' level of comfort discussing sexual orientation. There was a significant increase of 41 percentage points in the number who reported a 'high' level of comfort. It should be noted that half the participants reported having a 'high' level of comfort discussing sexual orientation before participating in the programme.

Table 66: Comfort discussing sexual orientation

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	18% (n=35)	1% (n=1)	0% (n=0)	–18
Moderate	32% (n=63)	6% (n=12)	9% (n=18)	–23
High	50% (n=96)	93% (n=181)	91% (n=176)	41 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.12 Discussing gender identity

Between the first and third waves of the evaluation, the data shows a decrease of 20 percentage points in the number of participants who reported a 'low' level of comfort discussing gender identity. There was a significant increase of 45 percentage points in the number who reported a 'high' level of comfort. Before participating in the programme, 43% of participants reported having a 'high' level of comfort discussing gender identity.

Table 67: Comfort discussing gender identity

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	21% (n=41)	1% (n=1)	1% (n=1)	–20
Moderate	36% (n=70)	10% (n=20)	11% (n=21)	–25
High	43% (n=83)	89% (n=173)	88% (n=172)	45 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.2.13 Discussing pleasure and sexual behaviour

Between the first and third waves of the evaluation, the data shows a decrease of 29 percentage points in the number of participants who reported a 'low' level of comfort discussing pleasure and sexual behaviour. There was a significant increase of 49 percentage points in the number who reported a 'high' level of comfort. Over one-third of participants reported having a 'high' level of comfort discussing pleasure and sexual behaviour before participating in the programme.

Table 68: Comfort discussing pleasure and sexual behaviour

Comfort	Wave 1	Wave 2	Wave 3	PP difference (W3–W1)
Low	29% (n=56)	2% (n=3)	0% (n=0)	–29
Moderate	36% (n=69)	12% (n=23)	16% (n=31)	–20
High	35% (n=69)	86% (n=168)	84% (n=163)	49 ↑
Total	100% (n=194)	100% (n=194)	100% (n=194)	

8.3 Chapter summary

The data in this chapter shows large increases in the number of participants who reported feeling comfortable discussing a range of SHP-related topics after the programme ended. While some participants reported high levels of comfort (ranging from 30% to 61%) in some areas before they participated in the programme, there were clear increases following the training, with the numbers of participants reporting high levels of comfort six months after completion ranging from 79% to 96%. These increases tested as statistically significant, with a confidence interval of 95%, which implies that there is a distinct probability that the increases are related directly to the programme as opposed to occurring by chance.

Chapter 9: Measuring views on the FPSHP after completion

9.1 Introduction

Directly following completion of the FPSHP and six months on, participants were asked to reflect on their experience of the programme and to provide a rating for a number of factors related to their satisfaction with the programme and to their perceptions of the helpfulness of the programme and of their own organisations in supporting them to deliver SHP initiatives in practice. Participants were asked to rate each of these factors on a scale of 0 to 10 with 0 representing 'not satisfied at all' or 'not helpful at all' and 10 representing 'very satisfied' or 'very helpful'. For this report, scores of 0 to 3 were categorised as 'not satisfied/helpful', 4 to 6 as 'satisfied/helpful', 7 to 10 as 'very satisfied/ helpful'. This chapter outlines the results.

9.2 Satisfaction with the programme

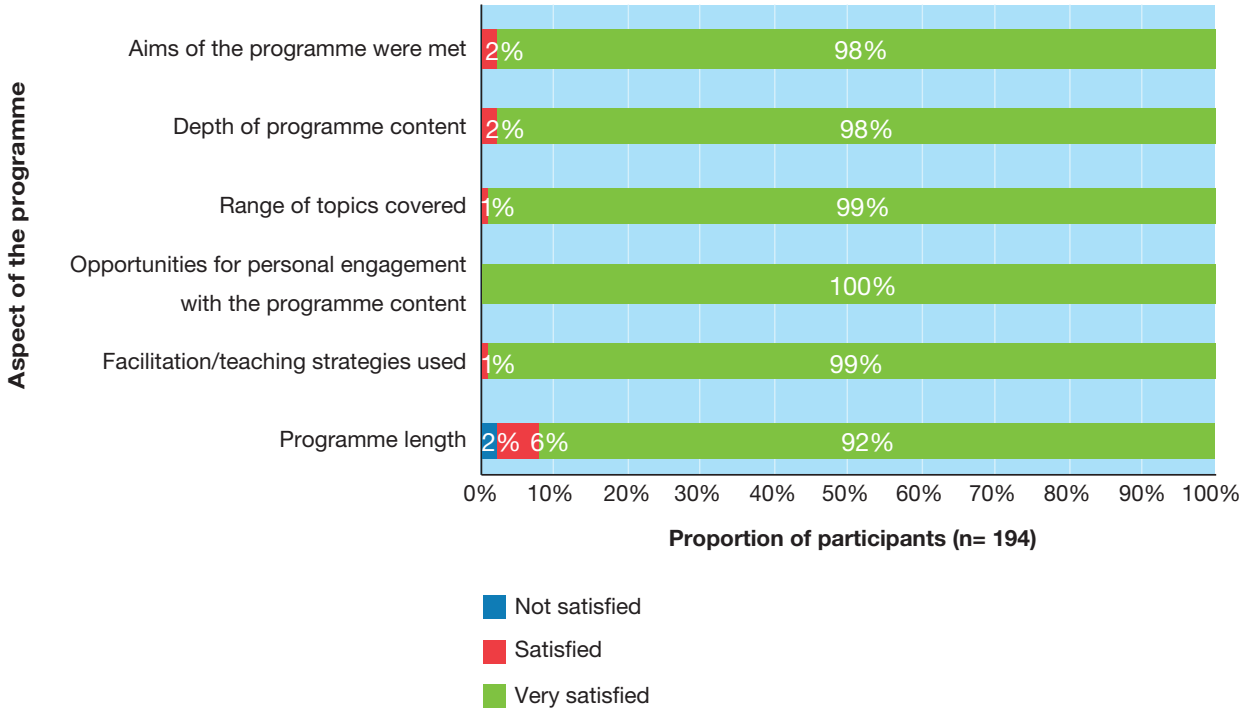
Directly following completion of the FPSHP, participants were asked to rate how satisfied they were with the programme across a number of areas. The results found very high satisfaction levels for all the measures. The vast majority of participants reported that the aims of the programme had been met and said they were 'very satisfied' with the:

- depth of the programme content
- range of topics covered
- opportunities for personal engagement with the topics covered
- facilitation skills and teaching strategies
- length of the programme.

Table 69: Satisfaction with aspects of the programme (at wave 2)

Measure	Not satisfied	Satisfied	Very satisfied
Aims of the programme were met	0% (n= 0)	2% (n= 3)	98% (n= 191)
Depth of programme content	0% (n= 0)	2% (n= 3)	98% (n= 191)
Range of topics covered	0% (n= 0)	1% (n= 2)	99% (n= 192)
Opportunities for personal engagement with the programme content	0% (n= 0)	0% (n= 0)	100% (n= 194)
Facilitation/teaching strategies used	0% (n= 0)	1% (n= 2)	99% (n= 192)
Programme length	2% (n= 4)	6% (n= 11)	92% (n= 179)

Figure 3: Overview of participants' self-reported satisfaction with the programme (wave 2)



9.3 Helpfulness of the programme

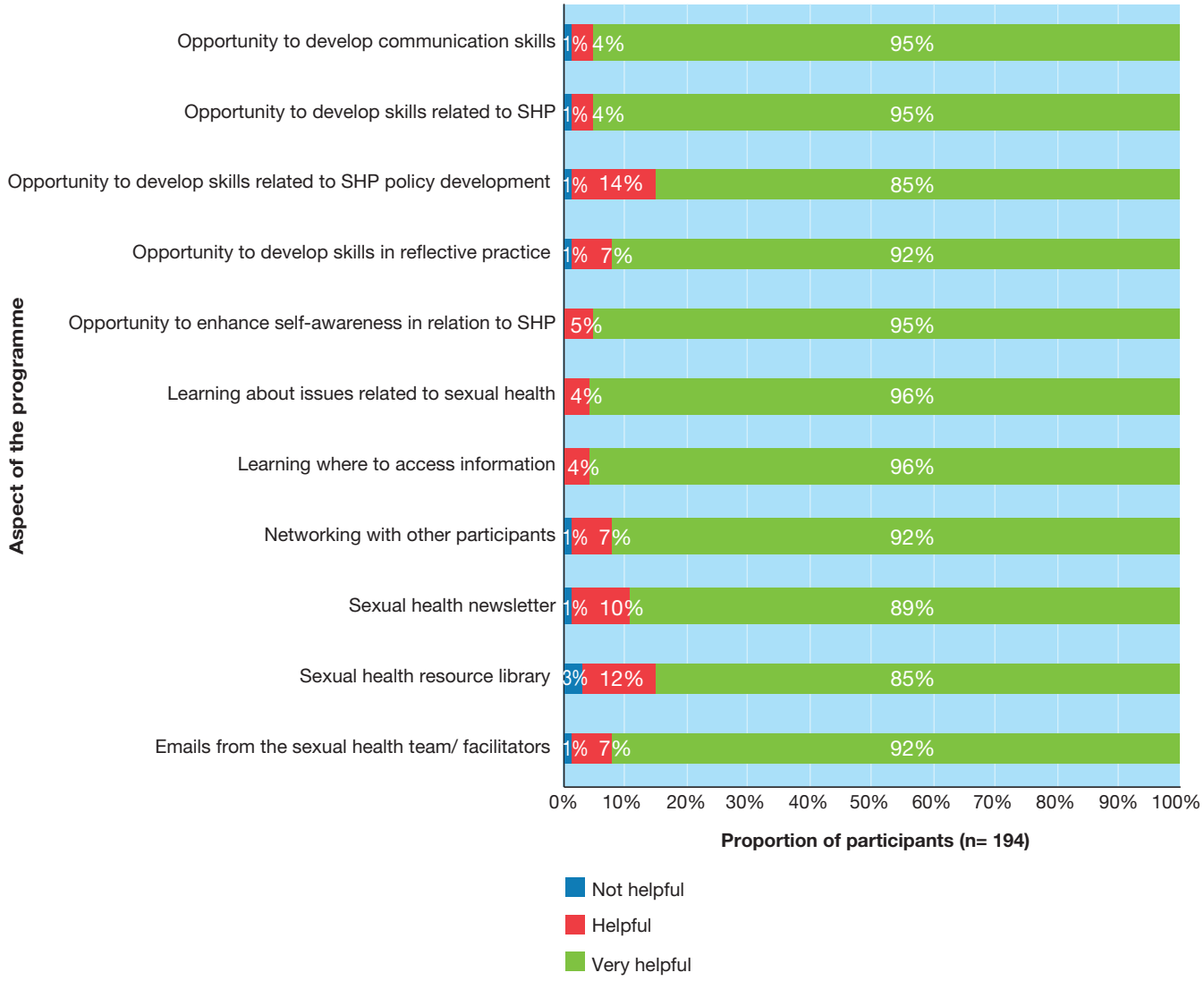
Six months following completion of the FPSHP, participants were asked to rate the helpfulness of different areas of the programme. The vast majority of participants reported that they found the following areas 'helpful' or 'very helpful':

- the opportunity to develop communication skills
- the opportunity to develop skills related to SHP
- the opportunity to develop skills related to SHP policy development
- the opportunity to develop skills in reflective practice
- the opportunity to enhance self-awareness in relation to SHP
- learning about issues related to sexual health
- learning where to access information
- networking with the other participants
- the sexual health newsletter
- the sexual health resource library
- emails from the sexual health team/facilitators.

Table 70: Perceived helpfulness of the programme (at wave 3)

Measure	Not helpful	Helpful	Very helpful
Opportunity to develop communication skills	1% (n= 1)	4% (n= 9)	95% (n= 184)
Opportunity to develop skills related to SHP	1% (n= 1)	4% (n= 8)	95% (n= 185)
Opportunity to develop skills related to SHP policy development	1% (n= 2)	14% (n= 28)	85% (n= 164)
Opportunity to develop skills in reflective practice	1% (n= 1)	7% (n= 13)	92% (n= 180)
Opportunity to enhance self-awareness in relation to SHP	0% (n= 0)	5% (n= 10)	95% (n= 184)
Learning about issues related to sexual health	0% (n= 0)	4% (n= 8)	96% (n= 186)
Learning where to access information	0% (n= 0)	4% (n= 7)	96% (n= 187)
Networking with other participants	1% (n= 1)	7% (n= 13)	92% (n= 180)
Sexual health newsletter	1% (n= 2)	10% (n= 20)	89% (n= 172)
Sexual health resource library	3% (n= 5)	12% (n= 24)	85% (n= 165)
Emails from the sexual health team/ facilitators	1% (n= 2)	7% (n= 13)	92% (n= 179)

Figure 4: Overview of participants' self-reported perceptions of the helpfulness of the programme (at wave 3)



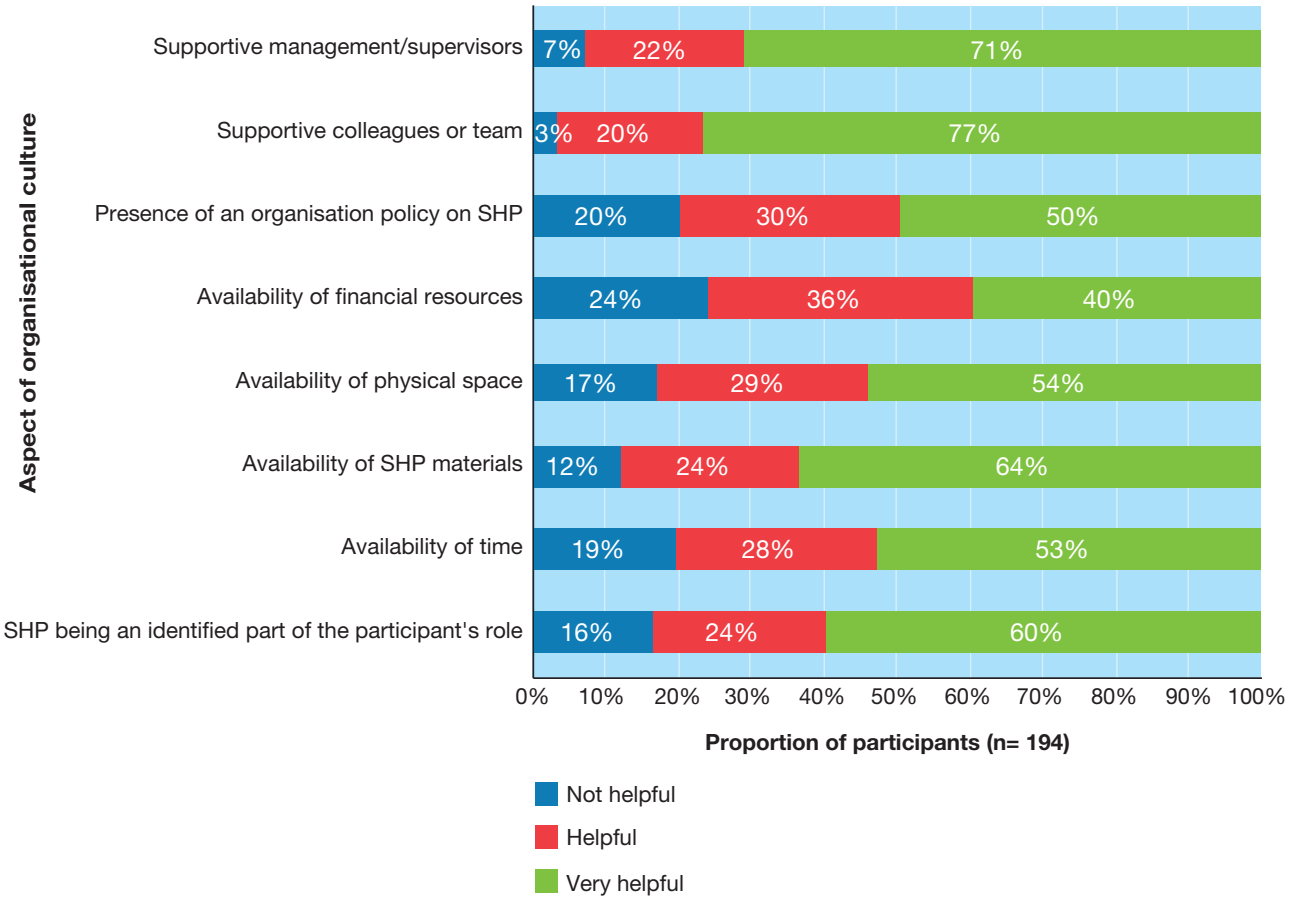
9.4 Helpfulness of the organisational culture in the workplace

The culture of employer organisations plays an important role in supporting participants to implement their FPSHP learning in practice. Six months following completion of the FPSHP, participants were asked to rate a number of different factors relating to the culture of their workplaces to help us understand more about the organisational factors that support or inhibit them in the delivery of SHP in practice. Across most areas, the results show that a majority of participants reported that their organisations are helpful in supporting them to deliver SHP. In the case of the availability of financial resources, half of participants ranked their organisation as helpful and half as not helpful. A sizeable minority of participants are also of the view that their organisation is not helpful when it comes to the presence (or absence) of an organisational policy on SHP and the limited availability of time and of physical space.

Table 71: Perceived helpfulness of organisational culture (at wave 3)

Measure	Not helpful	Helpful	Very helpful
Supportive management/supervisors	7% (n= 14)	22% (n= 43)	71% (n= 137)
Supportive colleagues or team	3% (n= 6)	20% (n= 38)	77% (n= 150)
Presence of an organisation policy on SHP	20% (n= 38)	30% (n= 59)	50% (n= 97)
Availability of financial resources	24% (n= 47)	36% (n= 69)	40% (n= 78)
Availability of physical space	17% (n= 32)	29% (n= 57)	54% (n= 105)
Availability of SHP materials	12% (n= 24)	24% (n= 46)	64% (n= 124)
Availability of time	19% (n= 37)	28% (n= 54)	53% (n= 103)
SHP being an identified part of the participant's role	16% (n= 32)	24% (n=45)	60% (n= 117)

Figure 5: Overview of participants' self-reported perceptions of organisational culture (at wave 3)



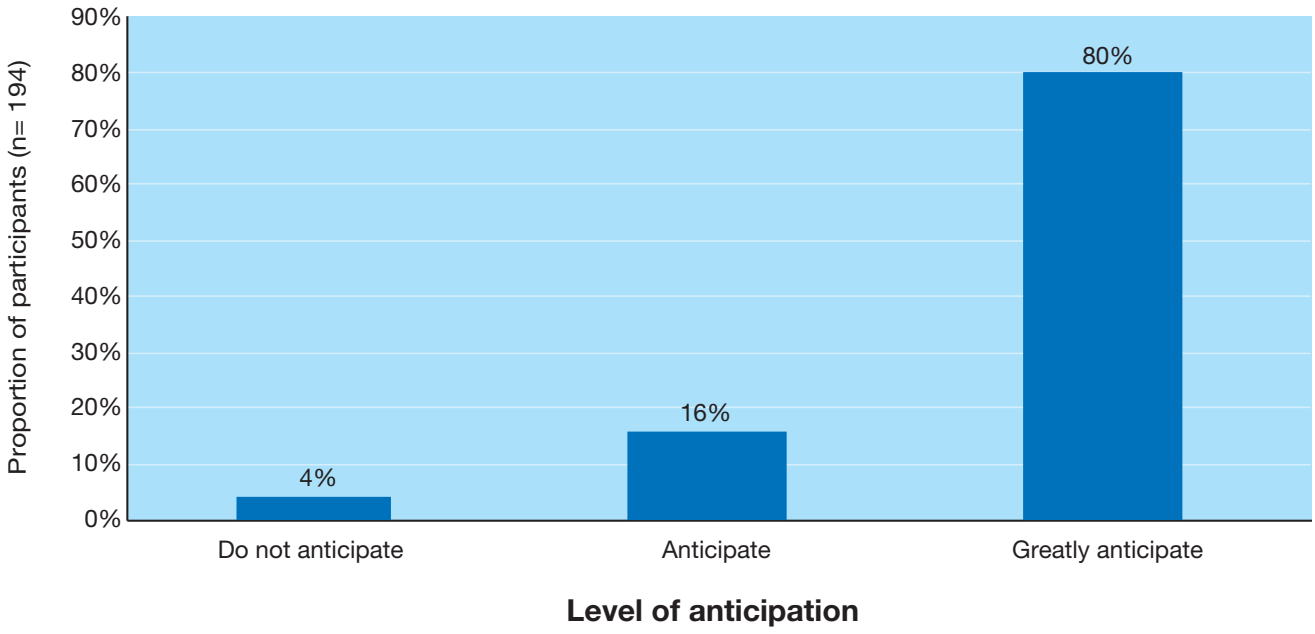
9.5 Sustainability of SHP changes in practice

Six months following completion of the FPSHP, participants were asked to rate on a scale of 0 to 10 how likely it is that they can sustain any SHP changes made in their practice as a result of participating in the programme. A rating of 0 indicated they did not at all anticipate that changes would be sustained, whereas a rating of 10 indicated they greatly anticipated changes being sustained. For the purposes of this report, scores of 0 to 3 have been categorised as 'do not anticipate', 4 to 6 as 'anticipate' and 7 to 10 as 'greatly anticipate'. The results indicate great optimism on the part of participants, with the vast majority reporting that they anticipate sustaining changes to their work practices.

Table 72: Anticipation of sustained changes in SHP practice (at wave 3)

Level of anticipation	% of participants
Do not anticipate	4% (n= 7)
Anticipate	16% (n= 32)
Greatly anticipate	80% (n= 155)

Figure 6: Overview of participants' self-reported anticipation of sustaining changes in their SHP practice (at wave 3)



9.6 Positive impact on SHP practices

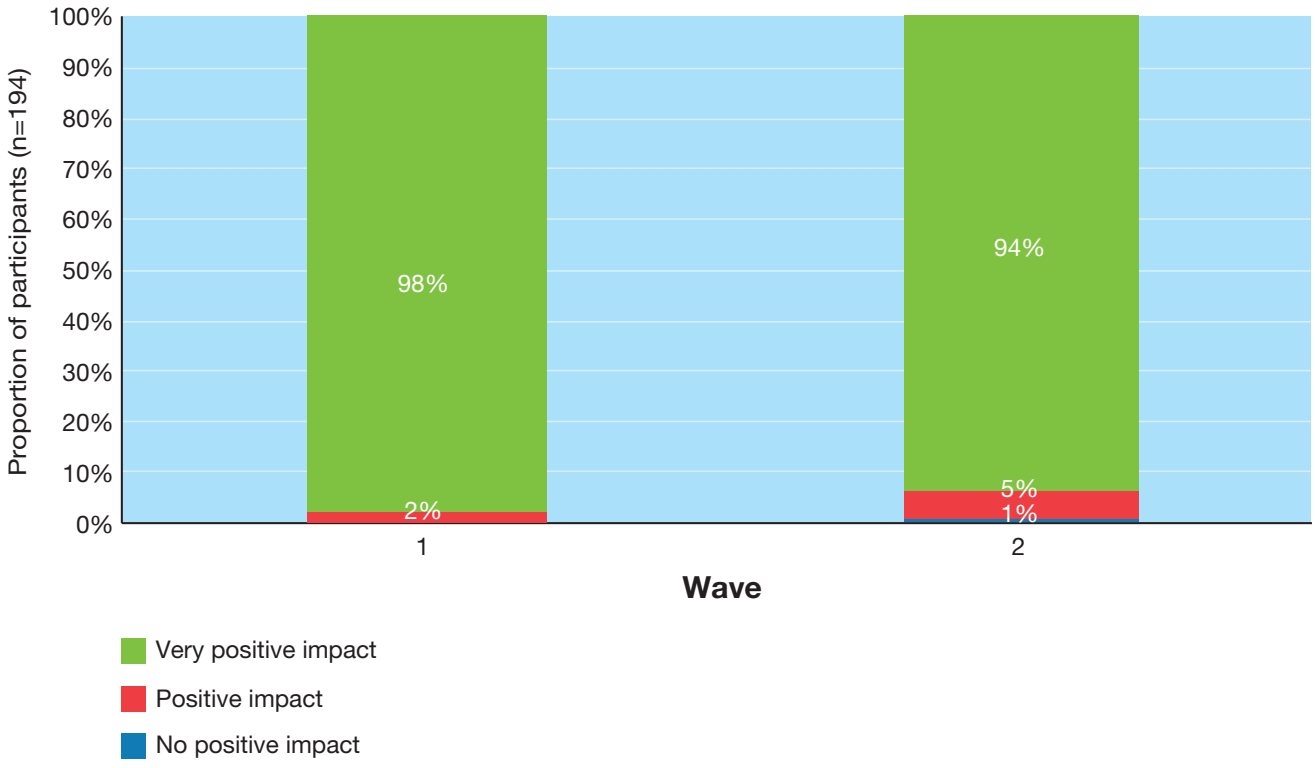
The second and third questionnaires asked participants to reflect on and to rate the impact that their participation in the programme has had on SHP practices in their work. Participants had to rate the impact of the programme on a scale of 0 to 10. A rating of 0 indicated that there had not been any positive impact and a rating of 10 indicated that the impact had been very positive. For the purposes of this report, scores of 0 to 3 have been categorised as 'no positive impact', 4 to 6 as 'positive impact' and 7 to 10 as 'very positive impact'.

The findings show that while 80% of participants were of the view on completion of the training course that the FPSHP had had a very positive impact on their SHP practices, this proportion had decreased by 16 percentage points to 64% six months later.

Table 73: Ratings of the positive impact on SHP practice

Rating	Wave 2	Wave 3
No positive impact	0% (n= 0)	1% (= 1)
Positive Impact	2% (n= 3)	5% (n= 10)
Very positive impact	98% (n= 191)	94% (n= 183)

Figure 7: Overview of participants' self-reported views on the impact of the programme on their work (at wave 2 and 3)



9.7 Chapter summary

The data in this chapter reveals the views of FPSHP participants about the programme. There were high levels of satisfaction across all measured aspects of the programme, with the vast majority of participants reporting that the programme had been very helpful regarding the development of their skills. The results indicate great optimism on the part of participants regarding sustaining changes to their work practices made as a result of their participation in the programme, and a majority also reported that the FPSHP had had a positive impact on their work, although the size of this majority had declined six months later. When asked specific questions about the culture of their workplace and whether it supports the delivery of SHP in practice, the results were less positive.

Chapter 10: Conclusion

10.1 Discussion and conclusion

This evaluation report has been informed by data collected from 194 participants between September 2016 and August 2018 across fourteen different FPSHP courses, using a customised evaluation tool. The aim was to understand how the FPSHP performs as a national programme in relation to the core metrics that have been developed in line with the course objectives. The large number of participants enabled statistically robust analysis and testing for significance, which has allowed inferences to be drawn with a level of statistical confidence about their accuracy.

The FPSHP participants were from a mix of employment backgrounds and represented a diverse range of professionals from social work, community development, health and education sectors. This composition is in line with the evaluation's recruitment aims.

The evaluation identified significant improvements following FPSHP participation across a number of measures related to the aims of the programme. These included increases in the number of participants who reported: feeling more confident to deliver SHP activities; having greater levels of knowledge about a range of sexual health topics; having more skills with regard to SHP activities; and feeling comfortable discussing a range of sexual health topics. These increases tested as statistically significant, with a confidence interval of 95%, which implies that there is a high probability that the increases are related to the programme as opposed to occurring by chance. The findings confirm, with a degree of certainty, that the programme has been successful in achieving its aims with the participants. These aims have been identified in the research literature as core aspects of SHP training for professionals.

The data is less definitive, however, in terms of whether the FPSHP is achieving its overarching objective of enabling participants to integrate SHP into their core work. The data shows marginal to moderate increases in the number of participants who reported engaging in a range of SHP activities following completion of the training. These increases were not statistically significant. It was also the case that six months after the programme, large proportions of participants reported 'never or rarely' engaging in many of the specified SHP activities that were measured. This finding is in contrast to participants' perceptions of the impact of the programme on their practice. Six months after completion of the programme, the majority of participants reported that the programme had had a very positive impact on their practice, notwithstanding a decrease in the size of this majority between wave 2 and wave 3, and high numbers anticipated that they would sustain changes in their practice.

In terms of satisfaction and helpfulness, participants reported a very positive perception of the programme. The high levels of full attendance also reflect the popularity of the FPSHP, as adhering to a ten-day programme can be a considerable commitment for busy professionals.

The participants' views on how helpful their own employer organisation's culture is with regard to supporting SHP were less positive. Participants reported mixed results on the helpfulness of a range of factors linked to their organisations. Some areas of work practice/culture were found not to be helpful in the delivery of SHP by a significant minority of participants. These included issues relating to financial resources, the presence (or absence) of an organisational policy on SHP and the limited availability of time and physical space.

The evaluation findings provide good evidence that the FPSHP has been successfully and efficaciously rolled out in new locations across the country and offer valuable insights into how it is impacting on participants. They suggest that the programme is succeeding in upskilling participants and increasing their comfort and confidence in delivering SHP activities as part of their professional roles. It is clearly meeting its aims at the individual level. It is also very popular with participants, who attend well and report high levels of satisfaction with the programme and perceive it as helpful.

However, the data also reveals that improvements in terms of the delivery of SHP activities are quite moderate, with many participants reporting that they still had not undertaken certain activities. This finding suggests that the programme is less effective at the organisational level. Some of the factors that may be inhibiting participants' ability to deliver SHP in practice beyond the remit of the training programme were identified in this evaluation but were not explored in depth. It should also be noted that while the perceived positive impact on SHP activities is high on completion of the programme, this drops back to some degree six months on.

The evaluation findings indicate that although the FPSHP has a significant impact on participants' ability to deliver SHP services, it may be insufficient in itself to bring about the required impact on their practice. Additional supports at organisational level may be required so that participants can translate their awareness, knowledge and skills into SHP activities within their work settings.

10.2 Implications for practice

The findings from this evaluation have been taken into account in the development of the SHCPP's Sexual Health Promotion Training Strategy 2019–2029. This strategy sets out a ten-year plan for building the SHP capacity of individuals and organisations working in the areas of health, education, community and youth work, so that they can better support their clients to achieve their optimum sexual health. Key actions in this strategy are to support

relevant employers to develop their in-house SHP training and to engage with HSE disciplines and other organisations to encourage the integration of SHP into their work. On a strategic level, the implementation of these actions will support the development of more supportive organisational cultures, which in turn will overcome some of the factors that may be currently inhibiting FPSHP participants from implementing their learning more extensively.

In the shorter term, the FPSHP national coordinator and facilitators may wish to take the following actions:

- Examine the findings of this evaluation and consider how to maintain the identified benefits of the FPSHP while simultaneously developing additional measures to improve the organisational environments in which FPSHP participants operate. The solution may involve decisions about the deployment of available resources for optimum effect.

- Consider engaging with FPSHP past participants to reflect on the findings of this evaluation and to explore the seeming discrepancy between some of the responses in relation to practice, the identified barriers to SHP implementation in the workplace, and possible interventions/activities to overcome the difficulties encountered.

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